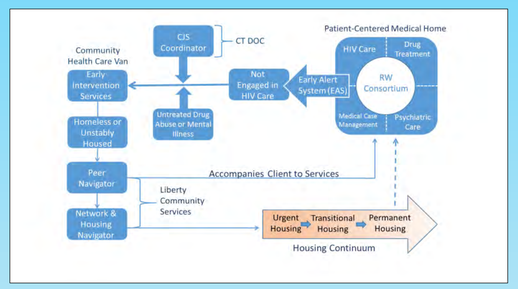
# Project mHEALTH^

# Yale University – Liberty Community Services – CT Department of Correction

## ^Medical Home Engagement and Aligning Lifestyles and Transitions from Homelessness

## Model description

- Patient-centered medical home without walls in New Haven
- Providing primary care, behavioral health, case management, and housing services
- Mobile medical clinic is main hub for services
- Collaborate with Liberty Community Services (housing provider) and CT Department of Correction

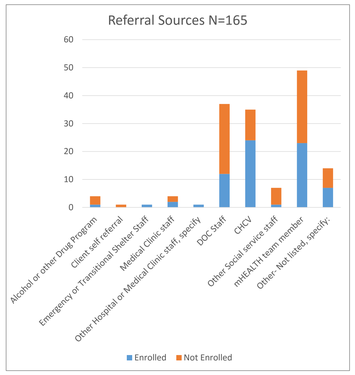



## Results (n=79)

- Average age 48 years
- 61% Male
- 60% Black
- 27% Hispanic
- 99% Retention at 6 months
- 90% Retention at 12 months
- 53% Homeless for more than 1 year
- Average length of homeless: 10 years
- 96% ever been in jail
- 86% ever been in prison

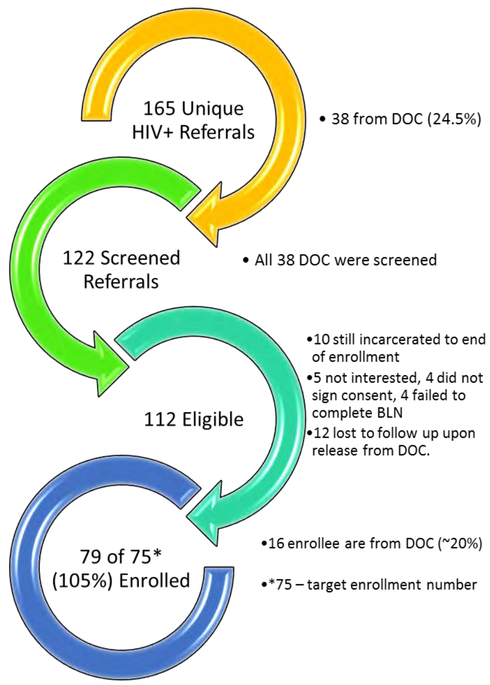
**Outcomes:**

- 75% Virally suppressed at 6 month
- 75% Housed at 18 months


| Baseline Characteristic | (N=79) |
|---|---|
| Age (mean (STD)) | 47.9 (10.0) |
| Gender | |
| Male | 48 (60.8%) |
| Female | 26 (32.9%) |
| Trans M->F | 4 (5.1%) |
| Trans F->M | 1 (1.3%) |
| Race | |
| Black/African American | 47 (59.5%) |
| White | 17 (21.5%) |
| Other | 15 (18%) |
| Hispanic or Latino | 21 (26.6%) |
| Ever Been in Jail | 76 (96.2%) |
| Jail Past Year | 40 (52.6%) |
| Ever Been in Prison | 68 (86.1%) |
| Prison Past Year | 32 (47.1%) |
| Current Housing Status | |
| First time homeless in past 3 years | 19 (24.1%) |
| 2-3 episodes in past 3 years | 12 (15.2%) |
| At least 4 episodes in past 3 years | 6 (7.6%) |
| Continuously homeless or unstably housed for a year or more | 42 (53.2%) |
| On Medicaid Insurance | 69 (87%) |
| Education Less than High School | 37 (47%) |
| Employment status | |
| Not Working | 43 (54.4%) |
| Disabled/Retired | 34 (43%) |
| Where stayed last night: | |
| Doubling up (staying with friends or family, couch surfer) | 28 (35.4%) |
| Transitional housing or residential treatment program | 23 (29.1%) |
| Shelter | 11 (13.9%) |
| Other (street, car, hospital, rehab center) | 17 (21.6%) |
| Average length of time being homeless | 9.8 years |
| Length of Time Since Had Housing for 1 Year or more | 69 (87.3%) |
| Three top reasons for becoming Homeless | |
| Drug or Alcohol Addiction | 60 (75.9%) |
| Unable to Pay Rent/Mortgage | 39 (49.4%) |
| Incarceration | 35 (44.3%) |
| Health care Utilization | |
| Average time living with HIV | 17.6 Years |
| Has a health-care provider | 74 (94%) |
| Seen a health-care provider in past 12 months | 73 (92%) |
| Mean ER visits last 6 months | 2 |
| Mean ER visits for Mental Health last 6 months | 1 (n=40) |
| Case management | |
| Has a case manager | 55 (69.6%) |
| Has an HIV case manager | 43 (78.2%) |
| Has a housing case manager | 11 (20%) |
| Risk factors | |
| Ever injected drugs | 42 (53.1%) |
| CESD score greater than or equal to 10 | 53 (67.1%) |
| VR-12 mean PCS (STDV) | 41.6 (11.4) |
| VR-12 mean MCS (STDV) | 38.4 (14.5) |

