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

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Model Description

- In 2012, with funding support from the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau through its Ryan White HIV/AIDS Program Part F Special Projects of National Significance (SPNS), Family Health Centers of San Diego (FHCSD) built a Primary Care Medical Home (PCMH) collaborative care model that serves homeless individuals living with HIV in San Diego County who face substance use and/or mental health challenges.
- The FHCSD model of care is built upon a developed collaboration between FHCSD as lead program organization in formalized partnership with People Assisting the Homeless (PATH). Family Health Centers of San Diego (FHCSD) is a private, non-profit federally qualified healthcare center with a mission to provide high-quality, affordable health care to individuals and families. PATH is a non-profit organization that provides services for homeless or unstably housed individuals in San Diego County.

Programmatic Goals

1) Improve housing stability among the target population.
2) Increase client engagement and retention in HIV care and treatment, resulting in viral suppression.
3) Build and sustain linkages to mental health and substance abuse.
4) Create a bridge to other supportive services such as case management and care navigation.

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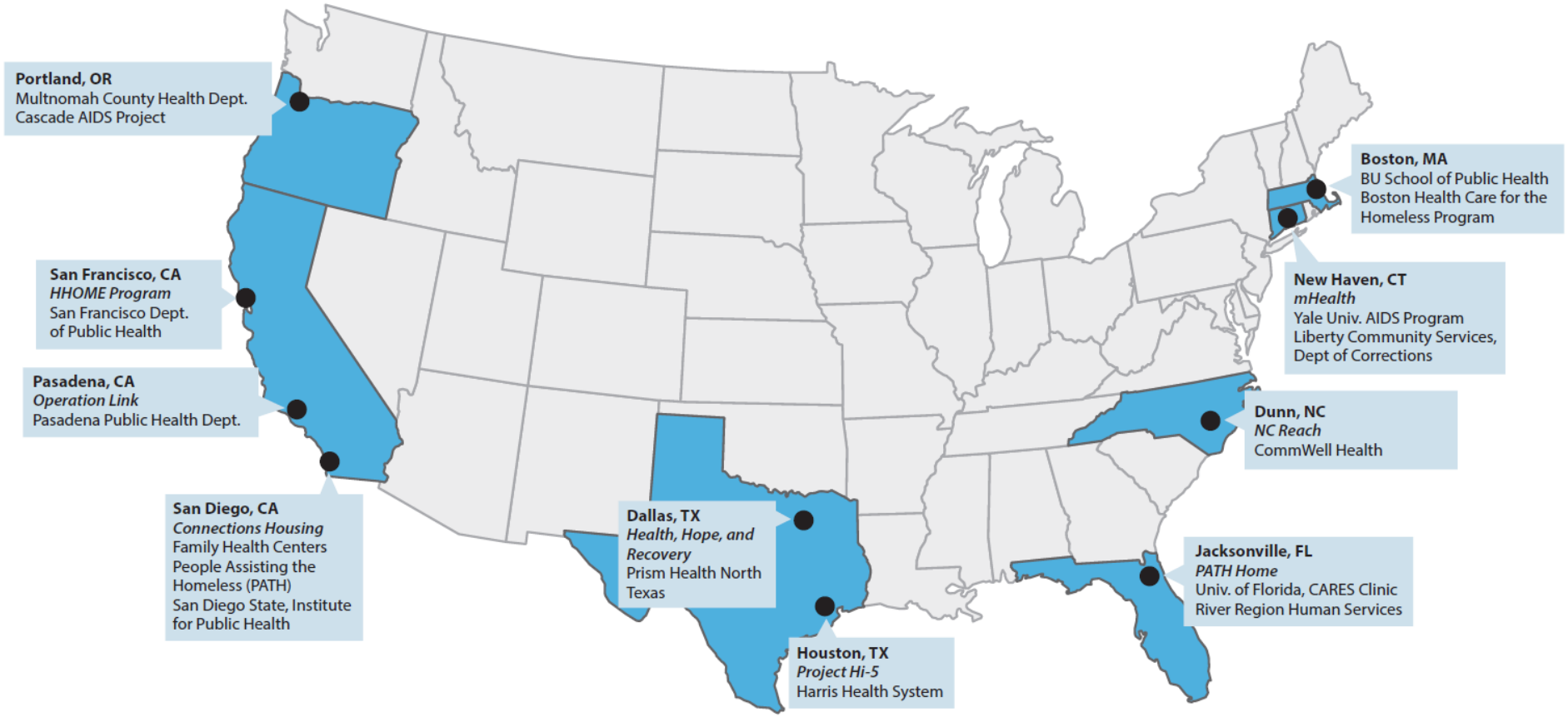

