In 2012, nine demonstration sites set out to integrate HIV care, mental health services and substance use treatment and obtain stable housing for people who are experiencing homelessness.

SPNS Initiative: Building a Medical Home for Multiply Diagnosed HIV-Positive Homeless Populations (2012 - 2017)

THE CHALLENGE

Reduce the barriers to engagement and retention in HIV care by creating a coordinated system of care including HIV primary care, substance use and mental health treatment, and housing and supportive services.

FOCUS POPULATION

People 18 years or older who are experiencing homelessness/unstable housing, living with HIV, and diagnosed with mental health and/or substance use disorders.

THE MODEL

The nine medical home models had the following characteristics:

- Partnerships between HIV and housing providers
- Integrated behavioral health and HIV services
- A network navigator in the health care team who worked intensively one on one with clients to reduce barriers to care and improve access to HIV care, housing and support services

KEY FINDINGS

- Training: 60 hours for navigators; 7-hour course for supervisors
- Case size for navigators: 20-30 clients
- Consistent clinical and administrative supervision
- Average length of intervention: 18 months
- Open access to HIV primary care, substance use/mental health services
- Frequent team huddles to address barriers to care and unmet needs
- Provision of emergency housing as a step towards permanent housing

IMPACTS

1,338 clients served from September 2012-May 2017

A sample of 909 SPNS clients enrolled in a multisite evaluation study and results showed:

- 70% achieved viral suppression by 12 months
- Out of 467 clients, 34% were in stable permanent housing and 30% were in temporary housing by 18 months

Plus new partnerships and coalitions among agencies

Learn more: http://cahpp.org/project/medheart

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 U90HA24974 (Special Projects of National Significance (SPNS) Initiative Building a Medical Home for Multiply Diagnosed HIV-positive Homeless Populations, in the amount of $535,710) awarded to the Trustees of Boston University. No percentage of this project was financed with non-governmental sources. 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.

Engaging clients who are living with HIV and experiencing homelessness in a rural setting

NC-REACH (Rurally Engaging and Assisting Clients who are HIV-positive and Homeless)
CommWell Health, Inc., Dunn, North Carolina

GEOGRAPHIC LANDSCAPE

- Designated Medically Underserved Professional Shortage Area in a rural area[1]
- Large, rural service area, approximately 6,574 sq. mi. (larger than Connecticut)

THE CHALLENGE

- North Carolina is among the top 15 states with the highest rate of HIV diagnoses per 100,000 people per year.[1]
- Nearly 22% of state's population lives in rural counties, which accounts for 80% of the state.[2]

FOCUS POPULATION

People 18 years or older who are experiencing homelessness, living with HIV, and diagnosed with mental health and/or substance use disorders.

THE MODEL

- Intensive care coordination between medical care, behavioral health services, and housing assistance.
- Use of a network navigator and continuum of care coordinator for care coordination.
- Network navigators provide transportation to services.

PARTNERS and LINKAGES

Quarterly meetings with regional service providers, including housing partners, private landlords, people from faith-based communities, local detox centers, and representatives from Veterans Affairs, Red Cross, Salvation Army, and United Way.

IMPACTS

80 clients served, of which 53 graduated to standard of care services

Increased understanding of "hidden homelessness" in region and how to address the issue through community outreach, housing coalitions, behavioral health integration, and new community partnerships.

Learn more: http://cahpp.org/project/medheart

[1]http://www.cdc.gov/hiv/statistics/overview/geographicdistribution.html
[2]Rural Health Information Hub. (2016). North Carolina. Retrieved from https://www.ruralhealthinfo.org/states/north-carolina Accessed 11/3/2016.

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Providing intensive client-centered care coordination to engage a population with complex needs in medical care and treatment

Health, Hope and Recovery (HHR)
AIDS Arms, Inc. dba Prism Health North Texas, Dallas, Texas

GEOGRAPHIC LANDSCAPE

Dallas metropolitan area

THE CHALLENGE

- Dallas is one of 12 U.S. cities with the largest share of people living with AIDS.[1]
- People living with HIV/AIDS are likely to have higher rates of homelessness and co-occurring mental health and/or substance use disorders than the general population.

FOCUS POPULATION

Adults 18 years or older who are living with HIV with co-occurring mental health and/or substance use disorder(s); experiencing homelessness/unstable housing or fleeing from domestic violence; and who receive or will receive HIV medical care at Prism Health North Texas

THE MODEL

Intensive care coordination to help clients navigate the complex system of services, including integrated HIV medical care and treatment for mental health and/or substance use disorders, and access to housing

PARTNERS and LINKAGES

- Voting member and active participant of Metro Dallas Homeless Alliance
- Formalized relationships with community partners to provide medical care, treatment for mental health and/or substance use disorders, dental care, transportation, legal assistance, employment and other necessary services

IMPACTS

157 clients served

- **Improved rates of adherence to medical care and viral suppression among HHR participants**
- **Enhanced collaboration with external partners to meet service needs of the priority population**
- **Expansion of organizational services to better meet the needs of the priority population**

Learn more: http://cahpp.org/project/medheart

[1]Dallas County Health and Human Services, Profile of HIV in Dallas County, 2014, Retrieved from https://www.dallascounty.org/department/hhs/documents/DCHHS_HIV_Profile_Dallas_2014.pdf. (DCHHS, 2014).

