

2017 USCA: HRSA Pathway

HRSA Innovative Service Models & Best Practices

Special Projects of National Significance Program
Building a Medical Home for Homeless HIV Positive Populations Initiative

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Special Projects of National Significance (SPNS)

HIV/AIDS Bureau (HAB)

Health Resources and Services Administration



Ryan White HIV/AIDS Program Framework

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



Vision

Optimal HIV/AIDS care and treatment for all.

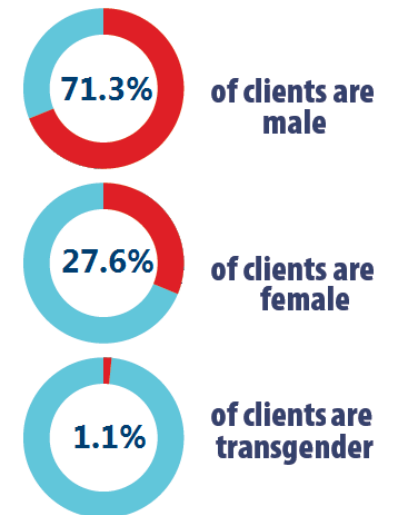
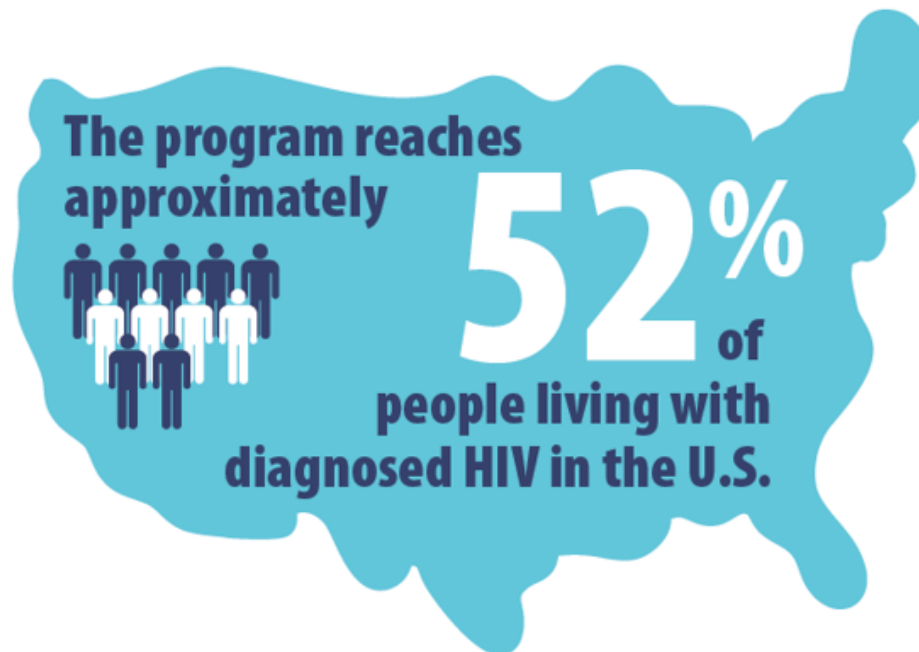
Mission

Provide leadership and resources to assure access to and retention in high quality, integrated care, and treatment services for vulnerable people living with HIV/AIDS and their families.

Select Demographic Characteristics of Clients Served by the Ryan White HIV/AIDS Program 2015 —United States and 3 Territories^a



ARE FROM RACIAL/ETHNIC MINORITY POPULATIONS.

