Frederiksted Health Care Inc. Presents

Safety Net: Jean Luc's Story

A LOOK INTO HIV CARE FOR THOSE UNSTABLY HOUSED IN

ST. CROIX USVI

BY SOCIAL AND COMMUNITY PROGRAMS

DIRECTOR AISHA-JAMILA MUSSINGTON

NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT 2024

Project Support

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Who Are We?

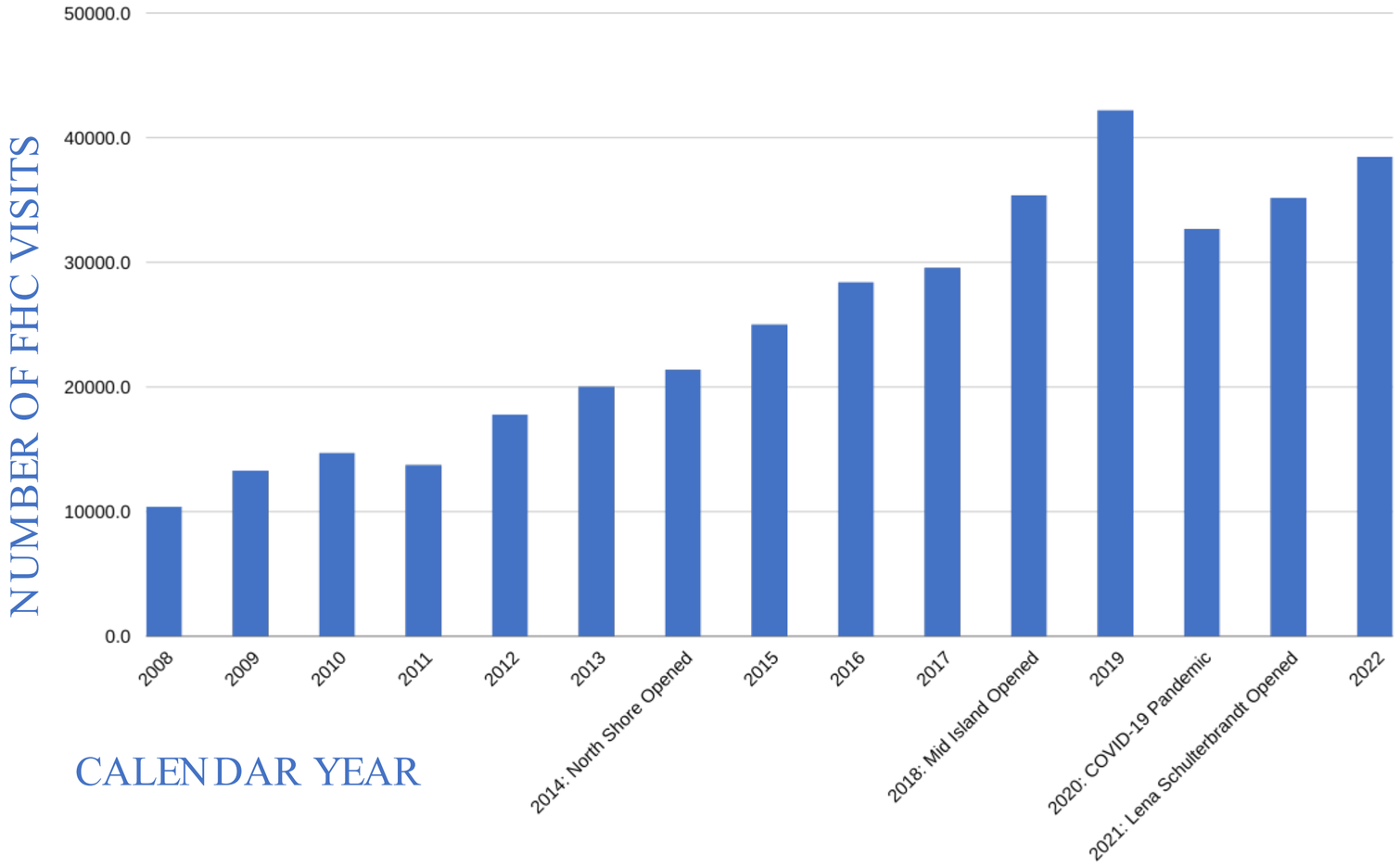
Intro to FHC

Frederiksted Health Care Inc.

A non-profit organization, we are :

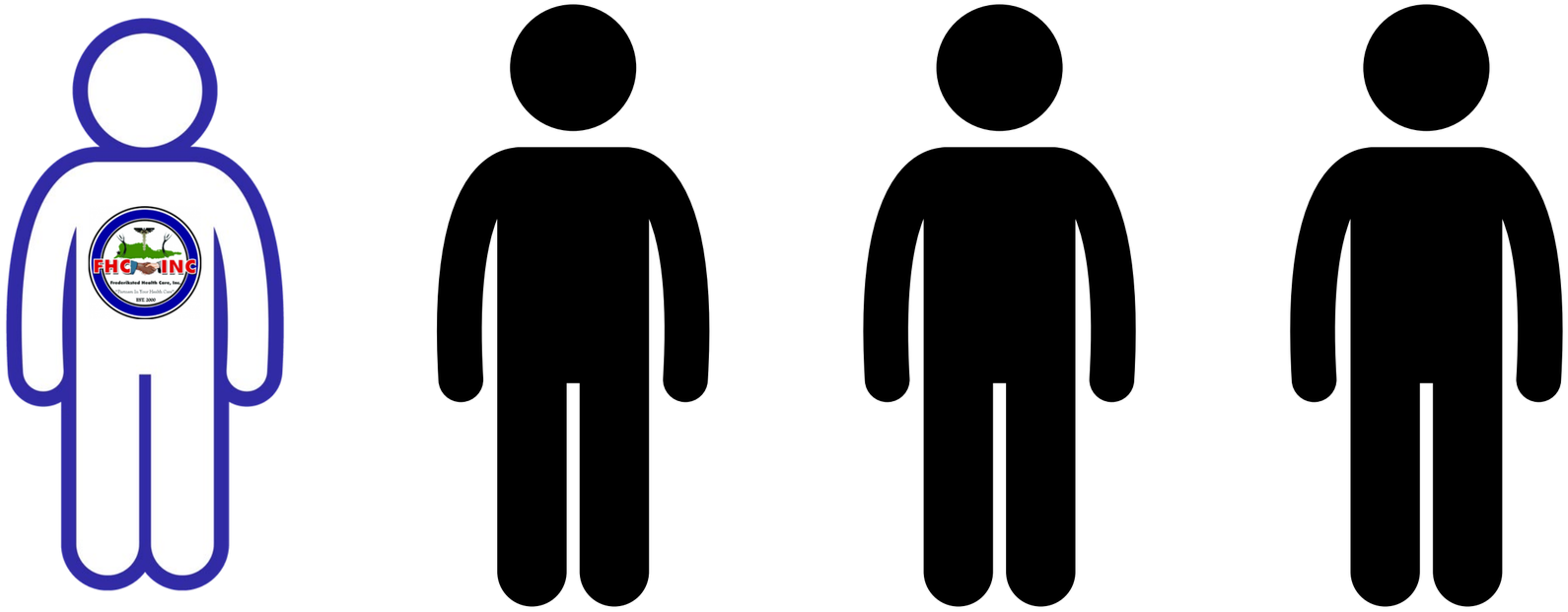
- FQHC (Federally Qualified Health Center
- PCMH (Patient Centered Medical Home
- HRSA Accreditation
- FSHCAA Deemed Health Center
- Five Sites (Ingeborg Nesbitt, Lena Shelter Brant, Mid Island, North Shore and North Shore Dental)

