

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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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**

**RYAN WHITE
HIV/AIDS PROGRAM
MOVING FORWARD
FRAMEWORK**



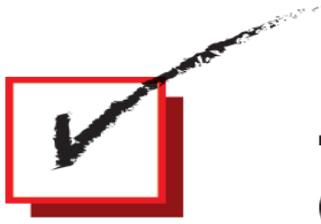
Purpose of SPNS

**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

Substance Users

Incarcerated

American Indians/
Alaska Natives

YMSM

Women
of Color

Adolescents

Transgender Women

Caribbean-Americans

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

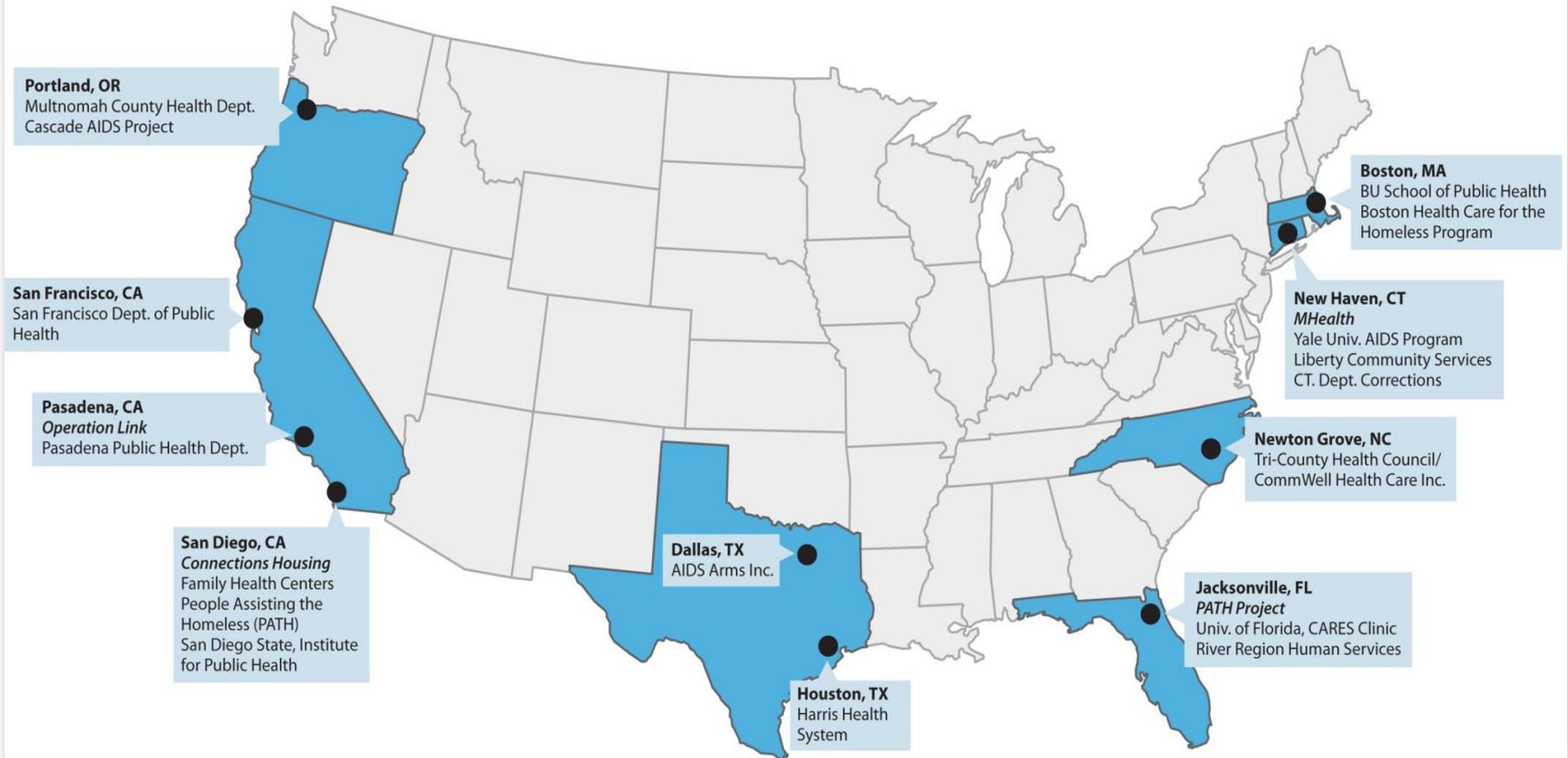
SPNS meets federal priorities...

Building a Medical Home for Multiply Diagnosed HIV-positive Homeless Populations

Build and maintain sustainable linkages to mental health, substance abuse treatment, and HIV/AIDS primary care services



HRSA/SPNS Initiative: Building a Medical Home for HIV Homeless Populations



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

*Definition of “homeless”: The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH): Defining “Homeless” Final Rule published in the Federal Register on December 5, 2011

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

SPNS	Email	Phone
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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

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)