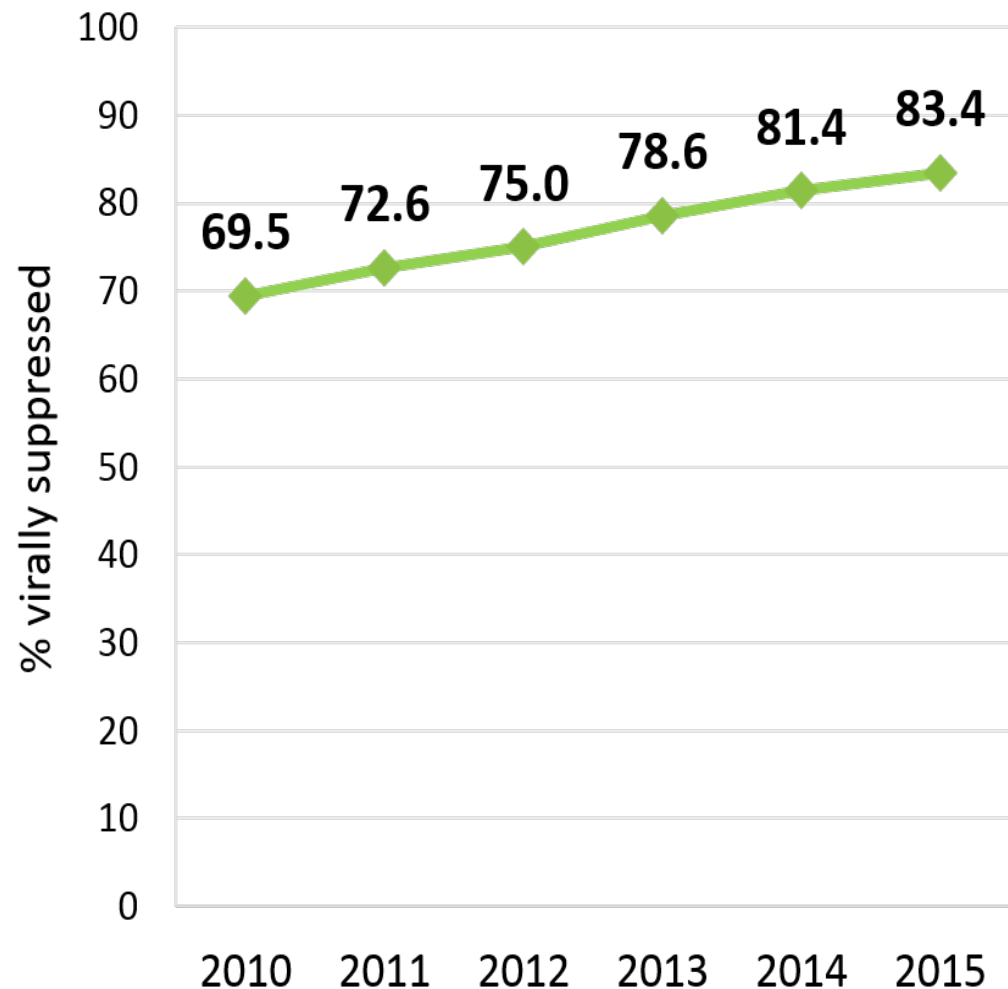


^a Guam, Puerto Rico, and the U.S. Virgin Islands.

Viral Suppression among Clients Served by the Ryan White HIV/AIDS Program 2010–2015—United States and 3 Territories ^a

It is estimated that 54.7% of people in the U.S. diagnosed with HIV are virally suppressed.

(Source: Centers for Disease Control and Prevention. *Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas—2014*. HIV Surveillance Supplemental)