FHC Visits Annually



Our Patients

1 IN 4 RESIDENTS OF ST. CROIX ARE FHC PATIENTS



Our Patients

Frederiksted Health Care Inc

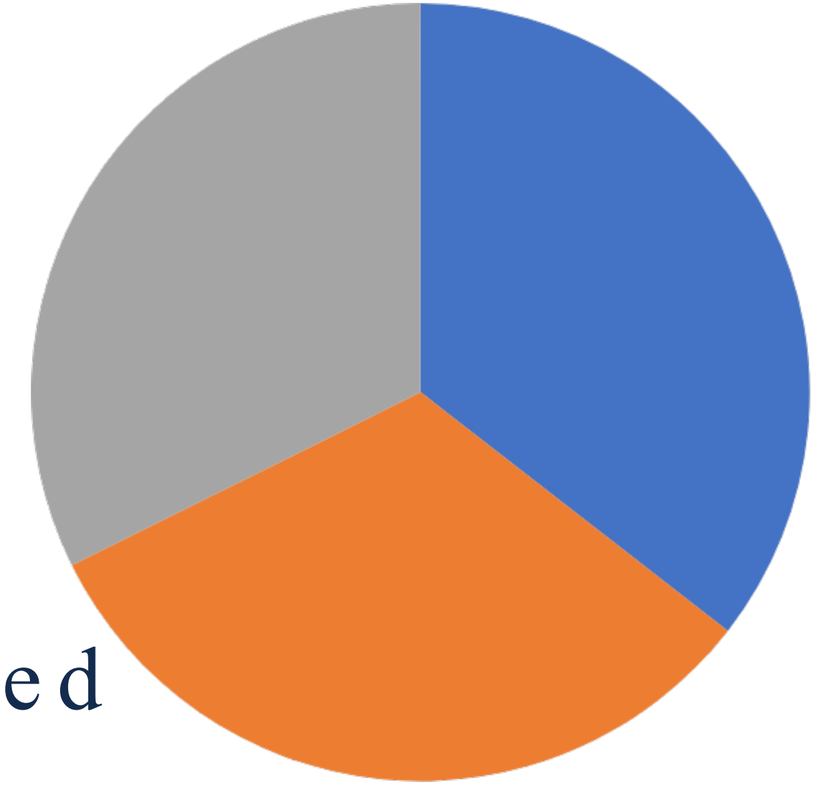
IS THE ONLY COMPREHENSIVE

HEALTH CARE CENTER ON

ST. CROIX

Patient Distribution

Kingshill
32.3%

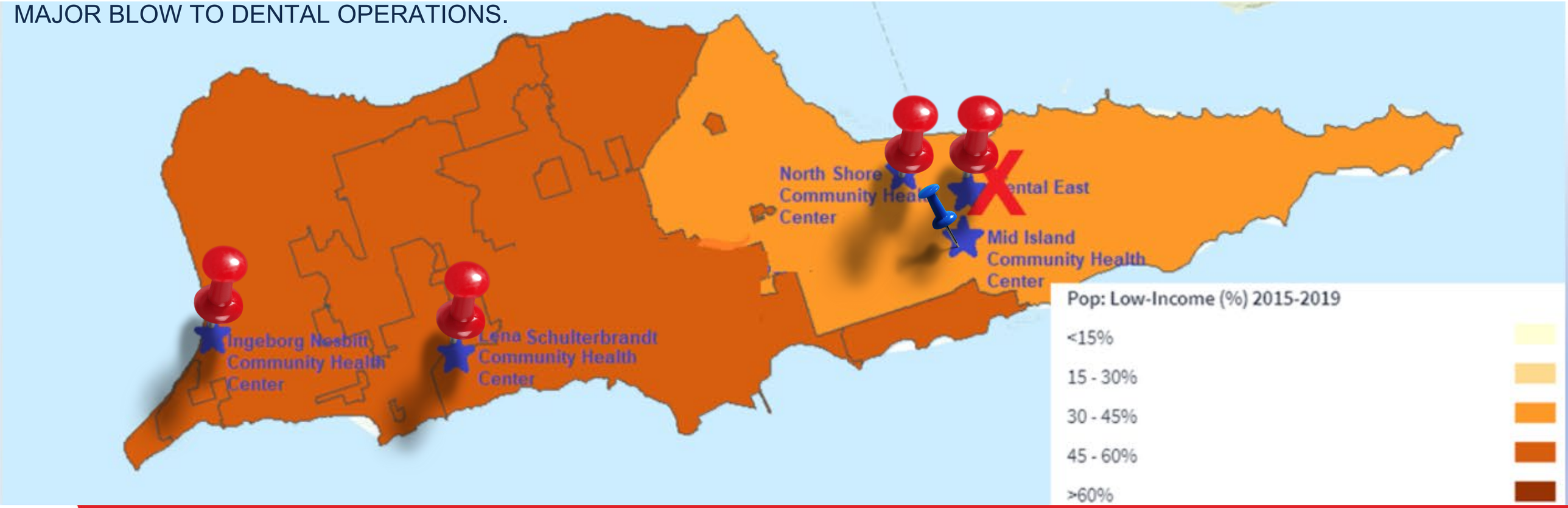


Christiansted
35.5%

Frederiksted
32.2%

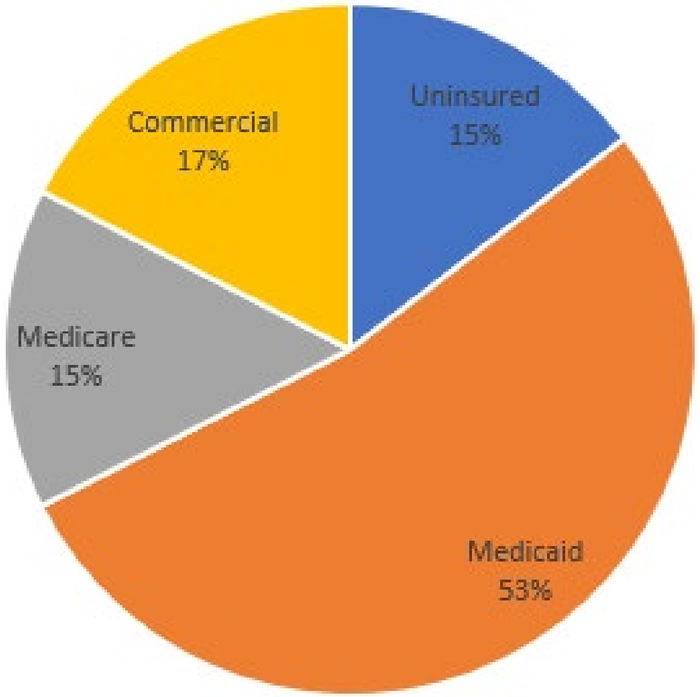
Location

OUR LOCATIONS ARE SPREAD ACROSS THE CENTRAL AND WESTERN PORTIONS OF ST. CROIX WHERE THE MAJORITY OF THE
INCOME POPULATION LIVES. OUR LOSS OF THE DENTAL EAST FACILITY NEAR OUR LARGEST POPULATION CENTER IN CHRIST
MAJOR BLOW TO DENTAL OPERATIONS.

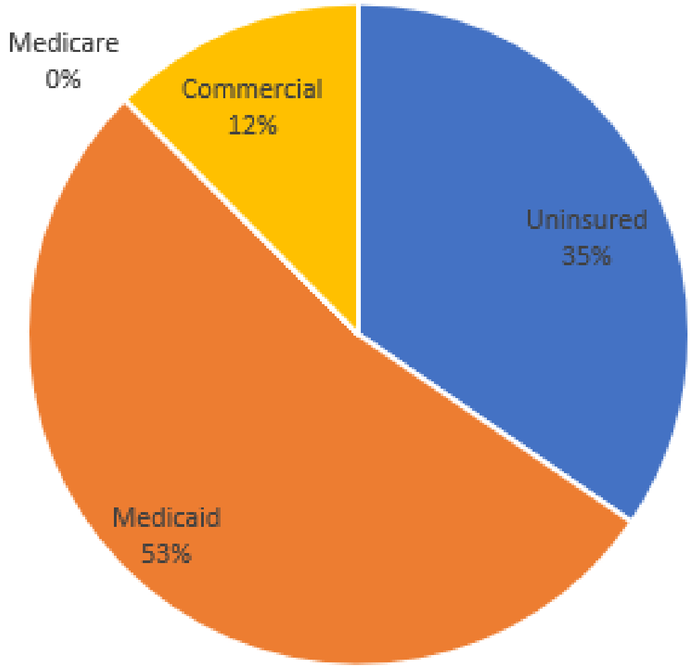


Payer Mix

Medical



Dental



*ANNUALLY APPROXIMATELY 1% OF THE HEALTH CENTERS POPULATION ARE FUNDED BY RYAN WHITE PART D CHAP PART C FUNDING

HRSA Awards


Health Resources and Services Administration
HRSA
Health Center Program
HEALTH DISPARITIES
REDUCER
2021
Awardee


FEDERAL TORT CLAIMS ACT
HRSA
Health Center Program
FSHCAA Deemed
Health Center
This entity receives HRSA Health Center Program grant funding under
42 U.S.C. § 254b and has been deemed a Public Health Service employee
for purposes of certain liability protections, including Federal Tort Claims Act
coverage, under 42 U.S.C. § 233(g)-(n).


Health Resources and Services Administration
HRSA
Health Center Program
ACCESS
ENHANCER
2022
Awardee


RECOGNIZED
NCQA
PATIENT-CENTERED
MEDICAL HOME

Division of Social and Community Programs

CDC High Impact Prevention PS21-2102

- FHC CDC High Impact Prevention Services program offers free & confidential HIV and Sexually Transmitted Infections screening and risk counseling on site each day at all 5 medical sites and at community events. We also provide a free condom distribution program, HIV and STI educational awareness, along with essential support services to reduce the risk of transmission of HIV/AIDS, STI, Tuberculosis and Hepatitis C

HRSA Ryan White HIV/AIDS Part C

- Ryan White Part C at FHC is a program which seeks To Enhance Capacities To Increase HIV Testing, Link HIV+ Persons To Medical Care, Increase Referrals, Provide Prevention and Essential Support Services For HIV+ Persons, Provide Prevention and Persons and High Risk With Unknown/Negative Serostatus, and Increase Program Monitoring & Accountability.

Homeless Health

- FHC Homeless Health Program aims To eliminate homelessness by ensuring comprehensive health care and secure housing for everyone. To accomplish this goal, we provide clinical, dental, and behavioral health services in tandem with our intensive case management program.

Division of Social and Community Programs

Mental Health First Aid

- Mental Health First AID program at FHC is a course that teaches you how to identify, understand and respond to signs of mental illnesses and substance use disorders. The training gives you the skills you need to reach out and provide initial help and support to someone who may be developing a mental health or substance use problem or experiencing a crisis.

Syringe Exchange

- Syringe Exchange is a harm reduction program providing exchange services, as well as, educational information, treatment referrals, risk-reduction counseling, and free safer sex materials (condoms, etc.) is integral to our mission to combat HIV and AIDS on St. Croix

340 B Discount Pharmacy

- 340 B: Is a federal discount pharmacy program offered by FHC to help it's patients, access to the medications they need, at deeply discounted costs. Also, we can help with insurance co-pays and deductibles or help you enroll in ADAP and MAP.

Division of Social and Community Programs

"Breaking Barriers, Building Bridges, Changing Lives"

☑ Homeless Health

FHC Homeless Health Program aims To eliminate homelessness by ensuring comprehensive health care and secure housing for everyone. To accomplish this goal, we provide clinical, dental, and behavioral health services in tandem with our intensive case management program.





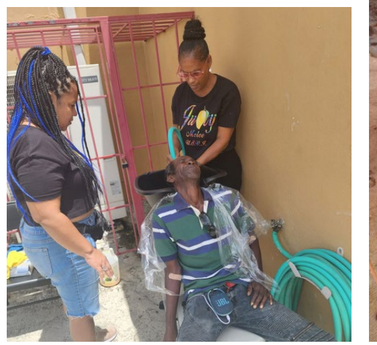

Homeless Health

WHAT WE DO

WE OFFER A HOMELESS Health Clinic the third Saturday of every month.