SPNS – NC REACH Team



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

GENERAL INFORMATION			SERVICES PROVIDED												
Name of Center	Key contact person	Location	Shelter	Housing assist	Substance use	Mental Health	Case Mgmt	Primary Medical Care Assistance	Meals Assistance	Domestic Violence	Financial Assistance	HIV prevention	Social support	Other (specify)	Notes
Adult Health Clinic Harnett Co. Health Dept.	Debra Hawkins 910-814-6198	307 W cornelius Harnett Blvd Lillington NC	No	No	no	Yes	yes	Yes	no	No	no	Yes	no	N/A	
Alliance of AIDS services-Carolina	Stacy Duck 919-834-2437	324 S. Harrington st. Raleigh, NC	No	Yes	Yes	Yes	Yes HIV	Yes	Yes	No	Yes	Yes	Support	n/a	n/a
Beacon Rescue Mission	John Cooke 910-892-5772	207W. Broad Street Dunn, NC	Yes	yes	no	Yes	no	no	yes	yes	no	no	no	n/a	Homeless shelter
Betsy Johnson Regional Hospital	910-892-1000	800 Teilghman Dr. Dunn NC	No	No	Detox by	Yes	no	Yes	no	No	no	Yes	yes	N/A	detox thru ER only
Carolina Outreach	Rhonda Nordin 910-438-0939	907 Hay St. Fayetteville NC	No	No	Yes	Yes	Yes	No	No	No	No	Yes	Yes	N/A	
Cape Fear Valley Behavioral Health services	Laura Taylor 910-615-3753	3425 Melrose Rd Fayetteville NC	No	Yes	yes	yes	yes	yes	no	no	no	yes	yes	n/a	
City Rescue Mission	Gladys Thompson 910-323-0446	120 North Cool spring st.	Yes	yes	no	Yes	no	no	Yes	yes	yes/ case by	no	yes	n/a	Female only cost \$50.00/
Community Health Interventions	Elazzoa McArthur 910-488-6188	2409 Murchinson Rd Fayetteville NC	No	No	no	no	yes	no	no	no	yes	yes	yes	n/a	
Christian Faith Ministries	Tabatha Franklin 919-776-8474	705 Chatham St. Sanford NC	Yes	No	no	no	no	no	Yes	No	No	no	Yes	n/a	Homeless shelter
Cumberland County Health	Phyllis McLemore 910-433-3600	1235 Ramsey St. Fayetteville NC	No	No	yes - by referral	Yes	no	Yes	no	No	no	Yes	n/a	N/A	
Cumberland Interfaith	Denise Jiles 910-826-2454	113 Stein St. Fayetteville NC	No	yes	no	no	no	no	Yes	no	no	no	no	n/a	In county only
Good Neighbor House for women	Karen Earp 919-934-3639	Smithsfield NC	Yes	Yes	no	no	yes	no	yes	yes	no	no	yes	n/a	Female only mandatory drug screen.
Healing Place of Wake County	Dennis Tripp 919-838-9800	1251 Goode St. Raleigh NC	Yes	Yes	no	no	Yes	no	Yes	yes	No	no	Yes	n/a	Cur of County case bu case cost \$7.00/day
Hope Center	Evelyn Campbell 910-920-4729	913 Person St. Fayetteville NC	Yes	yes	yes	yes	yes	no	yes	no	no	yes	yes	n/a	
House of Fordham Shelter	Linda Burroughs 919-736-7352	412 N. William st. Goldsboro NC	Yes	Yes	no	no	no	no	Yes	No	no	no	y	N/A	no cost
New Life Mission church/shelter	Pastor Grace Kim 910-864-4678	303 Maloney Ave. Fayetteville NC	Yes	No	No	No	No	No	Yes	No	No	no	Yes	n/a	
Potter's Wheel Ministries	Manager John	147 Faith Ln. Mount Olive NC	Yes	Yes	No	No	Yes	No	Yes	No	No	No	Yes	n/a	
Port Crisis Center, Human Services	252-413-1637	203 Government cir. Greenville NC	No	No	yes/detox	Yes	yes	Yes	no	No	no	Yes	yes	N/A	Detox facility
Project Homeless Fayetteville PD	Officer Stacey Sanders Community	467 Hay St. Fayetteville NC	No	liason only	no	no	no	no	liason	liason	no	no	yes	N/A	homeless liason
Roxie Ave.	Darnise Cannon 910-	1724 Roxie Ave			Detox										Cumberland

Community Outreach



Thank you

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

Contact Information



Lisa McKeithan, MS,
CRC

SPNS Project Manager

CommWell Health

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Dunn NC 28334

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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

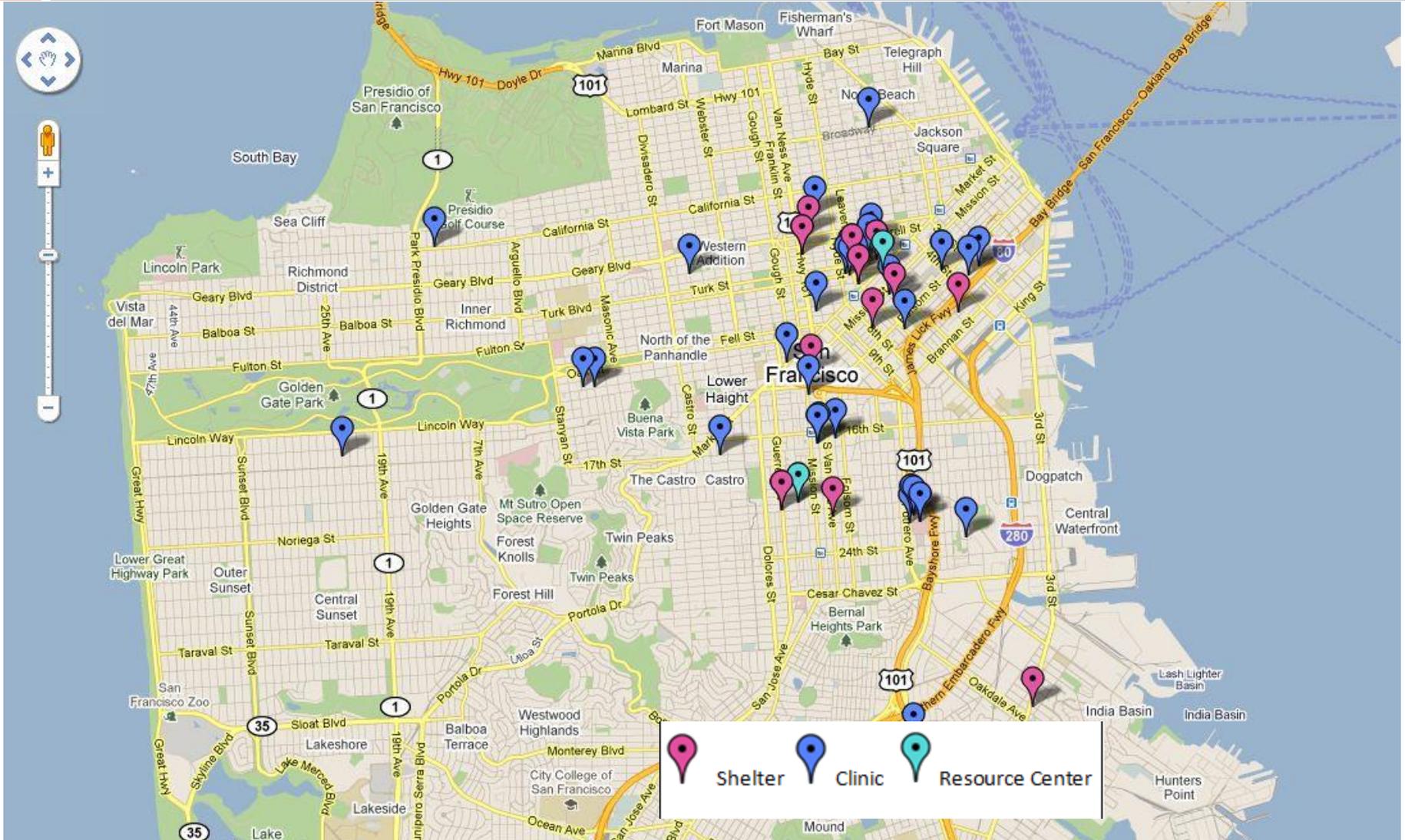
JASON DOW: peer navigator
SIOTHA KING-THOMAS: case manager
DEBORAH BORNE, MSW, MD: principal investigator
JANELL TRYON, MPH: researcher & evaluator
KATE FRANZA, LCSW: program manager
JOAN BROSNAN, RN: registered nurse
BRENDA MESKAN, MFT, clinical director

