Housing Awareness Month: Improving Health Outcomes for PLWH Experiencing Unstable Housing

The Role of the Ryan White HIV/AIDS Program (RWHAP)

Lessons from Special Projects of National Significance (SPNS): Innovative Strategies for Coordinating Health Care and Housing Services

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North Carolina Rurally Engaging and Assisting Clients who are HIV positive and Homeless (NC REACH) Project CommWell Health

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HIV Homeless Outreach Mobile Engagement (HHOME) Project San Francisco Department of Public Health
Learning Objectives

• Obtain an overview of the HAB/SPNS Building a Medical Home for Multiply Diagnosed HIV-positive Homeless Populations Initiative

• Discuss barriers rural and urban communities are facing to achieving stable, permanent housing and continuous quality care

• Learn about promising intervention strategies in working with homeless and unstably housed people living with HIV (PLWH) with co-occurring mental illness and/or substance use issues
Purpose of SPNS

Develop innovative models of HIV treatment

Quickly respond to emerging needs of clients
Advancing the HIV Care Continuum

SPNS has funded initiatives along the steps of the HIV Care Continuum including projects focused on:

- populations not in care
- outreach
- linkage to care
- medication adherence
- retention/re-engagement
SPNS grantees are located across the country and change work with the hardest-to-reach populations:

- Homeless
- Latinos
- American Indians/Alaska Natives
- YMSM
- Incarcerated
- Women of Color
- Transgender Women
- Caribbean-Americans
- Adolescents
Background and Significance

• National HIV/AIDS Strategy
  • Reducing the number of people who become infected with HIV
  • Increasing access to care and optimizing health outcomes for people living with HIV
  • Reducing HIV-related health disparities

Indicator 7: Reduce the percentage of persons in HIV medical care who are homeless to no more than 5 percent
SPNS meets federal priorities...
Build and maintain sustainable linkages to mental health, substance abuse treatment, and HIV/AIDS primary care services
Goal: To engage homeless/unstably housed persons living with HIV who have mental illness and/or substance use disorders in HIV and behavioral health care and obtain stable housing
Target Population

• Persons living with HIV who are age 18 or older

• *Persons who are homeless or unstably housed
  • Literally homeless
  • Unstably housed
  • Fleeing domestic violence

• Persons with one or more co-occurring mental health or substance use disorders

Intervention Models

• Building a medical home
  • Housing partnerships
  • Behavioral health partnerships
  • Systems integration

• Use of network navigators for systems integration and care coordination
Building Collaborative Partnerships

• Co-location of health care in housing/shelter units
• Creating special needs units for PLWH in housing programs
• Mobile health teams to housing agencies/health centers
• Emergency housing programs
• Establishing relationships with non traditional landlords
# HAB/SPNS Contacts

<table>
<thead>
<tr>
<th>SPNS</th>
<th>Email</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adan Cajina – SPNS Program Branch Chief</td>
<td><a href="mailto:Acajina@hrsa.gov">Acajina@hrsa.gov</a></td>
<td>(301) 443-3180</td>
</tr>
<tr>
<td>Melinda Tinsley, Public Health Analyst</td>
<td><a href="mailto:MTinsley1@hrsa.gov">MTinsley1@hrsa.gov</a></td>
<td>(301) 443-3496</td>
</tr>
<tr>
<td>Pamela Belton, Public Health Analyst</td>
<td><a href="mailto:PBelton@hrsa.gov">PBelton@hrsa.gov</a></td>
<td>(301) 443-4461</td>
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<tr>
<td>Renetta Boyd, Project Officer</td>
<td><a href="mailto:RBoyd@hrsa.gov">RBoyd@hrsa.gov</a></td>
<td>(301) 443-4549</td>
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<tr>
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<td>(301) 443-5785</td>
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<tr>
<td>John Hannay, Project Officer</td>
<td><a href="mailto:Jhannay@hrsa.gov">Jhannay@hrsa.gov</a></td>
<td>(301) 443-0678</td>
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<tr>
<td><strong>Evaluation Technical Assistance Center</strong></td>
<td></td>
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<tr>
<td>Serena Rajabiun, Principal Investigator, Boston University</td>
<td><a href="mailto:rajabiun@bu.edu">rajabiun@bu.edu</a></td>
<td>(617)638-1934</td>
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Additional Resources and Information

• Medical Home-HIV Evaluation & Resource Team (Med-HEART)
  http://medheart.cahpp.org/

• National HIV/AIDS Strategy (NHAS)
  http://aids.gov/federal-resources/national-hiv-aids-strategy/overview/

• HIV Care Continuum
  http://www.aids.gov/federal-resources/policies/care-continuum/

• List of SPNS Initiatives and SPNS Products
  http://hab.hrsa.gov/

• Target Center
  www.careacttarget.org/category/topics/spns
Lessons from SPNS: Innovative Strategies for Coordinating Health and Housing

Lisa McKeithan
CommWell Health
Lisa McKeithan is the Project Manager of the North Carolina Rurally Engaging and Assisting Clients who are HIV positive and Homeless (NC REACH) project at CommWell Health, a federally qualified health center, in Dunn NC. With over 5 years leadership experience in HIV research, Lisa is a certified rehabilitation counselor with a Bachelors of Arts and Masters of Science degrees from the University of North Carolina at Chapel Hill.

