NATIONAL 2016 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Using Interdisciplinary Teams to Provide Care to People Living with HIV/AIDS who are Homeless

Deborah Borne: San Francisco Department of Public Health
Amelia Broadnax: PATH/Family Health Centers of San Diego
Matt Feaster: Pasadena Department of Public Health
Kendall Guthrie: University of Florida CARES
Carole Hohl: Boston Healthcare for the Homeless Program

Disclosures

Presenters have no financial interest to disclose.

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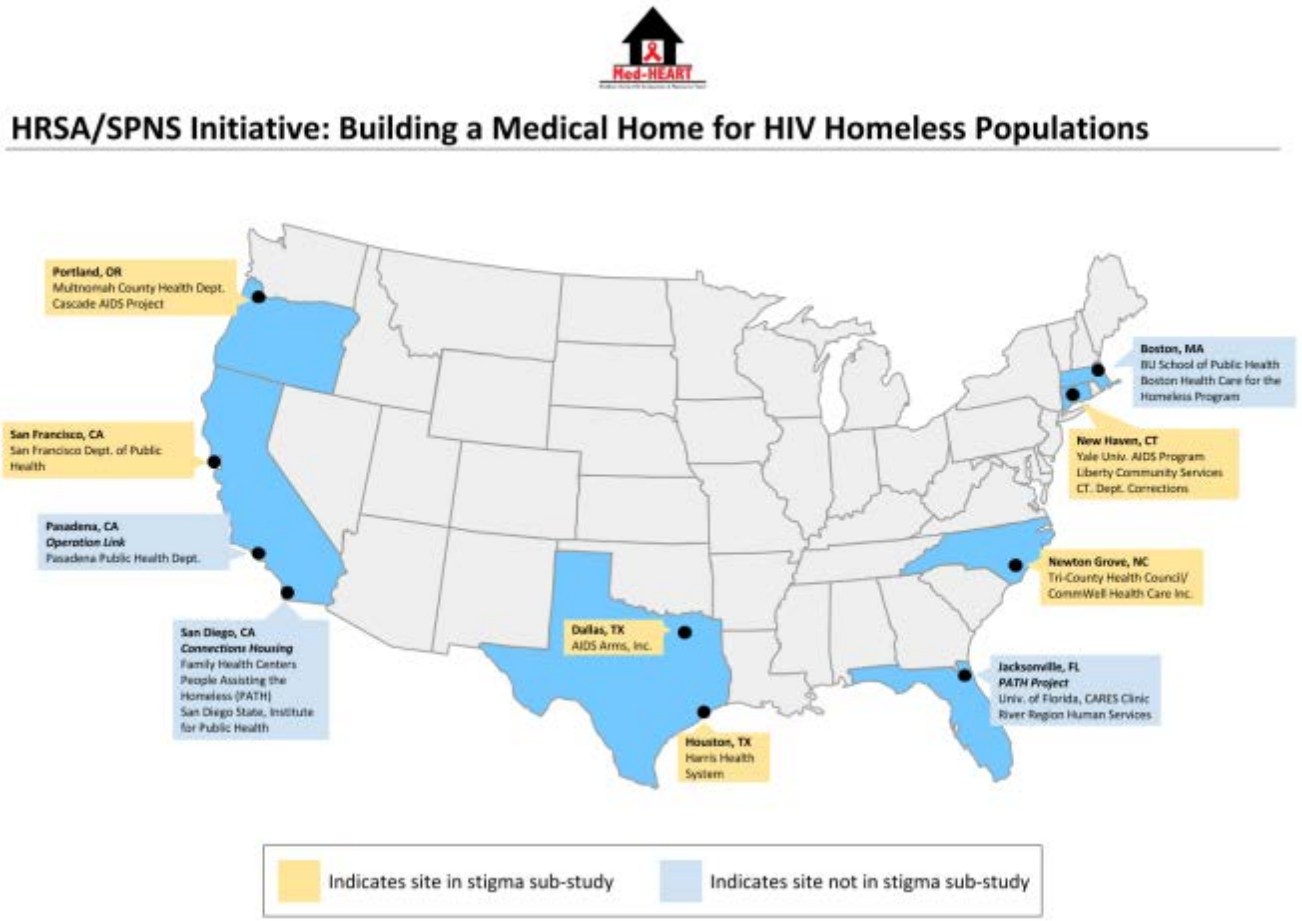
If you would like to receive continuing education credit for this activity, please visit:

http://ryanwhite.cds.pesgce.com

Map of SPNS Study Sites



Building a Medical Home for Multiply Diagnosed HIV Homeless/Unstably Housed Populations

- **Workshop 101:** Providing care to people who are homeless/unstably housed: Barriers & Facilitators to achieving the National AIDS Strategy goals

- **Workshop 201:** Using interdisciplinary teams to provide care to people living with HIV/AIDS who are homeless/unstably housed

- **Workshop 301:** Leveraging resources to sustain programs for HIV care and housing for people living with HIV

Learning Objectives

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

1. Describe the complex needs of PLWH who experience homelessness or are unstably housed, and elaborate on their differences from other Ryan White populations
2. Develop strategies to build staff skills and create external partnerships to facilitate care and services
3. Provide integrated care to people who are multiply diagnosed and homeless/unstably housed using different strategies, resources, and tools to
4. Use Ryan White funding to create partnerships with housing, behavioral health care and other community agencies, and generate other resources that can sustain medical homes and housing for PLWH who are homeless/unstably housed

HHOME: Targeting the Hardest to Serve

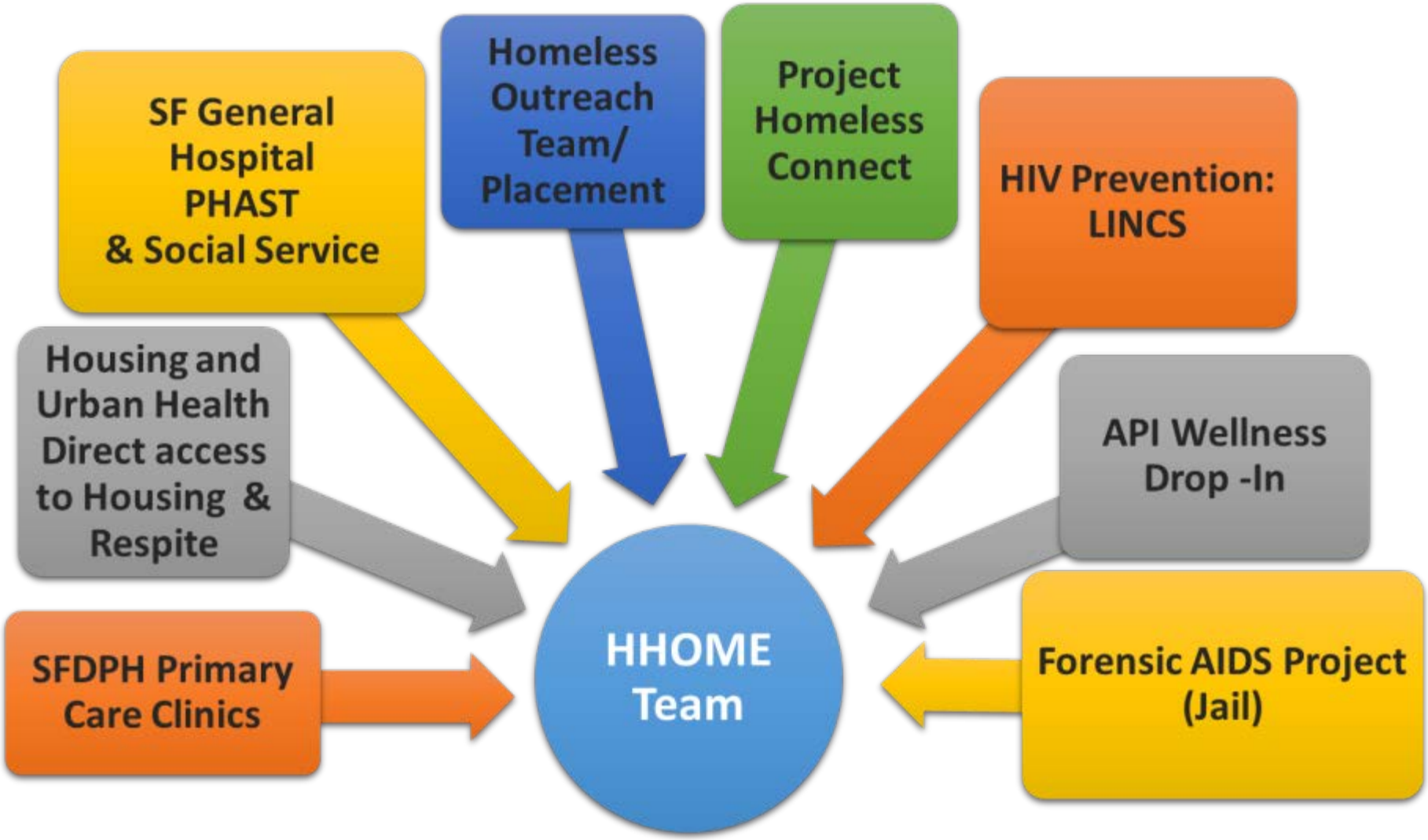
San Francisco Department of Public Health