San Francisco
Department of Public Health



ASIAN & PACIFIC ISLANDER
WELLNESS CENTER

SF Department of Public Health: MEDICAL CLINICS, CONSORTIUM CLINICS, & SHELTERS



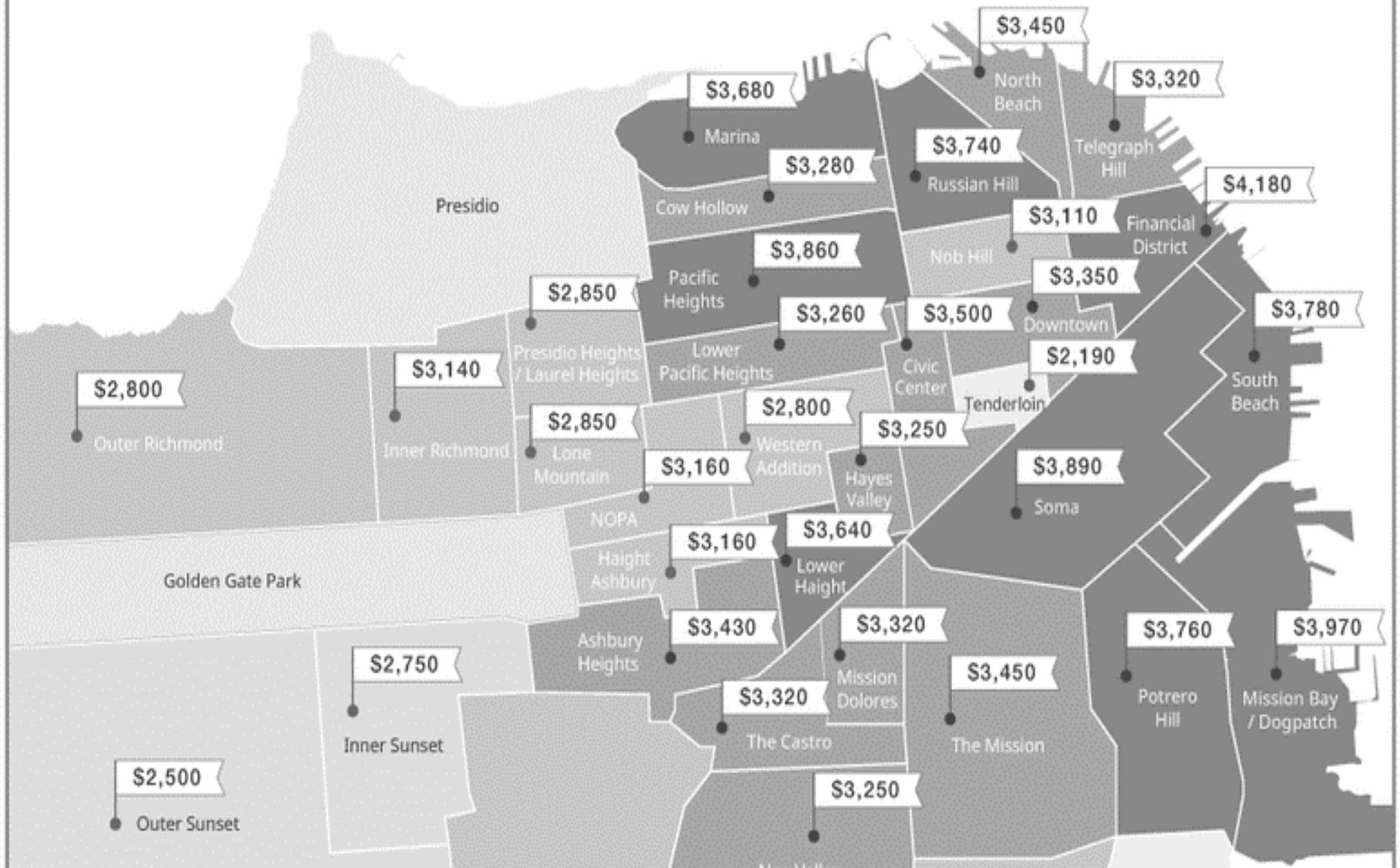
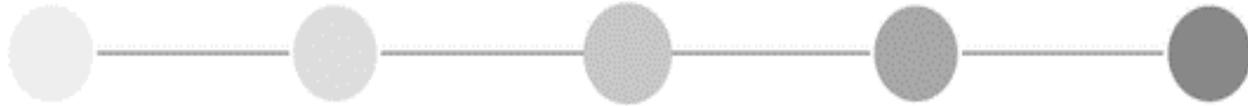
\$1,900 - \$2,399