She has a wealth of experience in the implementation of programs that reduce health disparities in rural communities. She affirms that in order to have a sustainable workforce, we must have healthy workers to secure the infrastructure of our communities. Lisa has dedicated her life to public service and ongoing advocacy efforts to foster accountability and community engagement. Serving as their visionary leader, NC REACH was awarded the Dr. Fayth M. Parks Rural HIV award for their innovative solutions in the fight against the HIV epidemic in rural communities.
Client Story
Video
Housing Instability (Rural)

- Homelessness
- Unstably Housed
Barriers to Retention in HIV Care in Rural Communities

• Housing instability
• Transportation needs
• Substance abuse
• Mental health
• Provider discrimination

• Stigma
• Lack of financial resources
• High no-show rates
• Lost to care and out-of-care
Challenges for Housing

- Transportation
- MH/SA treatment
- Limited resources - housing units, transitional housing
- Services for homeless but not HIV+
- Red tape - background checks, drug screens

- Funding (Cost for emergency shelters)
- Duplication of services
- Few Housing Providers
- Lack of permanent, affordable housing
- Fragmented system
- Poor coordination of services
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 Navigator

- Works closely with the HIV care team to foster culture of wellness
- Conducts community outreach
- Engages and recruits
- Connects participants to community housing and support services
- Builds partnerships in the community
- Provides transportation
More Network Navigator

- Connecting to community housing and other support services
- Participates in the multidisciplinary clinical team
- Providing supportive services to clients to maintain housing and reduce risky behaviors
- Making relevant supportive programs available for clients
- Serve as a liaison between the client and the landlords
Improve Health Outcomes

• Rural area
  – Transportation is provided
• Lack of available/affordable housing
  – Engagement with community resources
Improve Health Outcomes

• Lost to care and out-of-care
  – Home visits
  – Collaboration with providers

• Barriers in communication
  – Have translators on staff
  – Build rapport to gain trust
  – Being aware of their literacy level
  – Trainings in Cultural Competence
Community Housing Coalition

- Forum for local housing providers
- Quarterly meetings
- Development of shared goals and objectives
- Venue to share resources
- Two-way street: connecting clients to housing and medical
Community Housing Coalition
Improved Health Outcomes for Homeless and/or Unstably Housed Clients
## Resources

