



Welcome!

June 27, 2017

An article describing this meeting can be found at:

<http://cahpp.org/HRSA-meeting-2017-06-27>

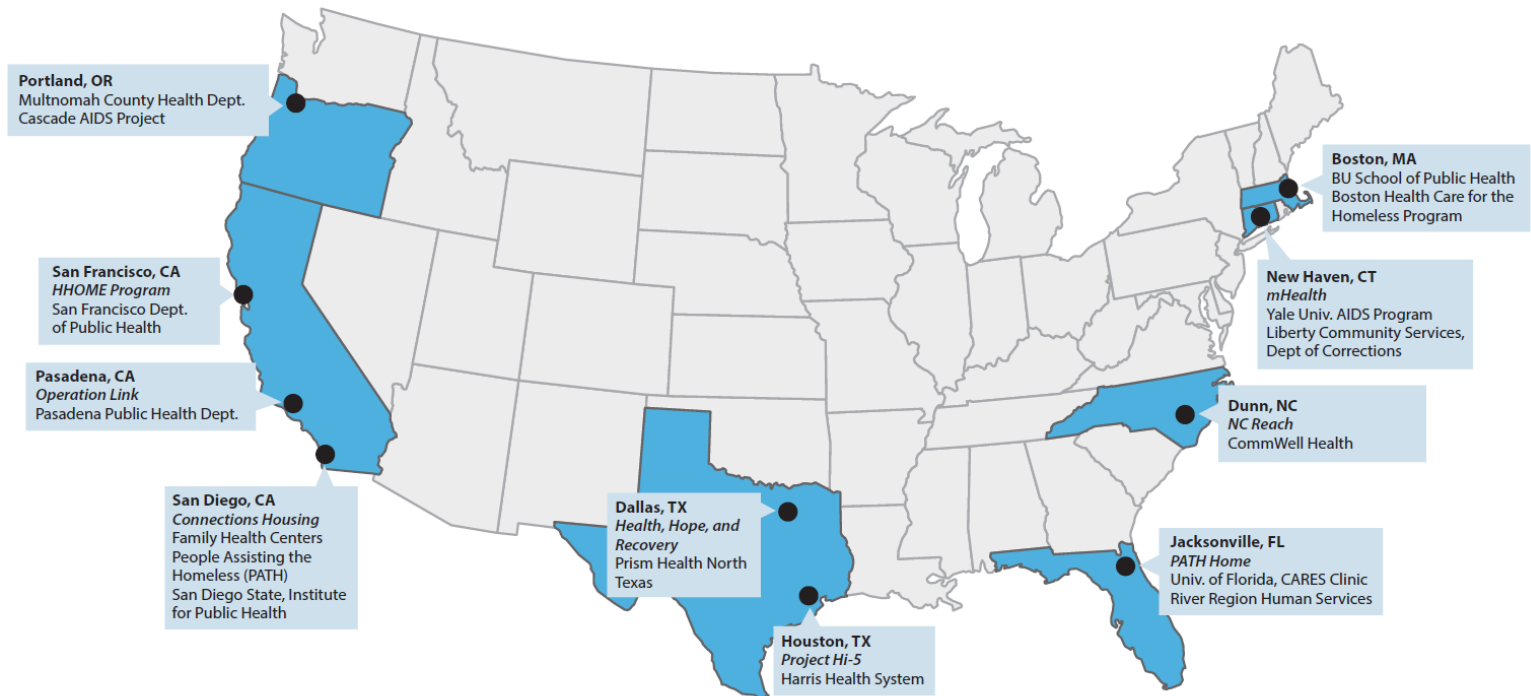


HRSA/SPNS Initiative: Building a Medical Home for Multiply Diagnosed HIV-Positive Homeless Populations

June 27, 2017

Goal: For people who are living with HIV, experiencing homelessness/unstable housing, and also have a mental illness and/or substance use disorder:

- Increase engagement and retention in HIV primary care
- Improve viral suppression rates
- Obtain stable housing



Focus Population

- Persons living with HIV/AIDS who are 18 years of age or older;
- **AND** are experiencing homelessness or unstable housing
 - Literally homeless,
 - Unstably housed,
 - Fleeing domestic violence;
- **AND** have one or more co-occurring mental health and/or substance use disorders

Program Model

- Patient-centered medical home (PCMH) framework
 - Comprehensive, coordinated, accessible quality care

Program Model

- Patient-centered medical home (PCMH) framework
- “Move beyond the clinic walls.”

“The ultimate goal is for people to be in a four-walls health center, which is the optimal best place for any human to be, to get their primary care...But for clients who cannot get their care in a four-walls clinic, how do we take the meat out of the walls of the clinic and create a mobile and accessible clinic? And that’s been the goal of the project.”

*– Deborah Borne, MD
Primary Investigator at HHOME-SFDPH*

Program Model

- Patient-centered medical home (PCMH) framework
- “Move beyond the clinic walls.”
- Integrated behavioral health and HIV primary care
 - Flexible, open access
 - Team communication/huddles

Program Model

- Patient-centered medical home (PCMH) framework
- “Move beyond the clinic walls.”
- Integrated behavioral health & HIV primary care
- Network navigators (aka, care coordinators, peer navigators, specialized case managers, service linkage workers)
 - Not traditional HIV medical case managers
 - Key member of the health care team

“My understanding is SPNS kind of really tries to keep people engaged in the medical piece, but they also kind of feel like the glue that really connects the medical piece to the housing piece.”

- Multnomah County Health Department Case Manager

Program Model

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- System level coordination (housing, health, mental health, substance use treatment providers)

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- System level coordination (housing, health, mental health, substance use treatment providers)
- Partnering with housing providers and landlords

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- Integrated behavioral health & HIV primary care
- Network navigators (aka, care coordinators, peer navigators, specialized case managers)
- System level coordination (housing, health, mental health, substance use treatment providers)
- Partnering with housing providers and landlords
- Reuniting with families

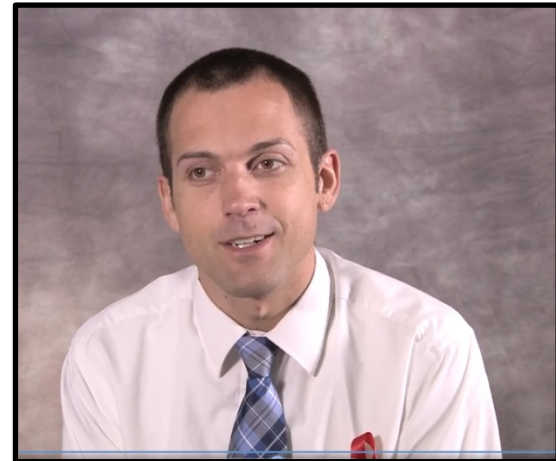
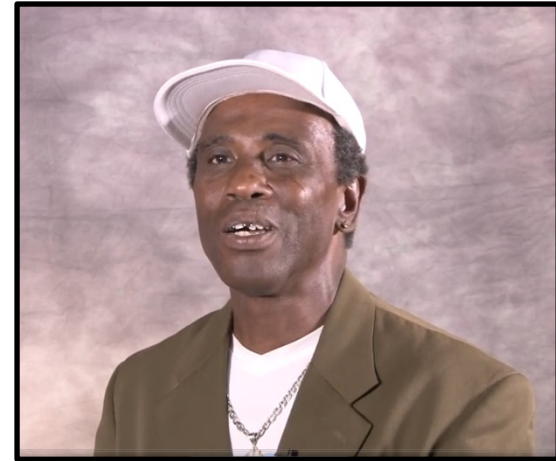
SPNS Participants

- 1,332 clients served
 - 62% literally homeless
 - 37% unstably housed
 - 1% fleeing domestic violence



SPNS Participants

- 1,332 clients served
- Gender
 - 75% Male
 - 21% Female
 - 4% Transgender
- Race/Ethnicity
 - 47% African-American/Black
 - 17% Hispanic
- Average (SD) years experiencing homelessness: 6.4 (8.4)



SPNS Participants

Characteristics	%
Incarceration history	81%
Diagnosed mental health condition*	75%
Experienced sexual assault	40%
Experienced physical injury	44%
Illicit substance use, ever	
High risk (dependence)	24%
Moderate risk (problem)	78%
Food insecure, past 30 days	59%
Out of care, 6+ months	32%
Experienced HIV stigma, ever	>50%