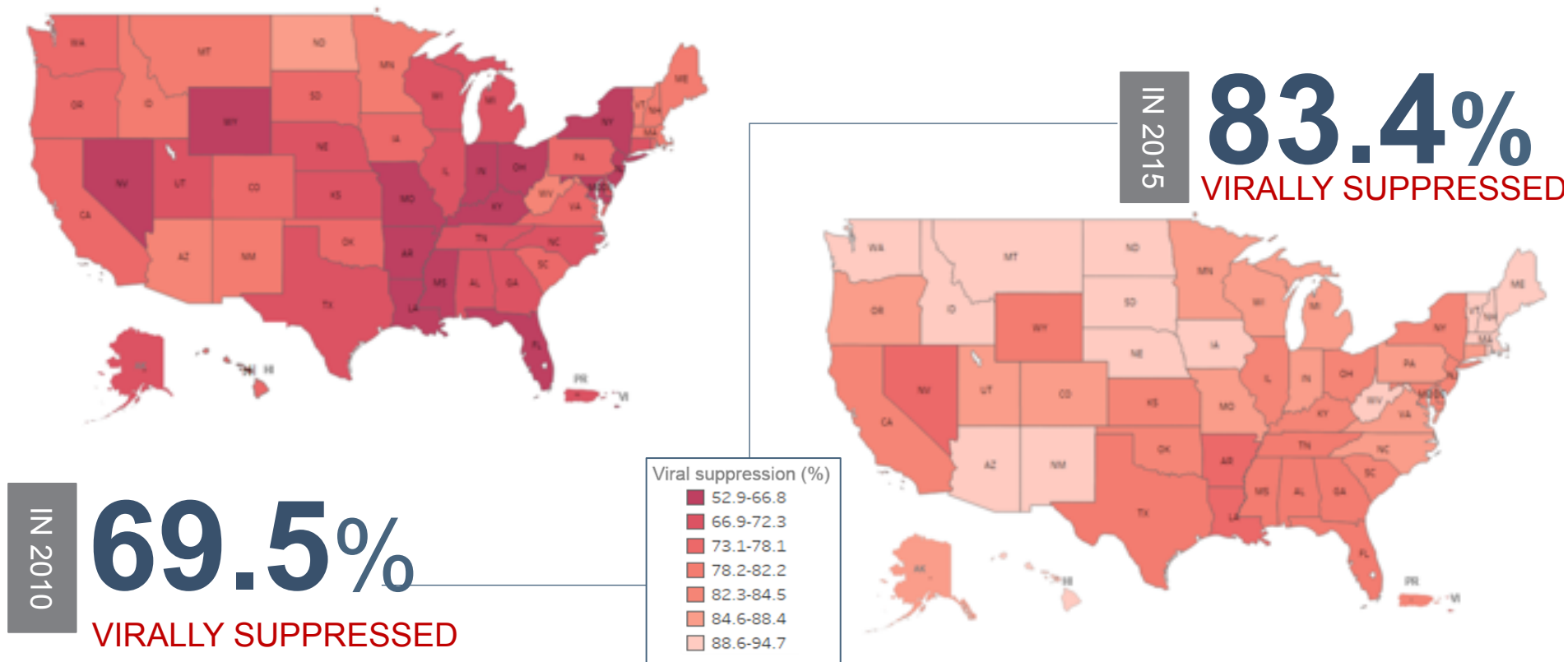


Viral suppression: ≥ 1 OAMC visit during the calendar year and ≥ 1 viral load reported, with the last viral load result < 200 copies/mL.

^a Guam, Puerto Rico, and the U.S. Virgin Islands.



Viral Suppression among Clients Served by the Ryan White HIV/AIDS Program, by State, 2010–2015—United States and 2 Territories^a



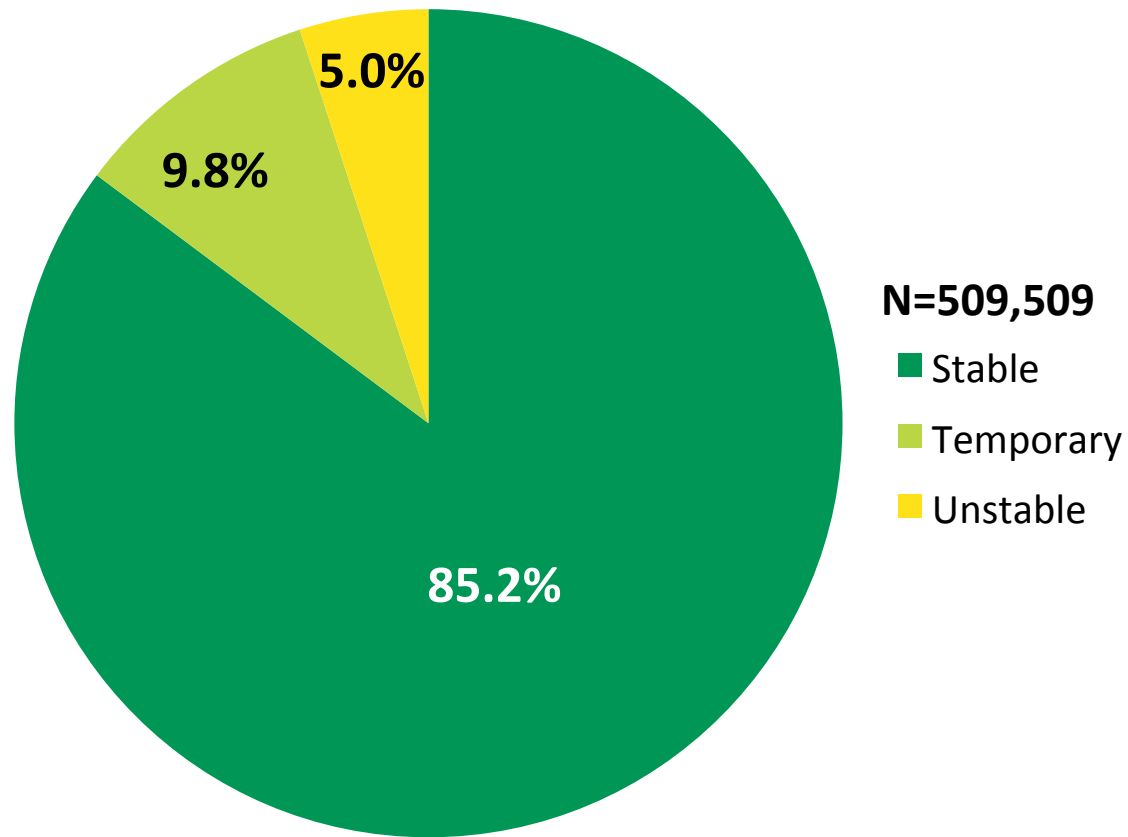
Viral suppression: ≥ 1 OAMC visit during the calendar year and ≥ 1 viral load reported, with the last viral load result < 200 copies/mL.

