Retaining Multiply Diagnosed, Homeless HIV Positive Individuals in Medical Care, Behavioral Health, and Case Management

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Disclosures

Presenter(s) has no financial interest to disclose.

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Learning Objectives

At the conclusion of this activity, the participant will be able to:

1. Describe challenges experienced by HIV positive individuals with mental health and/or substance use disorders who are homeless or unstably housed.
2. Articulate effective strategies to engage and retain HIV positive individuals with mental health and/or substance use disorders who are homeless or unstably housed in medical care and treatment.
3. Discuss appropriate interventions and strategies to address client needs and challenges as described in selected case vignettes.

Obtaining CME/CE Credit

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Outline

1. Introduction
2. Challenges faced by the multiply diagnosed homeless HIV population
3. Strategies for effectively working with the Multiply diagnosed homeless HIV positive population
4. Case studies
5. Q and A
6. Success Story

Introduction

What is the connection between HIV and housing?

The National HIV/AIDS Strategy Updated to 2020 notes,

“Access to housing is an important precursor to getting many people into a stable treatment regimen. Individuals living with HIV who lack stable housing are more likely to delay HIV care, have poorer access to regular care, are less likely to receive optimal antiretroviral therapy, and are less likely to adhere to therapy” (NHAS Updated to 2020, pg. 35)

HIV and Housing Research

A 2012 review of the scientific evidence related to HIV and housing indicated the following:

- "Strongly linked to poorer health status, homelessness has long been recognized as an important contributor of vulnerability to HIV infection"(Milloy et al, 2012)

- "Seroprevalence of HIV in homeless/marginally-housed populations is estimated to range from 10 to 20%, or typically five to ten times higher than among housed populations"(Milloy et al, 2012)

HIV and Housing Research

In 2016 a systematic review of 152 studies published in the American Journal of Public Health representing 139,757 HIV positive individuals found:

“strong evidence demonstrating that homelessness and unstable or inadequate housing are inconsistent with the sound medical management of HIV”(Aidala et al, 2016; pg e18)

“interventions meeting the housing needs of people with HIV can significantly improve their connection to HIV care, adherence to treatment, and health outcomes” ”(Aidala et al, 2016; pg e18)

HRSA/SPNS Initiative

- The HRSA/SPNS Initiative, 'Building a Medical Home for multiply diagnosed HIV positive homeless/unstably housed populations' aims to achieve the NHAS goals of retention in care, viral suppression and improving housing stability for people living with HIV and who are experiencing homelessness or unstable housing.
- In 2012 AIDS Arms, in Dallas, TX was selected as one of nine sites in the U.S. to participate in the initiative.
- The outcomes data presented in this session are from the local level evaluation of the AIDS Arms Health, Hope and Recovery program.