<table>
<thead>
<tr>
<th>Name of Center</th>
<th>Key contact person</th>
<th>Location</th>
<th>Shelter</th>
<th>Housing assist</th>
<th>Substances use</th>
<th>Mental Health</th>
<th>Case Mgmt</th>
<th>Primary Medical Care Assistance</th>
<th>Meals Assistance</th>
<th>Domestic Violence</th>
<th>Financia lAssist</th>
<th>HIV prevention</th>
<th>Social support</th>
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<tr>
<td>Adult Health Clinic Harnett Co. Health Dept</td>
<td>Debra Harkin 910-814-4198</td>
<td>307 W. ornament, Harnett Blvd, Lillington NC</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Alliance of AIDS services-Carolina</td>
<td>Stacy Duhart 803-834-2457</td>
<td>324 S. Harlington at Raleigh, NC</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>Beacon Rescue Mission</td>
<td>John Cooke 910-882-5777</td>
<td>207 W. Broad St, Dunn NC</td>
<td>Yes</td>
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<td>No</td>
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<td>Carolina Outreach</td>
<td>Phonda Northing 910-435-0393</td>
<td>307 Hay St, Fayetteville NC</td>
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<td>Cape Fear Valley Behavioral Health services</td>
<td>Laura Taylor 910-315-3773</td>
<td>3425 Metropolitan Pkwy, Fayetteville NC</td>
<td>No</td>
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<td>City Rescue Mission</td>
<td>Gladys Thompson 910-323-0446</td>
<td>1201 North Cool Sprinkle St.</td>
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<td>Community Health Interventions</td>
<td>Elza McCollister 910-436-5825</td>
<td>2403 Murchinson PI, Fayetteville NC</td>
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<td>Christian Faith Ministries</td>
<td>Tabatha Franklin 910-778-7247</td>
<td>705 Chatham St, Sanford NC</td>
<td>No</td>
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<td>Cumberland County Health</td>
<td>Phyllis McElroy 910-433-0300</td>
<td>1205 Fleming St, Fayetteville NC</td>
<td>No</td>
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<td>Yes by referral</td>
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<td>Cumberland Interfaith</td>
<td>Denise dilds 910-820-2454</td>
<td>110 Stein St, Fayetteville NC</td>
<td>No</td>
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<td>Good Neighbor House for women</td>
<td>Karen Eas 910-920-2000</td>
<td>Smithfield NC</td>
<td>Yes</td>
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<td>Healing Place of Wake County</td>
<td>Dennis Tripp 910-630-3000</td>
<td>3201 Good St., Raleigh NC</td>
<td>Yes</td>
<td>No</td>
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<td>Hope Center</td>
<td>Evelyn Campbell 910-920-4729</td>
<td>313 Person St, Fayetteville NC</td>
<td>Yes</td>
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<td>No</td>
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<tr>
<td>House of Fordham Shelter</td>
<td>Linda Barrow 910-736-7305</td>
<td>412 W. William St., Goldsboro NC</td>
<td>Yes</td>
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<tr>
<td>New Life Mission, Inc.</td>
<td>Pastor Grace Kim 910-304-4678</td>
<td>303 Malone Ave., Fayetteville NC</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Potter's Vine Ministries</td>
<td>Manager John 910-417-5176</td>
<td>417 Faith Ln, Mount Olive NC</td>
<td>Yes</td>
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<td>Port Cities Center, Human Services</td>
<td>252-413-1637</td>
<td>203 Government St., Greenville NC</td>
<td>No</td>
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<td>No</td>
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<tr>
<td>Project Homeless Fayetteville PDI</td>
<td>Officer Stacey Sanders 910-467-4124</td>
<td>467 Hay St, Fayetteville NC</td>
<td>No</td>
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<tr>
<td>Rosie Ave.</td>
<td>Darnell Cannon 910-1121</td>
<td>1724 Rosie Ave, Fayetteville NC</td>
<td>No</td>
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**CommWell Health**

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Community Outreach
Thank you

✓ HRSA
✓ ETAC
✓ CommWell Health
✓ Positive Life
✓ SPNS
✓ Boston University
✓ Pillar Consulting
✓ UNC-CH
Contact Information

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3331 Easy Street
Dunn NC 28334
Office (910) 567 6194 x 6054
Cell (910) 818-1237
THE HOMELESS HEALTH OUTREACH AND MOBILE ENGAGEMENT (HHOME) PROJECT
SAN FRANCISCO, CA
FUNDED BY: HRSA | SPECIAL PROJECT OF NATIONAL SIGNIFICANCE (SPNS) INITIATIVE

JASON DOW: peer navigator
SIOTHA KING-THOMAS: case manager
DEBORAH BORNE, MSW, MD: principal investigator
JANELL TRYON, MPH: researcher & evaluator
KATE FRANZA, LCSW: program manager
JOAN BROSnan, RN: registered nurse
BRRENDA MESKAN, MFT: clinical director
SF Department of Public Health:
MEDICAL CLINICS, CONSORTIUM CLINICS, & SHELTERS
Homelessness is an independent risk factor for elevated Viral Load
AFFORDABLE HOUSING SHORTAGE: SF Median Price for One Bedroom 2015
## DPH FY 2014-2015: Data for Clients Experiencing Homelessness

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<th></th>
<th>HOMELESS</th>
<th>HOMELESS &gt; 10 YEARS</th>
<th>TAY 18-24</th>
<th>WOMEN</th>
<th>AGE 60+</th>
<th>TOP 1-5% HIGH UTILIZERS</th>
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<td><strong>% HIV</strong></td>
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Coordinated Case Management System (CCMS) Homeless Client Data
HHOME: Integrated mobile primary care for the hardest-to-reach

To be considered for enrollment, a client must be:

- living with HIV
- experiencing **active substance use**
- **not adherent** to or prescribed HIV medicine
- living with mental illness
- living on the street or in HRSA-defined unstable housing
- **not currently engaged** in primary medical care, low CD4
SYSTEM WRANGLER
INTEGRATED MOBILE CARE: a citywide collaboration

- Mobile Medical Case Management
- Mobile RN Care Coordination and Adherence
- Mobile Integrated Primary Medical Care
- Timely Access to Medical Shelter, Stabilization Room and Respite
- City Wide Evaluation for Level of Acuity for Clients
- Coordination of community partners and services available to clients
- Access to all city Supportive Housing (outside of DPH)
- Integrated Patient HIV Registry
- Fully Utilize Peer Navigators as part of care team
HHOME Team