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number H97HA24956 (Special Projects of National Significance (SPNS) Initiative Building a Medical Home for Multiply Diagnosed HIV-positive Homeless Populations, in the amount of $1,560,860) awarded to AIDS Arms, Inc., dba Prism Health North Texas. No percentage of this project was financed with non-governmental sources. 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.

Providing comprehensive outreach and treatment to people who are experiencing homelessness and living with HIV wherever they prefer to receive care

Project Hi-5
Harris Health System, Houston, Texas

GEOGRAPHIC LANDSCAPE	Encompasses Harris County including the City of Houston, Texas
THE CHALLENGE	Fragmented system of services for people living with HIV who are experiencing homelessness and dealing with substance use or mental health challenges
FOCUS POPULATION	Adults in the greater Houston area who are experiencing homelessness, living with HIV, and with mental health and/or substance use disorders
THE MODEL	• Primary and specialty HIV care, case management, behavioral health, substance use treatment all provided through Harris Health System, including shelter-based clinics operated by its Health Care for the Homeless Program • Case managers and service linkage workers are involved in all aspects of client management from initial assessment through developing housing and care plans, accompanying clients to visits and long-term follow-up
PARTNERS and LINKAGES	• **The Beacon** – Day homeless shelter which facilitates HIV-testing among individuals experiencing homelessness • **Houston Healthcare for the Homeless** – Bus transportation services • **Houston Food Bank** – Food stamp enrollment on site at clinic • **Houston Police Department Homeless Outreach Team** – Obtaining temporary IDs • **Salvation Army** – Emergency beds for clients who are experiencing homelessness
IMPACTS	**240 clients served** • **Improved health status and housing stability for program participants** • **Greater understanding and empathy for patients experiencing homelessness among HIV clinic staff; greater expertise in providing basic HIV care among Health Care for the Homeless staff**

Learn more: http://cahpp.org/project/medheart

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number H97HA24959 (Special Projects of National Significance (SPNS) Initiative Building a Medical Home for Multiply Diagnosed HIV-positive Homeless Populations, in the amount of $285,860) awarded to the Harris Health System. No percentage of this project was financed with non-governmental sources. 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.

Navigators for medical, behavioral care and housing care navigators working together to serve San Diegans who are experiencing homelessness and living with HIV

PCMH Connections for Multiply Diagnosed San Diegans Living with HIV
Family Health Centers of San Diego (FHCSD), San Diego, California

GEOGRAPHIC LANDSCAPE

The 8th largest city in the country with a population of 1.3 million people[1]

THE CHALLENGE

- San Diego has the third largest HIV infection rate in CA.[2]
- The increasing rate of homelessness is made worse by lack of affordable housing and inadequate emergency shelters.

FOCUS POPULATION

Adults living with HIV, and with mental health or substance use disorders while experiencing homelessness, unstable housing, or domestic violence.

THE MODEL

- Medical and behavioral care services provided at FHCSD, coordinated with People Assisting the Homeless (PATH) to address housing needs
- Leverages earlier FHCSD-PATH collaboration that provides a mall of social services under one roof
- Close collaboration between a FHCSD case manager and PATH care navigator to support clients and connect them to needed services. PATH and FHCSD staff members are co-located at least one day per week at each other's primary facilities.

PARTNERS and LINKAGES

People Assisting the Homeless (PATH) to address housing needs

IMPACTS

254 clients served

- **Joint effort of navigators, medical case managers resulted in fewer gaps in care for clients**
- **Enhanced relationships with non-traditional landlords, property managers**

Learn more: http://cahpp.org/project/medheart

[1]https://www.census.gov/2010census/popmap/
[2]http://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/documents/HIV_Epi_Report_2015_FINAL.PDF

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number H97HA25090 (Special Projects of National Significance (SPNS) Initiative Building a Medical Home for Multiply Diagnosed HIV-positive Homeless Populations, in the amount of $300,000 annually) awarded to the Family Health Centers of San Diego, www.fhcsd.org. No percentage of this project was financed with non-governmental sources. 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.