\$2,400 - \$2,799

\$2,800 - \$3,199

\$3,200 - \$3,599

\$3,600 - \$4,200

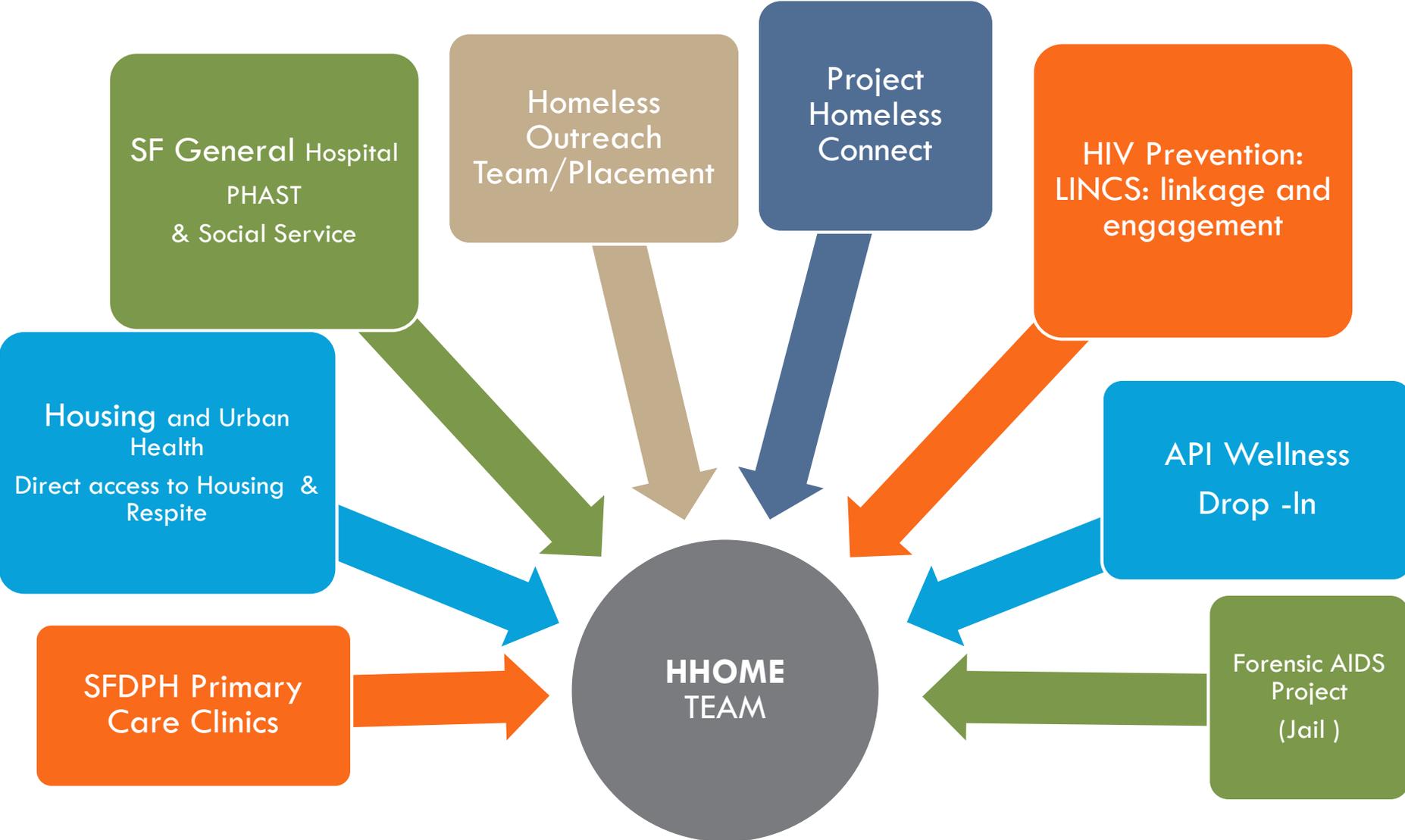


DPH FY 2014-2015:

DATA for CLIENTS EXPERIENCING HOMELESSNESS

	HOMELESS	HOMELESS > 10 YEARS	TAY 18-24	WOMEN	AGE 60+	TOP 1-5% HIGH UTILIZERS
Total Number	9,975	3,272	631	2,403	1,304	1,234
% HIV	7.5%	12.3%	2.7%	5.3%	6.6%	13.3%
	(747)					(173)

HHOME PARTNERS & STAKEHOLDERS



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

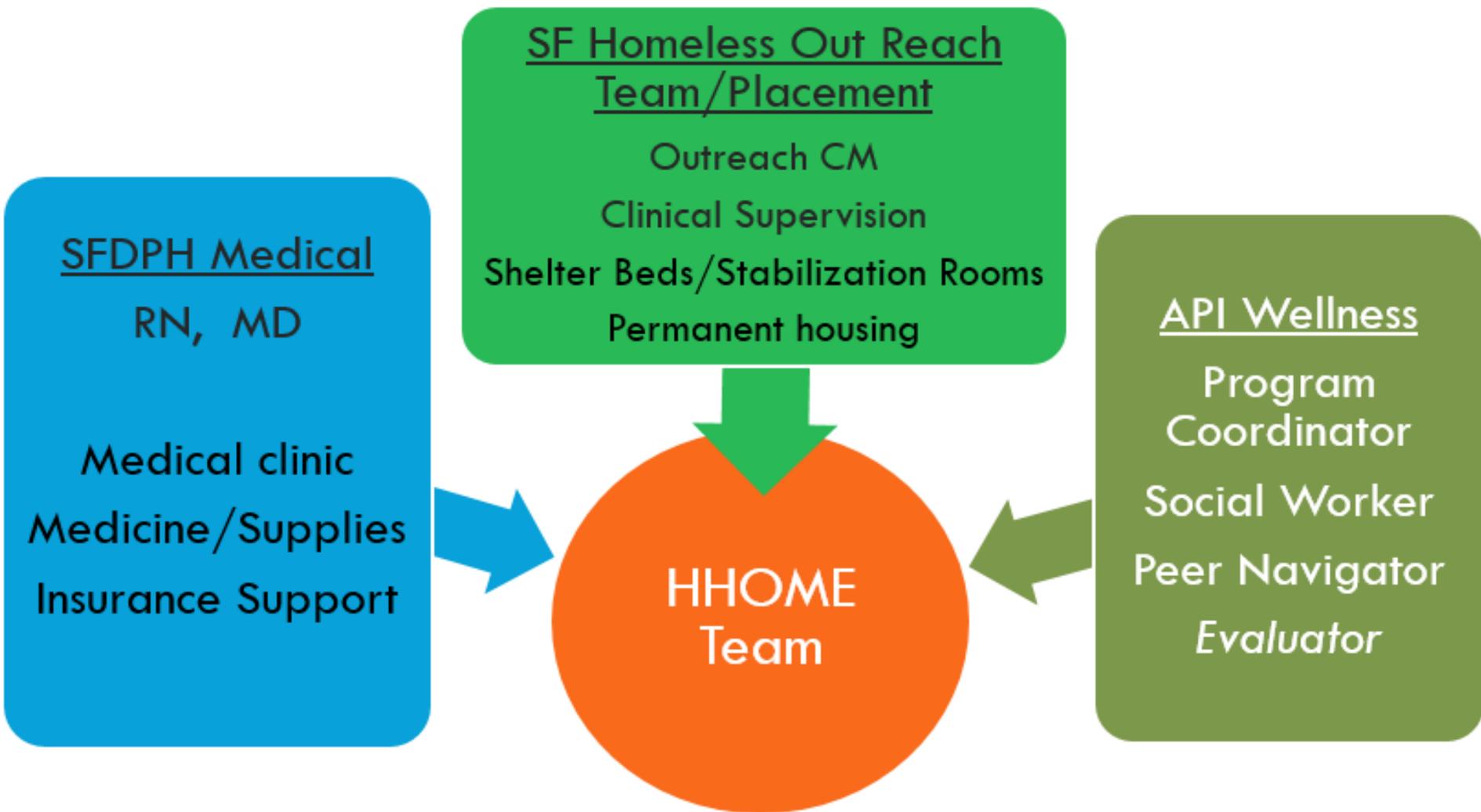
Access to all city
Supportive Housing
(outside of DPH)