Linking and Retaining HIV+ Multiply Diagnosed Homeless Clients in Care with HHOME Team
HHOME Team

Linking and Retaining HIV+ Multiply Diagnosed Homeless Clients in Care with Consumer as Captain of the HHHome Team

SF DPH Medical

Health Care for the Homeless Culture:

Addiction Medicine, Mental Health and Medical Treatment

SF Homeless Out Reach Team/Placement

Mobile Care Culture

HHOME TEAM

Consumer ‘Captain’ of Team

API Wellness

Drop in Clinic Drop in Center

Community Integrated Culture
ACUITY and CHRONICITY ASSESSMENT for REFERRALS
PARTICIPATION | ENROLLMENT

- CLIENTS SERVED: 90 in 2 years
- ENROLLED in STUDY: 61 participants
- ACTIVE PANEL:
  - 40 For team with 0.2 FTE MD
  - 20 per CM
- REFERRED: ~ 130 clients
MOBILE HOUSING CASE MANAGEMENT

HOUSING STATUS DEPENDS on:

- Readiness of client
- AND Housing availability (crisis in SF)

IT’S ALL ABOUT APPROPRIATE LEVEL

- skilled nursing facility (SNF)
- emergency shelter
- treatment/detox
- street*

HOUSING STATUS for ACTIVE CLIENTS

- Homeless/ Street: 33%
- Stabilization Room: 22%
- Treatment/ Detox: 7%
- Skilled Nursing: 7%
- Emergency Shelter: 7%
- Transitional Housing: 5%
- Permanently Housed: 26%
LONG-TERM HOUSING OUTCOMES

HOUSING STATUS for ACTIVE & DISCHARGED CLIENTS

- Homeless/ Street: 17%
- Shelter: 7%
- Stabilization Room: 3%
- Jail: 1%
- Assisted Living: 3%
- Permanently Housed: 43%
- Skilled Nursing: 3%
- Transitional Housing: 16%
- Stabilization Room: 3%
- Transitonal Housing: 7%
- Jail: 1%
- Unknown: 5%

HOUSING STATUS for DISCHARGED CLIENTS

- Homeless/ Street: 53%
- Shelter: 12%
- Skilled Nursing: 2%
- Transitional Housing: 7%
- Jail: 2%
- Assisted Living: 14%
- Stabilization Room: 5%
- Transitonal Housing: 5%
- Jail: 2%
- Unknown: 12%
Integrated Mobile Primary Care

*Street * Hospital * Shelter * SRO * Clinic * Treatment *
*Social Service*  CBO *Drop-In Center*
Medical Social Worker, Peer Navigator, Case Manager

**Primary Care: Medical, Psychiatry, Addiction Medicine**
Provider: MD
- Highest acuity clients
- Medical counseling/Advocacy
- Set Treatment Plan

**Nursing & Medication Adherence**
Provider: NURSE
- Complex Care Management
- Medication adherence
- Routine nursing care
Working with Mobile Housing Case Manager

- Housing as health care
- Benefits: SSI
- Client-centered care and health advocate
- Coach team on “Real World”

“Never give up, never surrender”
Siotha King-Thomas
Integrated Mobile Peer Navigation

- Work directly with patient
- Adherence coach with RN
  - Oversees med delivery, checks clients, tracks meds
- Weekly drop-in clinic with provider
- “In-a-flash” escorts and locates lost clients

“It’s not going to work if you’re doing more for the client than they are doing for themselves”

Jason Dow
Challenges to Engagement and Retention
Our Approaches
What Works

- Stabilization: Rooms & Shelter *when your ready, we are ready*
- Team Communication
- Flexible Treatment plans
- Cross training of team
- Starting treatment anywhere, anytime
- Insist on the Best Quality of Care
- Community Pharmacy
- Courage of consumer and team
Transitioning inside can be hard
Inside of the tents……….
Support Needed for Learning Life Skills
WHAT IT LOOKS LIKE
IN the BEGINNING
Clients struggle with organization and being indoors
WHAT IT CAN LOOK LIKE

It can take many weeks to many months for clients to adjust and then thrive indoors.
Despite the disproportionately high medical and psychosocial acuity of our clients, 63% of all active and discharged clients are virally suppressed, which is nearing the suppression rate of 67.1% for all Ryan White clients with unstable housing.
Contact Information for San Francisco Department of Health

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Q&A Begins........
Housing Awareness Month:
Improving Health Outcomes
for PLWH Experiencing Unstable Housing
The Role of the Ryan White HIV/AIDS Program (RWHAP)

Lessons from Special Projects of National Significance (SPNS):
Innovative Strategies for Coordinating Health Care and Housing Services