2016 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Leveraging Resources to Sustain Programs for HIV Care & Housing

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Disclosures

Presenters have no financial interest to disclose.

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Learning Objectives

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

1. Discuss strategies to use Ryan White, Medicaid and other public and private funding to obtain integrated health care and housing services
2. Identify opportunities to build the skills of agency staff and stakeholders to provide care, treatment and housing support

Obtaining CME/CE Credit

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

http://ryanwhite.cds.pesgce.com

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**

Purpose of this Session

- Brief presentations from 4 SPNS sites working with stakeholders and agency staff to integrate and sustain programs for improving HIV care and treatment and obtaining housing
- Group discussion to identify stakeholders create partnerships and leverage resources available in your community

Building a Medical Home SPNS Initiative

- To engage homeless/unstably housed persons living with HIV who have persistent mental illness and/or substance use disorders in HIV and behavioral health care and to assist in obtaining housing
- 9 sites across the U.S.

Intervention Model

- Building a medical home for HIV positive homeless population
  - Housing partnerships
  - Behavioral health partnerships
  - Systems integration
- Use of network navigators for systems integration and care coordination

Success

- Sites have been successful in developing and integrating the models into their settings
- 3 Keys for Success:
  - Identify and building partnerships and funding resources
  - Building and supporting the skills of RW and other staff to reduce barriers and provide care, treatment and housing
  - Facilitating policy /program changes to integrate and sustain the model in the system of care

NATIONAL 2016 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Harris Health System

Nancy Miertschin, HIV Project Manager

Houston, TX

About Harris County

- 4.3 million residents
- Most populous county in Texas
- Third most populous county in US
- Spans approximately 1,700 square miles

About Houston

- Approximately 2 million residents
- Fourth most populous city in the US
- Spans more than 600 square miles
- It's HOT and humid and we have limited public transportation!

Harris Health System

- Publicly funded, urban academic health care system in Houston, Texas
- 3 hospitals
- 26 community clinics, including Thomas Street Health Center
- Population served is 85% minority

HIV Services/Thomas Street Health Center

- First free-standing publicly funded HIV clinic in US
- 5,500 HIV+ patients per year
- 50% of Harris County's uninsured HIV patients
- 25% of all HIV+ persons in Harris County
- More than 90% minority
- Approximately 1,000 homeless and unstably housed patients

HIV Funding Sources

				Funding Sources and Total Grant Amounts				
				SPNS $300,000	Part A $6,882,901	Part C $778,236	Part D $331,902	CDC/City $362,760
		Position	FTE	Salary Support for SPNS Program Staff				
Project Hi-5 Program Elements	Medical Case Management	A	1	0.4	0.6			
		B	1	0.9	0.1			
		C	1	0.9	0.1			
	Service Linkage	A	1	0.02	0.45	0.08		0.45
		B	1	0.1	0.4			0.5
	TOTAL	FTE	5	2.32	1.65	0.08	0	0.95
		%	100%	46%	33%	2%	0%	19%

Project Hi-5

- 157 Enrolled in SPNS study
- 70 additional homeless patients have received Hi-5 services.
- Medical case management and Service Linkage for non-enrolled patients are billed to Part A.
- Part C pays for a portion of salary for one SLW who is certified to provide HIV testing.
- CDC/City funds pay for Service Linkage staff who link and re-link homeless patients to care.

Service Linkage Roles

- MAY provide HIV testing.
- Conduct and document initial patient assessments.
- Assist patients with access and adherence to care.
- Assure linkage to care through referrals and follow-up.
- Assist patients in navigating service delivery system.
- Work with medical case managers and other clinicians to ensure care plan is implemented.

★Also includes SPNS innovations.

Strategies for Maximizing Success

- Use consistent service definitions and Standards of Care for all funding sources (RW Part A).
- Build in coordination among case management services throughout the program.
  - Training
  - Regular combined meetings and shared supervision
- Keep RWPC informed about SPNS project and needs among HIV+ homeless.
- Begin 2-3 years before end of project to build in creasing salary support from other sources.