Deborah Borne

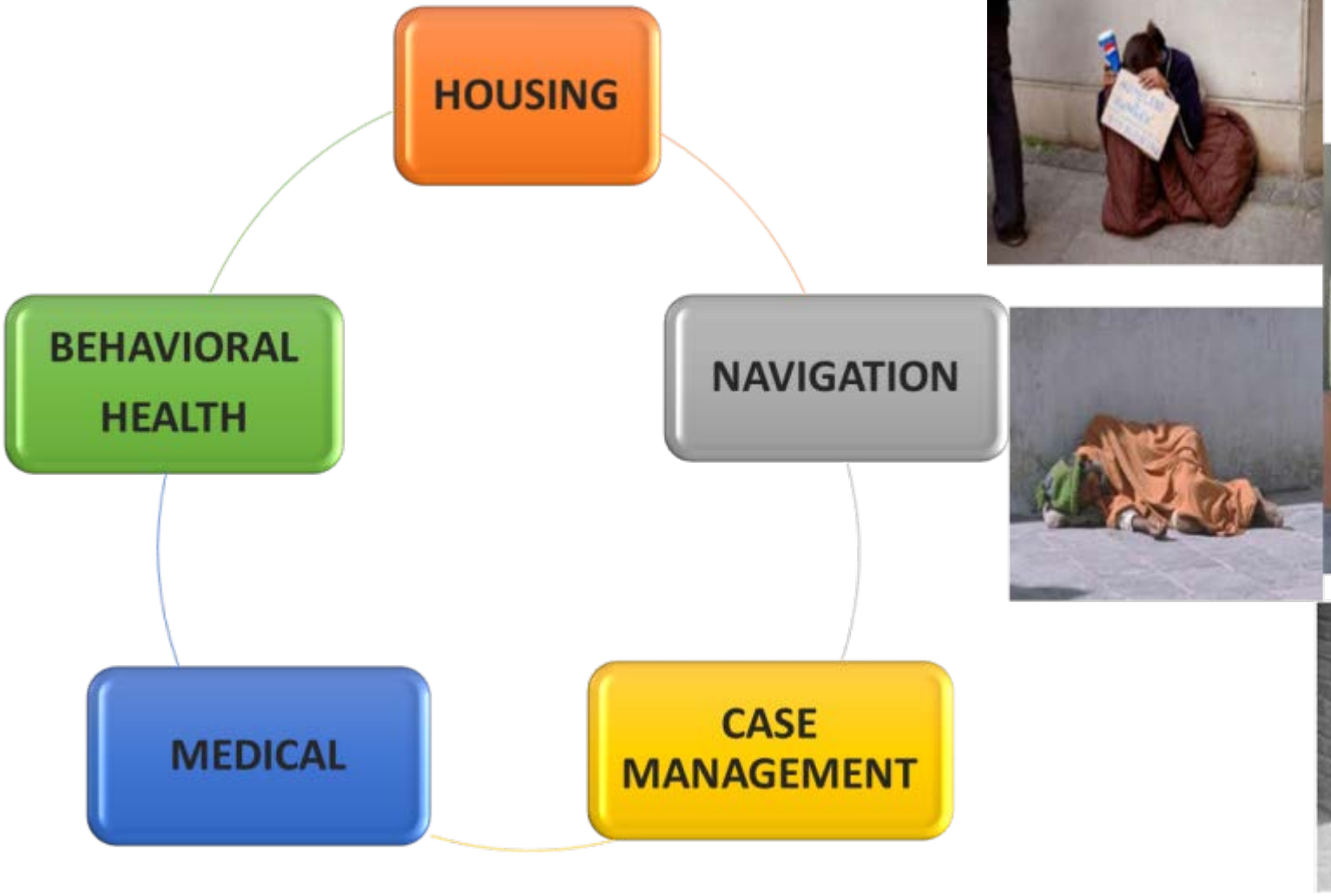
Population Served

- HIV-positive
- Not adherent to or prescribed HIV medicine
- Active substance use
- Active issues with mental illness
- Living on the street or in HRSA-defined unstable housing
- Not currently engaged in primary medical care