- Medical services
- Behavioral Health Services
- Dental Health Services
- Case Management Services
- Clinical Lab Services
- Breakfast and Lunch
- Showers
- Clothing and new shoe distribution program




Homeless Health

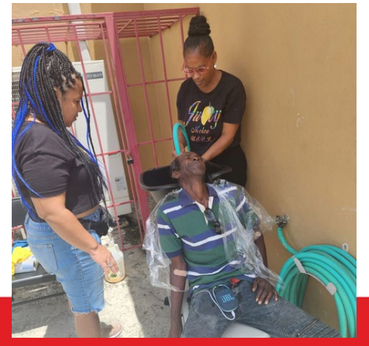
RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

HOW WE DO IT

- 3-5 Medical & Dental providers
- 2 Behavioral Health Specialists & MD/Psychiatrist
- Qualified staff provide Case management services
- Medication pickup
- Portable showers
- Clothing and Shoes distribution with Mr. Chris Finch
- Volunteers as food servers & escorts, haircuts and grooming
- Transportation to and from provided by FHC



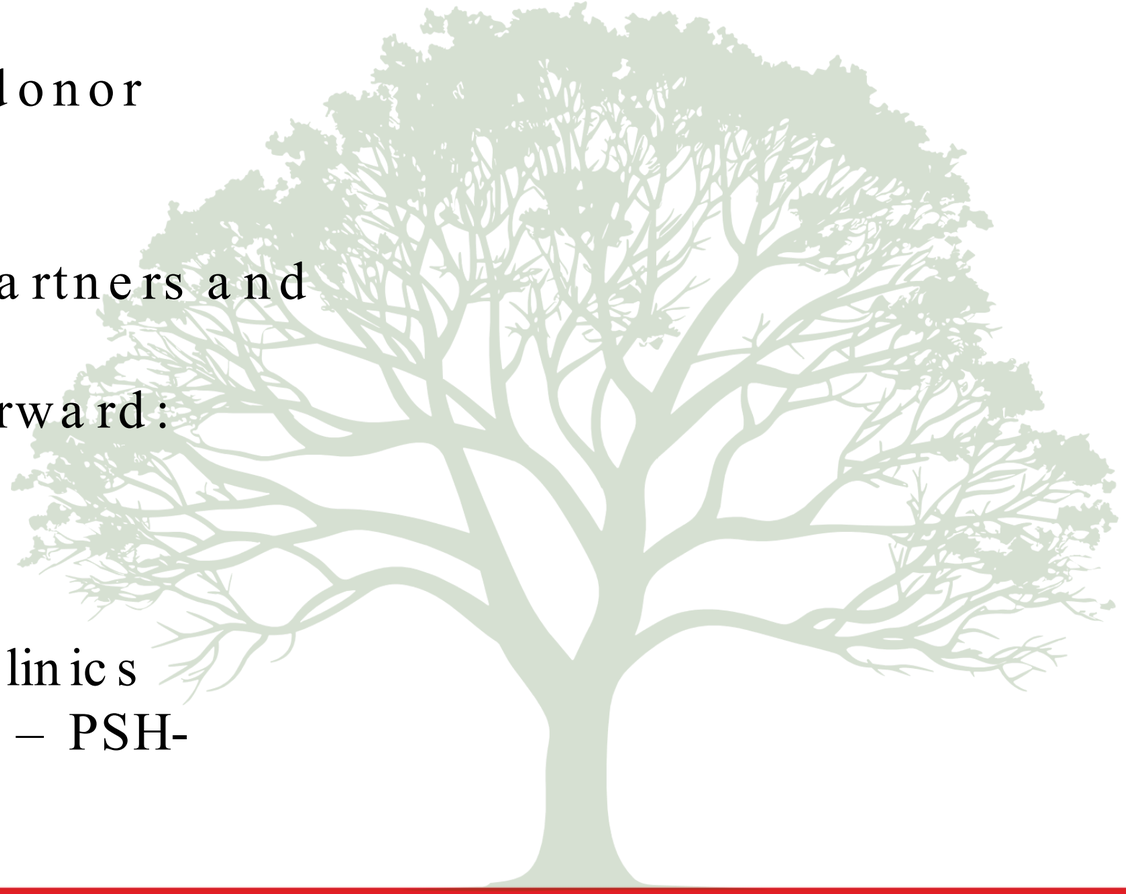




GROWING SUPPORT

FROM A GENEROUS COMMUNITY

- EDC (Economic Development Commission) donor renewed corporate & personal commitment
- Emergency Shelter Grant funding
- Extensive in-kind support from community partners and other stakeholders
- Many individuals & service clubs stepping forward:
- Toiletry kits
- Towels and bedding from area hotels
- New and used clothing and shoes
- Underwear and socks for showers between clinics
- Growing staff with case management duties – PSH-AC Team



SAMARITAN SATURDAYS

SAMARITAN SATURDAYS

NATIONAL 2024 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

SHOES, CLOTHING, MEDICAL AND FOOD ARE PROVIDED!

July 29th

8:00am to 2:0pm

516 STRAND STREET

FREDERIKSTED ST.CROIX

SAMARITAN SATURDAYS

NATIONAL 2024 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Supporters

St. Croix Foundation For Community Development

Frederiksted Health Care Inc.

Catholic Charities of the US Virgin Islands

Edouard Foundation

..with dozens of community volunteers and donors!

Division of Social and

"Breaking Barriers, Building Bridges, Changing Lives"

HRSA Ryan White Part C

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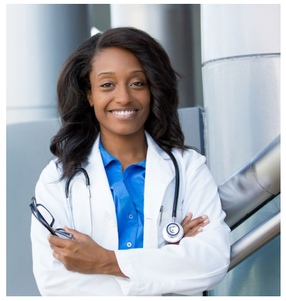
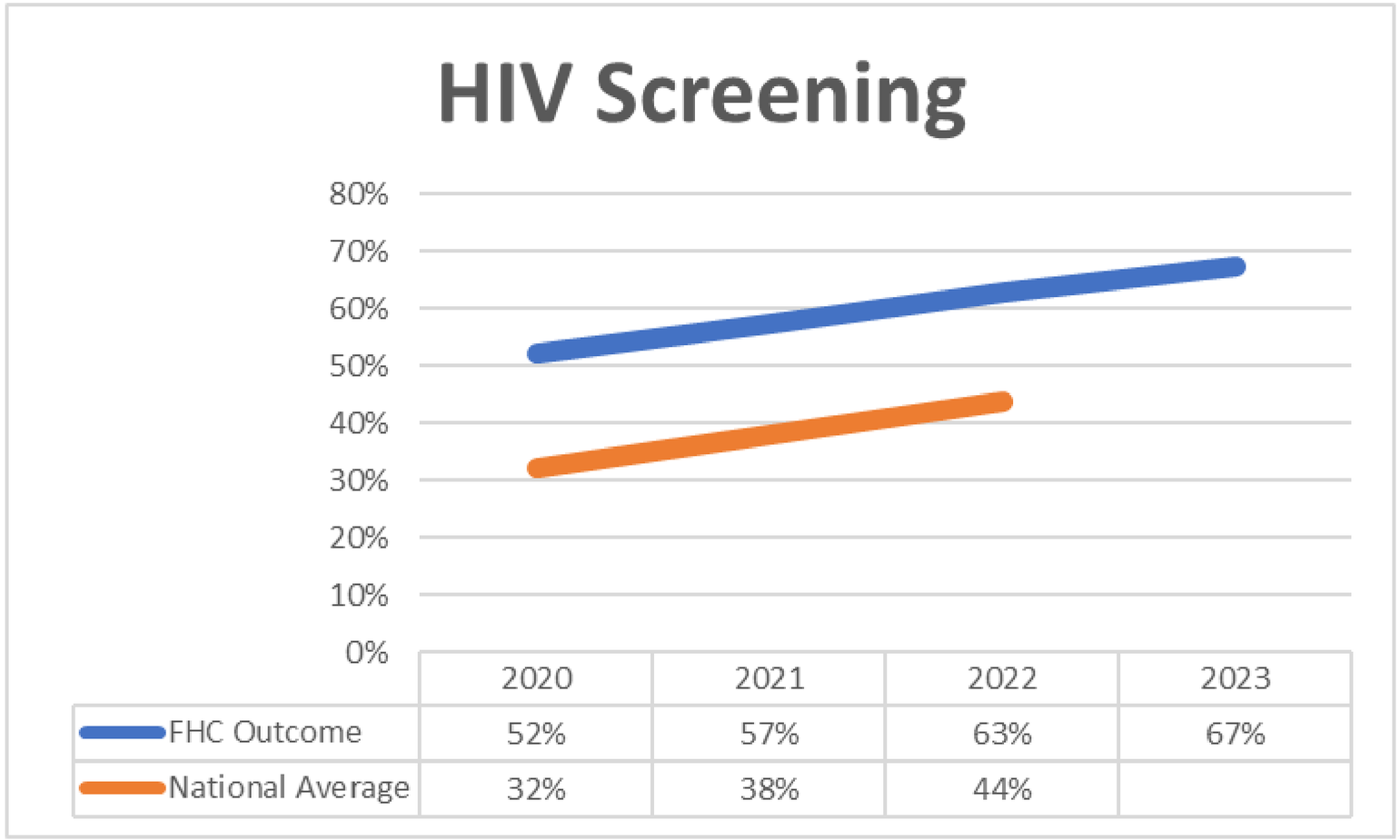