Using patient navigators to connect individuals who are multiply diagnosed, experiencing homelessness, and living with HIV with a medical home in Portland, Oregon

Building a Medical Home for Multiply Diagnosed People Experiencing Homelessness and Living with HIV/AIDS
Multnomah County Health Department, Portland, Oregon

GEOGRAPHIC LANDSCAPE

Portland, Oregon metropolitan area

THE CHALLENGE

- Engagement and retention in HIV specialty and primary care due to multiple barriers
- Lack of affordable housing
- Insufficient appropriate mental health and substance use treatment resources

FOCUS POPULATION

People living with HIV who are experiencing homelessness/unstable housing and diagnosed with mental health or substance use disorders

THE MODEL

Integration of patient navigators and housing support into a comprehensive HIV medical home model to better engage and retain patients experiencing homelessness to improve medical outcomes such as HIV viral suppression

PARTNERS and LINKAGES

Cascade AIDS Project – Housing case management services
Community partnerships with housing, mental health, substance use, legal, and social service agencies

IMPACTS

148 clients served

- **The impact of integrating SPNS navigators into our medical team: viral suppression for all clients increased from 79% in 2012 to 87% in 2016!**
- **Clients with a suppressed viral load are living less chaotic lives and are deeply connected to their medical care teams**
- **Navigation services will continue beyond the end of the project**

Learn more: http://cahpp.org/project/medheart

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number H97HA24958 (Special Projects of National Significance (SPNS) Initiative Building a Medical Home for Multiply Diagnosed HIV-positive Homeless Populations, in the amount of $1,485,860) awarded to Multnomah County HIV Health Services Center https://multco.us/health/hiv-health-services-center Approximately 5% of this project was financed with non-governmental sources. 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.

Using peer care navigators to connect individuals who are experiencing homelessness and living with HIV with a medical home in the San Gabriel Valley

Operation Link
City of Pasadena Public Health Department, Pasadena, California

GEOGRAPHIC LANDSCAPE

- Los Angeles has the largest population experiencing homelessness in the country.
- Of the 90,000 homeless individuals in LA, 1,165 live in Pasadena.
- Los Angeles has the second largest number of HIV cases in the country.[1]

THE CHALLENGE

- Vast geographic area
- Limited affordable housing resources
- Clients served by multiple medical providers; difficult to coordinate services

FOCUS POPULATION

- People in the San Gabriel Valley who are experiencing homelessness, living with HIV, and diagnosed with mental health and/or substance use disorders.
- Individuals newly released from treatment programs, shelters, or incarceration

THE MODEL

Peer Care Navigators (PCNs) work with clients to find established medical homes throughout the Los Angeles County area that would be both accessible from the clients' primary place of residence and able to meet the clients' medical, mental health, and substance use needs.

PARTNERS and LINKAGES

Collaboration with housing agencies in Los Angeles metropolitan area

IMPACTS

107 clients served, of which **67** graduated to standard of care services

Increased understanding of the needs of the population experiencing homelessness in Pasadena and surrounding region

Learn more: http://cahpp.org/project/medheart

[1]California Statewide Coordinated Statement of Need, September 2009, p. 16.

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number H97HA24960 (Special Projects of National Significance (SPNS) Initiative Building a Medical Home for Multiply Diagnosed HIV-positive Homeless Populations, in the amount of $1,497,156) awarded to the City of Pasadena Public Health Department. No percentage of this project was financed with non-governmental sources. 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.

Serving individuals who are experiencing homelessness and living with HIV through mobile integrated care: case management, navigation, HIV primary care, mental health and substance use treatment, and housing support

Homeless HIV Outreach and Mobile Engagement (HHOME) Program
San Francisco Department of Public Health, San Francisco, California

GEOGRAPHIC LANDSCAPE

San Francisco has one of the largest populations living with HIV in the U.S. with an estimated 15,995 people living with HIV,[1] and second highest rate of homelessness.[2]

THE CHALLENGE

The focus population includes individuals who are among the most difficult to engage and retain in care.

FOCUS POPULATION

People experiencing homelessness in SF who are medically fragile, facing complex co-morbidities/barriers, and not engaged in housing, HIV treatment, or behavioral health care

THE MODEL

- A mobile team-based intervention designed to engage/retain in care the most severely impacted and hardest-to-serve people experiencing homelessness and living with HIV
- Mobile team consists of a behavioral health clinician, a medical doctor, a nurse, a peer navigator and a case manager meeting patients wherever they are

PARTNERS

- **Asian & Pacific Islander Wellness Center** – Drop-in case management, mental health and counseling services, art therapy, and nutritional services
- **San Francisco Homeless Outreach Team** – Outreach, case management and housing for people experiencing homelessness in encampments, streets, parks and shelters
- **Tom Waddell Health Center, San Francisco Health Network** – Health Care for the Homeless integrated medical clinic offering urgent and primary care, mental health and addiction medicine services
- **Transitions Care Coordination, San Francisco Health Network** – Complex care management and coordination for high utilizers and underserved populations