Integrated Patient
HIV Registry

Fully Utilize Peer
Navigators as part
of care team

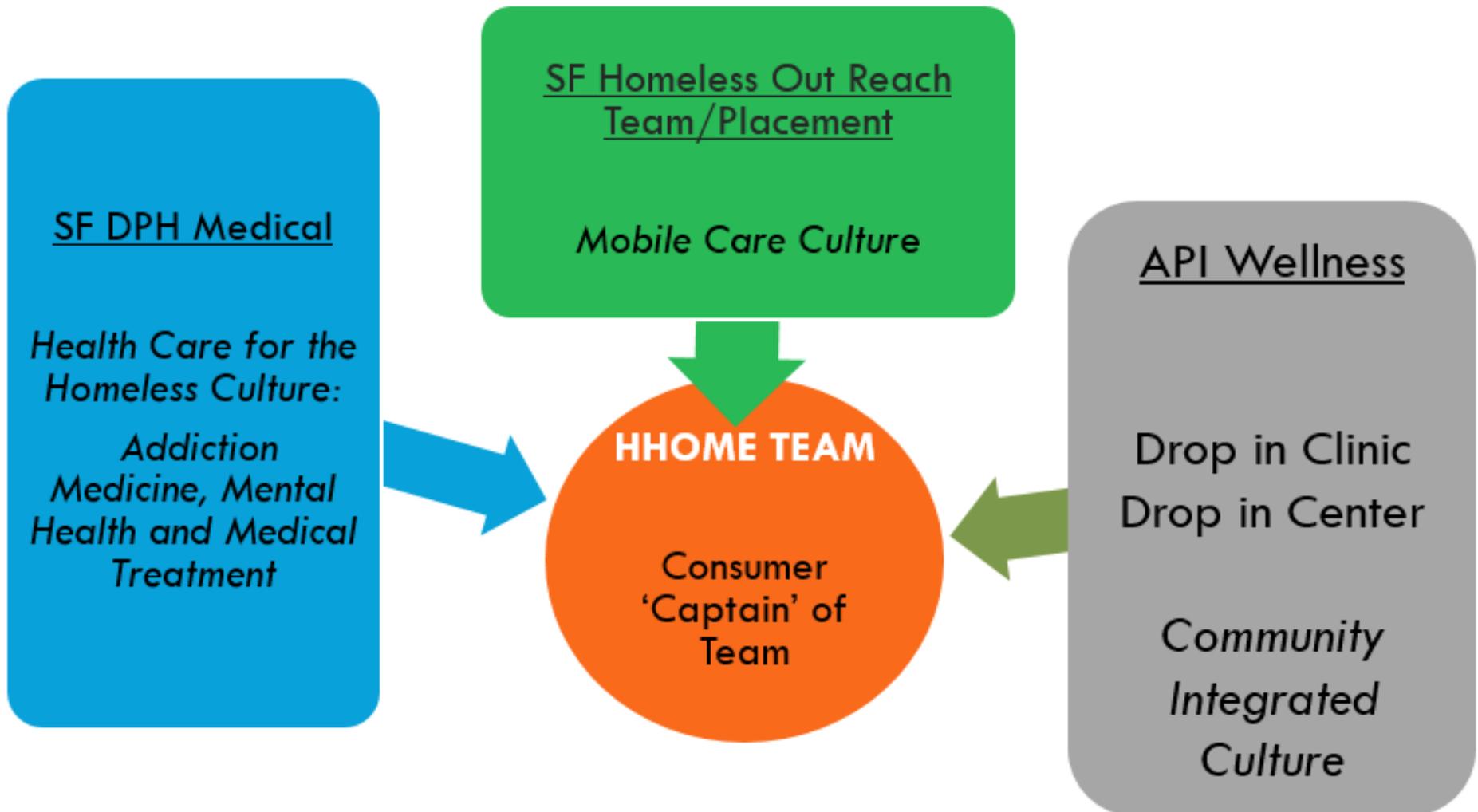
HHOME Team

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

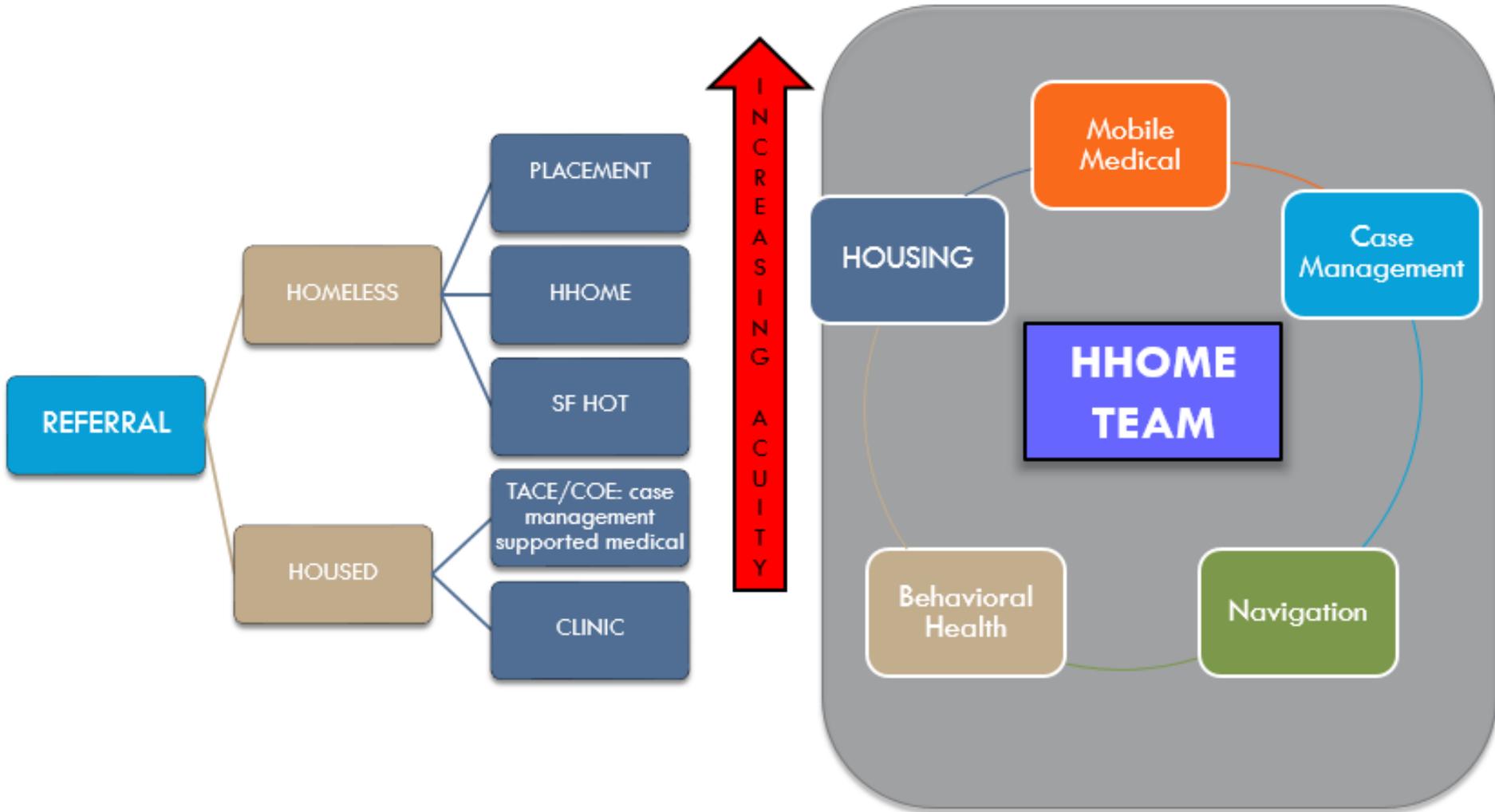


HHOME Team

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



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:

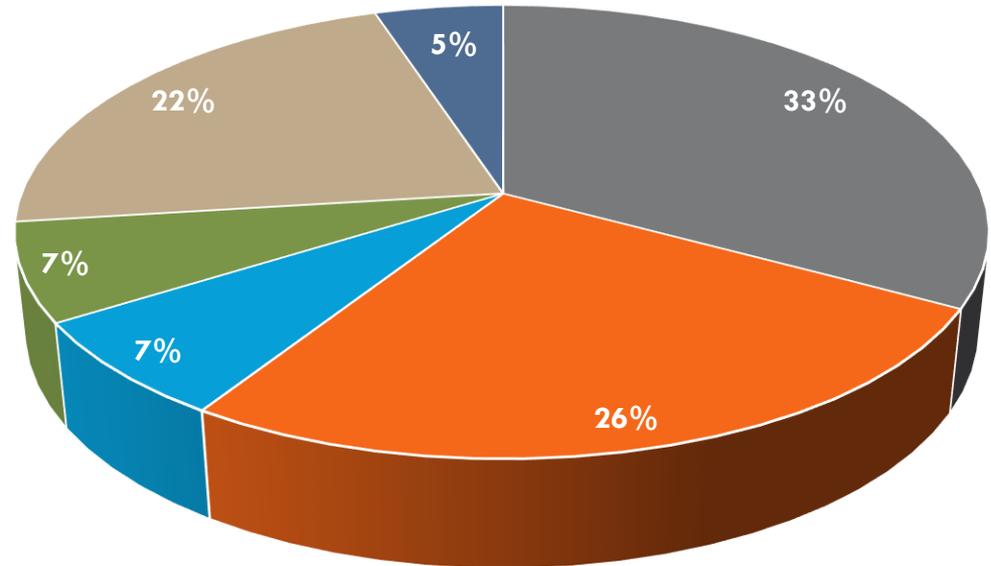
Readiness of client

AND Housing availability
(crisis in SF)

IT'S ALL ABOUT APPROPRIATE LEVEL

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

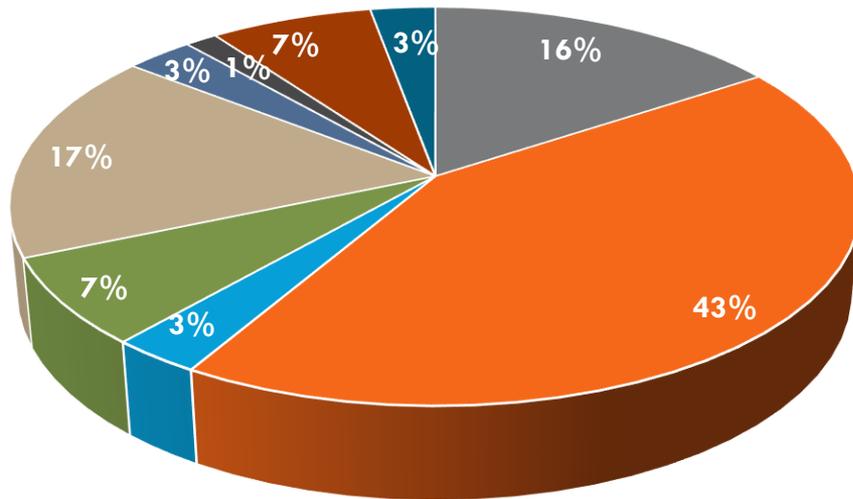