^a Puerto Rico and the U.S. Virgin Islands. Due to low numbers, data for Guam are not presented.

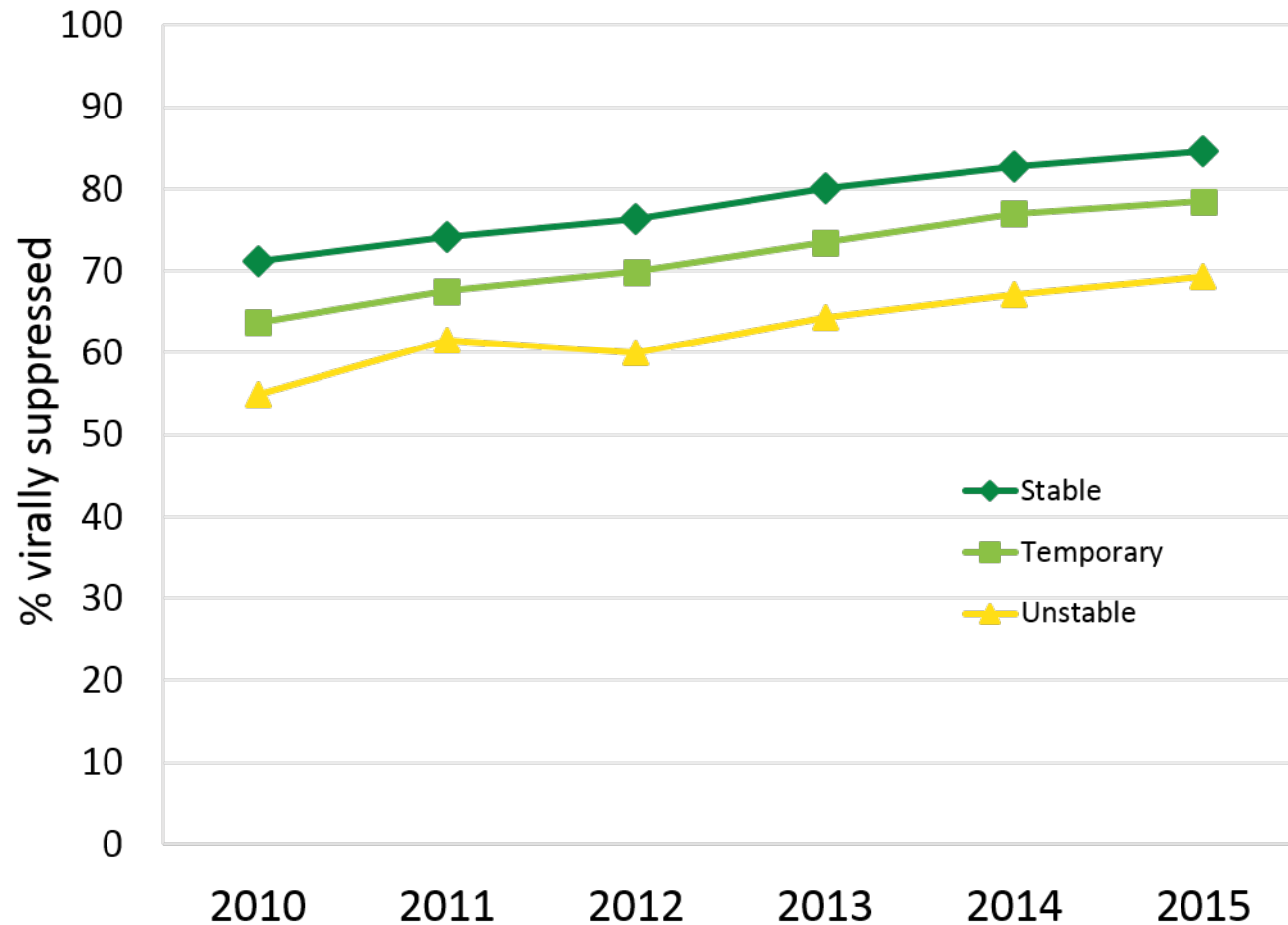


Ryan White Services Report, 2015

RWHAP Clients by Housing Status



Viral Suppression among Clients Served by the Ryan White HIV/AIDS Program, by Housing Status^a