Policy changes

- Streamlined eligibility process
- Fast track to see physician on same day as initial visit
- Coordination with Health Care for the Homeless staff

Partnerships

- Salvation Army – emergency housing
- Food Bank – on-site application
- Houston Police Department HOT Team – one-day IDs

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

Sharon Joslin, APRN, Clinic Director Community Health Care Van /Yale University

Silvia Moscariello, MBA, Program Director, Liberty Community Services, Inc.

Processes We Learned

- Collaboration with housing and health care providers used to maximum advantage of all programs in area and notify clients of our Team Effort
- Bimonthly meetings and frequent contact by text and phone for providers
- Identifying barriers for staff and clients
- Provide client perceived care needs for medical or housing or food or transportation or mental health or crisis intervention or substance abuse or immediate hospitalization
- Open door or phone policy for clients and creative strategies
- Discuss challenges and when our services were limited for clients.

Case Presentations: Bridging Housing and HIV Care with HUD & Ryan White/SAMHSA Funding

- J.J 66 y.o. male known to staff for poor social history with Department of Corrections in past (47 years ago) as sex offender unable to find housing and was couch surfing with his family members. He has had HIV for 40 years and cocaine use. He was refused at one clinic because he stole a staff member's cell phone. His health was deteriorating with age related problems, hip dysplasia and poor compliance to HIV medications, and missed many appointments. He now comes to the Van for DOT and maximized all medical resources as referrals and driving to services, housing has been used maximum contacts to secure housing.
- S.A. 46 y.o. female with long history of substance abuse (cocaine, PCP, benzo, THC) incarceration, personality disorder, anger, PTSD and poor medical compliance with HIV medications. She has detectable virus/ CD4 265. Lost multiple housing placements due to non-payment and fights with landlords. Utilizes the ED for Psychiatric issue She utilized DOT for medications but failed to show routinely and disruptive. The team is advocating strongly for a different level of care.

Housing and Mobile Health Care

- Meetings were held bimonthly for the entire study staff to discuss new and problematic clients . J.J. and S.A usually presented monthly.
- More frequent meetings and phone calls were completed with Housing Case Managers and Early Intervention Specialists (EIS) and medical, mental health and behavioral health staff from the CHCV because we were out in the community and easily accessible as walk in clinic daily, weekly, whatever to identify these clients' needs and set up visits to assist care plan with communication with PCP on EMR.
- We also asked J.J. to present at the Mayor's Task force and a legislative breakfast to local alderman. We also asked him to join our Ryan White Monthly consortium meetings as a consumer. He valued being asked and speaking to legislators.
- Housing navigators worked with many community resources to find suitable and safe home.

Challenges to Find Key Resources

- Clients who move out of our housing or care region can return
- Couple of clients with severe mental health issues that have difficulty maintaining housing and frequent the Emergency Rooms for severe mental instability, drug related problems, difficulty living with others in independent housing units available to them- utilize hospital based Community Care Team
- HUD monies cannot be used for incarcerated individuals because HUD does not consider them homeless – Is Jail and Prison Home?
- Substance abuse continues to present a difficult problem for many of our clients and programs often full
- Need ongoing funding to keep the dynamic team working together to support our HIV+ clients for housing and viral suppression and assistance with finding work or as J.J. put it “a purpose in my life these days” – work programs in city
- Need further dollars to keep our team working together bimonthly to support each client and each other we hope to prevent provider burnout

Client Barriers

- Moving to permanent housing that client liked
- Poor medication compliance at times when not coming for care or using substances
- Cocaine addiction
- Poor appointment attendance
- Need for new HIV provider when removed from 1 clinic
- Aging male with other chronic medical problems
- Client does not conform to rules of the housing that has been found
- Very poor medication compliance and remain detectable and low CD4
- Mental health condition disabling and over using ED and will not stay with one provider walks out of appointments
- Multi-drugs of abuse