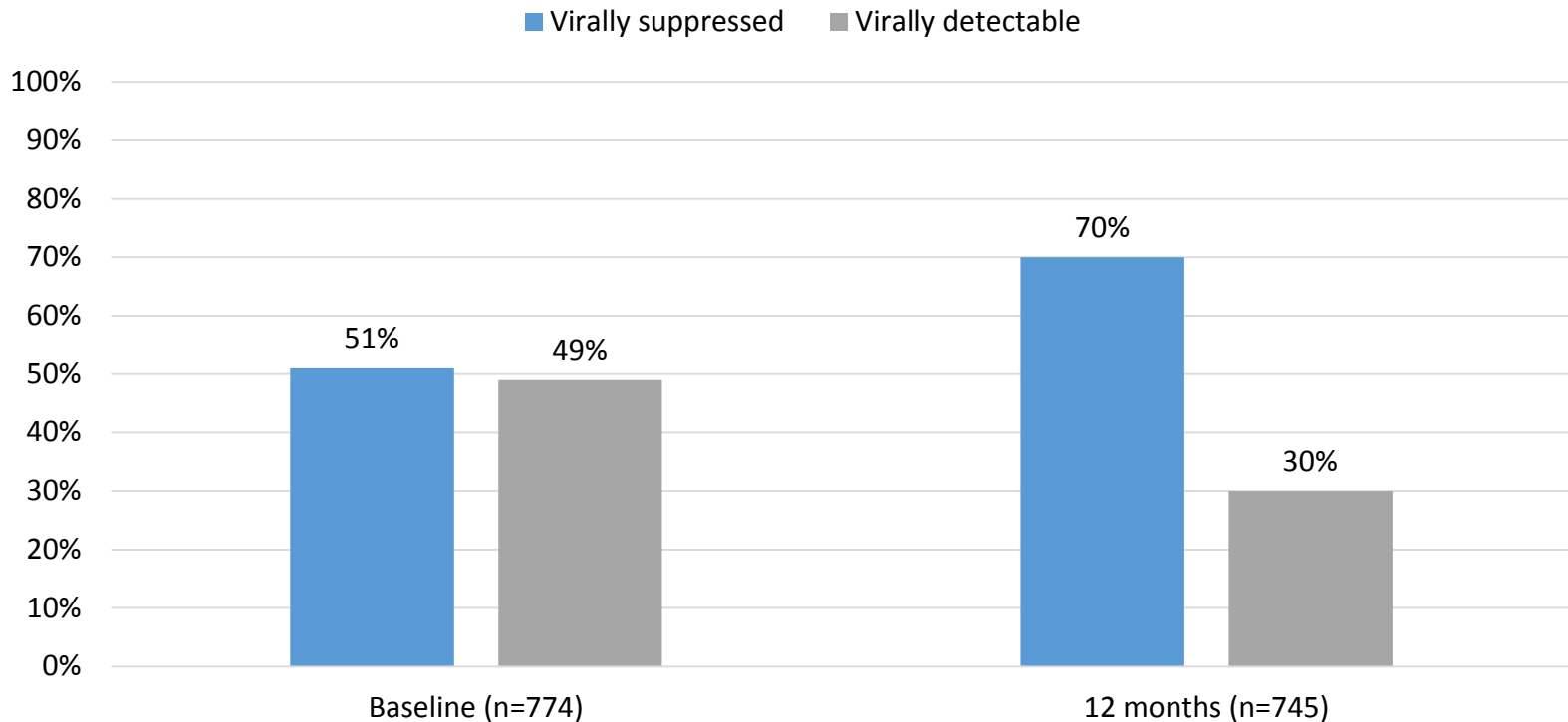


*Includes depression, anxiety, schizophrenia, and PTSD

Findings from the Multisite Evaluation Study, 2013-2017

(N=909)

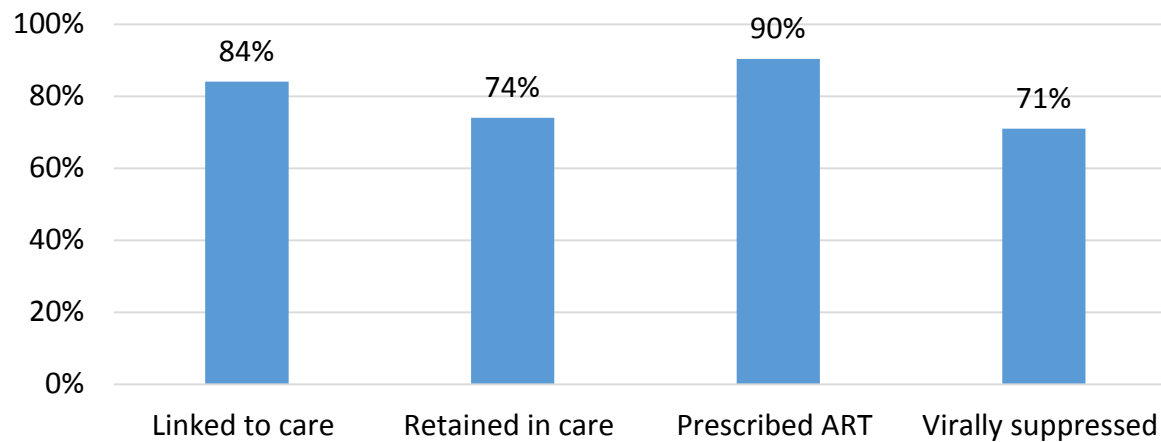
Changes in Viral Suppression



* Lowest VRL Prior to Enrollment (<200 copies/mL), 180 days prior to enrollment to 30 days post enrollment

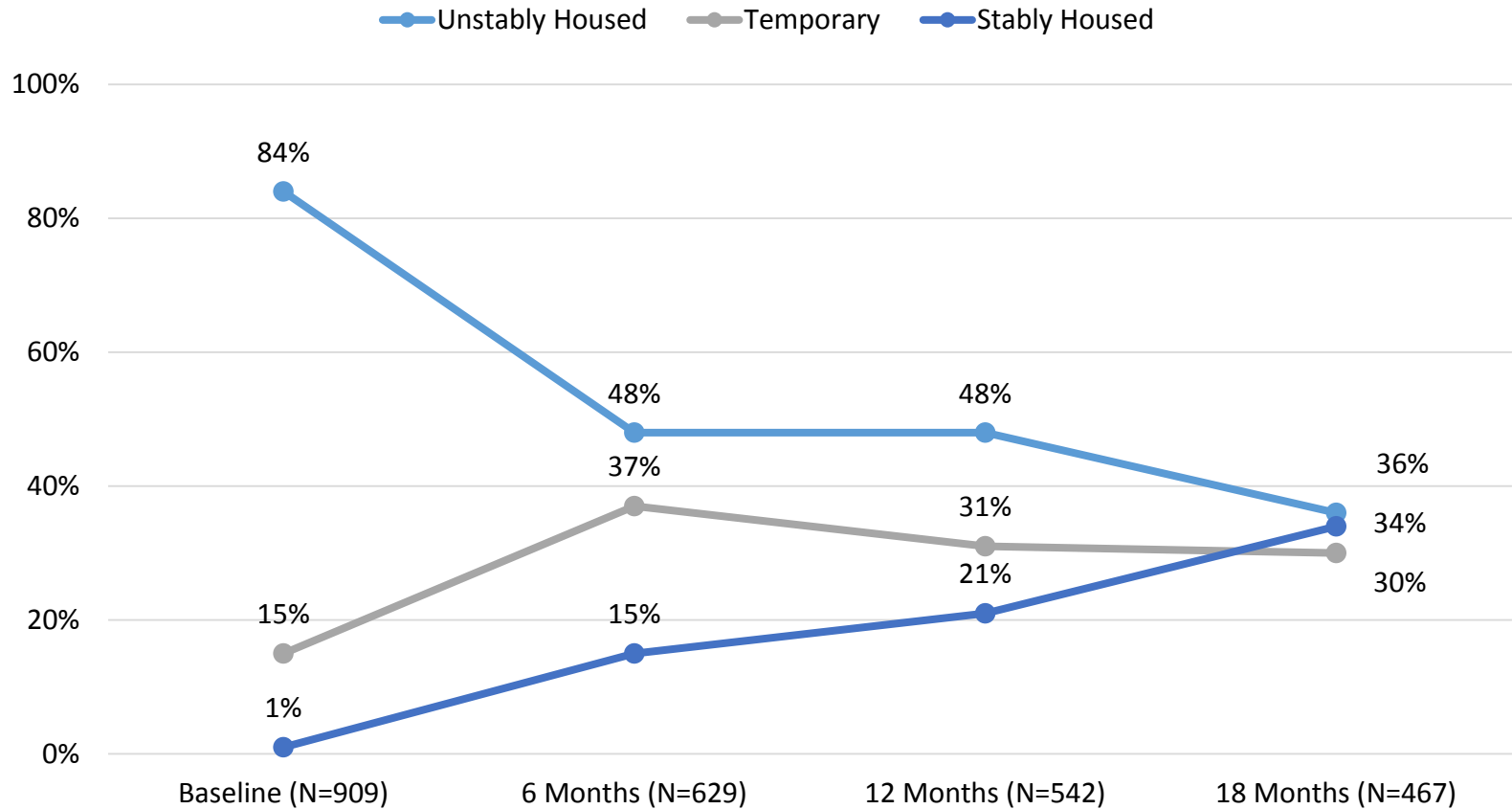
** Most recent VRL Load (<200 copies/mL) in post 12 month period** 30 to 395 days post enrollment

HIV Care Continuum (N = 334)

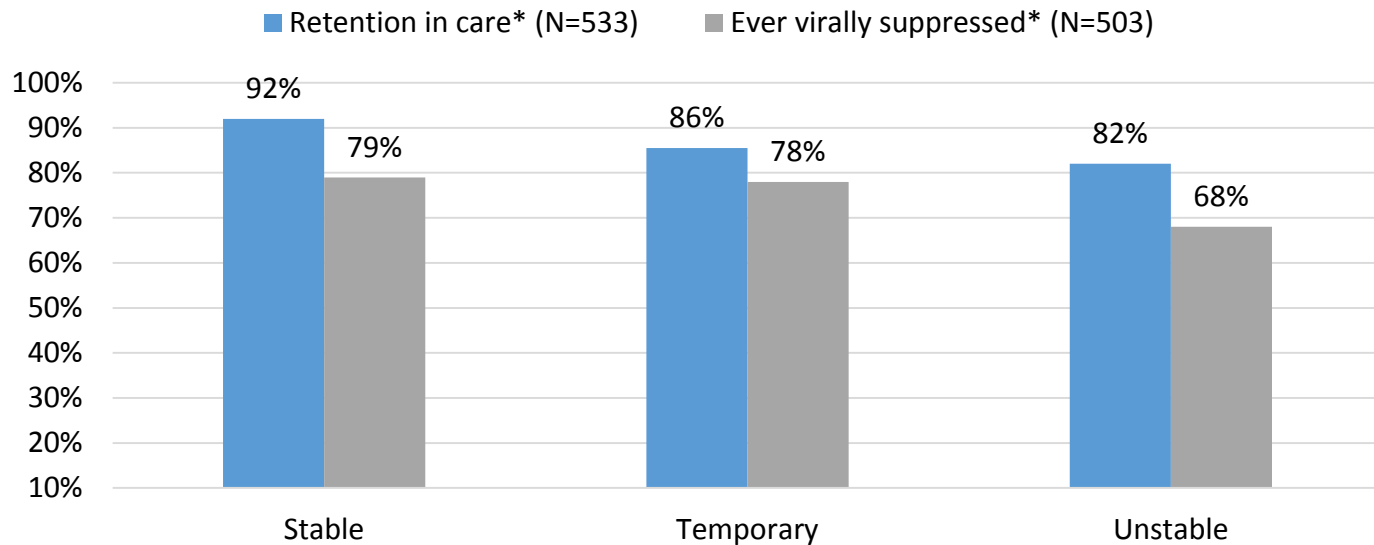


- **Linked to care:** Person out of care for at least 6 months or newly diagnosed at enrollment and connected in 90 days
- **Retention in care:** 2 HIV medical visits 90 days apart in 12 month period
- **Viral suppression (n=290):** Most recent lab test in a 12 month period, <200 copies/mL