Challenges

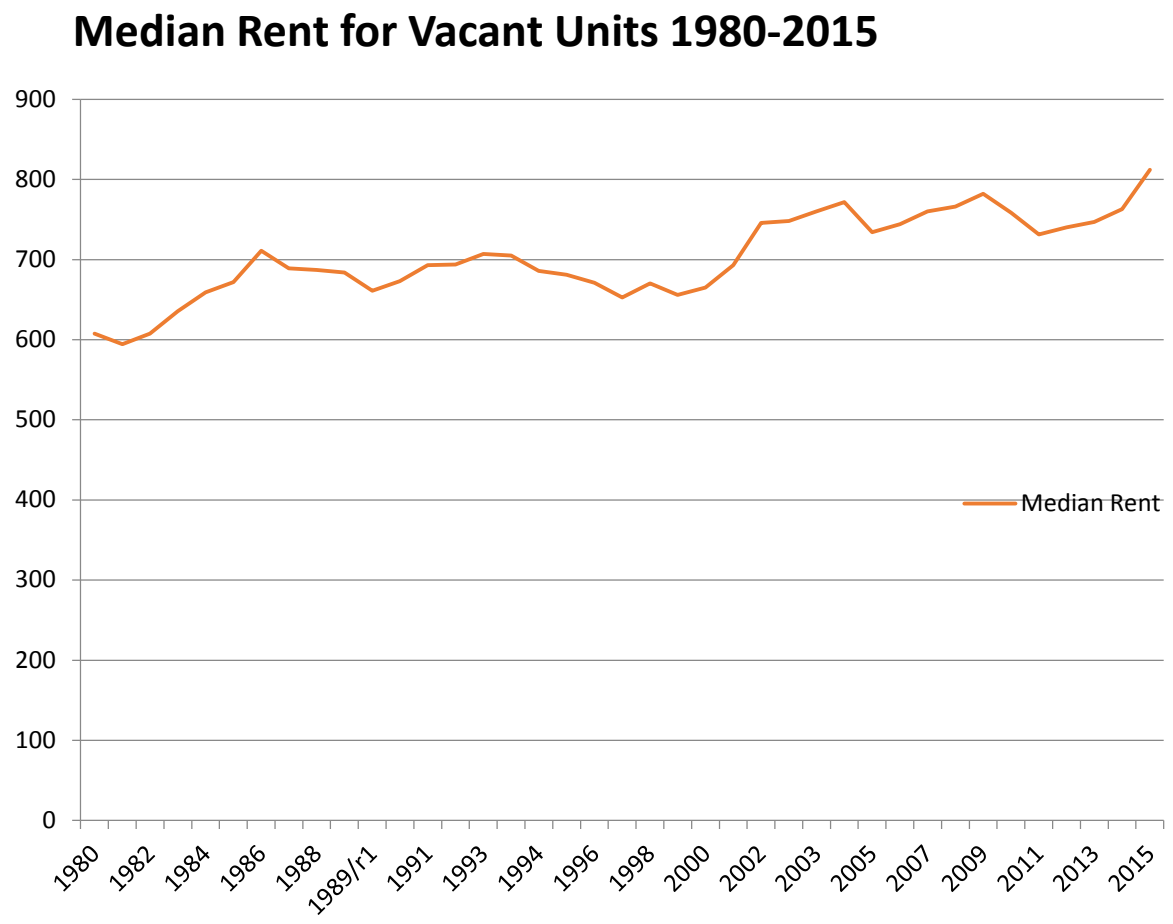
Scope of the Problem

In 2015 the HUD Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations reported that in US:

- 564, 708 homeless individuals total
- 104,084 homeless individuals with severe mental illness
- 103, 888 homeless individuals with chronic substance use
- 9,294 homeless individuals living with HIV/AIDS

Source: https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_NatlTerrDC_2015.pdf

Lack of Affordable Housing



Held constant in 2015 dollars, the median rent for vacant units has risen from $608 in 1980 to $812 in 2015.

Vacant For-Rent Units, by Selected Characteristics [Chart]. (n.d.). In *United States Census Bureau*. Retrieved July 25, 2016, from http://www.census.gov/housing/hvs/data/ann15ind.html

Lack of Access to Mental Health Disorder Treatment

- Based on 2011 data:
  - 62% of adults with mental illness did not receive treatment
  - 72% of adults reported a structural barrier to treatment
  - 47% reported an attitudinal barrier (Walker et al, 2015)
- Cost continues to be a barrier to accessing mental health care: barriers related to cost have risen between 1999-2000 and 2009-2010 (Rowan et al, 2015)

Lack of Identification Documents

- State issued ID card, birth certificate, and social security card are often prerequisites to receiving housing services, social services, including AIDS Drug Assistance programs
- When clients do not have their ID documents they often do not receive essential services
- Clients also have to repeatedly show documents to access services
- Once ID Documents are ordered it can take months or weeks to arrive

Stigma – Real

The construction of the definitions homelessness and HIV/AIDS, for example emanate from the professional worlds of research, public policy, and service provision for the most part, without consultation or inclusion from the views of the homeless persons or people living with HIV/AIDS. In addition, as part of the accessing and use of the social service system, stigmatized persons become subject to rules and procedures over which they play a minimal role. Thus, stigmatized persons not following rules and procedures outlined by professions and institutions reinforce their identification as deviant and abnormal and may even be denied access to systems (Takahashi, 1998).

Stigma – Real

Human services facilities play primary roles in the definition and reinforcement of stigma since the stigma of places is conditioned in part by the built environment, the organization of institutions and groups providing services to homeless persons and people living with HIV/AIDS, and the daily/life paths of individuals inhabiting or passing through the space (Takahashi, 1998).