Maximizing Resources

- Housing case managers work with all agencies in the city to identify where he would be able to live with poor social and incarceration histories and working directly with the criminal justice system (e.g. P.O.) or go to court with client to obtain clear facts about the case to help with housing restrictions & care
- EIS worker placed client in new clinics and would assist clients getting to appointments with calling, rides and scheduling appointments and monthly bus passes from Ryan White Dollars
- EIS worker placed client in Mobile Medical Home on the Community Health Care Van for Direct Observational Therapy of all medications that were in blister packaging for ease of administration and learning about medications and changes and working with community providers and case managers and VNA's, etc.
- EIS worker linked the CHCV with direct HIV provider appointments and the CHCV staff with new EPIC electronic medical record could document and send progress notes to HIV provider and others providers to assure compliance and document problems as they occurred.
- Behavioral Health and Mental Health Services met with client weekly in the beginning of the study then monthly and now as necessary for addiction counseling and services.

Case Follow Up

- J.J is housed and compliant with care and medications. His Viral load is undetectable and his CD 4 count is acceptable. He continues to come twice a week to the CHCV for medication adherence. We can see him for general medical issues and communicate with his PCP. He is awaiting hip replacement surgery. If he is ill or misses an appointment, he usually will contact us and the EIS workers take his medication to his home.

- S.A. is housed but we have just been informed she must leave because not paying her lease in 3 months. Non-compliant with medications and refuses to come to CHCV or have medications delivered. Refuses substance abuse or mental health inpatient treatment. We continue to keeps lines of communication open and send medications to her current home. We are working with the team at local hospital of community care outreach and inpatient mental providers to find her the best place for care and therapy.

Partners in Community Care

Biweekly meetings are held by staff of Liberty services and Community Health Care Van – Medical Mobile Home which includes Substance abuse counselors and Psychiatric APRN to follow up on all cases that present new challenges and discuss plans for possible solutions and keep reaching out to new community possibilities.

We never give up and keep trying all possibilities and resources and welcome back our clients when they are struggling

Successes

Study # 79 participants

Housed 33, lost housing 7, transitional to permanent 8

Discharged 24

Clients can receive medical services or just DOT – currently 13

Behavioral and Mental services are provided to all clients and heavily used

Satisfaction rates are very high 5/5 for health services

Our door or phone is always open, contact by clients high for patient navigators and EIS staff.

We are called “family” by many of our clients and they say, “if I fall off for a while, you guys will help me get back on track without problems”

NATIONAL 2016 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Health Hope and Recovery – AIDS Arms

Manisha H. Maskay, Ph.D.

Chief Program Officer

AIDS Arms Inc., Dallas, TX

AIDS Arms – Mission

To combat HIV/AIDS in our community by improving the health and lives of individuals living with the disease and preventing its spread.

AIDS Arms - Services

Primary Focus - Integrated programs and effective collaboration to:

- Outreach to and test those at high risk for HIV
- Provide education about HIV/STI prevention, risk reduction and treatment
- Link HIV positive people to medical care and psychosocial services; promote retention
- Provide medical care, psychosocial support services
- Ensure that HIV people are engaged, maintained in care
- Build/sustain collaborations with partner agencies to ensure respectful care for clients

Health Hope and Recovery – Program Model

- Includes intensive care coordination and behavioral interventions
- Provided by three full-time highly experienced social workers:
  - Knowledgeable about treatment of HIV as well as mental health and/or substance use disorders
  - Knowledgeable about necessary community resources
  - Skilled in providing care to people with complex needs
  - Able to advocate effectively for clients with housing, behavioral health, medical and other providers
  - Able to build bridges to necessary care

Use of Public/Private Resources to Sustain Program

Source	Purpose
Ryan White Parts A, B and C	Intensive non-medical case management/care coordination
Private donors	Emergency housing, support for HMIS subscription fees
Agency general funds	Documentation assistance, packaged snacks, transportation vouchers, assistance with other basic needs
Marketplace insurance plans	Medical and psychiatric care

Partnerships

Strategic focus on strengthening/sustaining partnerships with:

- Metropolitan Dallas Homeless Alliance
- Individual permanent housing providers including City of Dallas Shelter Plus program, Master Leasing and others
- Rental property managers/owners
- Motels
- Mental health/substance use disorder treatment providers
- Hospitals and medical providers
- Respite care providers

Capacity Building

Ongoing education and technical assistance for direct service and support staff on:

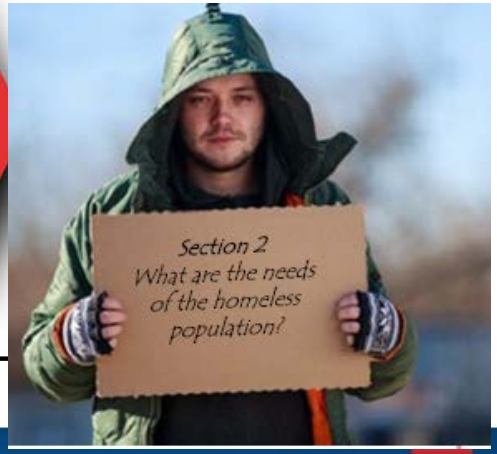
- Needs and challenges of homeless clients
- Providing trauma informed care
- Best practices for providing client-centered care for homeless individuals
- Motivational interviewing, strengths based and solution focused counseling techniques
- Emerging trends related to regulations and requirements for documentation to establish eligibility for services

Capacity Building - Example

Working with the Homeless Population

AIDS Arms, Inc.

June 9, 2016



Brought to you by:

Health Hope and Recovery - Benjamin Callaway, Luis Moreno, Miata Everett, Raymond Castilleja Jr. and Justin Vander

Case Management - Trang Mai and Gilbert Moreno

Capacity Building - Example

Health, Hope & Recovery

Ben Callaway, LMSW, Charles Peterson, LMSW, Luis Moreno, BSW
AIDS Arms, Inc.

Program Design

Strategies & Techniques:

- ✓ Cognitive Behavioral Therapy (CBT)
- ✓ Solution Based Therapy (SBT)
- ✓ Strengths-based Case Management (SBCM)
- ✓ Motivational Interviewing (MI)
- ✓ Harm Reduction
- ✓ Acuity Driven Standards of Contact

Duration of Intervention:

- 18-Months Intensive Case Management

Implementation Team:

- Program Director
- Care Coordinators

Comprehensive/Team Based Care

- Health, Hope and Recovery (3PSR) team attends (if/as) team meetings as needed
- Care Coordinator meets with the medical provider and/or the behavioral health team when necessary or communicates by phone or email.
- Care plans developed together by Care Coordinator and client are:
  - entered into the electronic health record (EHR)
  - available for review to the medical and behavioral health providers
- Behavioral health provided onsite when indicated.
- Clients requiring substance abuse treatment and/or treatment of complex mental health disorders referred to external providers.

AIDS Arms does not plan to pursue PCMH certification at this time.

Recruitment & Retention

Clients Recruitment, as of August 26, 2015:

Total H.H.R. clients served = 126

Total clients enrolled in study = 88

Total clients active in study = 76

Total clients transitioned to standard of care = 12

Client Retention, as of June 26, 2015:

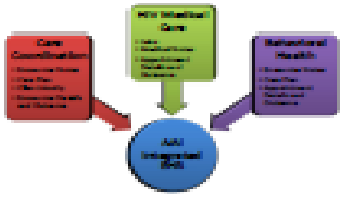
- > 3-Month Retention Rate: 78%
- > 6-Month Retention Rate: 67%
- >12-Month Retention Rate: 57%
- >18-Month Retention Rate: 47%

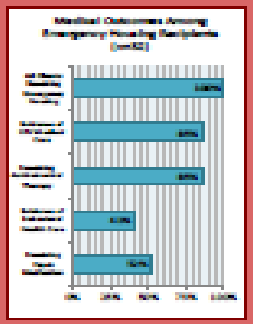
Access

- Patients may access medical and behavioral health providers on a walk-in basis for urgent needs.
- Patients may access the Care Coordinators without an appointment for urgent needs.
- Patients are able to communicate through text messages or by leaving a voice mail.
- All patients have 24/7 access to a medical provider on call.
- Bilingual staff and translation services are available to all clients for medical and case management services.
- All staff receives ongoing training regarding providing culturally and linguistically appropriate services tailored to the unique needs of each client and following CLAS standards.