Changes in Housing Status



Retention in Care and Viral Suppression by 12-month Housing Status



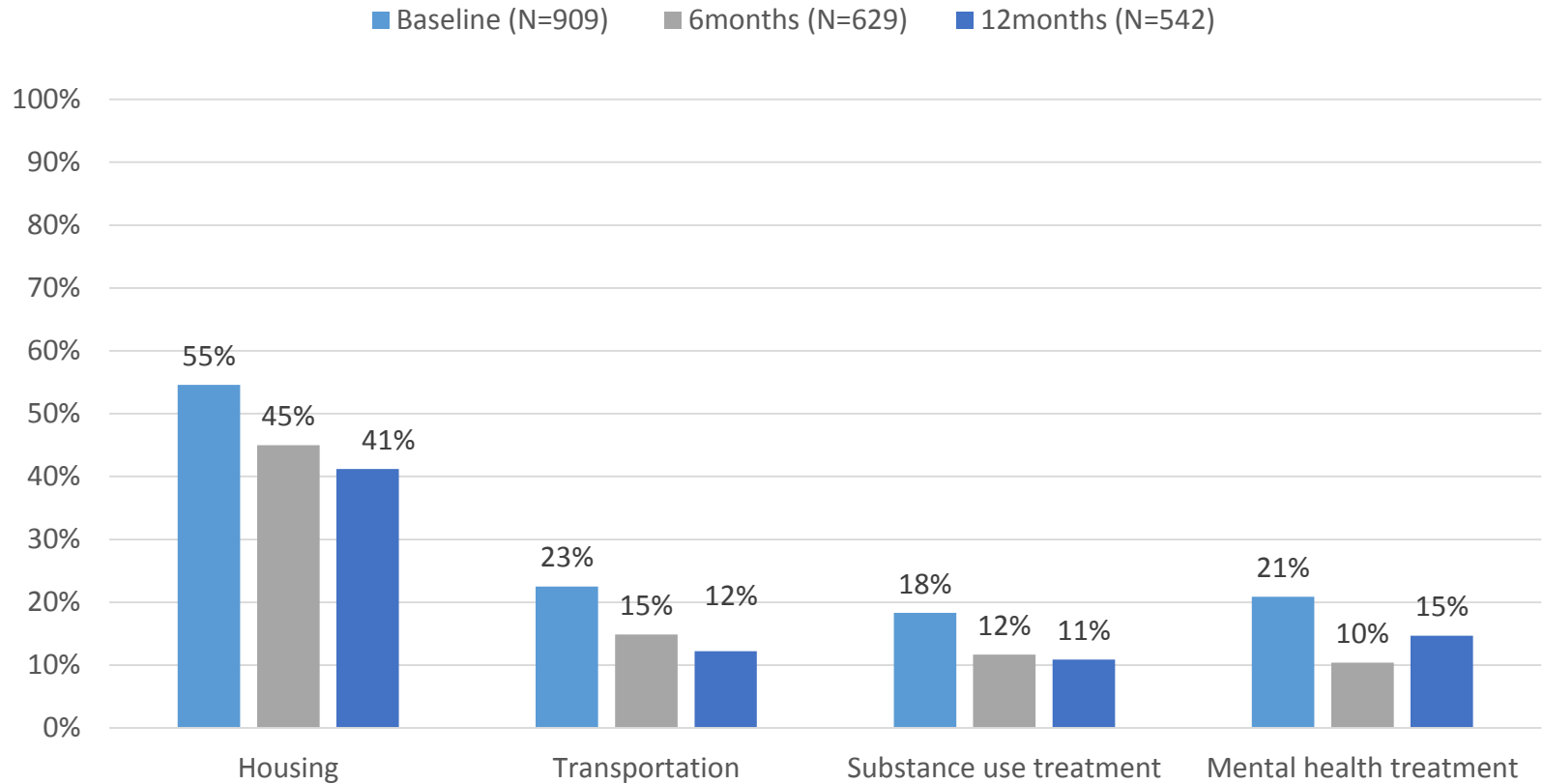
- **Retention in care:** 2 visits 90 days apart in 12 months, *p=.03
- **Viral suppression:** Most recent lab test virally suppressed <200 copies/mL post 12 months enrollment, p=.06

Changes in Employment Status

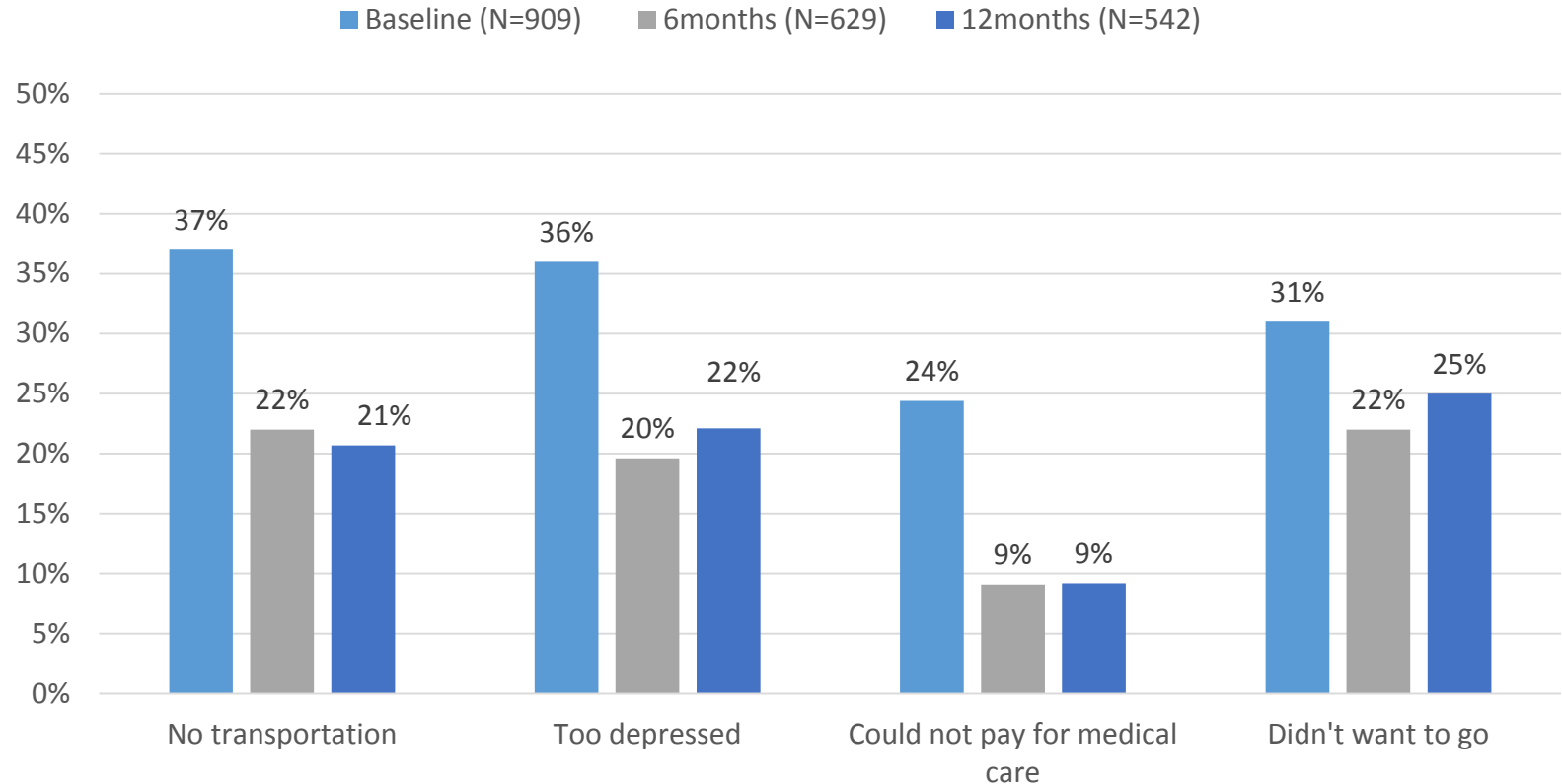
Employment status	Baseline (N=909)	Post 6 months (n=629)	Post 12 months (N=542)
Yes, employed*	12.4%	21.0%	23.0%
SSI/Retired	13.7%	16.9%	18.4%
No, not employed	73.5%	61.8%	58.6%

*Defined as working full time, part time, or occasionally

Reduction in Unmet Needs



Reduction in Barriers to Care



Intervention Dose

- 38,760 encounter forms
- 40 encounters per participant
- Length of time in the intervention: 18 months
- Average active case load size: 20-30 clients per intervention staff



Study Retention

- No differences in persons retained/not retained in the study.
 - Gender
 - Education
 - Incarceration history
 - Insurance status
 - History of physical or sexual trauma
 - Years living with HIV
 - Depression
 - Substance use
 - Quality of life
- People who were literally homeless and persons from racial/ethnic minority communities less likely to be retained post enrollment

Summary

- Promising findings:
 - Increased retention in care and viral suppression rates even for persons still experiencing unstable housing
 - Reduction in unmet needs and barriers to care
 - Substance use treatment
 - Mental health care
 - Housing
 - MOBILE, INTEGRATED, INTENSIVE CARE
 - Coordinating providers across the system level
 - Multidisciplinary care teams
 - Intensive one-on-one activities with individuals



Panel 1:

Models of Building a Medical Home for PLWH who Experience Homelessness

Carole Hohl, Boston Health Care for the Homeless Program

Sandy Sheble-Hall, Boston Health Care for the Homeless Program

Kendall Guthrie, UF Cares, Kristin Barrett, RRHS

Lisa McKeithen, CommWell Health, Inc.

Ruthanne Marcus, Yale University School of Medicine

Patient Centered

- Create a medical clinic in a behavioral health and housing program
- Provide transportation to scattered marginally housed people
- Take the clinic to where the patients are



UNIVERSITY of
FLORIDA

University of Florida Center for
HIV/AIDS Research, Education
and Service (UF CARES)



RIVER REGION
Human Services, Inc.