Stigma – Perceived

While the labeling and stereotyping of individuals by professionals and institutions are central in the stigmatization of homelessness and HIV/AIDS, the construction of self-identity as homeless or living with HIV/AIDS is also vital in the dynamic underlying the social relations of stigma. Individuals with stigmatized characterizations directly inherit the stigma defined through labels, stereotypes, and risk groups, but in addition, may also internalize these marginalized or devalued identities (Takahashi, 1998).

Strategies

Intensive Care Coordination and Navigation

Care coordinators at AIDS Arms maintain a smaller caseload of homeless HIV clients which allows them to provide the following care:

- Meeting clients at medical appointments
- Checking in with clients based on their regularly assess acuity
- Conducting psychotherapeutic interventions, including Motivational Interviewing and Cognitive Behavioral Therapy
- Meeting clients at shelters, in the streets, and at appointments for housing, medical care and social services
- Utilizing a strength based and harm reduction approach
- Coordinating services with medical providers
- Assessing acuity level regularly using a standardized tool

Trauma Informed Care

-There is evidence that trauma diagnoses are much more common in the homeless population, with the estimated prevalence in the homeless population being 38% to 53% and the prevalence in the general population being 2% to 3% (Fazel et al, 2014)

-Trauma Informed Care "refers generally to a philosophical/ cultural stance that integrates awareness and understanding of trauma" and that has shown promise in the fields of mental health and homelessness (Hopper et al, 2010)

-Trauma Informed Care - Primary goals are defined by those being served and focuses on recovery, self-efficacy, and healing

Evidence Based Treatment

Evidence-based treatment is the use of treatment methodologies for which there is scientifically collected evidence that the treatment works (Stout & Hayes, 2004).

- Coaching – setting expectations on what is needed – provider and client interactions
- Motivational Interviewing (MI) – goal oriented, client-centered, elicits behavior change, explores/resolves ambivalence
- Solution Based Therapy (SBT) – solution building rather than problem solving – explores future hopes rather than present problems

Housing- Emergency

AIDS Arms uses motels to provide Emergency Housing for clients in the following situations:

- Clients who are nearing placement in permanent housing to help them transition into housing and to help keep them engaged with the change process
- Clients who are in need of medical respite and have no other options

Emergency housing is limited to 6-8 weeks

Housing- Emergency

- Getting off the streets – allows client a sense of safety. Clients are able to rest, sleep and finding a sense of “normalcy”.
- Practice run – return to activities of daily living (hygiene, chores, cooking, shopping, adherence). How will daily life be without the chaos?
- Identify possible barriers – social support - vs - social network. Substance use/abuse, physical and mental health.
- Explore behavior changes – risk/harm reduction model, learning to be self sufficient, crisis planning, wellness recovery action planning (WRAP).

Housing- Permanent

Care Coordinators:

- Employ a strengths based and client centered approach where clients set their own goals which may be to obtain permanent housing
- Pursue the following permanent housing options for clients:
  - Housing First programs
  - Sober living programs
  - Section 8
  - Housing available on the private market
  - Boarding homes
  - Residential hotels

Collaboration with Stakeholders

The Continuum of Care ideally involves stakeholders outside of the traditional homeless system with the goal of educating these stakeholders and getting them to become part of the solution.

- Medical providers
- Housing providers
- Landlords
- Benefits providers
- Colleagues

Transition to Standard of Care

- Clients are transitioned out of the Health Hope and Recovery program after 12 to 18 months. The transition process is determined by the client's acuity level and needs.
  - Clients with lower needs are assigned to a Ryan White standard of care case manager for maintenance.
  - Clients assessed as having a high acuity level are assigned to a Standard of Care case manager with the training and experience necessary to support their ongoing needs. A client's acuity is assessed on a regular basis
- The transition process involves a ***warm and structured hand off***