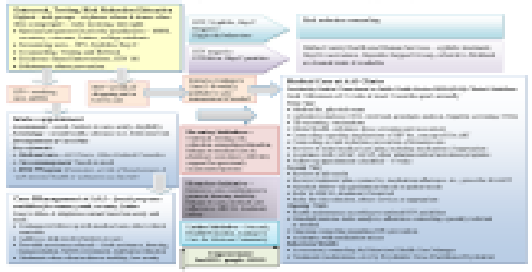
Care Coordination

- **Tracking of Referrals and Labs**
  Referrals are tracked with an excel spreadsheet that denotes date, source of referral, homeless status, receipt of medical care upon entry to program. Labs are examined via manual chart review.
- **Communication with Behavioral Health**
  The Behavioral Health Case Managers and Care Coordinator communicate via work email, office phone, and text messages on cell phones.
- **Electronic Health Records (EHR)**
  AIDS Arms, Inc. uses an Allscripts EHR.





Integrated Care & Services at AIDS Arms, Inc.



Quality Assurance & Performance Measurement

The Quality Assurance & Performance Measurement Plan for Health Hope & Recovery utilizes the PDSA Cycle: Plan, Do, Study, Act to ensure continuous improvement and ensure quality. All quality assurance activities are conducted either monthly, quarterly, or on an ongoing basis. A PDSA cycle has been developed for all program strategies and techniques.

Formalized Reports:

- ☐ Monthly Dashboard Reports
  - > Population Description
  - > Recruitment Progress
  - > Retention Rates
  - > Housing Status
  - > Retention in Medical Care
- ☐ Quarterly Process Evaluation Reports
  - > Peer Review Results
  - > Supervisor MI Observation Aggregate Results
  - > Cumulative Prior Year Results

The consumer advisory board serves the entire agency and not a specific program. It provides guidance regarding development of the client satisfaction survey, recruitment materials and educational programs, and provides assistance with other activities as needed.

Conclusion

AIDS Arms is moving forward in a strategic manner to build a medical home for patients and already has many of the key components – behavioral health, sexual health, dermatology etc. The agency is exploring options related to finding a medical partner that will provide specialty care for individuals who do not have health insurance or have Medicaid and who need treatment for complicated medical problems such as cancer, heart disease, liver disease, etc. Unfortunately, the only resource for these individuals is an overburdened County Hospital system. Whereas, this is where patients are referred, it is not an ideal partner in terms of completing a medical home framework.

Disclosures

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number ABXH42H008, a Special Project of National Significance. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Capacity Building - Example

A day in the life of staff members providing services to homeless clients …

- Text client to remind them of appointment.
- Meet client at shelter to provide a needed items such as sleeping bag, medication box and/or snacks.
- Work in collaboration with shelter staff and client to obtain letter of homelessness for housing eligibility.
- Discuss and assess client's past experiences with medical care including barriers to care such as substance use and mental health disorders.
- Create care plan in collaboration with client utilizing motivational interviewing to identify triggers for substance use and create a harm reduction plan to decrease high risk behaviors.
- Call client to schedule medical and behavioral health appointment.
- Assist client in programming medical appointments in cell phone provided by AAI to increase adherence to medical care.
- Provide education on DART system, bus pass and practical tips for attending medical appointments.
- Help internal and external colleagues learn about the Trauma Informed Model of Care as well as harm reduction strategies.

Ongoing Needs and Challenges

- Inadequate availability of affordable permanent housing
- Resistance to and inadequate adoption of housing first model
- Changing rules and interpretation of program requirements related to eligibility for housing assistance and other services
- Stigmatizing attitudes and behaviors from some housing, psychosocial support and other providers
- Inadequate understanding of the needs of homeless individuals.