PATH HOME

Partnership for Access to Treatment and
Housing

*A Collaborative Partnership of
UF CARES, River Region Human Services*

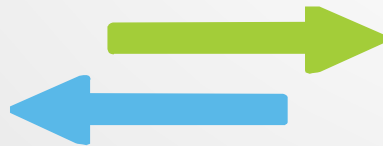


Jacksonville, Florida

- Largest City in the State in the contiguous United States by area.
- Jacksonville is currently ranked **NINTH** in the nation for the number of new HIV cases. (2016 Study from Emory University)
- The population within the Metropolitan City Limits is 827,908.
- Total population of Jacksonville is 1,345,596 according to the 2010 Census

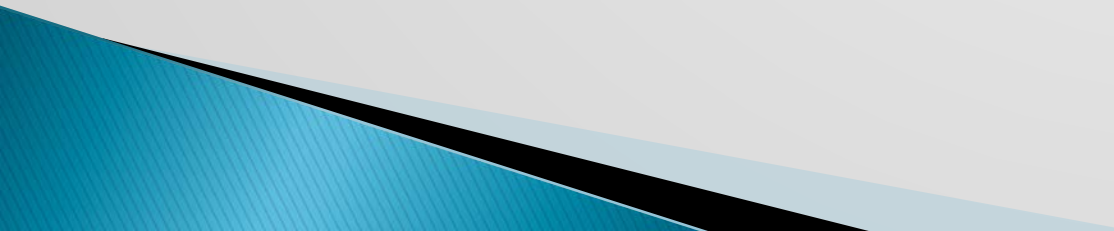
What is a PATH Home?

It is a collaboration that addresses both social and medical needs including barriers to care in order to create a means of access to a medical home.



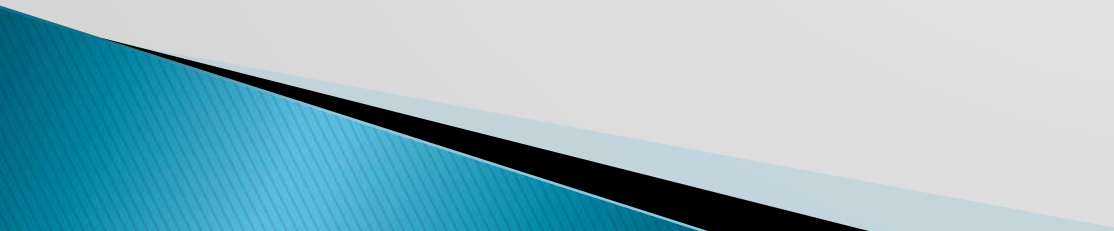
MODEL DESCRIPTION

UF CARES, a NCQA recognized Level 3 Patient Centered Medical Home (PCMH), in partnership with River Region Human Services, one of the area's largest providers of Housing, Mental Health and Substance Abuse services developed a patient centered medical home model for individuals who are HIV+, homeless, and have mental health and/or substance abuse needs.



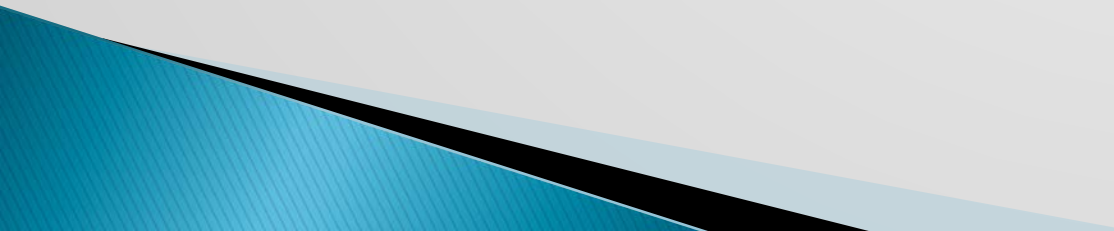
Integrated and Co-located

Integral to this model is the co-location of HIV primary care clinic within a behavioral & substance abuse treatment facility; this enables patients to enter the primary care system via behavior health/substance abuse pathways.



Robust patient centeredness is an important program GOAL

The model consists of a centrally located facility in Jacksonville, Florida, accessible to public transportation, where each patient receives Primary Care, Specialty care, Case Management, Mental Health, Substance Abuse and Nutrition Services all in one location; a single Point of Care facility.



- The medical home design will revitalize primary care by improving the efficacy of our efforts. We work to understand the landscape of homelessness in Jacksonville, FL and how to address it.
- This means going to where they are with a team prepared to provide the highest quality care.
- The medical home....is just better care, helping patients really feel so much better when they leave that they can't wait to come back.



Successes

One of the major successes of the PATH Home intervention consists of the exemplary intensive case management and peer navigation model used.

n Clinical C

On average, comprehensive case managers conducted 8 encounters per month (HIV related encounters) and 4 housing encounters (first 12 months data only);

Data also showed that during these encounters, on average, 13 activities were conducted (examples include linkage & retention in medical care, assistance with mental health or substance use treatment, housing, legal educational & emotional coaching, employment, etc.)

Challenges

Challenges brought forward opportunities for change. Here are some of the challenges encountered:

- ▶ Strong partnership put to test during rapid turnover
- ▶ Shifts in transportation policy
- ▶ Intensive case management continuum

Outcomes

- ▶ During the course of the project 103 patients were enrolled in the multisite evaluation; PATH Home served 167 patients altogether.
- ▶ Almost half of the PATH Home patients (49%) transitioned to standards of care.
- ▶ New partnerships (River Region Human Services, Gateway Community Services, and Ability Housing) were forged over the course of this intervention. As a direct result of this project, a new satellite medical clinic at Gateway Community Services is established.

Next Steps

Use the results of this project as a basis to influence change in the intensive case management policy landscape in the Jacksonville Transitional Grant Area (JTGA).

Pursue funding to replicate success of PATH Home by cultivating a city-wide, sustainable, coordinated model among HIV clinical care, housing, employment, substance abuse/mental health and legal aid partners.

Create momentum for local and regional HIV clinicians, behavioral health & substance abuse partner organizations, local housing agencies, etc., to discuss collectively on contingency of local response and integration of services.



Lessons from SPNS: Innovative Strategies for Coordinating Health and Housing

Lisa McKeithan, MS, CRC

Principal Investigator & Project Manager

CommWell Health



CommWell Health



Mission: Compassionate Delivery of Quality Medical, Dental and Behavioral Health for all

Vision: To be recognized and respected as a premier Community Health Center in the Nation

Accreditations: Primary and behavioral health care services by Joint Commission (since 2000)
Federally Qualified Health Center

16 Clinics: Medical-Dental- Behavioral Health

2 Residential Treatment Centers

Counties served: Bladen, Sampson, Johnston, Lee, Harnett, Wake, Cumberland, New Hanover, Brunswick, Wayne, Robeson



Challenges (Rural)

- Housing Instability
 - Hidden Homelessness
- Transportation
- Coordination of BH services
- Stigma
- Underemployment and Unemployment
- Lack of available/affordable housing



NC REACH: SPNS Program at CWH



- Innovation
 - Build and maintain sustainable linkages to mental health, substance abuse treatment, and HIV/AIDS primary care services that meet the complex service needs and ensure adherence to treatment of HIV positive homeless or unstably housed individuals.
 - Network navigators
 - Behavioral health
 - Housing services
 - Comprehensive care coordination team (Positive Life Program)

Network Navigators

- Works closely with the HIV care team to foster culture of wellness
- Educates providers and staff about homelessness, medical literacy, and cultural sensitivity
- Coordinates and accompanies clients to BH services
- Builds partnerships in the community (formal and informal)
- Provides transportation/Rapport building
- Provides resources for supportive services to clients to maintain housing and reduce risky behaviors
- Serves as a liaison between the client and the landlords



Behavioral Health Integration

Team Communication/Weekly Huddles and Meetings with medical provider, BH, & SA counselors



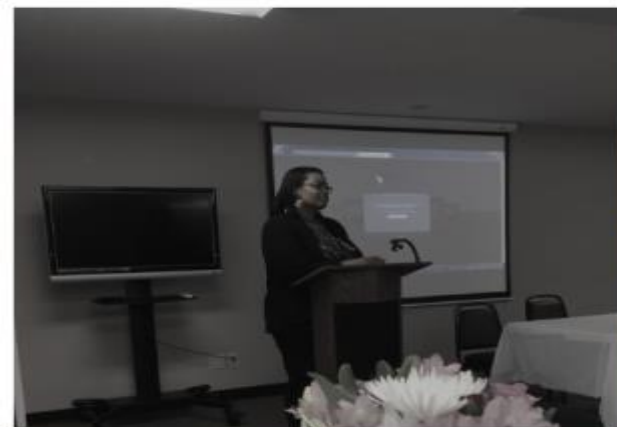
Successes

- Integration of HIV care and housing services in a coordinated intervention
- Reduction of duplication of services, unmet needs and barriers to care
- Community-based education about “hidden homelessness”, HIV, ART, prevention, discrimination and stigma
- Reconciliation with family members



Community Housing Coalition

(system level partnerships & referrals)



Results

- Total Enrolled : 80 clients
- VL Suppression: 83%
- Stably Housed: 75%
- Patients Transitioned to SOC: 74%
- Patients lost to follow up: 3%
- BH/SA Referral and Completed 1 Visit: 100%

Sustainability

- Incorporating the NN/CCC in future care strategies
- Maintaining community partnerships
- Community Housing Coalition Luncheon



- ❖ HRSA
- ❖ ETAC
- ❖ CommWell Health
- ❖ Positive Life
- ❖ SPNS
- ❖ Boston University
- ❖ Pillar Consulting
- ❖ UNC-CH

Thank you



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PROJECT MHEALTH MEDICAL HOME ENGAGEMENT AND ALIGNING LIFESTILES AND TRANSITIONS FROM HOMELESSNES

**YALE UNIVERSITY – LIBERTY COMMUNITY
SERVICES –
CONNECTICUT DEPARTMENT OF
CORRECTION**



Patient Centered Medical Home without Brick & Mortar

Primary Care

- HIV and HCV testing and treatment
- STI testing and treatment
- Glucose and BP screening
- TB screening
- Pregnancy testing
- Referral to specialty care
- Directly Observed Therapy
- PrEP

Behavioral Health

Removing Barriers

- Harm reduction philosophy
- Aggressive institutions of MAT
- Multiagency Coordinated Care Team
- Care based on developmental stages
- Urgent response to crises
- Integrated SA/MH/PCP care