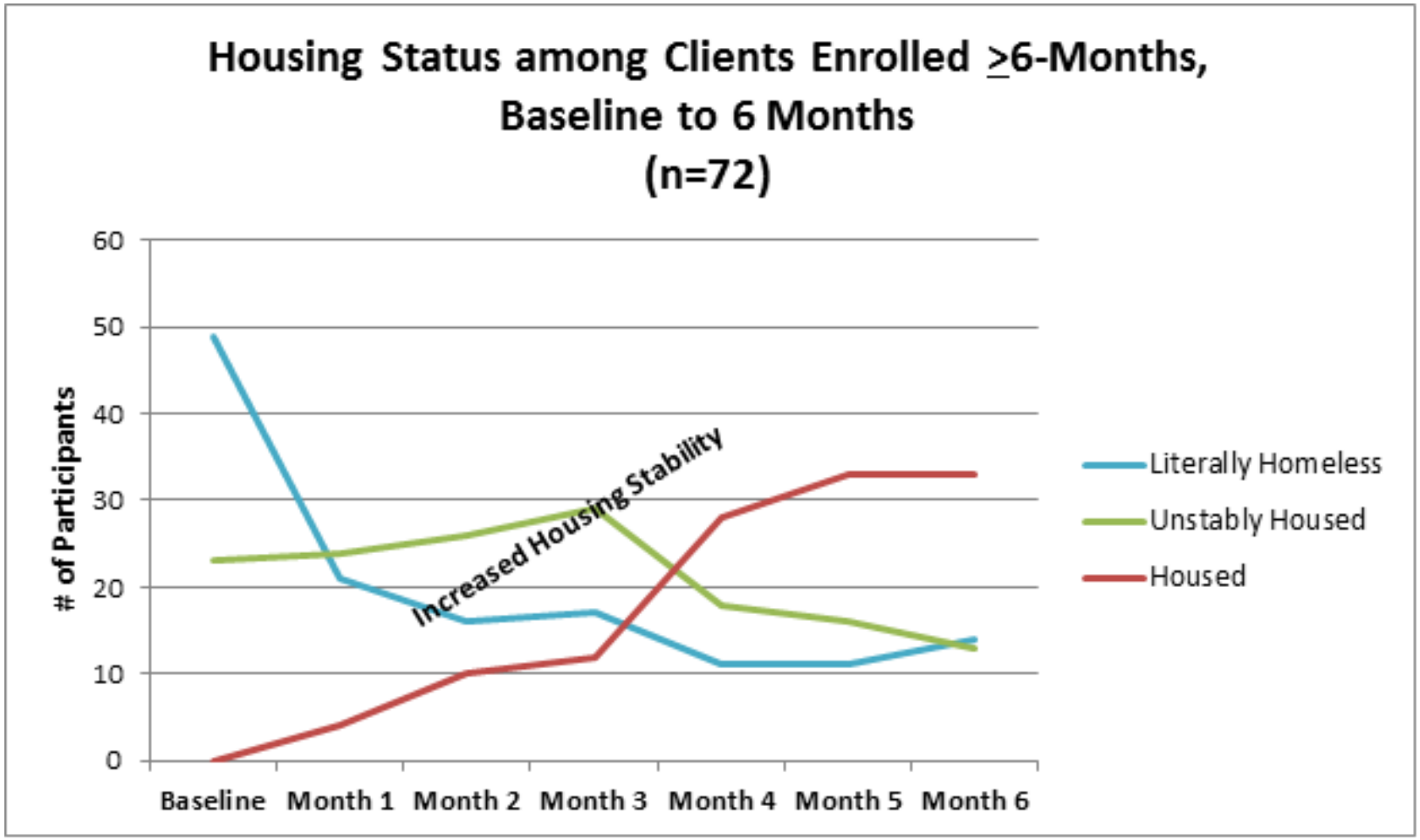
Outcomes

Outcomes data that follow are based on ***local*** AIDS Arms Health Hope and Recovery evaluation data only.