## Findings




Preliminary Results for VL suppression (<200)

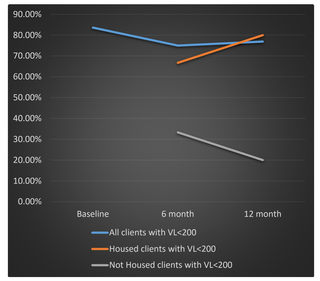
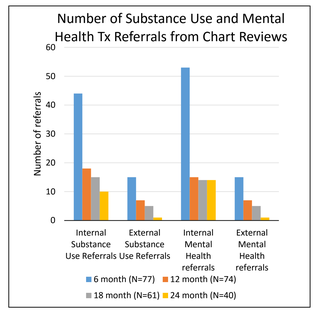
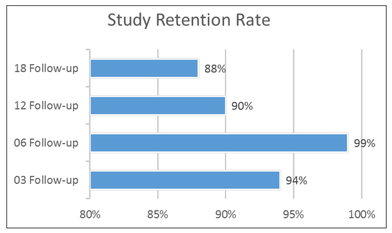
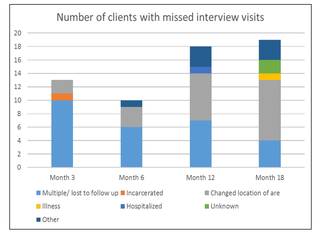
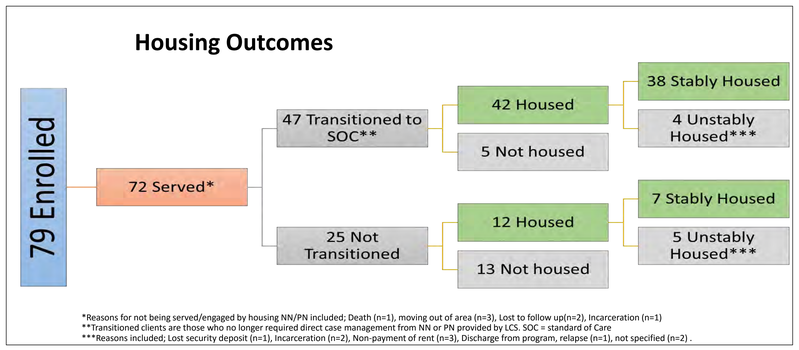



Chart Review Data since enrollment (N=76):
* 73 clients with Mental Health Diagnosis
  → 44 Depression Diagnosis
  → 8 Anxiety Diagnosis
  → 25 Mood Disorder Diagnosis
* 66 clients with Substance Use Diagnosis




*Reasons for not being served/engaged by housing NN/PN included; Death (n=1), moving out of area (n=3), Lost to follow up(n=2), Incarceration (n=1)
**Transitioned clients are those who no longer required direct case management from NN or PN provided by LCS. SOC = standard of Care
***Reasons included; Lost security deposit (n=1), Incarceration (n=2), Non-payment of rent (n=3), Discharge from program, relapse (n=1), not specified (n=2) .

## Challenges

- Complex clients with multiple needs: mental illness, substance use disorders, criminal justice history, homeless, living with HIV
- HUD definitions of chronic homelessness, including considering incarceration as "housing"
- Difficult to engage clients in care
- Multiple competing needs (eg, keeping medical appointments, filling prescriptions, adherence to medication regiments)
- Relapse to drug/alcohol use
- Reincarceration
- Lack of social support

## Successes

- Built relationship with housing provider, Liberty Community Services
- Enhanced collaboration with CT Department of Correction
- Leveraged personal community relationships to access care
- Initiated electronic medical record for comprehensive patient care
- Engaged clients in HIV care
- Successfully housed 54 clients
- Near perfect retention rates
- Continuation of program despite reincarceration

## Sustainability

- Additional grant support from SAMHSA
- Initiated billing for primary care and behavioral health services
- Maintained relationships with Ryan White Continuum providers
- Leveraged funding for creative housing solutions

## Acknowledgments

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| | N (%) – average# referrals |
|---|---|
| Internal Substance Abuse Treatment Referral | 35 (64%) - 5 |
| External Substance Abuse Treatment Referral | 12 (22%) - 3 |


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| # of clients with reported | N (%) – average# referrals made |
|---|---|
| Internal Mental Health Treatment Referrals | 42 (76%) - 3 |
| External Mental Health Treatment Referrals | 16 (29%) - 3 |
| Prescribed Psychiatric Medication in past 6 months | 37 (67%) |

| | Prior to enrollment (N/average) | Post enrollment (N/average) |
|---|---|---|
| CD4 count | 44/563 | 51/575 |
| VRL count | 30/4918 | 47/2667 |

| | Accessing care past 6 month (N/ average # visits) |
|---|---|
| HIV primary care medical visits | 54/4 |
| Case management visits | 55/2 |

| # of clients | N (%) |
|---|---|
| Screened for HCV | 54 (98%) |
| Prescribed prophylaxis since enrollment | 8 (15%) |
| Prescribed ART past 6 months | 51 (93%) |
| With ER Visit Documented in Chart | 32 (58%) |
| With In-Patient Hospital Stay Documented in Chart | 22 (40%) |