HHOME Partners

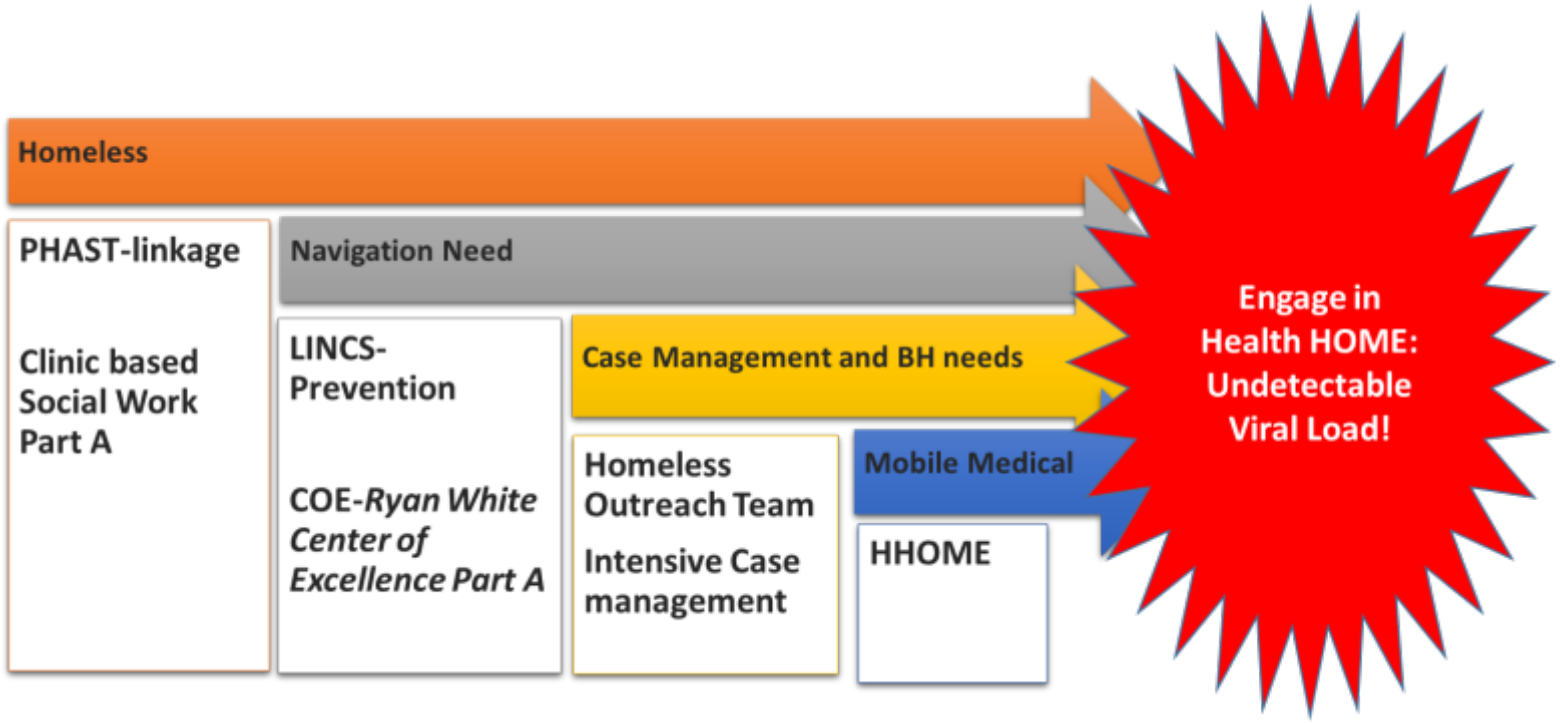


Acuity and Chronicity Assessment



Levels of Support

- Based on need for difficult to engage homeless HIV clients.



How does our program work?

Mobile Primary Care: *Opportunity to Cross-Train*

- *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
- clinical check
- Medical counseling/Advocacy
- Set Treatment Plan

Nursing & Medication Adherence

- Provider: NURSE
- Lower acuity clients
- Medication adherence for all clients
- Routine nursing check

Working with Housing Case Manager

- Housing as health care
- Benefits: SSI
- Client-centered care and health advocate
- Coach team on “Real World”