CT Department of Correction

Housing Services

Creating Housing Solutions

- Maximizing resources
- Housing=Health
- Strong community leadership
- Collaboration
- Shared housing model
- 7-Day/week staff support
- Evening hours

Ryan White Continuum New Haven EMA

- Fairhaven Clinic
- Cornell Scott Hill Health Center
- AIDS Project New Haven
- Nathan Smith Clinic
- Haelen Center
- Yale Child Study Center

ACCESS

The CHCV is in
your
neighborhood

New Haven
is a
moderate
size city
(pop
130,000)

- Appointments recommended but walk-ins accommodated
- Clinicians keep cell phone access
- Staff training in cultural competency
- Clients engaged frequently via text, phone calls, email, or outreach
- Intervention staff use agency cars to transport to facilitate access
- Network and Peer Navigators work closely with Case Managers

Co-
location of
Primary
Care and
Behavioral
Health
Services

"Storefront"
is an
extension
of CHCV

"Storefront"
located
near
hospital, lab
services,
housing
services,
and drug
treatment
programs

BEHAVIORAL HEALTH



Mental Health

- SBIRT
- CBT/Motivational Interviewing
- Integration of psychiatry with addiction treatment
- Stronger relationship with Yale Psychiatry
- Improved continuum of care
- Referral to in-patient, IOP, crisis intervention, observation unit, ECT
- Transitions Reentry Clinic

Substance

Use Disorders

- Medication Assisted Therapies
 - Vivitrol
 - Suboxone
- APT Foundation referrals
 - MMT/Suboxone
- Counseling
- Referral to Recovery Programs
- NA/AA Support



CASE MANAGEMENT



Outreach & Engagement

- Ryan White providers
- Federally Qualified Health Centers
- Probation and Parole
- Drug treatment programs (e.g., Virginia Wells, Project More)
- Housing providers
 - New Reach
 - Columbus House
 - Grand Ave Shelter

Medical Case Management

- Liaison between provider and pharmacy
- Oversee DAART
- CADAP
- Husky
- SNAP/Food Stamps
- SSI
- Probation
- Primary Care Appointments
- Transportation
- Legal Services



HOUSING SERVICES – LEAVE NO “BRICK OR MORTAR” UNTURNED

- You must know:
 - the community
 - the eligibility requirements
 - the housing models
 - landlords
 - funding sources
- You must be involved in the systems – CAN, Continuum, etc.
- Relationships are everything

- Maximize resources
- Housing=Health
- Strong community leadership
- Collaboration
- Nontraditional operating hours
 - 7-Day/week staff support
 - Evening hours

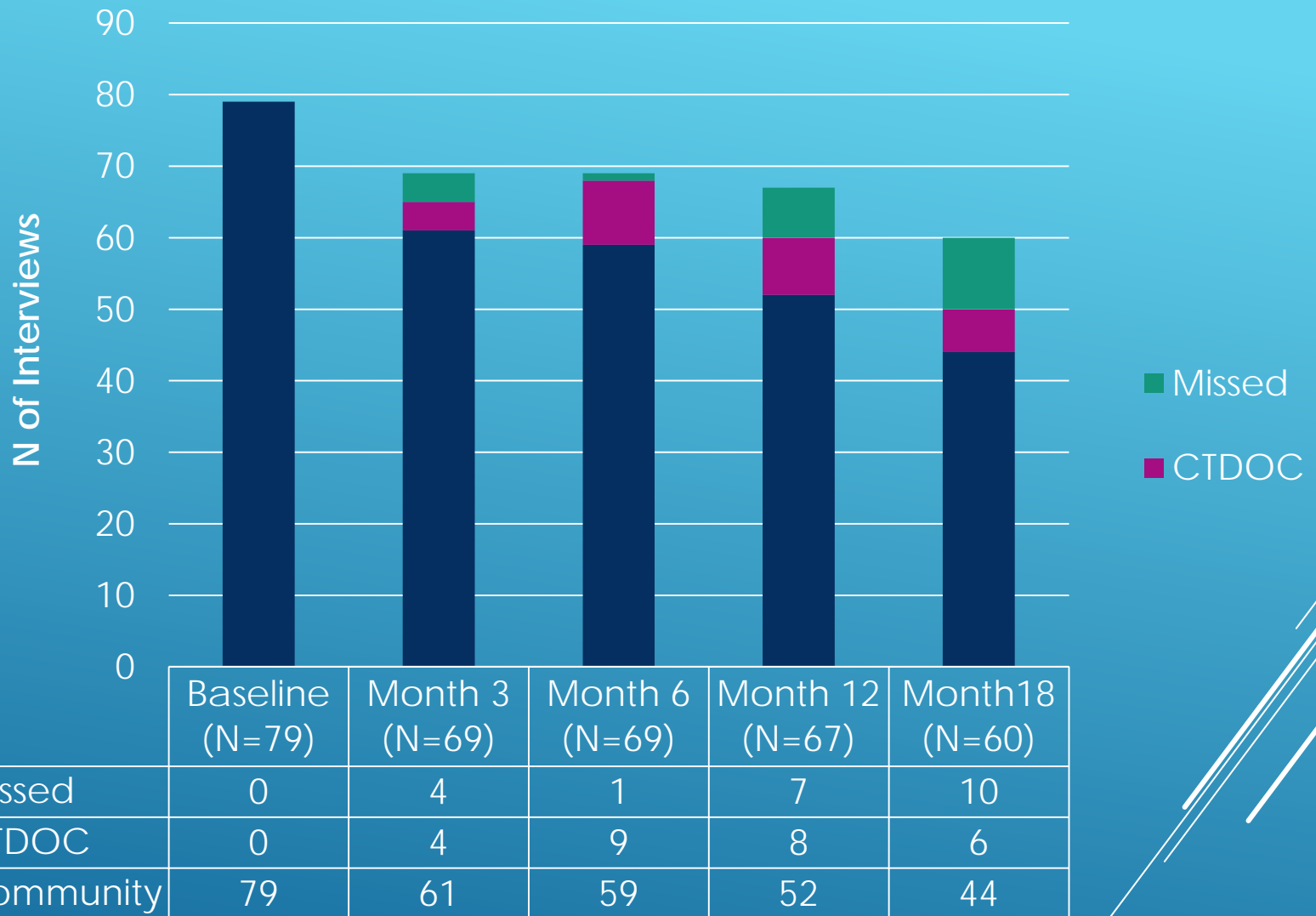
Housing Models

Permanent Supportive Housing, Rapid Rehousing, Shared Living, Sober Living, Transitional Living, Board & Care, Rooming Housing/Boarding Houses

CONNECTICUT DEPARTMENT OF CORRECTION - CONTINUITY THROUGH INCARCERATION

- Challenge of HUD definition of homeless includes incarceration
- DOC staff supported on grant
- Pre-release planning
- Coordination of medical care
- Tracking of re-incarceration
- Continuous access for researchers (even upon reincarceration)





	Month 3	Month 6	Month 12	Month 18
Retention Rates with CTDOC visits	94%	99%	90%	83%
Retention Rates without CTDOC visits	88%	86%	78%	73%

COMPREHENSIVE/TEAM BASED CARE & COMMUNICATION

IMPROVES



ENGAGEMENT IN CARE

- Biweekly formal meetings
- Informal huddles between SPNS staff, CMs, program managers, PCPs, and behavioral health
- Cell phone, email, text, face-to-face
- On-site behavioral health

- RW Early Intervention Services – newly diagnosed and out of care
- CHCV follow-up – case managers bring clients to medical appointments
- Electronic Medical Record (EMR) used system-wide at hospitals and clinics and on CHCV
- Provide transportation to appointments
- HIV treatment and care
- HCV treatment and care, and referral to specialists, as needed

CHALLENGES

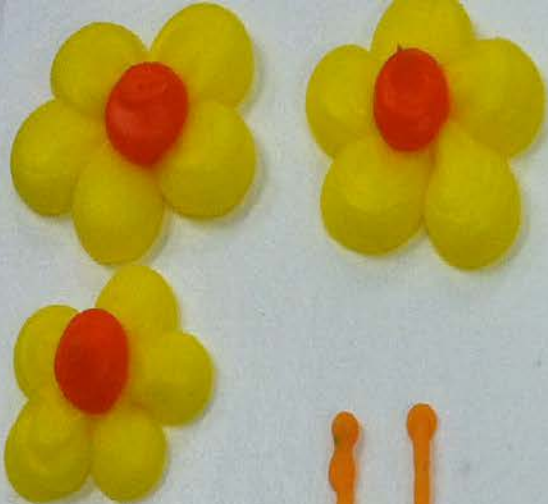
- Complex clients with multiple needs: mental illness, substance use disorders, criminal justice history, homelessness, living with HIV
- HUD definitions of chronic homelessness, including considering incarceration as “housing”
- Difficult to engage clients in care
- Multiple competing needs (e.g., keeping medical appointments, filling prescriptions, adherence to medication regimens)
- Relapse to drug/alcohol use
- Reincarceration
- Reimbursement for CM services
- Housing not linked to treatment- pros and cons
- Post housing adjustment
- Impact of incarceration and sexual offences
- Insurance for behavioral health with mobile services in CT
- Employment barriers – un/under-employment

SUCCESSSES

- Built relationship with housing provider, Liberty Community Services
- Enhanced collaboration with CT Department of Correction: parole and probation
- 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
- Accompany clients to appointments (eg, medical, DSS, court)
- Co-location of services
- Greater ties to the community
- Walk-in care psychiatric care- filling a community need

Great
Job

m Health
Team!



Panel 2: Integrating & Sustaining Care among PLWH

Serena Rajabiun, Boston University

Manisha Maskay, Prism Health North Texas

Nancy Miertschin, Harris Health System

Angelica Palmeros, Pasadena Public Health Department



Session Goals

- Describe strategies for building organizational and staff capacity to serve people living with HIV/AIDS who are homeless with co-occurring mental health and/or substance use disorders.
- Identify challenges with integrating and sustaining care.
- Recommend areas for continued policy support and allocation of resources.



Sustaining an Integrated Model of Care

HRSA, HAB Special Projects of National
Significance: Building a Medical Home for
Multiply Diagnosed HIV Homeless/Unstably
Housed Populations

Manisha H. Maskay, Ph.D.