Goal: To engage people who are experiencing homelessness/unstably housed and living with HIV who have mental illness and/or substance use disorders in HIV and behavioral health care and obtain stable housing

Focus Population

- People living with HIV who are 18 years of age or older;
- And are experiencing homelessness or are unstably housed
  - Literally homeless
  - Unstably housed
  - Fleeing domestic violence
- And/or have one or more co-occurring mental health or substance use disorders

Implementation Model

- **Network navigators** (aka, care coordinators, peer navigators, specialized case managers)
  - 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." MCHD Case Manager
- Integrated behavioral health integration & HIV primary care
  - Team communication/huddles
- Partnering with housing providers & landlords
- System level coordination (housing, health, mental health, substance use treatment providers)
- "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 without the walls out of the clinic and create a clinic? And that's been the goal of the project"*. –Deborah Borne, MD PI HHOME-SFDPH

National SPNS participants

- 1,332 clients served
  - 62% literally homeless
  - 37% unstably housed
  - 1% fleeing domestic violence
  - 75% Male
  - 21% Female
  - 4% Transgender
  - 47% African-American/Black
  - 17% Hispanic

National SPNS participants

- 81% history of incarceration
- 75% diagnosed mental health condition (depression, anxiety, schizophrenia, PTSD)
- 40% experienced sexual assault
- 44% experienced physical injury
- Illicit substance use
  - 24% high risk (dependence)
  - 78% moderate (problem)
- 59% food insecure, past 30 days
- 32% out of care more than 6 months

FHCSD Housing Results

254 clients served – San Diego

- 83 permanently housed
- 24 temporarily housed
- 31 relocated out of state
- 15 couch surfing
- 61 homeless
- 7 incarcerated
- 15 deceased
- 18 unknown

FHCSD SPNS Participants

- 108 study participants
- 77 virally suppression
  - 24 literally homeless
  - 8 unstably housed
  - 5 fleeing domestic violence

FHCSD SPNS participants

- 108 clients served
  - 94 Male
  - 7 Female
  - 7 Transgender

  - 62% White
  - 31% African-American/Black
  - 5% American Indian/Alaska Native
  - 2% Asian

Initiative Evaluation

- Baseline Interviews
  - 3 months
  - 6 months
  - 12 months
  - 18 months

- Evaluation Incentives
  - $25 Gift card offered to participants to complete evaluation questionnaires

Intervention Dose

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

FHCSD & PATH Successes

- Creation of a Primary Care Medical Home
- Expansion of Formalized Housing Partners
- Increased Collaborative Organizational Relationships
- Enrollment of Participants in Evaluation to Determine Efficacy
- Creation of a One-Stop-Shop Comprehensive Services Model
  - Legal Services
  - Case Management
  - Navigation
  - Employment Readiness
  - Behavioral Health Services
  - Support Groups

- **Community Advisory Board**-Involve consumers to ensure program design continues to meet changing needs.

SPNS Challenges

- Lack of Housing Options in San Diego County
  - Lack of permanent housing
  - Lack of permanent shelters and winter shelters
  - Shortage of affordable housing and housing supportive services
- Untreated Mental Health and/or Substance Use Issues
- Loss of Employment, Financial Hardship, Non-livable Wages
- Immigration Status
- Untreated Chronic Illness

Summary

- Promising findings from the SPNS Initiative to engage multiply diagnosed HIV-positive populations in HIV Care to achieve viral suppression

Lowest viral suppression prior to enrollment (<200 copies/mL), 180 days prior to enrollment to 30 days post enrollment

Lowest viral suppression (<200 copies/mL) first 12 months** 30 to 395 days post enrollment

- General trends in retention of care and viral suppression rates for persons still experiencing unstable housing
- Reduction in unmet needs and barriers to care
  - Substance use treatment
  - Mental health care
  - Housing
- Need for multi-level strategies to coordinate providers across the community, within the organization, and intensive one-on-one with individuals

Program Outcomes

- Nevertheless, permanent housing alone is not enough.
- Supportive services such as
  - medical care
  - mental health
  - substance abuse counseling
  - educational training
  - job placement
- Are also paramount and necessary to successfully house this population.
- Through the provision of these wrap-around services, our SPNS intervention improved
  - timely entry
  - engagement
  - retention in HIV care
  - supportive services
- For homeless and unstably housed people living with HIV with co-occurring mental illness and/or substance use disorders.

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THANK YOU