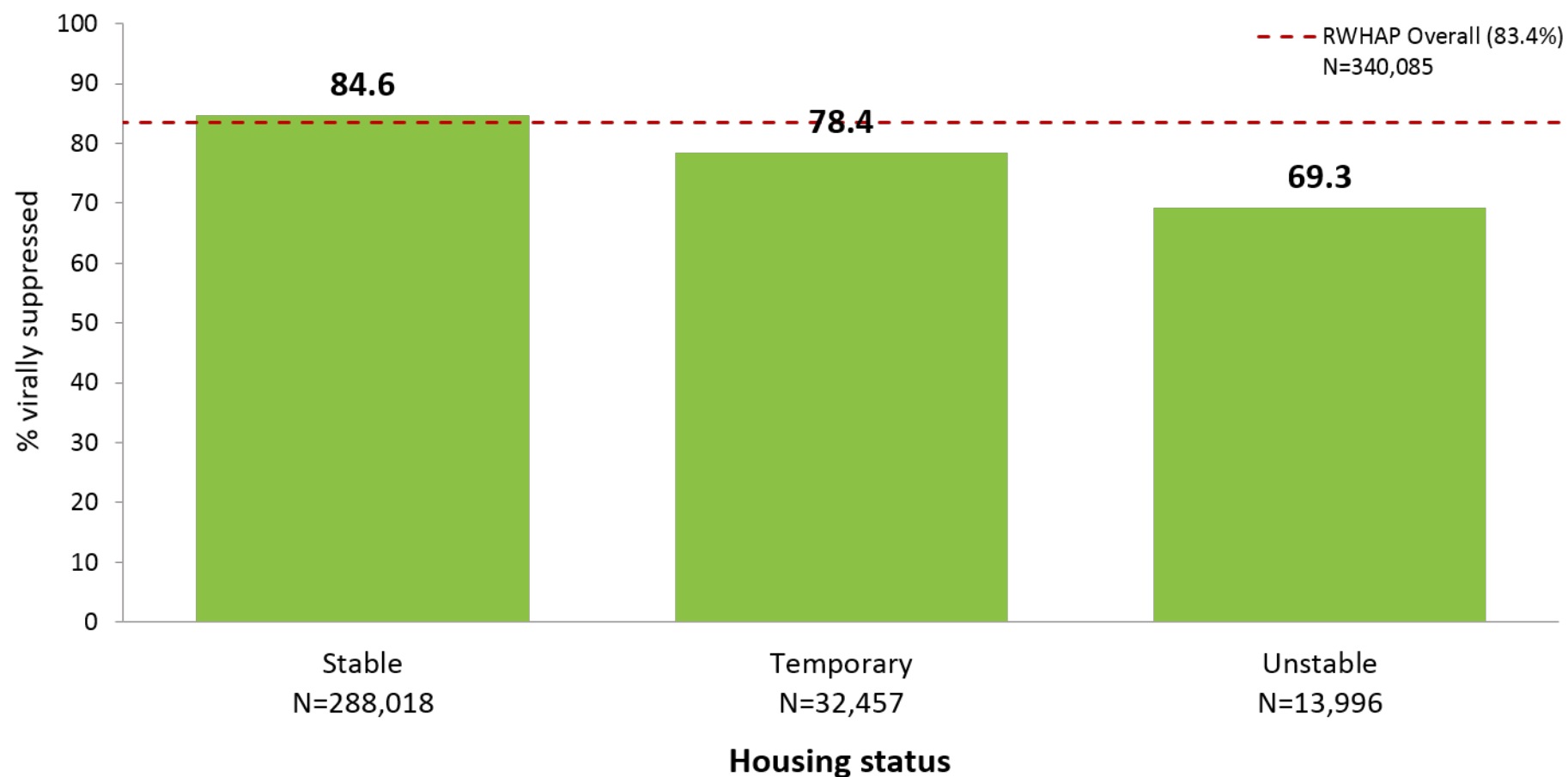


Viral suppression: ≥ 1 outpatient/ambulatory medical care visit during the calendar year and ≥ 1 viral load reported, with the last viral load result < 200 copies/mL.^a Guam, Puerto Rico, and the U.S. Virgin Islands.