Treatment Provider

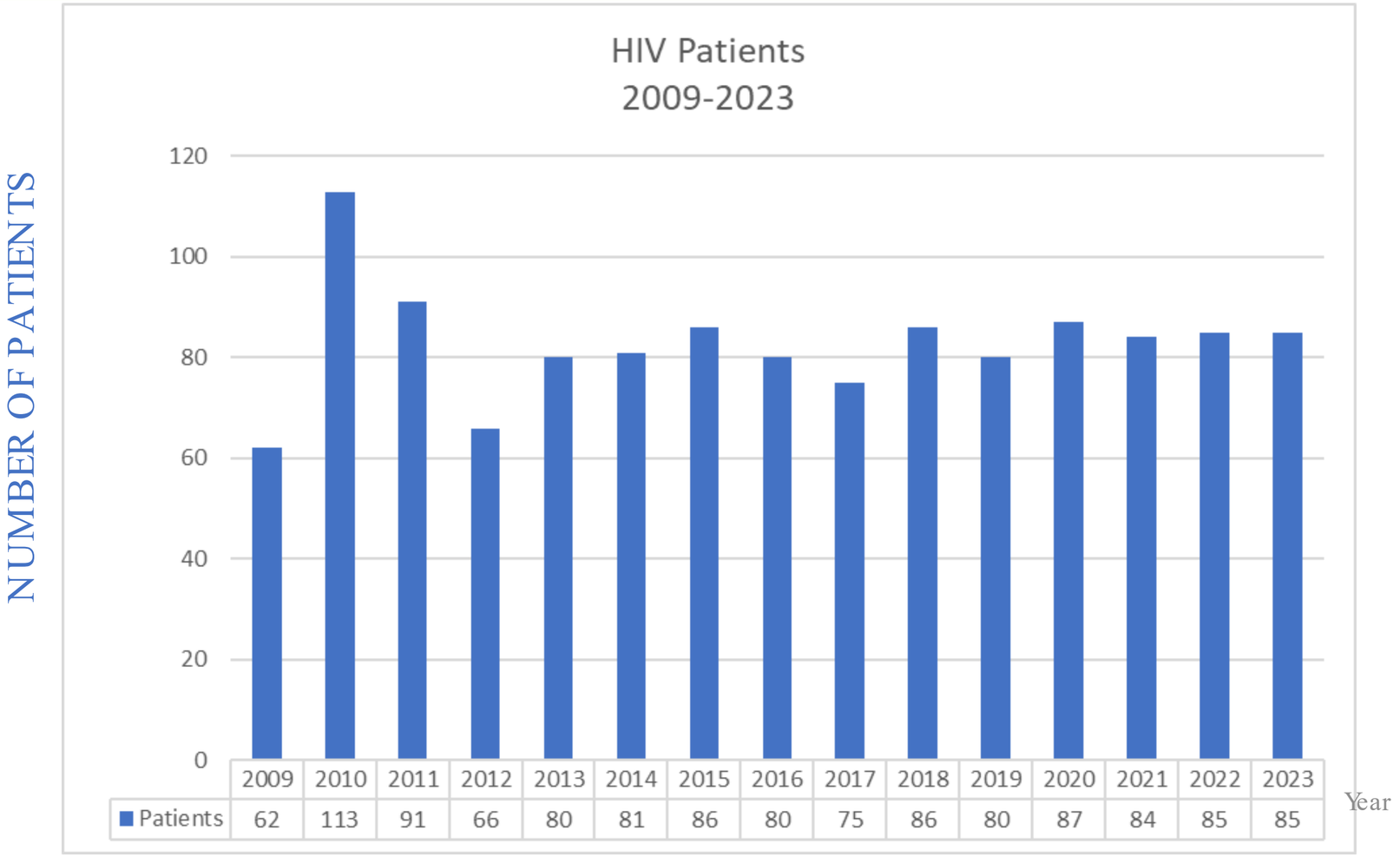
Case Management

Medication Adherance

HIV Screening



The Unduplicated



HIV Care Continuum

Continuum Aspect	CY2016	CY2017	CY2018	CY2019	CY2020	CY2021	CY2022	CY2023
Diagnosis of HIV Infection	1.0%	0.9%	1.5%	0.7%	0.5%	2%	0.4%	0.2%
Linkage to Care	100%	100%	100%	100%	100%	100%	100%	100%
Retention in Care	73%	77%	76%	77%	79%	100%	100%	79%
Receipt of Antiretroviral Therapy	100%	100%	100%	100%	100%	100%	100%	100%
Achievement of Viral Suppression	80%	82%	79%	85%	81%	86%	88%	86%

More Facts

FIGURE 6. RETENTION IN CARE 2016-2023

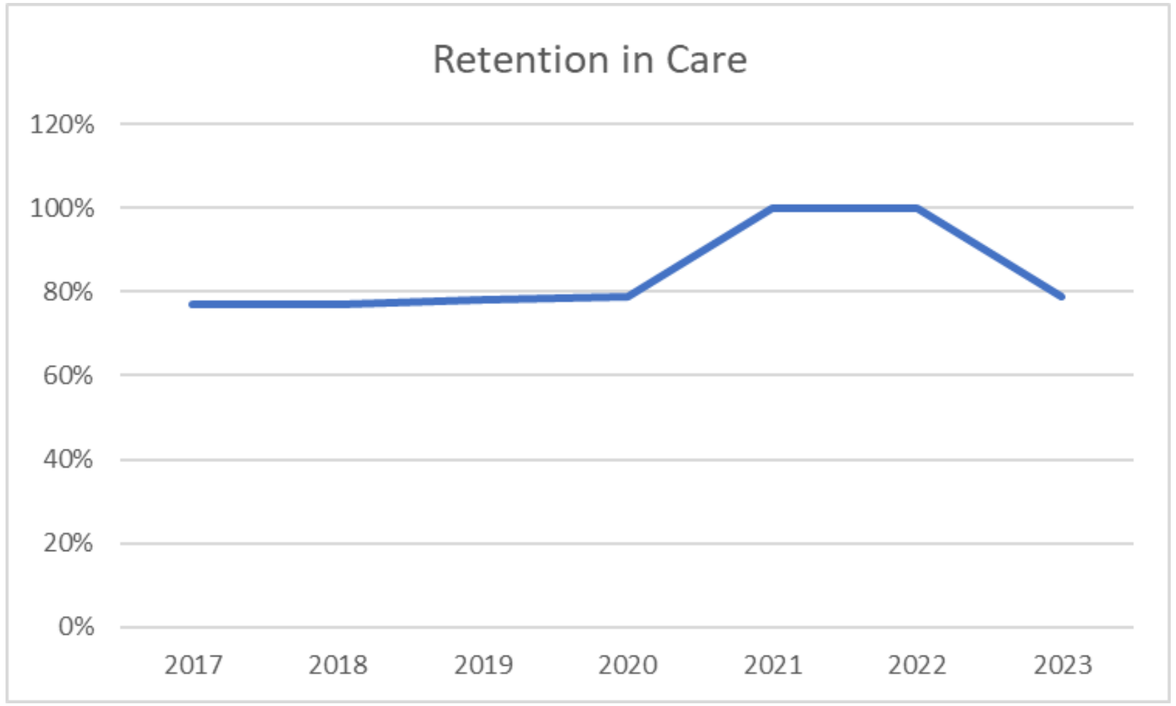
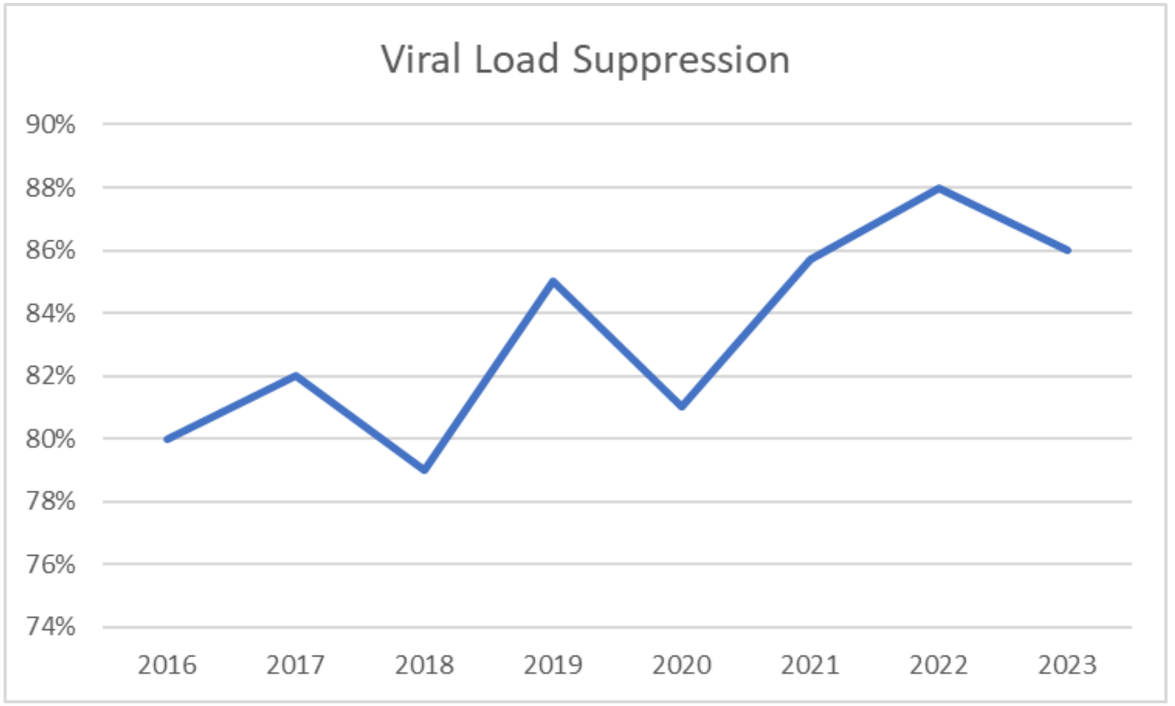
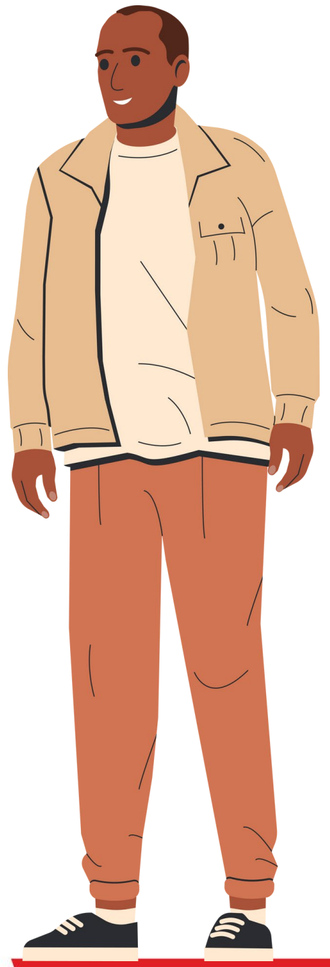


FIGURE 7. VIRAL SUPPRESSION 2016-2023



A Case Study

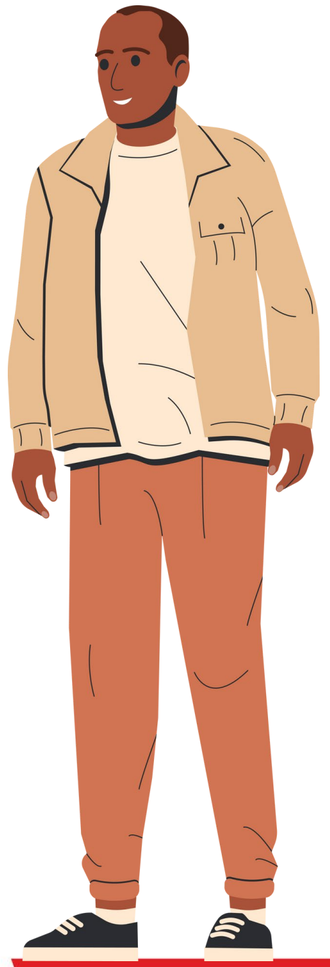
Meet Jean Luc Martin



NAME: JEAN LUC MARTIN
AGE: 53y
BIRTH PLACE: ST.LUCIA (Island in the Caribbean (English/ French Creole)
RESIDED IN VI: 36 years as an immigrant who overstayed his visitor's VISA
WORKED: DAY LABOURER received cash payments
SEXUAL ORIENTATION: BISEXUAL
KNOWN DIAGNOSIS: DIABETES Type 2 Managed through Metformin
INSURANCE: Expired MAP (Medicaid)