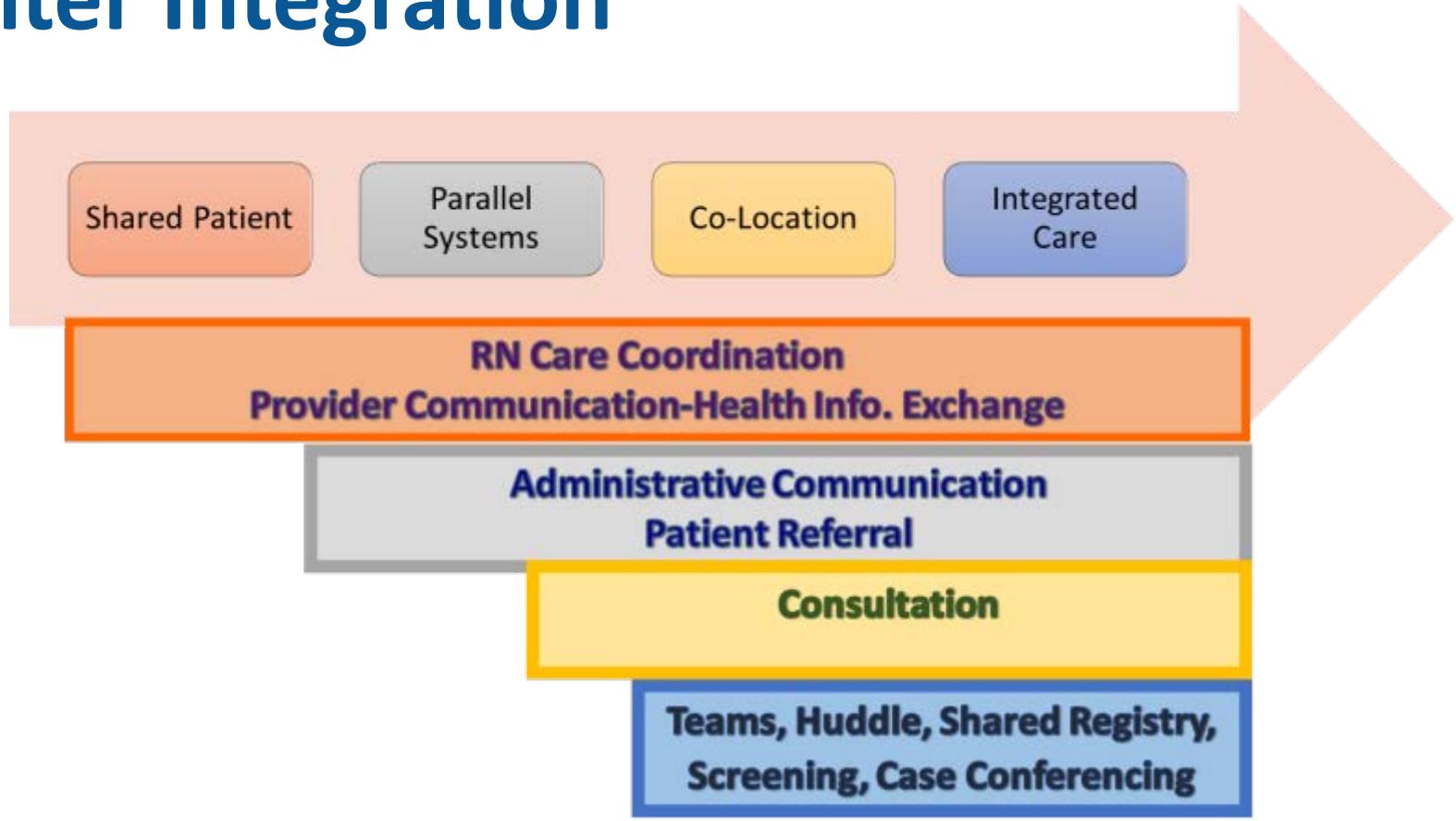
“Never give up, never surrender”
Siotha King-Thomas

Integrated Peer Navigation

- Work directly with patient
- Adherence coach with RN
  - Oversees med delivery, check clients, track 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

Types of Medical/Behavioral Health Center Integration



Training and Communication

- Level of communication fits the acuity of the client
  - Text, email, huddle, weekly case conference, daily summary, retreat
- Cross training of team
  - Multi-discipline training
- Flexible Treatment Plans
- QI
  - Integrated patient registry
  - Check lists
- All team skills
  - Trauma-informed care
  - Motivational interviewing
  - Harm reduction

Resources

- National Health Care for the Homeless Council: https://www.nhchc.org/
- SAMHSA's SSI/SSDI Outreach, Access, and Recovery Technical Assistance: https://soarworks.prainc.com/
- http://www.samhsa.gov/nitt-ta/training-technical-assistance
- Coldspring Center for Social and Health Innovation: http://coldspringcenter.org
- Center for Social Innovation: http://center4si.com

PATH (People Assisting the Homeless)

PATH/Family Health Centers of San Diego
Amelia Broadnax

Using Interdisciplinary Teams to Provide Care to People Living With HIV/AIDS Who Are Homeless/Unstably Housed

Collaboration

Open communication during meetings, as well as regular e-mail and verbal communication between PATH Care Navigator and FHCSD SPNS Case Manager is key to coordinating a wraparound system of resources and care for the population served.

FHCSD and PATH forms of documentation, include the usage of ARIES and Homeless Management Integration System (HMIS),which allows for complete collaboration and coordination.

Clients housed at PATH receive referrals from housing case managers and care navigator for services throughout PATH's Depot; the referrals are inputted into HMIS which allows a paper trail for services the client is currently working on or has completed. This process reduces double-dipping.