Ryan White Services Report, 2015

Viral Suppression by Housing Status



N represents the total number of clients in the specific subpopulation.

Viral suppression: ≥ 1 outpatient/ambulatory medical care visit during the calendar year and ≥ 1 viral load reported, with the last viral load result < 200 copies/mL.



Ryan White HIV/AIDS Program

Why Housing Support?



- In 2015, 9.8% of RWHAP clients had temporary housing and 5.0% had unstable housing situations
- Populations identified as most at-risk for exposure to HIV or poor HIV health care outcomes experience highest rates of unstable housing (youth, people who inject drugs [PWID], transgender persons)
- Clients with unstable housing have lower rates of retention in medical care and viral suppression compared to clients with stable or temporary housing

The Ryan White HIV/AIDS Program

~~Support Services~~

Under Title XXVI of the Public Health Service Act, recipients receiving Ryan White HIV/AIDS Program Parts A, B, and/or C funds are required to spend at least 75% of grant funds on Core Medical

Services:

In the Ryan White HIV/AIDS Program, up to 25% can be spent on support services defined as services that are needed for individuals with HIV/AIDS to achieve their medical outcomes. Examples include:

- Medical transportation
- Outreach services
- **Housing Services**
- Linguistic services
- Referrals for health care and support

The Ryan White HIV/AIDS Program

Housing Support

- Housing support services funded under Ryan White HIV/AIDS Program Parts A, B, and D.
- Allowable services include (Policy Clarification Notice 11-01):
 - Housing referral
 - Short-term or emergency housing
- **Program Guidelines for Housing Support:**
 - Must be payer of last resort
 - Must ensure that housing is limited to short-term support
 - Must develop mechanisms to allow new clients access to housing services
 - Must develop long-term housing plans for every client in housing

How Can Ryan White HIV/AIDS Program Recipients Support Housing?

- Examples of coordination may include some of the following:
 - Inclusion of housing services in planning processes and procurement
 - Focus on housing for needs assessment studies
 - Co-located housing and care services
 - Targeted adherence programs for PLWH experiencing unstable housing
 - Enhanced strategic relationships with housing providers/experts
 - Inclusion of a housing indicator as a risk for non-adherence and/or medical retention
 - Assessment of housing status as part of a care plan
 - Resource commitment as appropriate



RWHAP Resources

Ryan White HIV/AIDS Program

<https://hab.hrsa.gov/about-ryan-white-hivaids-program>

Policy Clarification Notice #16-02: Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds

https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

Ryan White HIV/AIDS Program Annual Client Level Data Report, 2015

<https://hab.hrsa.gov/sites/default/files/hab/data/datareports/2015rwhapdatareport.pdf>