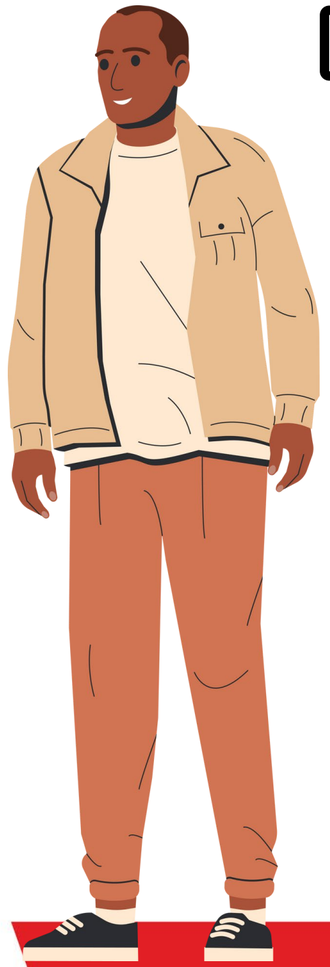
A Case Study

Meet Jean Luc Martin 2



Jean Luc got married at 25 and had two female children with his wife Sonia. They were married for 45 years until they divorced. At the 45 year mark, Sonia found out that Jean Luc had been having affairs with men, was on the downlow and consequently, he lost his marriage, home, children, and savings (Alimony payments to wife). Exacerbating the issue is the fact that the economy slowed resulting in him being let go from his company he worked for since he was 17. His savings are depleted and Jean Luc is coach surfing with various acquaintances when he can, when that is not possible he stays on the beach. As a result of all the loss he faced, Jean Luc engaged in condomless sex with multiple sex partners specifically in the MSM community so he could feel loved. Jean Luc suspects he has depression and he is also not feeling physically well. Jean Luc decide to come to FHC for a walk-in.

What do we do?



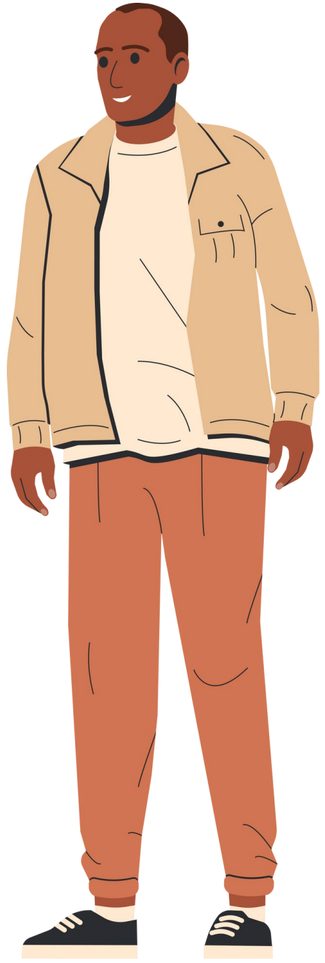
See a provider (Doctor)

See a provider (Doctor), who then based on his history decides that he should get a rapid HIV Test along with a STI screening (HepC, Chlamydia, Gonorrhea, and Syphilis) because it is FREE based on our CDC PS 21-2102 High Impact Prevention Services Grant. Jean Luc screening indicates that he is positive for HIV. He is then linked to the RWHAP treatment program.

The provider also did a full screening and realized Jean Luc's diabetes is uncontrolled and as a result of his home and food insecurity situation his A1 C is now 10.2. As a result, has to take insulin which needs to stay refrigerated.

As a certified PCMH (Person Centered Medical Home FQHC) The provider notices Jean Luc's multiple diagnoses to include his psychosocial status engages a multidisciplinary support team for Jean Luc. Jean Luc's situation can be categorized as a Syndemic. The team consists of a RWHAP Nurse, a RWHAP Clinical case manager, a CDC client navigator, a homeless health case manager and a behavioral health therapist. Courtesy of the RWHAP part C treatment program employing a one-stop-shop approach to Jean Luc's care.

How do we work?

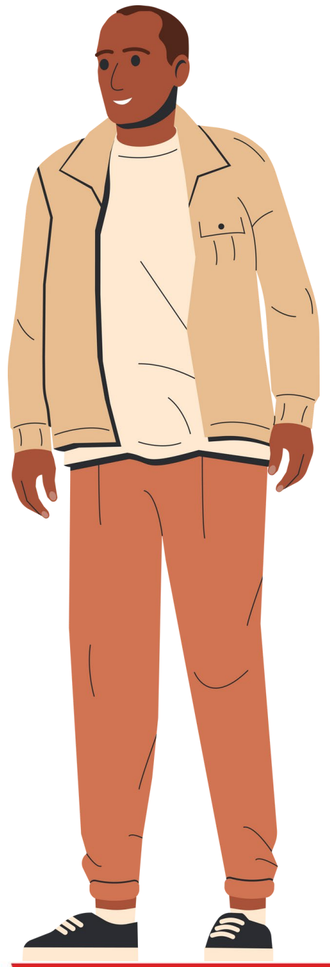


In three-month phase evaluations:

☑ Month 1 Jean Luc Prognosis:

-Diabetic A1 C 10 Monjaro, metformin glipizide
-Viral Load 190,000
-CD4 Count 185
-Prescribed prophylaxis (AIDS Category)
-RWHAP nurse prior authorization for link to the 340 B discount program through Neighborhood pharmacy for all medications (HIV Meds, Diabetes meds, BH meds)
- Clinical Case management develops care plan with client (needs Direct Observation Therapy for medication adherence), links to nutritionist, dentist, transportation, EFA for groceries and ADAP program for insurance to pay for treatment services, client is not a legal resident
-Behavioral Health Diagnosis: Depression
-Substance Use Diagnosis: Alcoholism
-Homeless case management (needs daily showers, snack bags, clothing)
-CDC client navigator (Steps to Care for linkage to the Village for SU residential treatment program, MTOC for HOPWA (Housing Opportunities for persons with advanced HIV disease) program

How do we work? 2

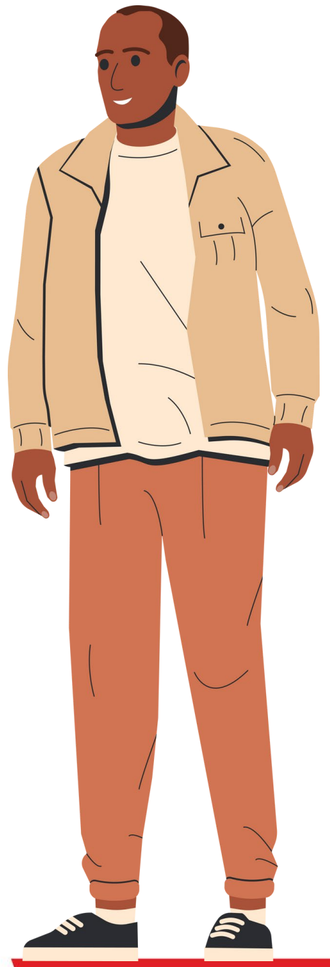


In three-month phase evaluations:

- [x] Month 3 Jean Luc Prognosis:

-Diabetic A1 C 7.5 off of insulin, metformin glipizide
-Virally suppressed 5000
-CD4 Count 350
-RWHAP treatment program has monthly interdisciplinary client case review meetings, use of acuity scale to measure client's progress
-RWHAP nurse coordinates with 34O program neighborhood pharmacy to bubble wrap medication, automatic refills,
-Nutritionists prescribes Glucerna 1 box per month
- Attends Samaritan Saturday one stop shop wellness clinic for the unhoused
-DOT continues with RWHAP case management until turned over the Village Case management-conference calls once weekly for follow up, transportation to appointments also through coordination and cooperation between two partners
-Resides at the Village Westcare Partners for Recovery SU program for 90 day 12 step program
- CDC Navigation Steps to Care follows up with all partners to close loop for linkages, HOPWA program through MTOC (Meeting the Needs of the Community) still on hold only 11 spots on island client is number 13 on the list turns case over to RWHAP non-medical case management for follow-up

How do we work? 3



In three-month phase evaluations:

☑ Month 6 Jean Luc Prognosis:

-Diabetic A1 C 6.0 reduced dose of metformin glipizide
-Viral Load undetectable
-CD4 Count 450
-Successfully completed the Village 90 day 12 step program
-A spot became available through HOPWA for client to move into
-RWHAP non-medical case management helps with moving in (transportation, received support from the Homeless Health program to outfit semi furnished apartment
-RWHAP nurse coordinates for 340 B program to deliver meds directly to home.
Client is now housed, undetectable, diabetes well controlled, in therapy with BH, achieved sobriety from alcohol, youngest daughter has made contact and would like to visit him for two weeks with her new family, member of our CAB consumer advisory board.

How did we get here?

We grew into this safety net

Learnt from the mistake of working in silos. Frederiksted Health Care Inc Ryan White Part C program currently manages an active client count of 78 persons. Based on the past 8 years, we usually average between 70 and 100 clients.

We employed AETC for consultancy on Care Plans

Motivational Interviewing, QAQI PDSA projects and policy and protocol development and improvements.

Intentionality

In the past 7 years the program was intentional about community engagement, staff training, client advocacy and the minimization of barriers to care to achieve treatment adherence. The Division of Social and community programs has also obtained more grants for expansion of essential support services which enhances our Part C program evidenced by Jean Luc's success story.

Barriers to Care the USVI territory of ST. Croix faces

- Expensive Cost of Living (Food Prices/ Rent Prices
- Rural Community, poor community based of the Federal poverty guidelines
- Very Limited DATA to assess prevalence of HIV, Homelessness
- 1 main Hospital temporary modules limited beds (62 beds) (no psych unit) population of over 41000
- Susceptible to Major Hurricanes (Faced 2 devastating category 5 hurricanes in 2017)
- Only has limited RWHAP part B funds and one RWHAP part C program. Do not have Part A, D, and F
- No EHE funding
- Housing Shortage
- Not eligible for SSDI
- Limited Medical resources (Have to fly off island) for specialty care
- Economy is not diversified (government is the largest employer)
- Under developed infrastructure (technology and energy). Frequent black outs
- Roads are bad

What do we hope to achieve?