HOUSING STATUS for ACTIVE CLIENTS



- Homeless/ Street
- Shelter
- Skilled Nursing
- Stabilization Room
- Permanently Housed
- Transitional Housing

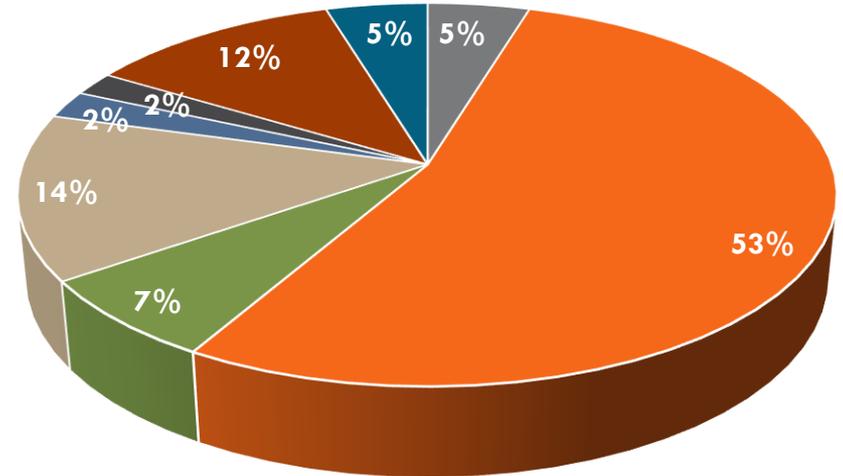
LONG-TERM HOUSING OUTCOMES

HOUSING STATUS for ACTIVE & DISCHARGED CLIENTS



- Homeless/ Street
- Shelter
- Stabilization Room
- Jail
- Assisted Living
- Permanently Housed
- Skilled Nursing
- Transitional Housing
- Unknown

HOUSING STATUS for DISCHARGED CLIENTS



- Homeless/ Street
- Shelter
- Stabilization Room
- Jail
- Assisted Living
- Permanently Housed
- Skilled Nursing
- Transitional Housing
- Unknown