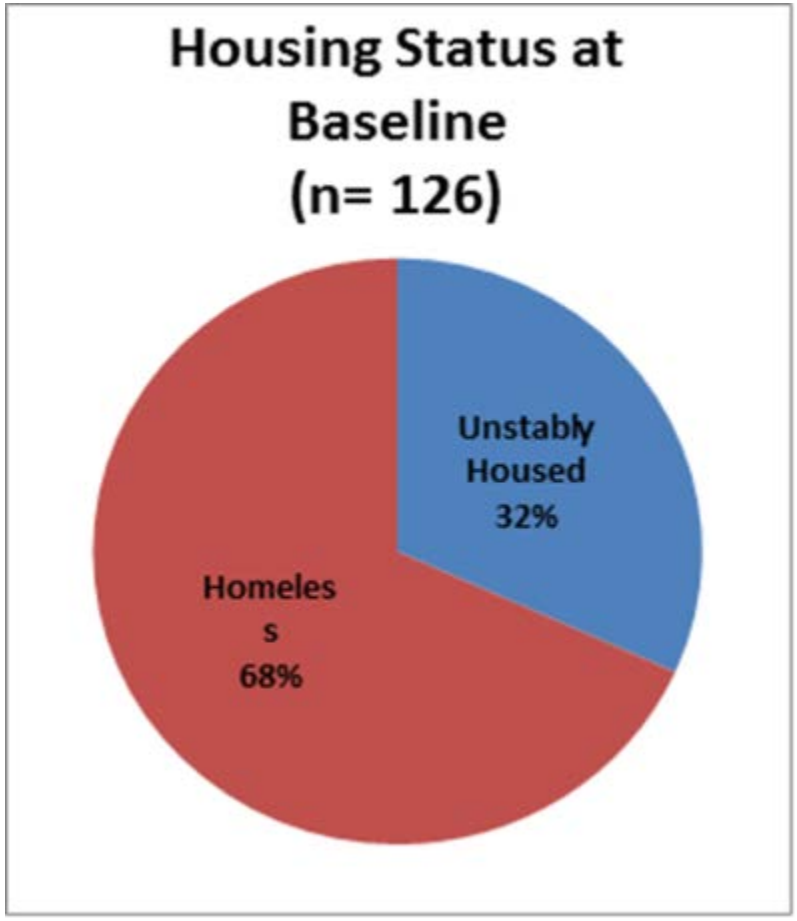
Retention in Care outcomes

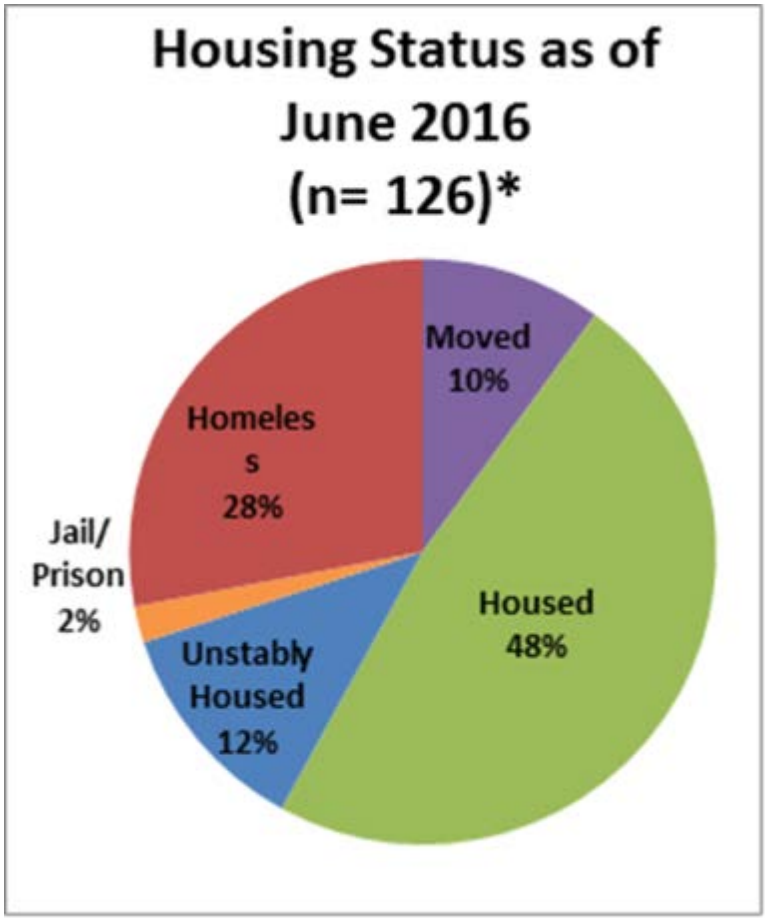
Total # of Clients Enrolled in 2015	108	100%
Evidence of Care in 2015	83	77%
At least 1 HIV visit during period 1: Jan-Jun 2015	60	56%
At least 1 HIV visit during period 2: Jul-Dec 2015	74	69%
*"Engaged"	51	47%
*Engaged= 1 visit during each 6-month period (Period 1: Jan-Jun, Period 2 Jul-Dec)		
Medical engagement may be an underestimate. Medical visit history only available for clients receiving care at AIDS Arms clinics.		