Partnerships

Continued partnerships with all of the Community Based organizations in our Ryan White continuum of care and our Homeless continuum. More funding opportunities to expand programs and resources in DSCP for instance a vending machine and mobile shower and laundry unit for our Homeless Health program. More funding for housing opportunities.

HOPWA

11 HOPWA units is and has been severely insufficient for the Housing needs for the HIV community. Consider funding for medical escort for off island accompaniment for specialist treatment. Basically, expand and strengthen our safety net!

Community Based

	Program				
Client #	Start Date	End Date	Age	Race	Ethnicity
1	11/21/2019		56	Non-Hisp	Black
2	12/4/2019		45	Hispanic	Black
3	2/4/2020	6/7/2022	35	Non-Hisp	Black
4	2/24/2020	7/28/2021	53	Non-Hisp	White
5	4/28/2020	12/9/2021	57	Hispanic	Black
6	7/7/2021	5/10/2022	41	Hispanic	Black
7	8/16/2021		49	Non-Hisp	Black
8	9/22/2021		54	Non-Hisp	Black
9	2/22/2022	3/1/2022	61	Non-Hisp	Black
10	4/28/2022	7/29/2022	62	Hispanic	Black
11	12/14/2023		25	Non-Hisp	Black

THIS SLIDE REPRESENTS CLIENTS IN THE HOPWA PROGRAM SHARED BETWEEN FHC AND MTOC

MTOC

Meeting The Needs

of the Community

is a valued

Community Based

Program

we collaborate with them for

HOPWA services

Total HOPWA Clients served

Gender & Age Group	2019	2020	2021	2022	2023
Males 18-30	1	1	1	0	0
Males 31-50	7	5	6	8	7
Males 51+	5	4	5	4	3
Females 31-50	7	7	7	5	4
Females 51+	6	8	6	6	3
TOTAL SERVED	26	25	25	23	17
Race & Ethnicity	2019	2020	2021	2022	2023
Blacks	26	24	23	23	17
Whites	0	1	2	0	0
Hispanic	7	8	8	6	6

Best Practices/Lessons Learned

- Various programs and services offered at Frederiksted Health Care Inc. through the Division of Social and Community Programs were designed to be complementary. A one-stop shop approach which in itself is a type of in network safety net for clients served
- Moreover, the practices employed are evidence-informed and ultimately operationalized with cultural sensitivity in a resource-depleted area.
- Reality suggests that much of what is done by DSCP organically are elements of evidenced-based care strategically employed based on functionality to produce a system that works. The following approaches are the fabric that make up this system.

Best Practices/Lessons Learned

1. A status-neutral approach.
2. Patient-Centered HIV Care Model
3. S.A.F.E.T.Y. Model
4. Harm reduction approach

- [x] The power of Community Engagement. Effective Community Engagement is essential to success. It is impossible to meet all the needs of every client by yourself. Leveraging this skill is efficient and effective when measuring impact.

Thank YOU!

BY SOCIAL AND COMMUNITY PROGRAMS

DIRECTOR AISHA-JAMILA MUSSINGTON

NATIONAL 2024 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Dental Care for those Unstably Housed in Portland with HIV

Dr Foster Page – BDS, PhD

Dr Pindyck – DMD

OHSU School of Dentistry

Portland, Oregon

NATIONAL 2024 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Project Support

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Objectives

- Introductions
- HRSA Funding
- Russell St Dental Clinic
- Homelessness & unstable housing
- People who inject Drugs
- Portland - HIV cases and PWID
- Bridges and other partners
- What next

Who are we?

NATIONAL 2024 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Dr Foster Page
Division Head Dental Public Health SOD
OHSU

Dr Pindyck
Clinical Director Russell St Dental Clinic

Russell Street Clinic Dental (RSC)

- Community Clinic residing in a federally designated underserved area
- Black Community in NE Portland
- History back to the Black Panthers
- Kaiser Permanente
- Dr. David Rosenstein – Oregon Health & Science University School of Dentistry (OHSU SOD)
- Federal grant to serve low-income patients in 1975

Oregon Health & Science University School of Dentistry (OHSU SOD) – CBDPP

- The Community Based Dental Partnership Project (CBDPP) was developed by the OHSU SOD Department of Community Dentistry
- Part F Community Based Dental Partnership Project – supported RSC directly since 2002
  - Site for 4th year dental student (75) & dental hygiene students (90)
  - Portland Community College, Clark College, Pacific University, Mt. Hood Community College

HRSA Funding – Ryan White

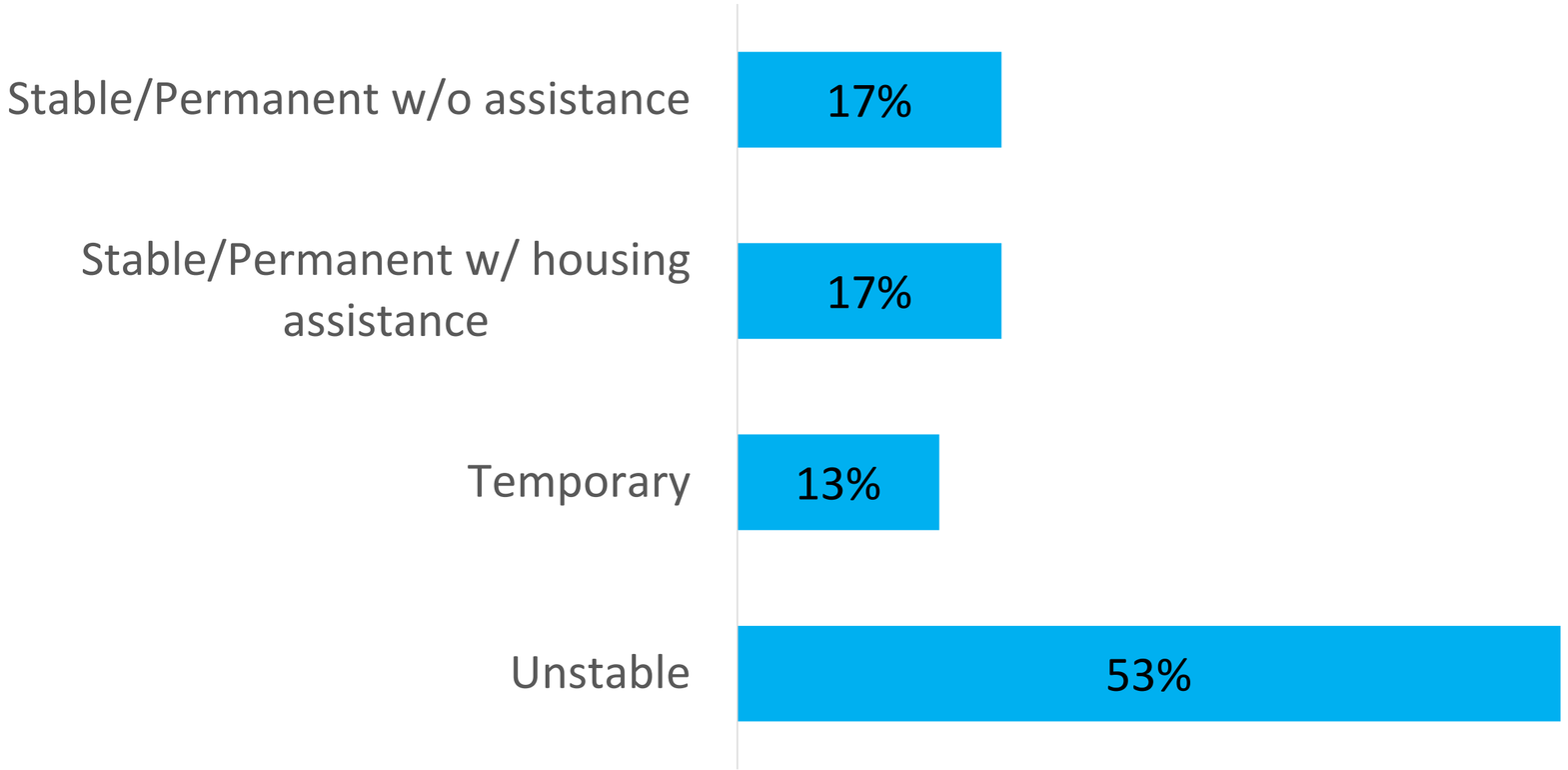
- Funded by HRSA Ryan White since the 1990s when working with Multnomah County
- Russell St Dental Clinic Funding
  - Ryan White HIV/AIDS Program Part F Community Based Dental Partnership
  - Ryan White HIV/AIDS Part A & B – Multnomah County
  - Ryan White HIV/AIDS Program Part C Capacity Development Program - Infrastructure Development - Office Dental Equipment (2023)

Who we see at RSC

- We are a community health clinic that sees the following patients:
  - Ryan White Grant - approx. 50% of patients
  - Oregon Health Plan (Medicaid) - approx. 40% of patients
- Demographics of the clinic
  - Provide care for 600+ RW patients
  - Age – 300 patients are over the age of 45
  - Ryan White patients – half are living at 300% below the federal poverty line

RSC patients - housing

Around 1 in 3 Russell Street patients reported being worried about housing stability in the next year



RSC Team

- Dentists – 4
- Hygienists – 3
- Dental students
- Hygiene students
- Residents
- Dental navigator

Mission of RSC

- Improving the oral and general health of patients
  - With HIV
  - Community the clinic serves
- OHSU SOD continually seeks to reach underserved communities –
  - Those who may be eligible for dental care, particularly populations with undiagnosed HIV
  - Those who would benefit from additional opportunities for testing and immediate oral health services from experienced providers

HIV and homelessness in Portland

- In 2018, approximately 9.5 % of people with HIV in the U.S. experienced homelessness compared to less than one percent of all Americans
- Portland's homeless people account for 14% of all new HIV diagnoses
- In 2019 20% of the 1400 Multnomah County, Portland HIV patients are homeless
- Homeless patients were half as likely to achieve viral suppression as compared to those who had a permanent/stable home
- Managing their care is very difficult as medications are lost, stolen or patients forget to take them
- HIV patients in Portland say “Get housed or die” when asked