Multnomah County HIV Clinic

Jodi Davich, Clinic Manager

Portland, Oregon

Multnomah County HIV Clinic
Portland, Oregon

Multnomah County HIV Clinic

- Patient-centered primary and HIV care (PCMH) since 1990
- Part of Multnomah County's network of 8 Community Based Health Centers and 14 School Based Health Centers
- HSC is the largest provider of primary care to Oregon's uninsured and low-income persons living with HIV (PLWH)
- We serve 1 in 4 PLWH in the Portland area AND 1 in 5 PLWH statewide
- Although the majority of our patients live in the Portland metro area, we serve clients from all over the state

Multnomah County HIV Clinic
Portland, Oregon

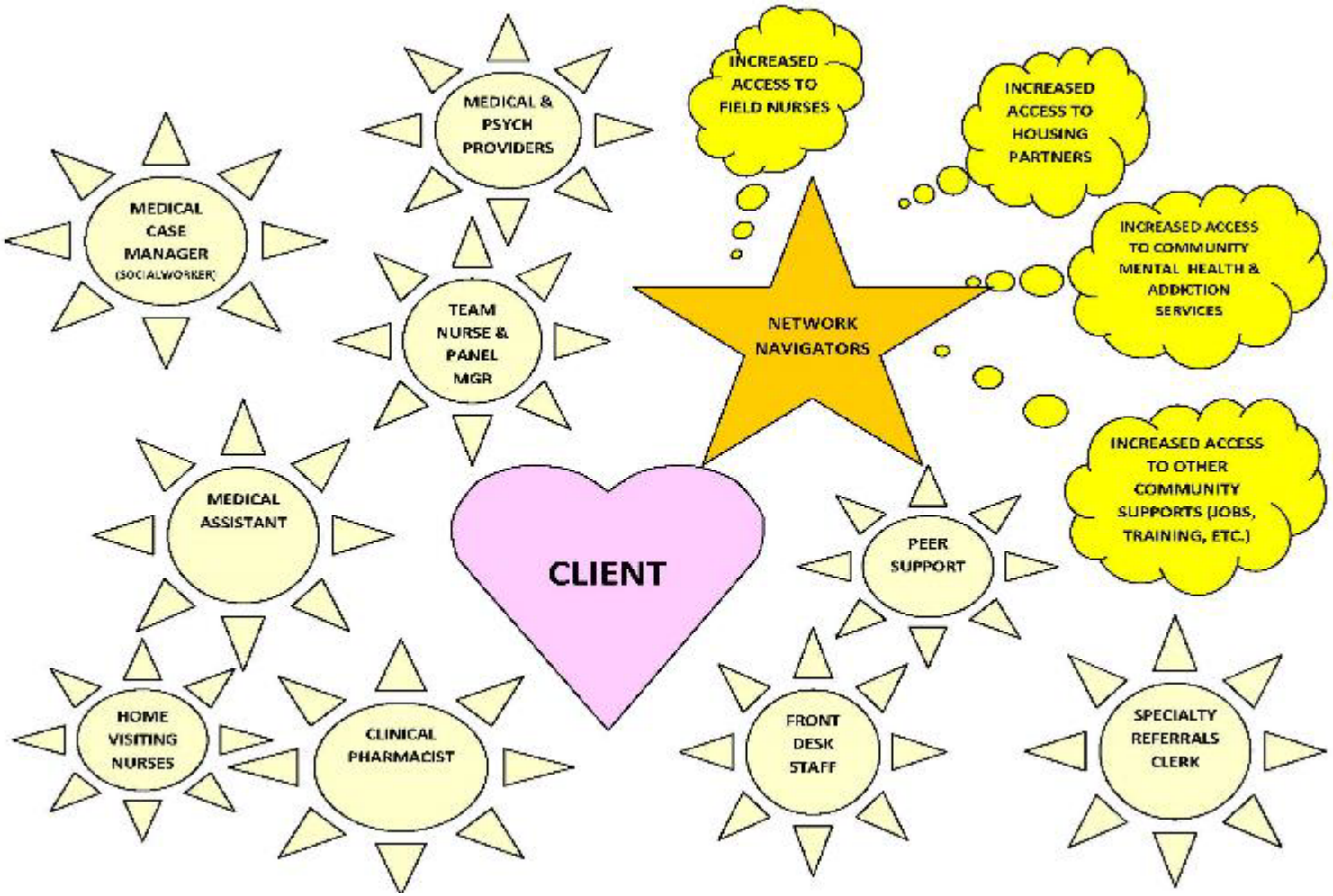
We serve 1400 PLWH annually

- 86% of clients are male, 13% female and 1% transgender
- 51% of clients are over 50 years old
- Primary HIV transmission categories are: MSM (74%) and IDU (18%)
- 30% of clients are persons of color—16% limited English speakers
- 20% incarcerated at least once in the past 2 years (high recidivism)
- High rates of substance abuse (29%) and mental illness (56%)
- Our population is overwhelmingly low income (71% ≤ 138 FPL)
- **1 in 5 patients are homeless or unstably housed**

Primary Care Medical Home

- Multi-disciplinary teams
- Engage our clients in all aspects of their medical care
- Remove barriers to care
- Improve clinical outcomes
- Improve the patient experience of care
- Decrease or sustain the cost of care
- Increase staff satisfaction and involvement
- Certified by the State of Oregon and Joint Commission

Navigators as part of the team



Navigators and clients

Before starting

- Prior to participation in the SPNS demonstration project HSC did not use patient navigators
- Concerns about losing an incredibly valuable, rich resource (patient navigators) at the end of the grant period
- Solution-bill insurance for navigation services
- Oregon Health Authority (OHA) manages the State Medicaid Program (the Oregon Health Plan) and approves five Traditional Health Worker Medicaid provider types:
  - **Community Health Worker (CHW)*** - Advocates for patient & community health
  - **Personal Health Navigator (PHN)* - Assists individual & groups with positive health outcomes**