Housing Outcomes

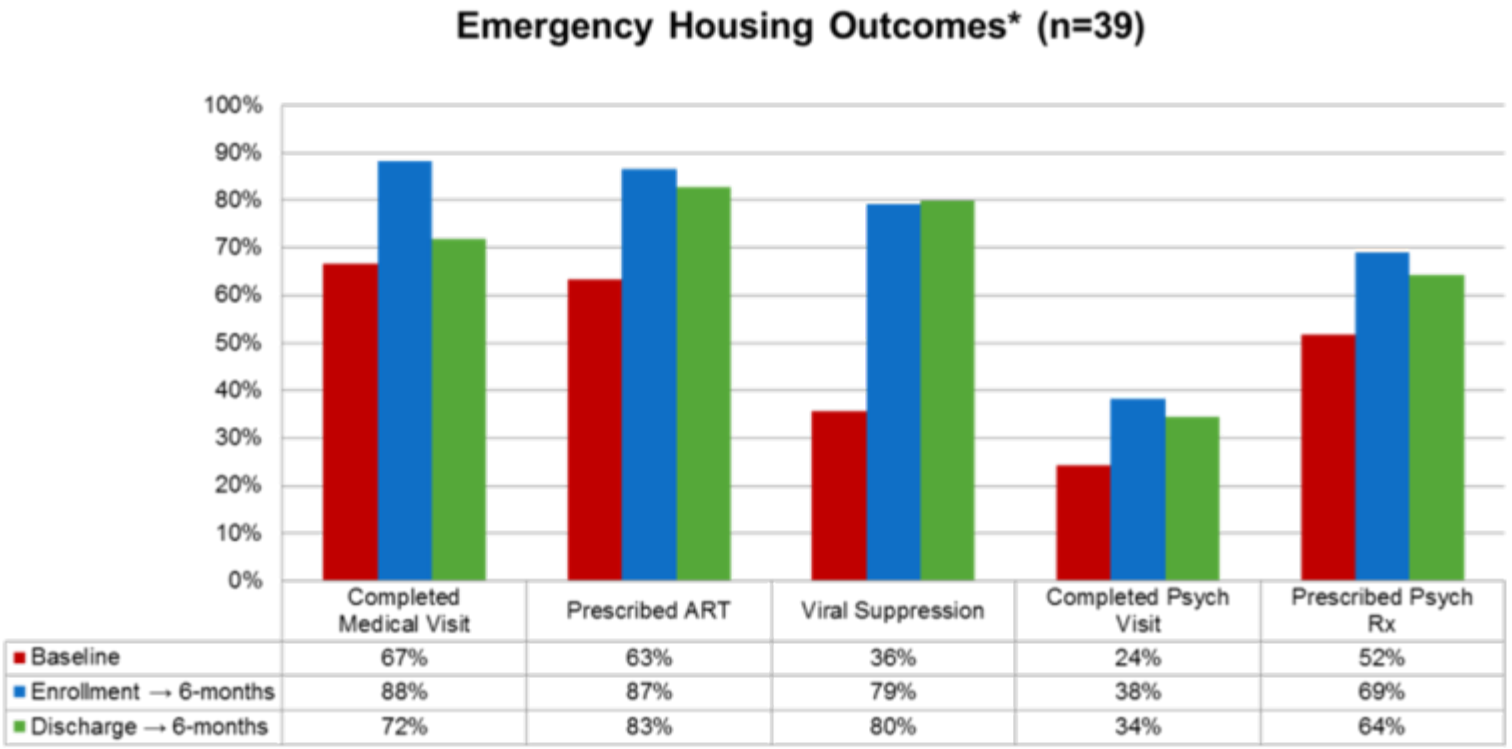


Housing Outcomes





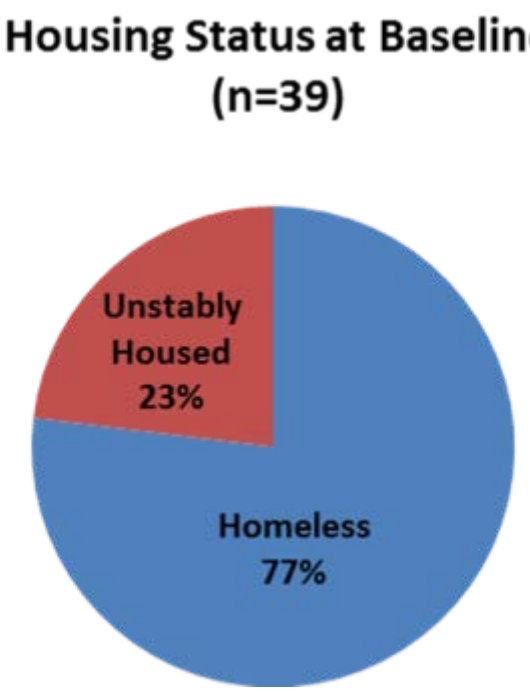
Emergency Housing Outcomes

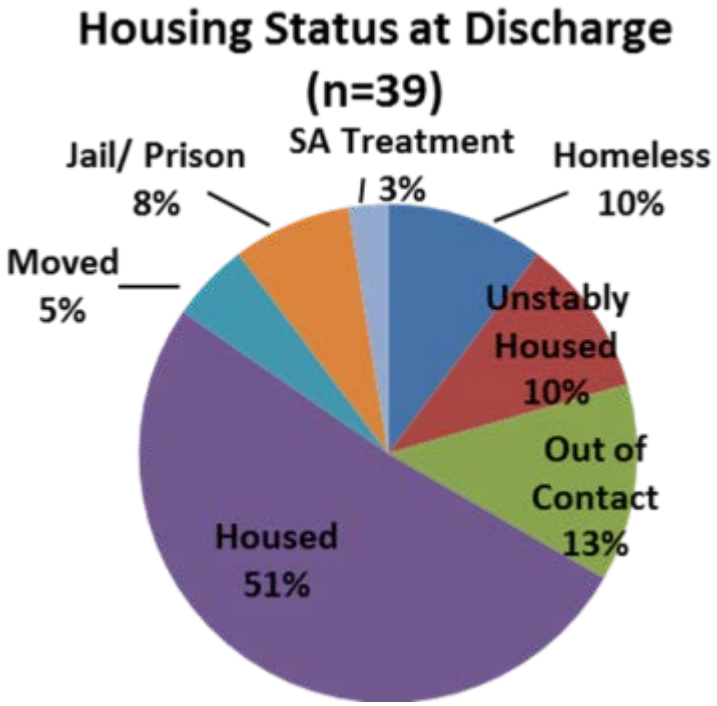


	Completed Medical Visit	Prescribed ART	Viral Suppression	Completed Psych Visit	Prescribed Psych Rx
Baseline	67%	63%	36%	24%	52%
Enrollment → 6-months	88%	87%	79%	38%	69%
Discharge → 6-months	72%	83%	80%	34%	64%

*Missing records were excluded from analysis

Emergency Housing Outcomes





Case Studies

Case 1

- 27 year old, HIV positive male who identifies as gay
- History of Domestic Violence, Substance Use, and Major Depressive Disorder
- Declines to access shelters due to stigma
- Hourly retail job, $10.00/hour 30 to 35 hours per week
- Does not have birth certificate or social security card
- Sometime sleeps on the streets, sometimes on a friend's couch