Centers for Disease Control and Prevention. https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-special-report-number-25.pdf
https://www.oregonlive.com/health/2019/11/homeless-with-hiv-a-lack-of-housing-makes-a-preventable-disease-deadly-in-oregon.html

HIV and homelessness - Recent evidence

- HIV-seropositive persons are disproportionately overrepresented among the homeless population
- CDC reported that 8.4% of people in HIV medical care were homeless
- A qualitative review of 17 published papers examining the effect of homelessness on health status, HIV treatment adherence, and health outcomes
    - Homelessness is highly prevalent among people with HIV and strongly associated with poorer health status, lower adherence to antiretroviral therapy, and worse CD4 cell count and viral load outcomes

CDC HIV Prevention Progress Report, 2019. Downloaded on 12 May 2020 at: https://www.cdc.gov/hiv/pdf/policies/progressreports/cdc-hiv-preventionprogressreport.pdf.
Milloy M-J, Marshall BDL, Montaner J, Wood E. Housing status and the health of people living with HIV/AIDS. Current HIV/AIDS Report. 2012;9(4):364–74

Unstably Housed & People with HIV

- People with HIV who experience homelessness have poorer clinical outcomes than people who are not homeless with HIV.
- Limited information on people with HIV who experience other forms of housing instability
- Independent of homelessness, people who were unstably housed
  - More likely to be younger
  - Have lower educational attainment
  - Previously incarcerated
  - Live at or below the poverty level
  - Poorer mental health and clinical outcomes

Unstably Housed & People with HIV

J Assoc Nurses AIDS Care. Author manuscript; available in PMC 2022 May 22.
PMCID: PMC9124455
Published in final edited form as:
NIHMSID: NIHMS1807788
J Assoc Nurses AIDS Care. 2022 May-Jun; 33(3): 283–294.
PMID: 34812797
Published online 2021 Nov 22. doi: 10.1097/JNC.0000000000000314

Characteristics of Adults With Diagnosed HIV Who Experienced Housing Instability: Findings From the Centers for Disease Control and Prevention Medical Monitoring Project, United States, 2018

Ruthanne Marcus, PhD, MPH, Epidemiologist,* Yunfeng Tie, PhD, Epidemiologist, Sharoda Dasgupta, PhD, MPH, Epidemiologist, Linda Beer, PhD, Epidemiologist, Mabel Padilla, MPH, Epidemiologist, Jennifer Fagan, MA, Health Scientist, and Joseph Prejean, PhD, Branch Chief

- Interventions to address housing instability, integrated with clinical care, could benefit not just people with HIV who are homeless but also those who are unstably housed

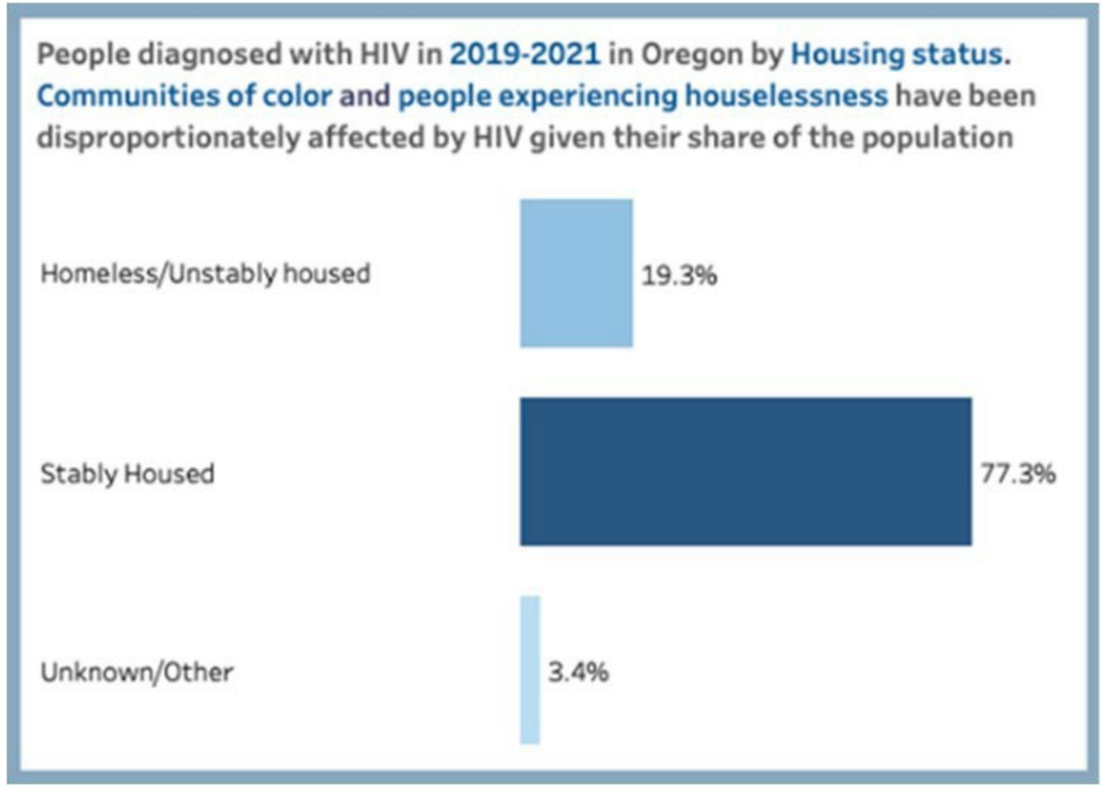
People who inject drugs

- There have been HIV outbreaks and clusters among people who inject drugs (PWID) reported in rural and urban settings over the last decade
- In the early 2000's, Oregon saw an increase in opioid use disorder, as well as opioid overdose hospitalizations and deaths
- Between 2000 and 2015 the opioid mortality rate tripled in Oregon
    - In larger urban settings like Seattle, WA, houselessness and injection drug use were associated with an outbreak of HIV in highlighting vulnerabilities in this marginalized community

Hodder SL, Feinberg J, Strathdee SA, et al. The opioid crisis and HIV in the USA: deadly synergies. Lancet. 2021;397(10279):1139–50 Oregon Health Authority, Public Health Division. Opioid Overdose in Oregon: Report to the Legislature. 2018 https://www.oregon.gov.oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Documents/OH A2479.pdf

Portland - Houselessness

- Multnomah County's point-in- time homeless
  - 2022 count showed > 5,200 people experiencing homelessness
  - 30% increase from the 2019 count
- More than 3,000 of those people are unsheltered
- Intersectionality of addiction and homelessness makes providing adequate testing and treatment especially difficult for HIV



https://www.opb.org/article/2022/05/05/multnomah-county-oregon-releases-first-homeless-count-point-in-time-two-years/
https://public.tableau.com/app/profile/oregon.health.authority.public.health.divison/viz/EndHIVOregon/End HIVORHome.

Portland – HIV cases and PWID

- Portland area is one of the hardest hit by a new front of HIV transmissions
- Surging among intravenous drug users and their sexual partners
- Multnomah County in 2019 - 71 people were diagnosed with new cases of HIV in total
    - Nearly doubling the number reported in that population in 2016 and 2017 combined
- The outbreak has surged among intravenous drug users who are – or who soon become -- homeless, and their sexual partners

Portland – HIV cases and PWID

- A recent study of the use of injection drugs and any form of methamphetamine in the Portland area
- Increase in HIV cases in Clackamas, Multnomah, and Washington Counties; 2018–2020
- Of the 396 cases identified
  - Half reported being unstably housed
  - Three quarters of cases with a diagnosis between the ages of 17 to 39
  - Two-thirds located in Multnomah County

Walters J, Busy L, Hamel C, Junge K, Menza T, Mitchell J, Pinsent T, Toevs K, Vines J. Use of Injection Drugs and Any Form of Methamphetamine in the Portland, OR Metro Area as a Driver of an HIV Time-Space Cluster: Clackamas, Multnomah, and Washington Counties, 2018-2020. AIDS Behav. 2022 Jun;26(6):1717-1726.

BRIDGES
COLLABORATIVE CARE CLINIC

Bridges Collaborative Care Dental Clinic

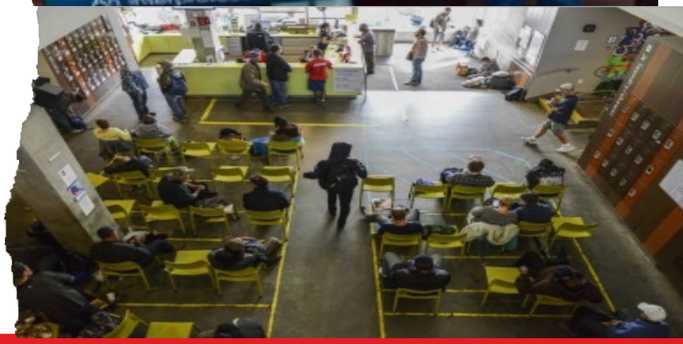
Bridges Collaborative Care Clinic (BCCC)

- OHSU SOD - partnership with the Bridges Collaborative Care Clinic
  - Started four years ago
  - A student-run, interprofessional free clinic that provide
  - Medical and dental care to underserved communities particularly unhoused individuals in the Portland area
- Link homeless individuals accessing dental care at BCCC to a dental home at RSC as well as testing and linkage services to Partnership Project and other care services
- Ryan White HIV/AIDS Program Part C Capacity Development Program - Infrastructure Development - Office Dental Equipment (2023)

What is BCCC?