Chief Program Officer

June 27, 2017

Prism Health North Texas

formerly known as AIDS Arms, Inc.

- Serves 12 North Texas counties
- Operates 5 service sites:
 - two clinics providing primary HIV medical care and integrated behavioral health care
 - mobile/onsite case management, psychosocial support and testing services
 - HIV empowerment center for PLWH
 - case management at the local health department

Prism Health North Texas

- Provides integrated care and services:
 - Outreach to and testing for those at high risk for HIV/STIs
 - HIV/STI prevention - risk reduction and treatment education and counseling services
 - Pre-exposure prophylaxis (PrEP)
 - Linkage of HIV-positive people to medical care and psychosocial support services
 - Primary HIV medical and behavioral health care
 - Psychosocial support services to promote engagement and retention in care, treatment adherence
- Builds collaborations with partner agencies to ensure respectful care for clients

Focus on Populations with Special Needs

- Re-entry population groups
 - Women and youth
 - People of Mexican origin
- and*
- ***Health Hope and Recovery*** – developed and implemented to serve:
 - HIV-positive individuals, diagnosed with mental health and/or substance use disorders, who are homeless, at risk for homelessness or fleeing from domestic violence

Health Hope and Recovery - The Need

- Dallas County PLWHA
 - 13,883 (2010)
 - 16,146 (2014)
- Dallas County Homeless Count (2011)
 - 5,783; 6% self-reported that they had an HIV dx
- PHNTX HIV+ clients with co-occurring mental health/substance use disorders (2015)
 - 50 % screened positive
 - 19 % received treatment
- PHNTX HIV+ clients – homeless/unstably housed (2015)
 - 6 %

Health Hope and Recovery – Integrated Care

Health Hope and Recovery functions within the Agency's integrated model of care for PLWH which includes:

- HIV primary medical care
- Integrated behavioral health care
- Case management
- Risk reduction counseling
- Co-located pharmacy services
- Empowerment Center for PLWH – the HIVE

Health Hope and Recovery - Model of Care

- Intensive care coordination and behavioral interventions that are client centered
- Provided by three full-time social workers:
 - Knowledgeable about treatment of HIV as well as mental health and/or substance use disorders
 - Knowledgeable about necessary community resources
 - Skilled in providing care to people with complex needs
 - Mobile – able to meet with clients at places and times convenient to them
 - Able to advocate effectively for clients with housing, behavioral health, medical and other providers
 - Able to build bridges to necessary care

Health Hope and Recovery - Partnerships

Strategic focus on strengthening/sustaining partnerships with:

- Metro Dallas Homeless Alliance
- Individual permanent housing providers including City of Dallas Shelter Plus Care, Master Leasing and others
- Rental property managers/owners
- Shelters
- Motels
- Mental health/substance use disorder treatment providers
- Hospitals and medical providers
- Respite care providers

Health Hope and Recovery – Key Outcomes

- A total of 157 clients served
- 120 clients enrolled in multi-site study
 - Staff recorded 5761 encounters with clients during a 3-year period (Jan 1, 2013 - Feb 1, 2016)
 - 75% achieved stable housing
 - 85% achieved viral suppression (viral load <200) compared to 43% at baseline

Health Hope and Recovery - Essential Components for Success

Individual level outcomes optimized as a result of:

- Regular meetings with clients based on ***acuity*** and ***need***
- Expedited access to medical and behavioral health care
- Care-team case conferences to address client needs and/or challenges
- Strategic use of tangible reinforcements – food, water, clothing, hygiene packs and other necessary items
- Assistance with obtaining and storing of documents necessary to access services
- Emergency housing
- Ongoing process and outcome evaluation

Health Hope and Recovery - Sustaining Necessary Services

Intentional - starting at the inception of the program

- Ongoing process evaluation to determine which components are essential for optimal outcomes
- Rigorous documentation
- Capacity building to enhance organizational ability to care for priority population
- Transition of services to a specialized case management team with the necessary skills to serve the priority population
- Active participation in Metro Dallas Homeless Alliance and other partnerships
- Strategic fundraising

Health Hope and Recovery - Capacity Building

- Obtaining and utilizing the Housing Management Information System (HMIS) to help expedite access to permanent housing
- Ongoing education and technical assistance for internal and external direct service and support staff on:
 - Needs and challenges of homeless clients
 - Trauma-informed care
 - Best practices for providing client-centered care for homeless individuals
 - Motivational interviewing, strength-based and solution-focused counseling techniques
 - Emerging trends related to regulations and requirements for documentation to establish eligibility for services

Capacity Building – Example

Working with the Homeless Population

AIDS Arms, Inc.

June 9, 2016

Brought to you by:

Health Hope and Recovery - Benjamin Callaway,
Luis Moreno, Miata Everett, Raymond Castilleja Jr. and
Justin Vander

Case Management - Trang Mai and Gilbert Moreno



Capacity Building - Example



Health, Hope & Recovery

Ben Callaway, LMSW, Charles Peterson, LMSW, Luis Moreno, BSW
AIDS Arms, Inc.



Program Design

Strategies & Techniques:

- ✓ Cognitive Behavioral Therapy (CBT)
- ✓ Solution Based Therapy (SBT)
- ✓ Strength-Based Case Management (SBKM)
- ✓ Motivational Interviewing (MI)
- ✓ Harm Reduction
- ✓ Audit Driven Standards of Care

Duration of Intervention:

- 18-Month Intensive Case Management

Implementation Team:

- Program Director
- Care Coordinator

Comprehensive/Team Based Care

- Health, Hope and Recovery SPN01 team attends clinical team meetings as needed
- Care Coordinator meets with the medical provider and/or the behavioral health team when necessary or communicated by phone or email
- Care plans developed together by Care Coordinator and client are:
 - entered into the electronic health record (EHR)
 - available for review to the medical and behavioral health providers
- Behavioral health provided onsite when indicated
- Clients requiring substance abuse treatment and/or treatment of complex mental health disorders referred to external providers

AIDS Arms does not plan to pursue PCMH certification at this time.

Recruitment & Retention

Clients Recruitment, as of August 15, 2015:

Total HCR clients served = 128
+
Total clients enrolled in study = 88
+
Total clients active in study = 78
+
Total clients transitioned to standard of care = 12

Clients Retention, as of June 26, 2015:

- > 3-Month Retention Rate: 73%
- > 6-Month Retention Rate: 67%
- > 12-Month Retention Rate: 57%
- > 18-Month Retention Rate: 47%

Access



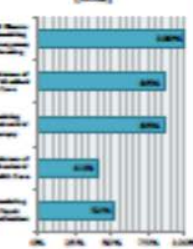
- Patients may access medical and behavioral health providers on a walk-in basis for urgent needs.
- Patients may access the Care Coordinator without an appointment for urgent needs.
- Patients are able to communicate through text messages or by leaving a voice-mail.
- All patients have 24/7 access to a medical provider on-call.
- Intake staff and transition services are available to all clients for medical and/or case management services.
- All staff receives ongoing training regarding providing culturally and linguistically appropriate services tailored to the unique needs of each client and following CLAS standards.

Care Coordination

- **Tracking of Referrals and Latex:**
Referrals are tracked with an excel spreadsheet that denotes date, source of referral, response date, list of medical care upon entry to program. Latex are examined via manual chart review.
- **Communication with Behavioral Health:**
The Behavioral Health Case Managers and Care Coordinator communicate via work email, office phone, and text messages on cell phones.
- **Electronic Health Records (EHR):**
AIDS Arms, Inc. uses an Integrated EHR.



Medical Outcomes Among Emergency Housing Recipients (n=42)



Integrated Care & Services at AIDS Arms, Inc.



Quality Assurance & Performance Measurement

The Quality Assurance & Performance Measurement Plan for Health, Hope & Recovery utilizes the PCMH Cycle: Plan, Do, Study, Act to ensure continuous improvement and ensure quality. All quality assurance activities are conducted either monthly, quarterly, or on an ongoing basis. A PCMH cycle has been developed for all program strategies and techniques.

External Reports:

- ✓ Monthly Dashboard Reports:
 - > Population Description
 - > Recruitment Progress
 - > Retention Rates
 - > Housing Status
 - > Retention in Medical Care



Quarterly Process Evaluation Reports:

- > Peer Review Results
- > Superior MI Observation Aggregate Results
- > Cumulative Prior Year Results

The consumer advisory board serves the entire agency and not a specific program. It provides guidance regarding development of the client satisfaction survey, recruitment materials and educational programs, and provides assistance with other activities as needed.

Conclusion

AIDS Arms is moving forward in a strategic manner to build a medical home for patients and already has many of the key components – behavioral health, medical health, dermatology, etc. The agency is exploring options related to finding a medical partner that will provide specialty care for individuals who do not have health insurance or have Medicaid and who need treatment for complicated medical problems such as cancer, heart disease, liver disease, etc. Unfortunately, the only resource for these individuals is an overburdened County medical system. Whereas, this is where patients are referred, it is not an ideal partner in terms of "creating a medical home framework."

Disclosures

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number 5U49CE000501, a Special Agent of National Significance. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Capacity Building - Example

A day in the life of staff members providing services to homeless clients ...

- Text client to remind them of appointment.
- Meet client at shelter to provide a needed items such as sleeping bag, medication box and/or snacks.
- Work in collaboration with shelter staff and client to obtain letter of homelessness for housing eligibility.
- Discuss and assess client's past experiences with medical care including barriers to care such as substance use and mental health disorders.
- Create care plan in collaboration with client utilizing motivational interviewing to identify triggers for substance use and create a harm reduction plan to decrease high risk behaviors.
- Call client to schedule medical and behavioral health appointment.
- Assist client in programming medical appointments in cell phone provided by AAI to increase adherence to medical care.
- Provide education on DART system, bus pass and practical tips for attending medical appointments.
- Help internal and external colleagues learn about the Trauma Informed Model of Care as well as harm reduction strategies.