  - **Peer Support Specialist** - Focus on recovery from addiction/mental health issues
  - **Peer Wellness Specialist** - Focus on recovery from addictions/mental health/physical health conditions
  - **Doula** - Assists with women's pre-natal health care

Sustaining navigation services

EFFORTS TO SUSTAIN NAVIGATION SERVICES

- Assisted navigators to complete required training in order to become a Certified Medicaid Traditional Health Worker
- Identified documentation requirements and train navigators how to document their work in patient EHR
- Realigned other client support resources to build on the navigation model (Part D)
- Integration of navigators as clinic employees
  - Can be more easily sustained through various funding streams: third party billing, Bureau of Primary Health Care and Ryan White Grants, and one-time only CCO monies. Direct hires save on administrative costs associated with contracted services

Sustaining Navigation Services

CURRENT SITUATION

- Navigators transitioning to county employees
- Developing MOU with CAP to ensure continued support, integration and coordination
- Not yet able to bill Medicaid
- Utilize a combination or data reports and chart reviews to track patient outcomes
- Health Department received funds from CareOregon to integrate community health workers (patient navigators)
- In October 2015, HSC was able to hire an additional navigator
- Serves SPNS clients and other clients (refugees)
- Records “touches” in Epic to support funding

Why we support this model

Alicia in January 2013

- 50 Year Old, African-American Female
- AIDS, Syphilis, Anorexia, Bipolar Disorder, PTSD, DV
- History of Poly-substance Abuse, Probation
- Chronic Homelessness
- Engagement in Care Limited to Crisis Situations
- SSI, Medicaid
- **Clinic patient for 10 years**
- Poor Adherence to ARVs [February 2013]
  - CD4: 98 (7%)
  - VL: 632

Why we support this model

Alicia in May 2016

- Re-engaged in SPNS in 2014
- Probation Ended
- Transitional Housing (Royal Palm) to Stable Housing
- 8 Months of Sobriety
- MH meds and ARV adherence
- Companion Animal
- Engaged in Women of Wisdom Support Group
- Current Labs [May 2016]
  - CD4: 218 (15.1%)
  - VL: <20 virally suppressed (undetectable)

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