Furthermore, release of information (ROI) forms are created to strengthen the team in securing viable information to increase sustainability for the client

Housing

FHCSD and PATH have found that clients staying in the interim beds (at least 90 days), and moving to transitional housing are more successful at retaining permanent housing because they have had time for skill building, such as money management, credit repair, computer classes, typing, and relapse prevention.

Operation Link

Pasadena Department of Public Health
Matt Feaster

Background

- Pasadena one of three city public health departments in California
- Original idea mobile health clinic. Issues arose:
  - Trust issues of the government
  - Scheduling issues
  - General size of Los Angeles County
- Began outreach with hygiene kits

Peer Navigation: Clinical Services

- Implemented Peer Navigation, working with over 10 LAC organizations.
- No formal MOU's (for care), but were are all part of the Ryan White System.
- Partnership involved relationship building with LAC Health Services

Peer Navigation: Housing

- Our navigators worked to build capacity first in Pasadena. Vouchers increased from 5 to 20. Affordable housing units did not increase.
- Pasadena has the Coordinate Entry System.
- Uneven distribution of resources in LAC, our area is lower than neighboring areas.

Barriers: Clinical Reorganization

- With the implementation of the Affordable Care Act (ACA), we needed to close clinical operations.
- Our clinic was transferred to a large FQHC. Still co-located and offers more services.
- Retained ADAP, redoubled focus to prevention/education.

Conclusions: Role of the Navigator

- They are working to advocating, especially in LAC.
- Work to connect with clients and build trusting relationships both with client and partners in the system.
- Getting things done the first time, instead of repeat visits for same issue.
- Increased capacity for our peers with increased trainings.

University of Florida CARES

University of Florida
Kendall Guthrie

Identify Partners

Identify perspective agencies who not only possess the skills and resources necessary to perform required expectations, but the good name and history of providing quality services.

In this case:

- HIV Medical Services
- Primary Care Services
- Medical Case Management
- Housing
- Substance Abuse Services
- Mental Health Services

Formalizing the Partnership

Formalize agreement which outlines:

- Expectations
- Roles
- Responsibilities
- Budgets
- Deliverables
- Timelines
- Remedy Language

Staff: Selection & Training

Staff selection is key to a working partnership. Staff should possess the ability to perform the job, work well with clients and understand the dynamics of collaborative working relationships.

Along with trainings such as Motivational Interviewing, Trauma Informed care, Avoiding Burnout, staff should be trained or educated on the importance of inter-company relations.

If possible, trainings should be completed together rather than in separate agencies. (Developing a Team Environment)

Staff: Selection & Training

Cross Train Staff:

This allows for coverage in the absence of a key staff member. The program continues to function properly when someone is not available.

This also allows for everyone to get an understanding of the full process, know what part they play in the success of the program and provides and appreciation for the contribution of other team members.

Information Sharing

Ensure there is a clear and concise way to share information.

- Formal Process for Documentation
- Systems Access
- Multidisciplinary Staffing
- Team Meetings/Huddles
- Consents for Release of Information
- Memorandums of Agreement

Communication

Effective Communication is KEY to any relationship

- Meet Regularly (Team Meetings, Partner Meetings)
- Reevaluate the program: Discuss regularly successes and failures
- Make changes where appropriate
- Address issues as they arise
- Celebrate success

Sustainability

Seek other resources for funding

Align services with already established functions within the organization

Continue to develop partnerships with organizations already providing services in the area.

About PATH Home

Path Home representatives made a presentation at our Emergency Services and Homeless Coalition meeting. Representatives continue to go to monthly meetings and participate in the coalition.

PATH Home staff began making presentations in the community (i.e. homeless shelters, Ryan White providers) leading to contacts for housing and funding.

Staff made direct contact with each housing provider in the community and obtained application packets with program criteria. A contact person at each agency was identified.

Using these contacts; lists of properties and property managers that are willing to work with housing programs were obtained. If they're willing to help with the clients in those programs… why not ask about our clients?