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

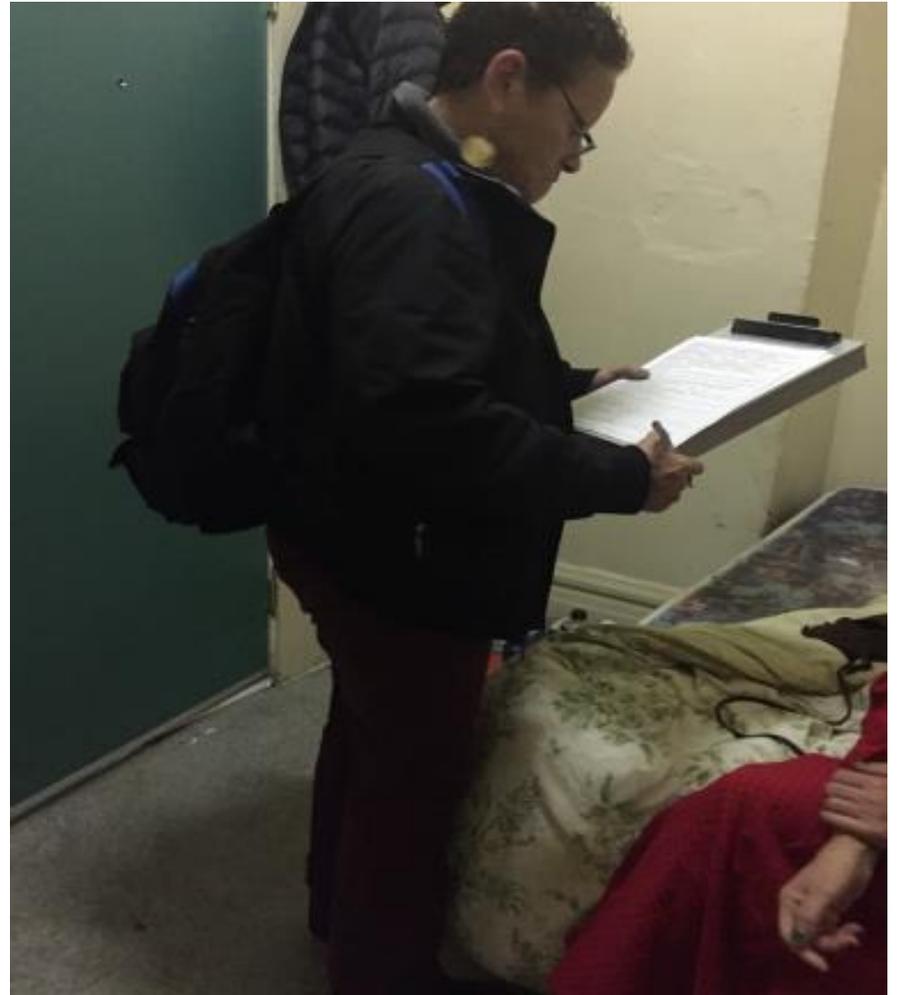
- Complex Care Management
- Medication adherence
- Routine nursing care