Special Projects of National Significance (SPNS)—Purpose & Mission

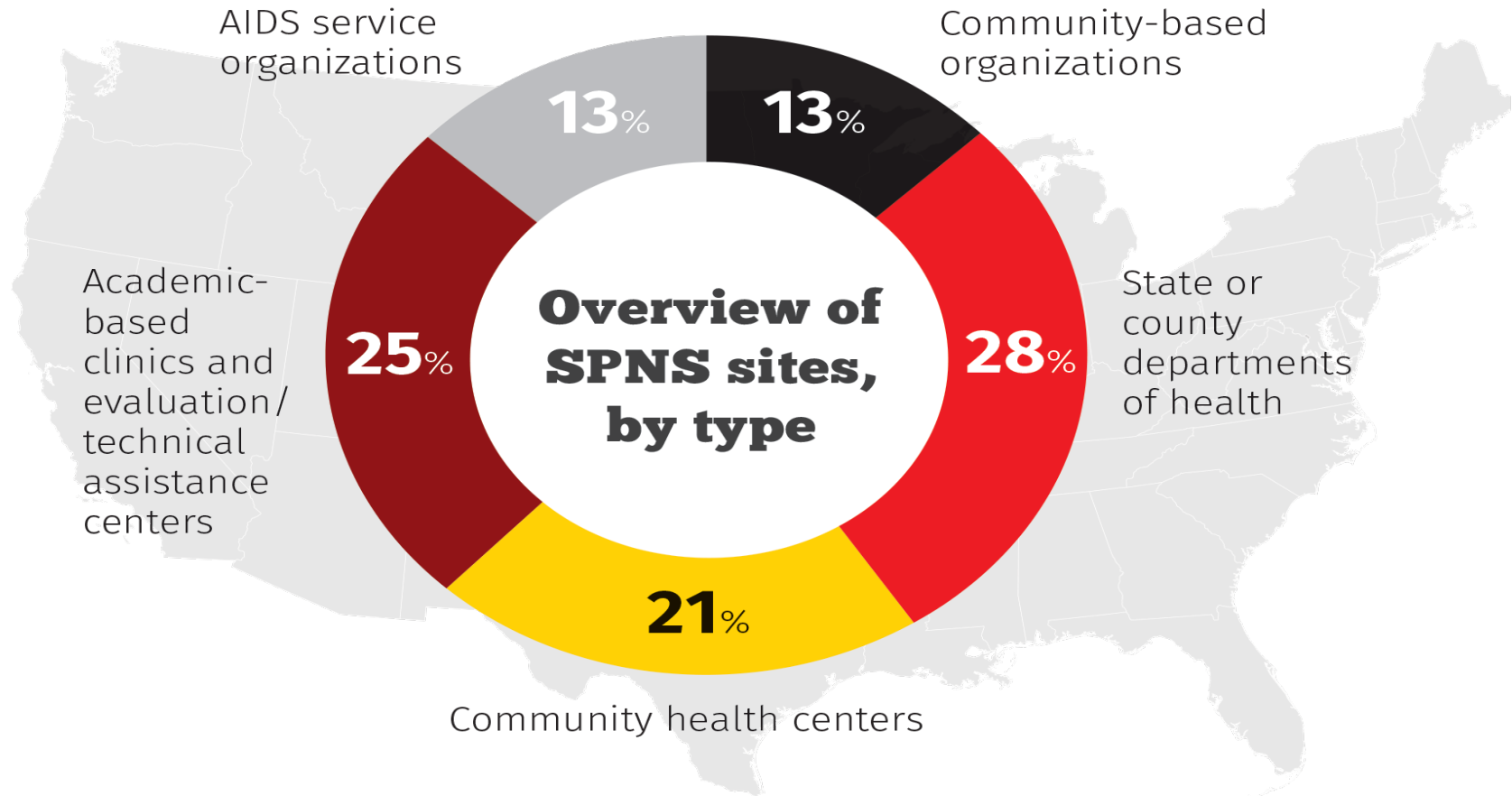
- SPNS is a component of the Ryan White HIV/AIDS Program, funded under Part F of the Ryan White HIV/AIDS Treatment Extension Act
- SPNS Program supports the development of innovative models of HIV care to quickly respond to the emerging needs of clients served by the Ryan White HIV/AIDS Program
- SPNS evaluates the effectiveness of these models' design, implementation, utilization, cost, and health-related outcomes, while promoting dissemination and replication of successful models

Mission

Provide HIV service delivery through demonstration projects and evaluation focused primarily on underserved and uninsured populations

Types of SPNS Grantees

70 Current SPNS Sites



SPNS recipients represent public and private nonprofit organizations that serve people living with HIV/AIDS.