IMPACTS

106 clients served

- **67% of clients are housed or have been linked to the appropriate level of residential care**
- **66% achieved viral suppression at least once while working with the program**
- **Strengthened community partnerships between public clinics, medical and psychiatric hospitals, the jail system, case management programs, surveillance and linkage organizations**

Learn more: http://cahpp.org/project/medheart

[1]SF HIV Annual Epidemiology Report 2015. Retrieved from https://www.sfdph.org/dph/files/reports/RptsHIVAIDS/AnnualReport2015-20160831.pdf
[2]SF Homeless Point-in-Time Count & Survey 2015. Retrieved from http://sfgov.org/lhcb/sites/default/files/2015%20San%20Francisco%20Homeless%20Count%20%20Report_0.pdf

This program was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number H97HA24957 (Special Projects of National Significance (SPNS) Initiative Building a Medical Home for Multiply Diagnosed HIV-positive Homeless Populations, in the amount of $300,000) awarded annually to San Francisco Department of Public Health. No percentage of this program was financed with non-governmental sources. 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.

A partnership for access to HIV treatment, mental health/substance use treatment, and housing in Jacksonville, Florida

The Partnership for Access to Treatment and Housing (PATH Home) University of Florida Center for HIV/AIDS Research, Education and Service (UF CARES), Jacksonville, Florida

GEOGRAPHIC LANDSCAPE

In 2010, Jacksonville had more than 4,000 individuals who were experiencing homelessness, an almost 20% increase over the 2008 point-in-time count[1]

THE CHALLENGE

- People living with HIV who are experiencing homelessness present complex demands on the HIV care continuum
- Stigma in accessing services, lack of knowledge of available services, mental health and substance use comorbidities all interfere with HIV care treatment adherence

FOCUS POPULATION

People who are unstably housed or experiencing homelessness and living with HIV/AIDS, located in Jacksonville, Florida

THE MODEL

- UF CARES staff provided HIV primary care twice a month at a clinic held at River Region Human Services, an agency that provides housing, substance use treatment services, and mental health care.
- Peer navigators served as an extension of case management services, providing intensive case management and linking clients to the services at both River Region and the clinical care provided by UF CARES.

PARTNERS and LINKAGES

- **River Region Human Services, Inc.** – housing, substance use treatment, mental health care
- **Ability Housing** – Housing services
- **Gateway Community Services** – Substance use treatment

IMPACTS

167 clients served

Strengthened partnerships with River Region Human Services and Gateway Community Services.

Learn more: http://cahpp.org/project/medheart

[1]https://www.unf.edu/uploadedFiles/aa/coas/cci/projects/2010%20Homeless%20Report.pdf

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number H97HA24962 (Special Projects of National Significance (SPNS) Initiative Building a Medical Home for Multiply Diagnosed HIV-positive Homeless Populations, in the amount of $285,860.00) awarded to University of Florida, Gainesville, FL. No percentage of this project was financed with non-governmental sources. 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.

Navigators engaging people experiencing homelessness and living with HIV into a medical home coordinated with the criminal justice system, mobile van-based services, and a multi-service housing provider

Project mHEALTH (Medical Home Engagement and Aligning Lifestyles and Transition from Homelessness)
Yale University School of Medicine, New Haven, Connecticut

GEOGRAPHIC LANDSCAPE

- New Haven, CT is the 4th poorest city in the U.S. for its size and has been in economic decline since the 1960s.
- High rates of poverty, homelessness, unemployment, illegal activity resulting in incarceration, substance use, and HIV/AIDS are common challenges.

THE CHALLENGE

Poor and unstably housed people living with HIV/AIDS (PLWHA) experience poor HIV treatment outcomes compared to their housed counterparts

FOCUS POPULATION

People who are experiencing homelessness/unstable housing and living with HIV, primarily those transitioning from the criminal justice system and those not retained in HIV care

THE MODEL

- Use of a patient-centered medical home for homeless PLWHA incorporating increased coordination and referrals between a mobile medical clinic, the criminal justice system, and the city's largest housing provider for PLWHA
- A network and peer navigator provide intensive case management to retain individuals with mental illness, substance use disorders, and chronic homelessness in health care

PARTNERS and LINKAGES

- **Liberty Community Services** – Housing service provider with network and peer navigator
- **Connecticut Department of Correction (DOC)** – Collaboration with criminal justice system and DOC referrals coordinator

IMPACTS

79 clients served

- **Clients with a suppressed viral load are living less chaotic lives and are deeply connected to their medical care teams**
- **Navigation services will continue beyond the end of the project**

Learn more: http://cahpp.org/project/medheart

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number H97HA24963 (Special Projects of National Significance (SPNS) Initiative Building a Medical Home for Multiply Diagnosed HIV-positive Homeless Populations, in the amount of $300,000 annually) awarded to Yale University. No percentage of this project was financed with non-governmental sources. 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.