Case 2

- 39 year old, HIV positive female
- History of prostitution, substance use, and some depression
- Transitioned from Louisiana to Texas due to family not tolerating risky behaviors
- Shelter resistant due to previous sexual assault at a shelter - trades sex for place to stay and for drugs, or resides in a tent city
- Client in enrolled and living in an inpatient substance use treatment facility; 20 days from treatment completion client begins to explore housing options
- Because the client has not been in a shelter, tracking her homeless status – a pre-requisite for enrolling in any supportive or subsidized housing - is a challenge.
- Previous methods of documenting homelessness have been deemed unacceptable due to policy changes. Case manager had provided necessary documentation and pictures of encampment under bridge where client resides in tent, her personal belongings, and other items, along with other documentation
- Case manager re-submitted information twice but client continues to be rejected due to the entire area being unfamiliar with the new guidelines for documenting chronic homelessness. These changes in documenting homelessness impact all housing programs and has become quite a challenge for tracking a clients' homelessness and getting the client housed. What would your next steps be?

Case 3

- 51 year old, HIV positive male who identifies as gay
- History of domestic Violence, substance Use, and Schizophrenia
- Difficulty maintaining housing for the last 25 years
- Social Security Disability benefits of $1000/mo.
- Several past evictions – criminal history
- Has long history of staying at local shelters , stays on the streets in good weather, trades sex for drugs, money and shelter.

Question and Answer

Client Success Story

References

Aidala, A. A., Wilson, M. G., Shubert, V., Gogolishvili, D., Globerman, J., Rueda, S., … Rourke, S. B. (2016). Housing Status, Medical Care, and Health Outcomes Among People Living With HIV/AIDS: A Systematic Review.*American Journal of Public Health*, *106*(1), e1–e23. http://doi.org/10.2105/AJPH.2015.302905**y**

Evidence-Based Practice: Methods, Models, and Tools for Mental Health Professionals (1). Hoboken, US: Wiley, 2004. ProQuest ebrary. Web. 25 July 2016.

Fazel, S., Geddes, J. R., & Kushel, M. (2014). The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations. *Lancet (London, England)*, *384*(9953), 1529–1540. http://doi.org/10.1016/S0140-6736(14)61132-6

Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the Storm: Trauma-Informed Care in Homelessness Services Settings. *The Open Health Services and Policy Journal TOHSPJ, 3*(2), 80-100. doi:10.2174/1874924001003020080

HUD 2015 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations [Chart]. (n.d.). In *HUD Exchange*. Retrieved July 25, 2016, from https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_NatlTerrDC_2015.pdf

The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update. (2016, January 21). Retrieved July 25, 2016, from http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update**/**

Milloy, M.-J., Marshall, B. D., Montaner, J., & Wood, E. (2012). Housing Status and the Health of People Living with HIV/AIDS. *Current HIV/AIDS Reports*,*9*(4), 364–374. http://doi.org/10.1007/s11904-012-0137-5

NATIONAL HIV/AIDS STRATEGY for the UNITED STATES: UPDATED TO 2020. (2015, Jul). Retrieved July 26, 2016, from https://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update.pdf

Rowan, K., McAlpine, D., & Blewett, L. (2013). Access and Cost Barriers to Mental Health Care by Insurance Status, 1999 to 2010. *Health Affairs (Project Hope)*, *32*(10), 1723–1730. http://doi.org/10.1377/hlthaff.2013.0133

References

Takahashi, L. M. (1998). *Homelessness, AIDS, and Stigmatization The NIMBY syndrome in the United States at the end of the Twentieth Century*. Oxford, New York: Oxford University Press.

Vacant For-Rent Units, by Selected Characteristics [Chart]. (n.d.). In *United States Census Bureau*. Retrieved July 25, 2016, from www.census.gov/housing/hvs/data/ann15ind.html

Walker, E. R., Cummings, J. R., Hockenberry, J. M., & Druss, B. G. (2015). Insurance status, use of mental health services, and unmet need for mental health care in the United States. *Psychiatric Services (Washington, D.C.)*,*66*(6), 578–584. www.doi.org/10.1176/appi.ps.201400248

Wen, H., Druss, B. G., & Cummings, J. R. (2015). Effect of Medicaid Expansions on Health Insurance Coverage and Access to Care among Low-Income Adults with Behavioral Health Conditions. *Health Services Research, 50*(6), 1787-1809. doi:10.1111/1475-6773.12411

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