Use of Public/Private Resources to Sustain Program

Source	Purpose
Ryan White Parts A, B and C	Intensive non-medical case management/care coordination
Private donors	Emergency housing, support for HMIS subscription fees
Agency general funds	Documentation assistance, packaged snacks, transportation vouchers, assistance with other basic needs
Marketplace insurance plans	Medical and psychiatric care

Ongoing Needs and Challenges

- Inadequate availability of affordable permanent housing
- Resistance to and inadequate adoption of Housing First model
- Changing rules and interpretation of program requirements related to eligibility for housing assistance and other services
- Increasing requirements related to documents needed to establish eligibility and frequency of updates
- Stigmatizing attitudes and behaviors from housing, psychosocial support and other providers
- Inadequate understanding of the needs of HIV-positive homeless individuals with mental health and/or substance use disorders

Conclusion

Although we have served the priority population for many years, the initiative provided substantive information about what is necessary to optimize health outcomes for HIV-positive persons with mental health and/or substance use disorders who are homeless or unstably housed.

Thank you!

Harris Health System

Nancy Miertschin, HIV Project Manager

Houston and Harris County

- 4.3 million residents
- Third most populous county and fourth most populous city in US
- Spans approximately 1,700 square miles
- It's HOT and humid and we have limited public transportation!



Harris Health System

- Publicly funded, urban academic health care system in Houston, Texas
- 3 hospitals
- 26 community clinics, including Thomas Street Health Center
- Population served is 85% minority

HIV Services/Thomas Street Health Center

- First free-standing publicly funded HIV clinic in US
- 5,500 HIV+ patients per year
- 50% of Harris County's uninsured HIV patients
- 25% of all HIV+ persons in Harris County
- More than 90% minority
- Approximately 1,000 homeless and unstably housed patients

HIV Funding Sources

				Funding Sources and Total Annual Grant Amounts					
				SPNS \$300,000	Part A \$6,882,901	Part C \$778,236	Part D \$331,902	CDC/City \$362,760	
				FTE Support for SPNS Program Staff					
Project Hi-5 Program Elements	Medical Case Management	A	1	0.4	0.6				
		B	1	0.9	0.1				
		C	1	0.9	0.1				
	Service Linkage	A	1	0.02	0.45	0.08		0.45	
		B	1	0.1	0.4			0.5	
TOTAL			FTE	5	2.32	1.65	0.08	0	0.95
			%	100%	46%	33%	2%	0%	19%

Project Hi-5

- 157 Enrolled in SPNS study
- 70 additional homeless patients have received Hi-5 services.
- Medical case management and Service Linkage for non-enrolled patients are billed to Part A.
- Part C pays for a portion of salary for one SLW who is certified to provide HIV testing.
- CDC/City funds pay for Service Linkage staff who link and re-link homeless patients to care.

Service Linkage Roles

- MAY provide HIV testing.
- Conduct and document initial patient assessments.
- Assist patients with access and adherence to care.
- Assure linkage to care through referrals and follow-up.
- Assist patients in navigating service delivery system.
- Work with medical case managers and other clinicians to ensure care plan is implemented.

Strategies for Maximizing Success

- Use consistent service definitions and Standards of Care for all funding sources (RW Part A).
- Build in coordination with other case management services throughout the entire HIV program.
 - Training
 - Regular combined meetings and shared supervision
- Keep RWPC informed about SPNS project and needs among HIV+ homeless.
- Begin 2-3 years before end of project to build increasing salary support from other sources.

Policy changes

- Streamlined eligibility process
- Fast track to see physician on same day as initial visit
- Coordination with Health Care for the Homeless staff

Partnerships

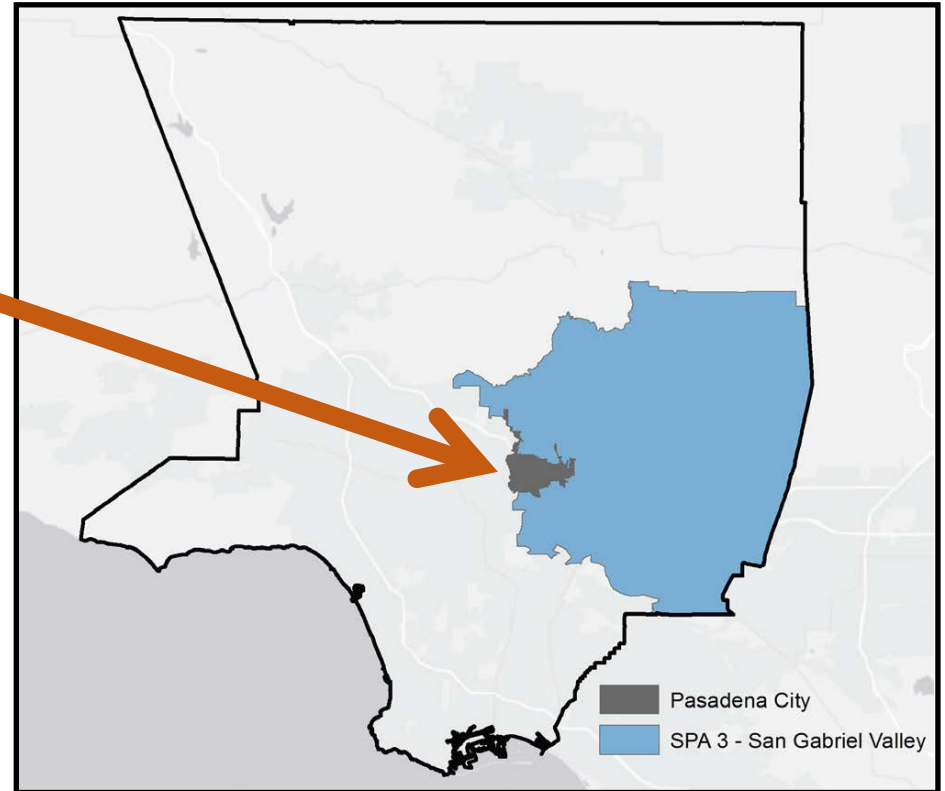
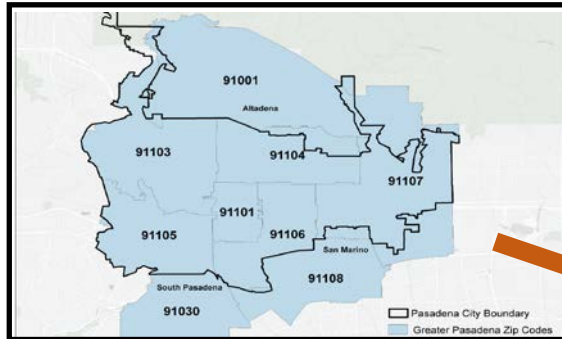
- Salvation Army – emergency housing
- Food Bank – on-site application
- Houston Police Department HOT Team – one-day IDs

Late breaking news !!!

Operation Link: Pasadena Public Health Department

Angelica Palmeros, Pasadena Public Health Department

City of Pasadena



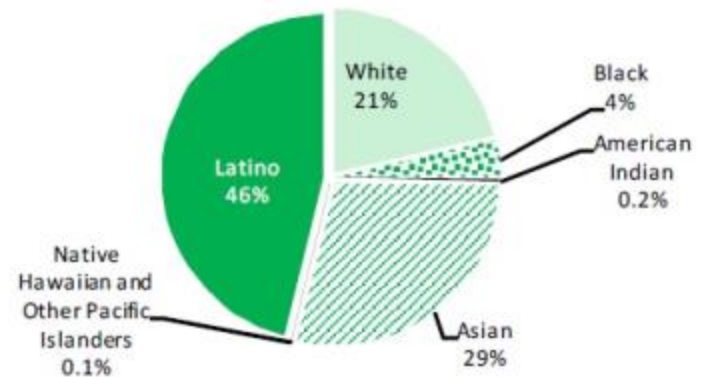
San Gabriel Valley SPA 3

Demographics

Demographics	Los Angeles County	SPA 3
Total population ¹	10,019,362	1,777,760
% male/female ¹	49%/51%	49%/51%
% of population ages 0-17 ¹	23%	22%
% of population ages 65+ ¹	12%	13%
% of adults who report having a disability ²	19%	17%
% of adults who primarily speak English at home ²	61%	55%

Population by Race/Ethnicity¹

Total SPA 3 Population: 1,777,760



Source: Los Angeles County Public Health Department, 2016

Cont. SPA 3

Racial/Ethnic Disparities

Health Indicator	Los Angeles County	SPA 3				
		SPA 3 Overall	White	Black	Latino	Asian
% of adults with less than a high school diploma ³	24%	22%	7%	11%	36%	18%
% of population that lives in poverty (household income <100% Federal Poverty Level [FPL]) ³	17%	13%	8%	14%	16%	12%
Median household income ³	\$56,241	\$68,417	\$79,430	\$62,899	\$59,511	\$72,285
% of households that are crowded ^{a,3}	12%	10%	2%	4%	20%	9%
% of population that is foreign-born ³	35%	38%	10%	8%	36%	71%
Life expectancy (in years) ⁴	81.8	82.7	80.5	78.0	83.3	86.6 ^b

^a The U.S. Census Bureau defines crowded housing as more than one person per room.