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

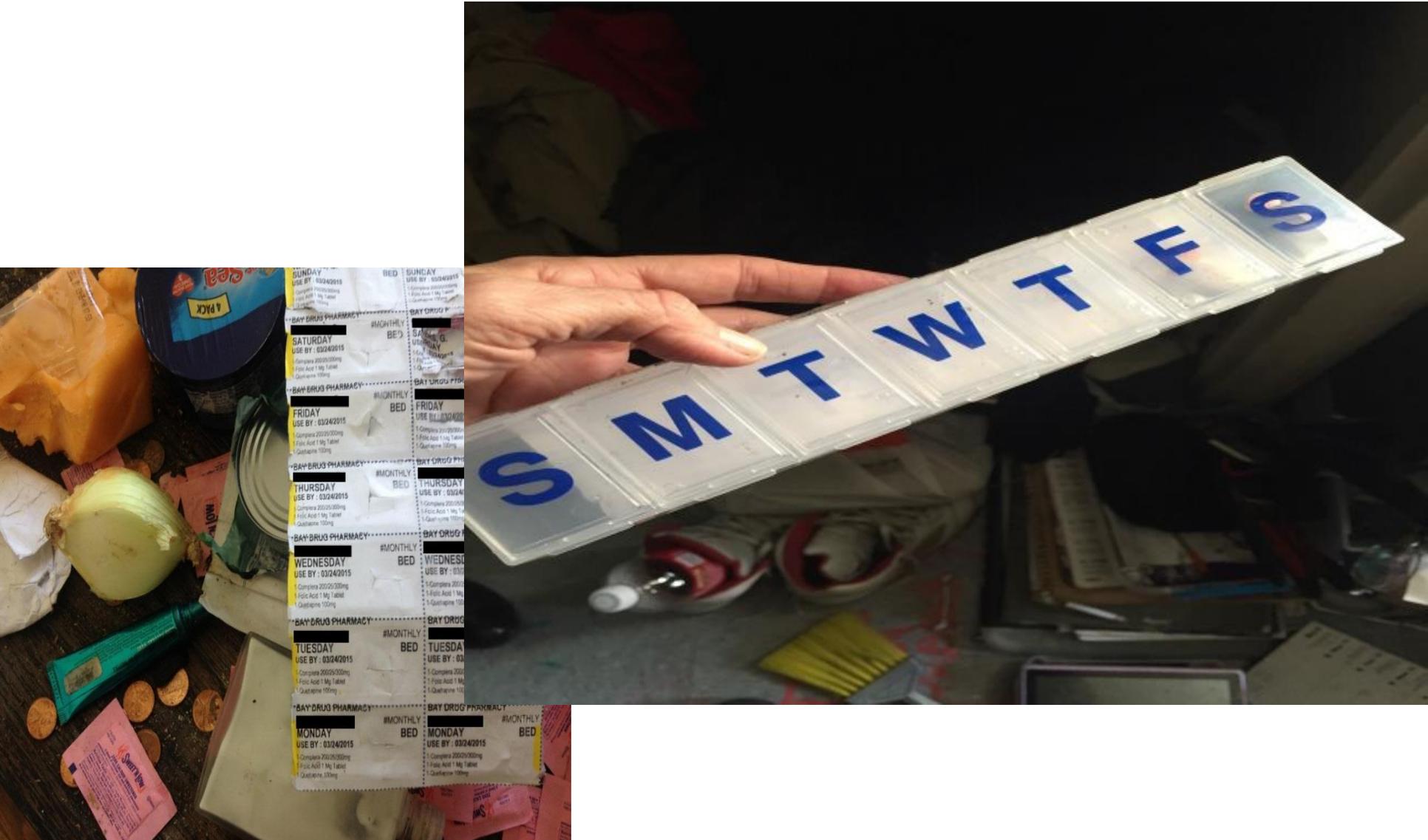


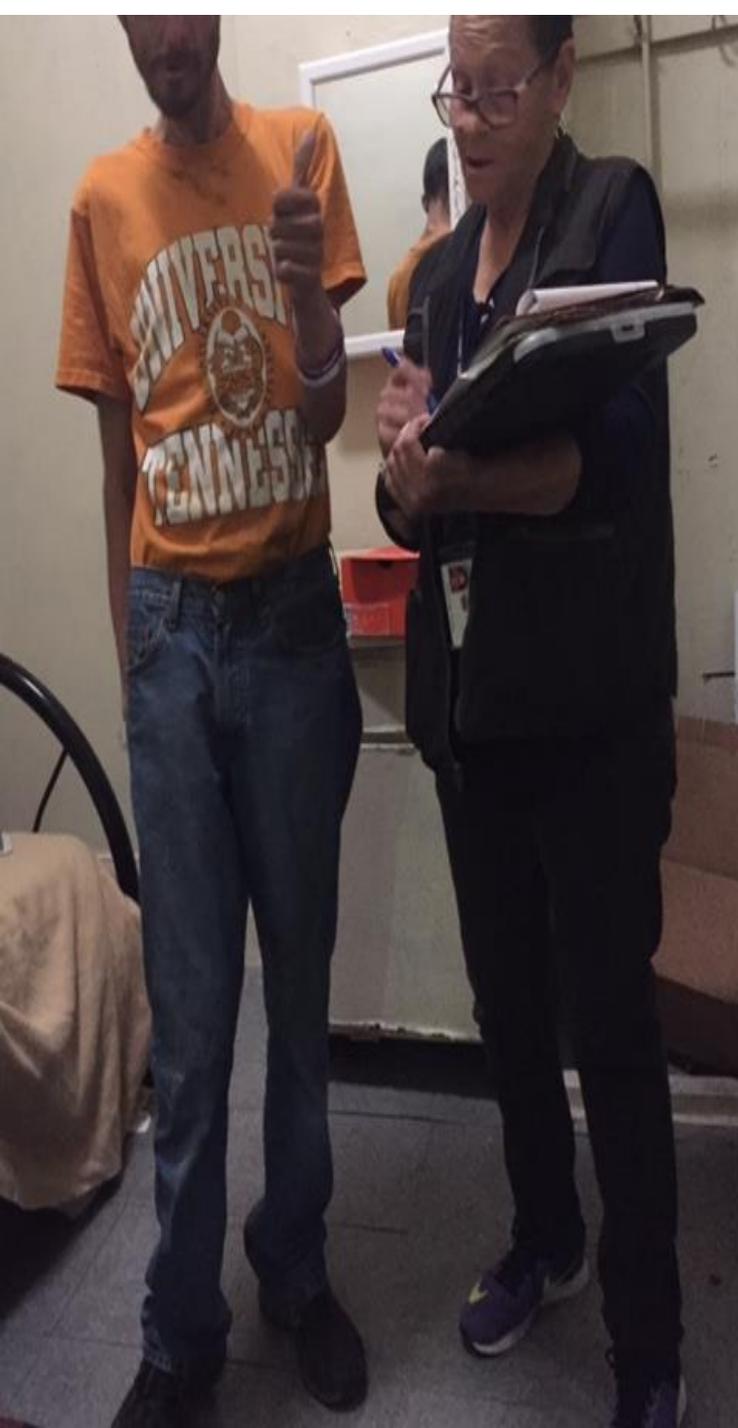
Challenges to Engagement and Retention

Our Approaches



CREATIVE APPROACHES TO ADHERENCE





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





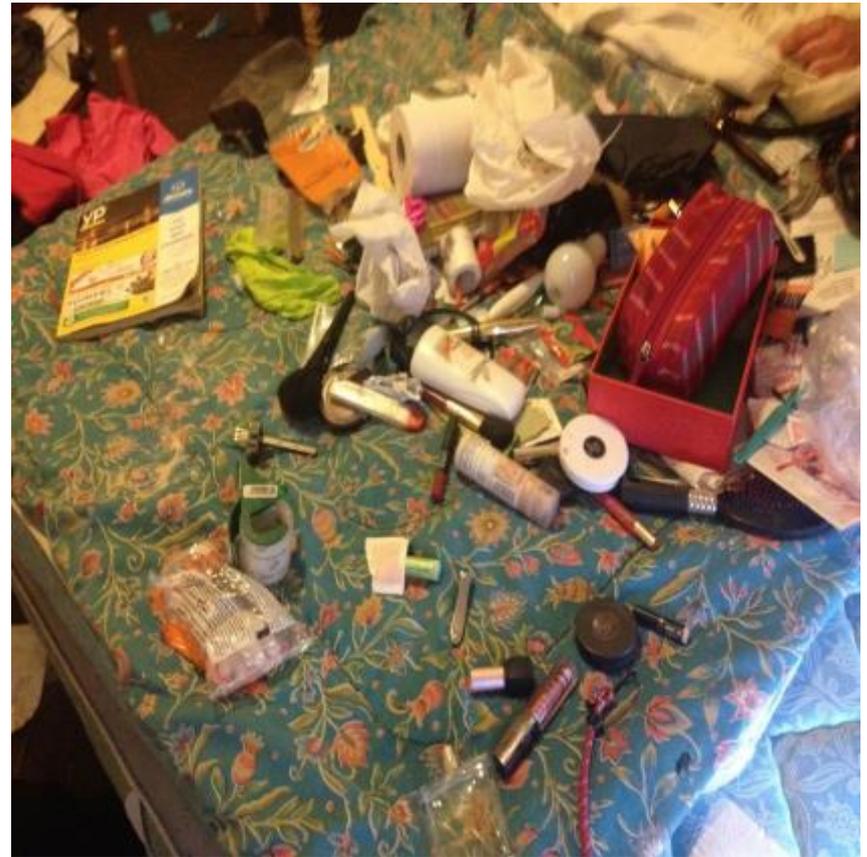
Support Needed for Learning Life Skills



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



CLINICAL OUTCOMES

Source: Ryan White HIV/AIDS Program Annual Client-Level Data Report (RSR) 2014

VIRAL SUPPRESSION 2016

RYAN WHITE UNSTABLY
HOUSED CLIENTS

67

HHOME CLIENTS

63



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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and Principle Investigator*

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Q&A Begins.....



Thank You...

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***