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**

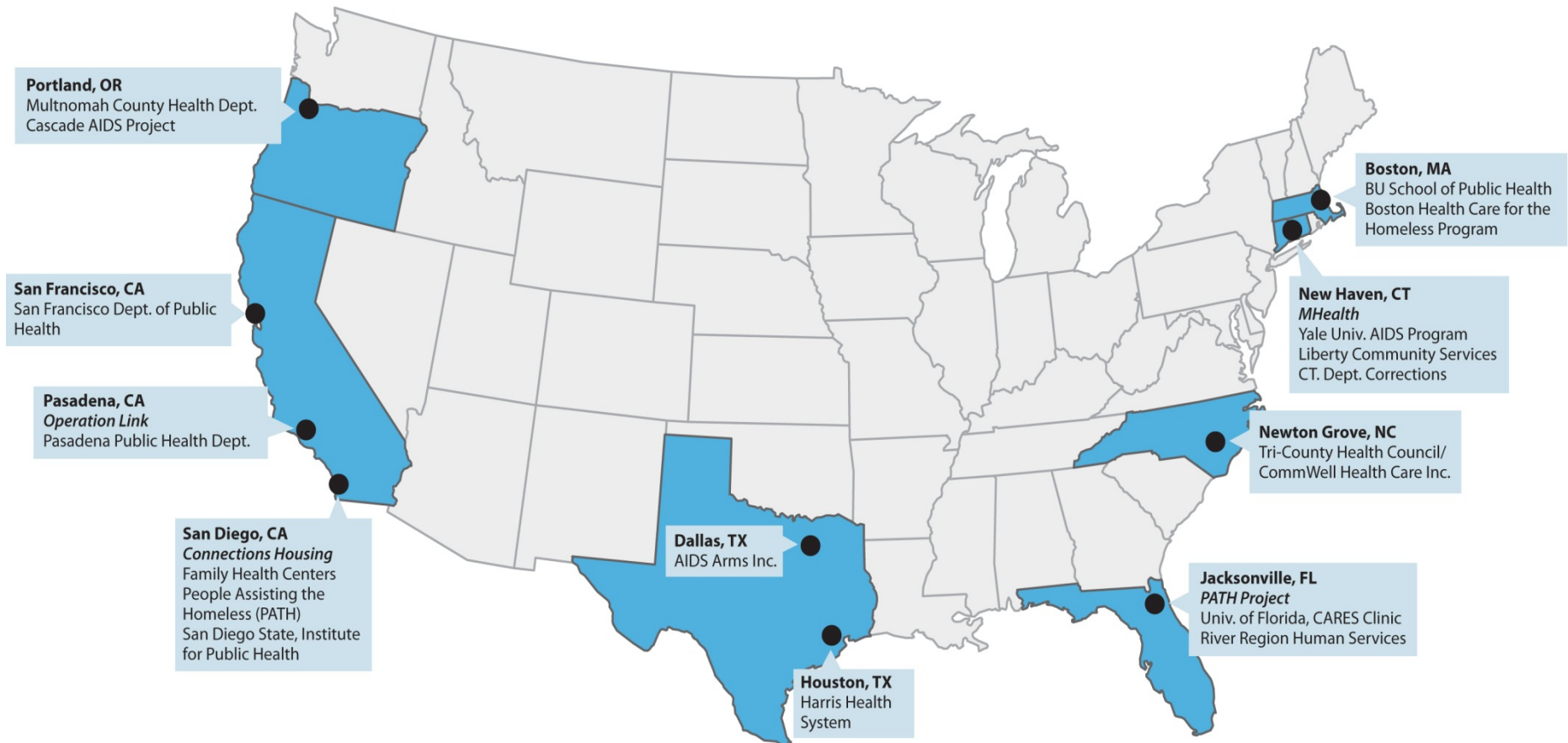
Building a Medical Home for Multiply Diagnosed HIV-positive Homeless Populations

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



<http://medheart.cahpp.org/>

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

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



Building Collaborative Partnerships (cont.)

- **City/county wide Ryan White HIV/AIDS Program and housing committees- Coordinated Access Initiatives**
 - Greater New Haven Opening Doors Committee Health and Housing Team Meetings
 - Peer Navigator serves on the Coordinated Access Committee for Pasadena County as the key contact for working with HIV Homeless
 - UF Cares & River Region in Jacksonville, FL
 - Harris County, Houston, TX Coordination with Ryan White HIV/AIDS Program Part A for housing support

Building Collaborative Partnerships (cont.)

- **Increased access to behavioral health care**
 - Use of medication assisted therapy (Vivitrol and Suboxone)
 - Increased internal coordination with behavioral health as part of primary care team
 - Priority access to residential treatment
 - Access to Behavior Health Nurse Practitioners & case managers

Use of Network Navigators/Care Coordinators

- **Client Tracking and Outreach**
 - Find those who have fallen out of care
 - Connect with people coming out of prison
- **Supporting Retention in Care**
 - Accompaniment to appointments
 - Transportation
 - Appointment reminders
 - Help with getting/scheduling appointments
 - Bridging communication with providers

Use of Network Navigators/Care Coordinators (cont.)

- **Providing Emotional Support**
 - Relationship building/trust
 - Encourage clients to keep going to their appointments
 - Coaching and support
 - Reducing stigma

- **Systems navigation & service coordination**
 - Educating on how systems work
 - Brainstorming on how to get resources

Further Information on SPNS

List of SPNS Initiatives

- <https://hab.hrsa.gov/about-ryan-white-hivaids-program/part-f-special-projects-national-significance-spns-program>

Target Center

- www.careacttarget.org/category/topics/spns

SPNS Products

- <https://hab.hrsa.gov/about-ryan-white-hivaids-program/special-projects-national-significance-spns-program-initiative-products>

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