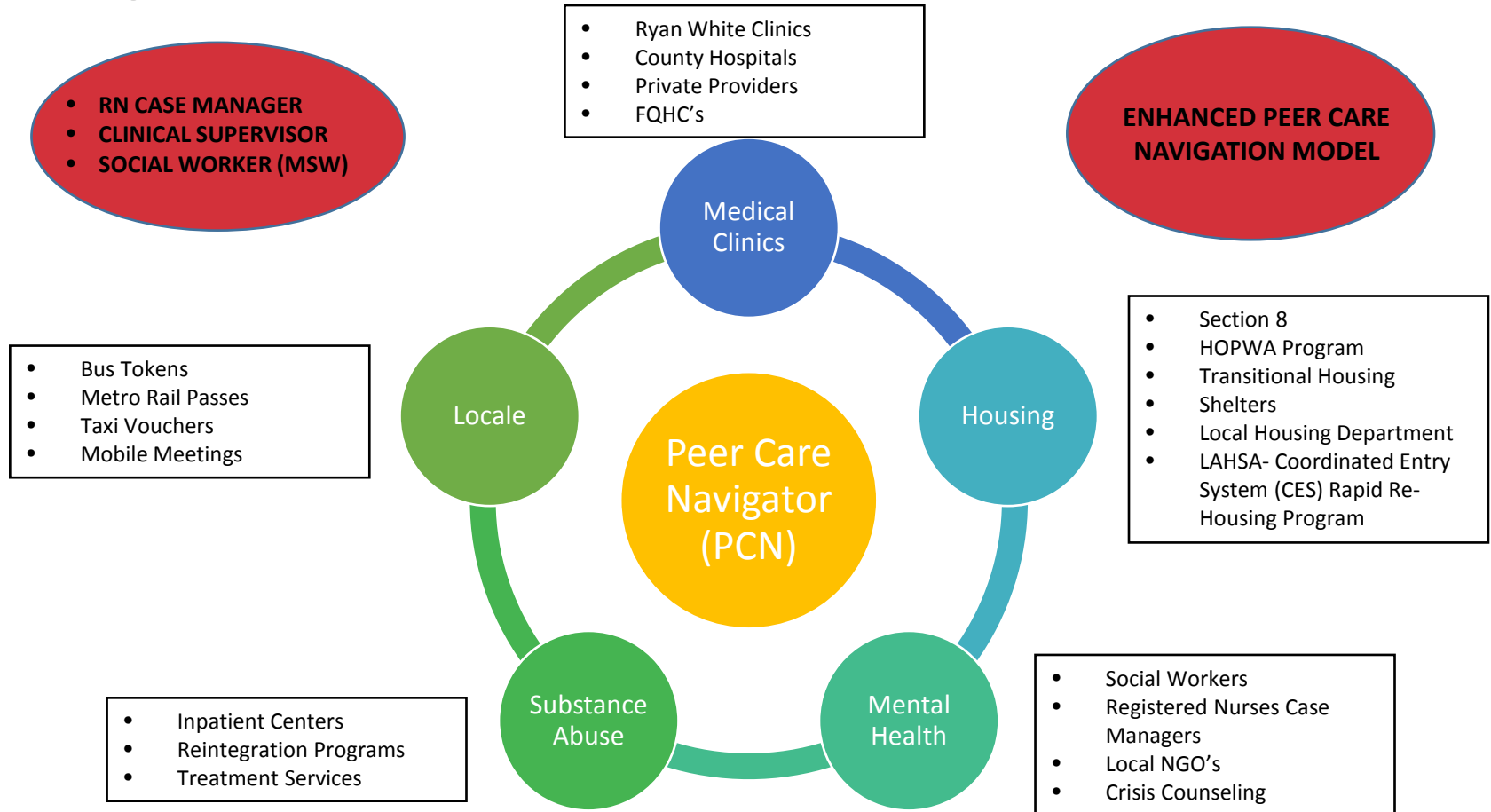
^b Includes Native Hawaiian and Other Pacific Islanders (NHOPI).

Source: Los Angeles County Public Health Department, 2016

Pasadena Facts

- The Los Angeles basin has the largest homeless population in the country—almost 90,000 individuals, of which 1,165 live in Pasadena. Of this homeless population, it is estimated that more than 2,700 are living with HIV, 22,500 suffer from severe or persistent mental illness, and 31,500 suffer from some sort of addiction. The basin has the second largest number of HIV cases in the country.
- The City of Pasadena, located within the San Gabriel Valley of Los Angeles, is one of only three cities in the state of California that maintains its own independent local health jurisdiction.
- In 1991, the City of Pasadena Public Health Department (PPHD) in partnership with a collaboration of community agencies recognized the growing need for HIV services in the San Gabriel Valley. PPHD began providing HIV/AIDS medical outpatient services to HIV-infected individuals .
- In 2016, clinical services of AECCS was transferred to a local federally qualified health center (FQHC) John Wesley Health Centers. Currently, the PPHD focuses on prevention services in HIV.

Operation Link: The Model



Programmatic Success

- PCNs accompanying clients to appointments to serve as advocates and provide peer support and system navigation.
- PCNs following up with and even going out to search for clients who missed appointments.
- Providing sensitivity training to clinic staff on homelessness issues and how to meet their unique needs, best practices.
- New partnerships with medical and housing providers, including a sharp increase in HOPWA vouchers.
- Increased provider education on HIV, homelessness and cultural sensitivity towards MSM, MSM/W including transgender clients.
- Pasadena Partnership The Continuum of Care (CoC) received accreditation (medical home certification-JACO, NCQA).



Programmatic Challenges

- Finding long-term care for clients near where they were housed was difficult due to the geographic distribution of Los Angeles County.
- Client did not have a reliable method of communication.
- Lack of affordable housing in the Pasadena area.
- Client displayed from supportive services to new services, transition impacted adherence.
- Lack of housing and services options for undocumented clients.
- Lack of basic life skills training for newly housed clients.
- Lack of adequate supportive housing for clients experiencing severe mental health and/or addiction problems.

Sustainability

- Operation Link expanded its scope to include individuals not living with HIV.
- Pasadena Public Library received a grant to sustain the PCN's position.
- Looking into billable Medi-Cal and Medicare services.
- Partnership with various city departments (Police, Library, Housing, Public Works and Parks, and Human Services and Recreation) to implement from a field-based approach.
- Developing partnership with the Union Station, in areas that can create capacity building and leveraging of funds.
- Passage of County Measure H, funding for homelessness in LAC.
- Incorporate ADAP Services, HIV Screening and Testing, Hep C Screening.
- Implemented Welligent, Inc. Electronic Behavioral System with billing model included.
- Applied for Beacon Behavioral Healthcare (crave out) to bill private insurances.
- Developed an MOU with FQHC- Community Health of Pasadena to offer behavioral health services, to target populations including individuals who are homeless.

Building Partnerships

- Union Station Homeless Services Program
- Los Angeles County Systems, Health Services, Substance Abuse and Mental Health.
- The Los Angeles Housing Authority(LAHSA).
- Pasadena Police Department, Human Services and Recreation, Pasadena Fire Department, Pasadena Library, and Housing Department.
- John Wesley Health Center and Community Health of Pasadena (CHAP)
- Housing Works (Los Angeles)



Our next steps...

- Union Station Homeless Services Program, jointly applied for a SAMHSA grant “Homeless Benefits Services” proposed Enhanced Model, including an outreach team for evenings and weekends.
- Building partnerships with Los Angeles County Systems, Health, Health Services, Substance Abuse and Mental Health.
- Building Partnership with The Los Angeles Housing Authority, including applying for funds to increase 2.0 Full-time staff to deploy from Libraries (City of Pasadena has 10 active libraries).
- Continue partnership with Police Department, recently awarded Prop 47 funding to work with re-entry systems. In partnership with Health Department, implementing a Peer Navigator Model to address mental health and substance abuse issues, including housing and other needs.
- Developing partnerships with non-HIV Primary Health care.

Ongoing needs and policies

- Measure H- Homeless Initiative.
- Housing Incentive Landlord Program (Housing Department)
- Partnering with City of Pasadena City Attorney's Office- Homeless Clinic.
- Increasing access to services, evenings and weekends.
- Participation of the Medi-Cal DMC and County Pilot, Mobile Substance Abuse Services.



Questions

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- Angelica Palmeros, Pasadena Public Health Department
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Panel 3: Hearing from people who have benefited from SPNS services

James Apt, Boston Health Care for the Homeless Program (moderator)

Jamie Christianson, Myranda Harris, Multnomah County Health Department

Amelia Broadnax, Michael Delaney, Family Health Centers of San Diego

Deb Borne, Scott Carlisle, San Francisco Department of Public Health



The stories behind the numbers: Clients share life-changing impact of project at HRSA meeting

This panel included no presentation slides. A description of the panel discussion can be found at <http://cahpp.org/stories-behind-the-numbers>



Summary and Key Components for Replication

June 27, 2017

Key Components for Replication

- Mobile and team-based care
- Open access to integrated services:
 - HIV primary care, substance use treatment and mental health, housing, and social services
- Frequent team huddles and communication
- Acuity assessments and integrated care plans
- Trauma-informed and welcoming culture that understands the needs of people living with HIV and experiencing homelessness

Key Components for Replication

- Trauma-informed leadership and commitment to staff supervision, training, and competency:
 - Initial training/continuing education for program staff: 60 hours
 - Motivational interviewing
 - Trauma-informed care
 - Cross training and working in teams
 - Harm reduction
- Continued support for navigators (i.e., Community Health Workers) as part of the care team

Key Components for Replication

- Resources to obtain and store documentation for eligibility of services
- Resources to ensure basic needs are met: clothing, food, showers, access to cell phones to address the social determinants of health
- Addressing the life-long impact of trauma:
 - Services to maintain housing as intensive as services to obtain housing
 - End-of-life and palliative care
 - Life skills and vocational training

Future Investment for Policies and Programs

Because of changes with housing access eligibility, resources for:

- Education and training for medical and social service providers on eligibility requirements.
- Advocacy for groups lost in the homeless definition:
 - People with incarceration history
 - Medically frail and elderly
 - People attending residential treatment programs

Future Investment for Policies and Programs

- Emergency housing and respite
- Continued support and advocacy for Housing First Programs, especially at the local level
- Education/training programs to reduce stigma of homelessness, substance use, mental health, and HIV
 - General public
 - Ryan White providers
 - Housing, navigators, and social service providers

Future Investment for Policies and Programs

- Financial and technical resources to support system-level coordination and partnerships
 - Continuum of care committees with housing, HIV, health and behavioral health, and social service provider participation
 - Integrated, accessible data systems
 - **MOBILE, INTEGRATED, INTENSIVE**

Resources

- www.cahpp.org/project/medheart
 - [Site implementation manuals](#)
 - [Housing resources toolkit](#)
 - Assessment tools
 - Sample training materials
 - Living skills guides
 - [Client story videos](#)
 - [One-page overview of multisite project and individual sites](#)
 - [Multisite and individual site poster presentations](#)

Resources in Development

- Multisite Implementation Manual
- American Journal of Public Health Supplement
 - Featured articles
 - Changes in housing status on the HIV Care Continuum
 - Factors associated with housing stability
 - The impact of care coordination interventions on stigma and engagement and retention in care
 - Patient-centered medical home models for people living with HIV/AIDs who are experiencing homeless or unstable housing

“...Having staff who understand what homelessness is, what mental health is... What is substance abuse and what is not having a social support... Then having the knowledge and resources available so they can pick up the pieces when they meet with clients...having leadership and staff who can go out there and advocate for clients and close the gaps with providers within the community...”



Med-HEART

Medical Home-HIV Evaluation & Resource Team

MOBILE INTEGRATED INTENSIVE

Thank You!