- A student run and student led organization
- Interprofessional collaboration between OHSU, PSU, OSU
- Non-profit, funded by grants and donations
- Mission: serve vulnerable populations in the Portland Metro area
- Community partnerships with Transitions Project (TPI)

Branches	
Medical	Reproductive Health
Dental	Wound Care
Pharmacy	Behavioral Health
Opthalmology	



Core Values of BCCC Dental

Provide an opportunity for students to:

- Learn how to run a dental clinic
- Navigate working with special populations who have unique circumstances
- Experience the benefit of working and providing care in public health environment

Serve our community by:

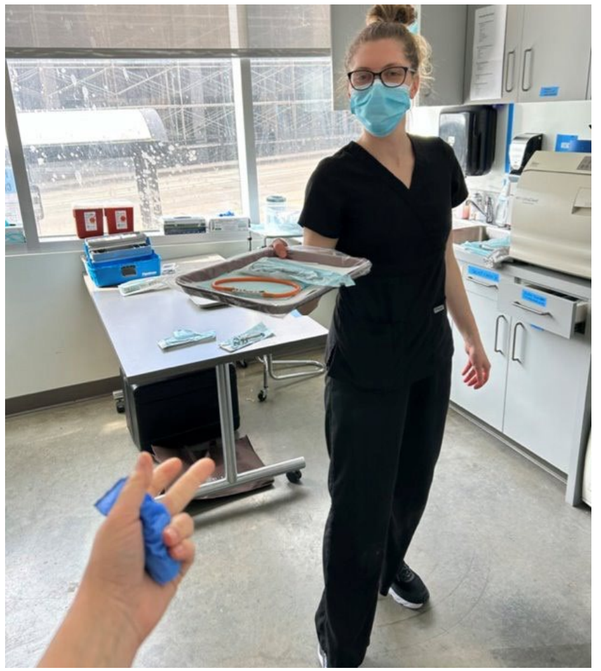
- Providing basic dental care to underserved individuals
- Educating underserved individuals on how to maintain their oral health
- Connecting individuals to the resources they need to thrive

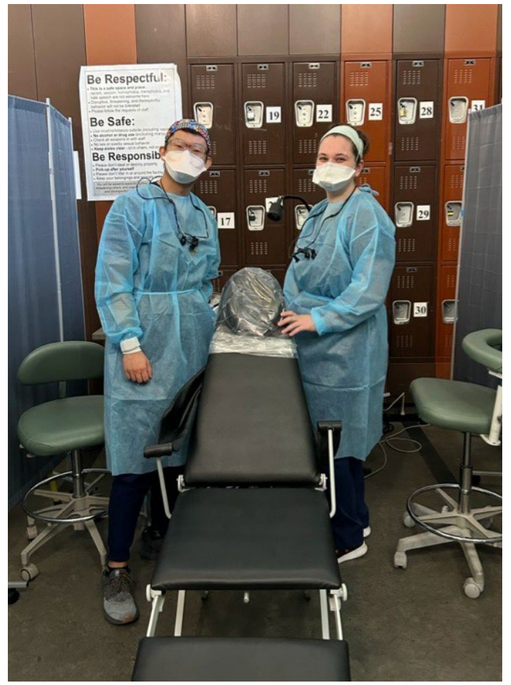
Dental Services

- Exams & Radiographs
- Oral Hygiene Instructions
- Cleanings
- Fluoride Treatments
- Fillings
- Extractions (simple and surgical)
- Low-Cost Resources/ Referrals

<u>What sets us apart?</u>

- Entirely free
- Regular, recurrent clinics
- More than just urgent care
- Easily accessible



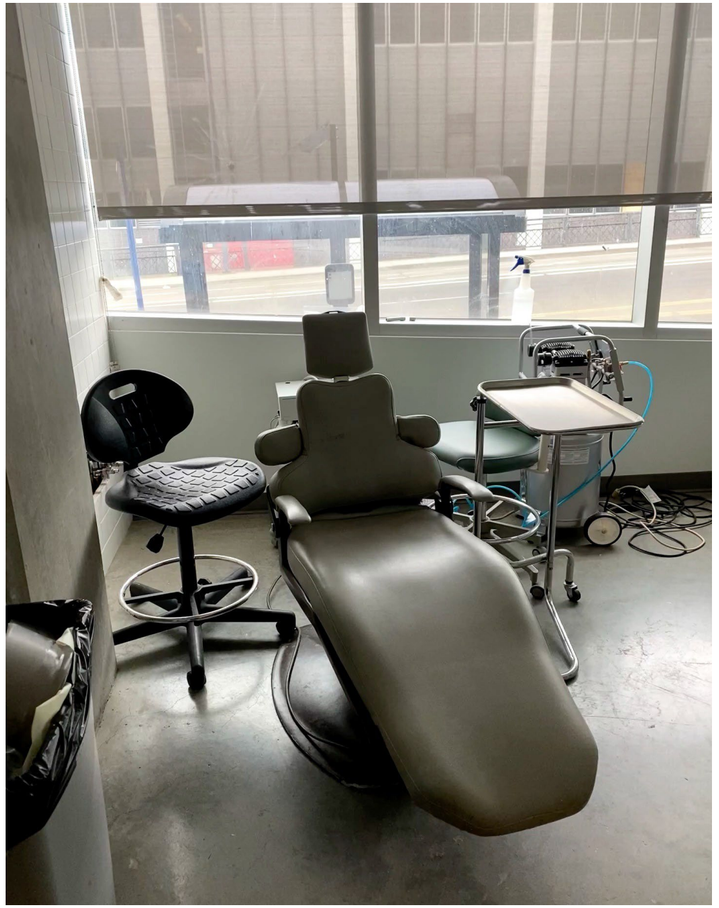


Where we came from

Creation of BCCC Dental: Oct 2017

First clinic: Feb 2022

- One clinic per month
- One operating chair
- Volunteers per clinic 2-3 DS3 & DS4 Students only
- One faculty preceptor
- Prophies only
- Patients seen per clinic 3-4



Where we are now

Summer 2024

Bi-monthly Saturday Clinics

Monday full-day

Operating chairs - 4 to 6

Student volunteers per clinic 15-20

DS1- DS4 Students

Faculty preceptors per clinic 2-3

- GPR resident preceptors

Patients seen per clinic - 15+

Full range of services

Bridges Team

- Support the broader public health initiative of Portland
  - Engaging with homeless and unstably housed people
  - Others who present to them with pain and dental problems
- There is a need to go to the homeless and unstably housed
- Seek out those who require care to prevent a further rise in HIV cases
- Dental care from dental student volunteers and OHSU SOD staff
  - Opportunity to capture and support those patients that may be being missed

Dental Navigator

- The use of patient navigators to create a network of services for PWH who are unstably housed can improve housing stability and lead to improvements in HIV-related outcomes

Home » American Journal of Public Health (AJPH) » **December 2018**

The Influence of Housing Status on the HIV Continuum of Care: Results From a Multisite Study of Patient Navigation Models to Build a Medical Home for People Living With HIV Experiencing Homelessness

Serena Rajabiun PhD, MPH, MA, **Janell Tryon** MPH, **Matt Feaster** MPH, **Amy Pan** PhD, **Lisa McKeithan** MS, **Karen Fortu** MPH, **Howard J. Cabral** PhD, **Deborah Borne** MD, MSW, and **Frederick L. Altice** MD, MA

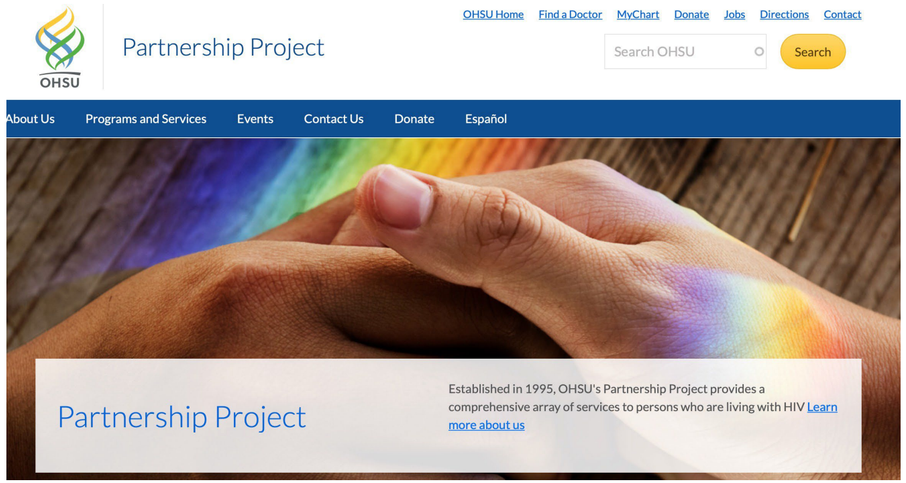
Accepted: August 18, 2018 Published Online: December 11, 2018

Bridges and RSC

- Part C Capacity Development Program - Infrastructure Development - Office Dental Equipment (2023) has allowed us to see more patients at Bridges
- All patients that require care and a permanent dental home are navigated to RSC from Bridges
  - An extra chair at RSC so we can see more patients from Bridges
  - Able to HIV test so can link care to OHSU Infectious Disease team and our partners

Partners

- Multnomah County Health Department
- Cascade AIDS Project
- OHSU Partnership Project
  - Provides a comprehensive array of services to people with HIV
  - Referral services through the existing case management network
- RSC ensure that all patients have a PCP
  - If they do not, we refer them to Partnership Project



Lessons Learnt

- Everything takes time – HIV testing
- Systems put in place need to be reviewed often as patients initially did not follow through with finding dental home
- Dental navigator was required to capture data to support patient engagement
- Need a better process to support unstably housed individuals
- Better alignment with partners – partnership project managed care

What is next?

- Ryan White HIV/AIDS Program Part C Capacity Development Program - HIV Care Innovation - Coordination of Care (2024)
- HIV continuum of care we need to specifically target the areas of increasing diagnosis of HIV, patients' retention of care, and linkage to care once diagnosed
- RSC to expand our collaboration and training with OHSU HIV Clinic and Bridges
- Better leverage the capacity for access to HIV testing, prevention, care, treatment, and supportive services
- Linking of health conditions in a non-traditional setting dental clinic

What is next?

- Manage our patients overall care better - aware that those with HIV often experience viral hepatitis, and sexually transmitted infections (STIs) = “syndemic”
- Addressing a syndemic can be challenging
- Difficult when provision of care is not linked and/or provided in different settings
- Explore opportunities to engage the dental team and support their training to do more
- Oregon dentists can provide vaccinations – HPV
- In the future we could also screen for STIs
  - Oregon, ranks 9th in the nation for syphilis infections and among the top 20 states for congenital syphilis

https://www.hiv.gov/federal-response/national-hiv-aids-strategy/national-hiv-aids-strategy-2022-2025

NATIONAL 2024 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Thank you

Acknowledge:

OHSU SOD Division of Dental Public Health

OHSU SOD Research Team

OHSU Internal Medicine and Health Equity team

Russell St Dental Clinic team and patients

Bridges – Students and patients