NATIONAL 2016 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Housing & Health: Integration for Improved Health

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Disclosures

Collaborative Solutions 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. Demonstrate housing as a key social intervention for improving health and well-being for persons living with HIV/AIDS.
2. Explain best practices and strategies to improve housing and health integration for improved health outcomes.
3. Hold a strategy discussion with colleagues in his/her organization on how to improve collaboration between housing and healthcare systems

Obtaining CME/CE Credit

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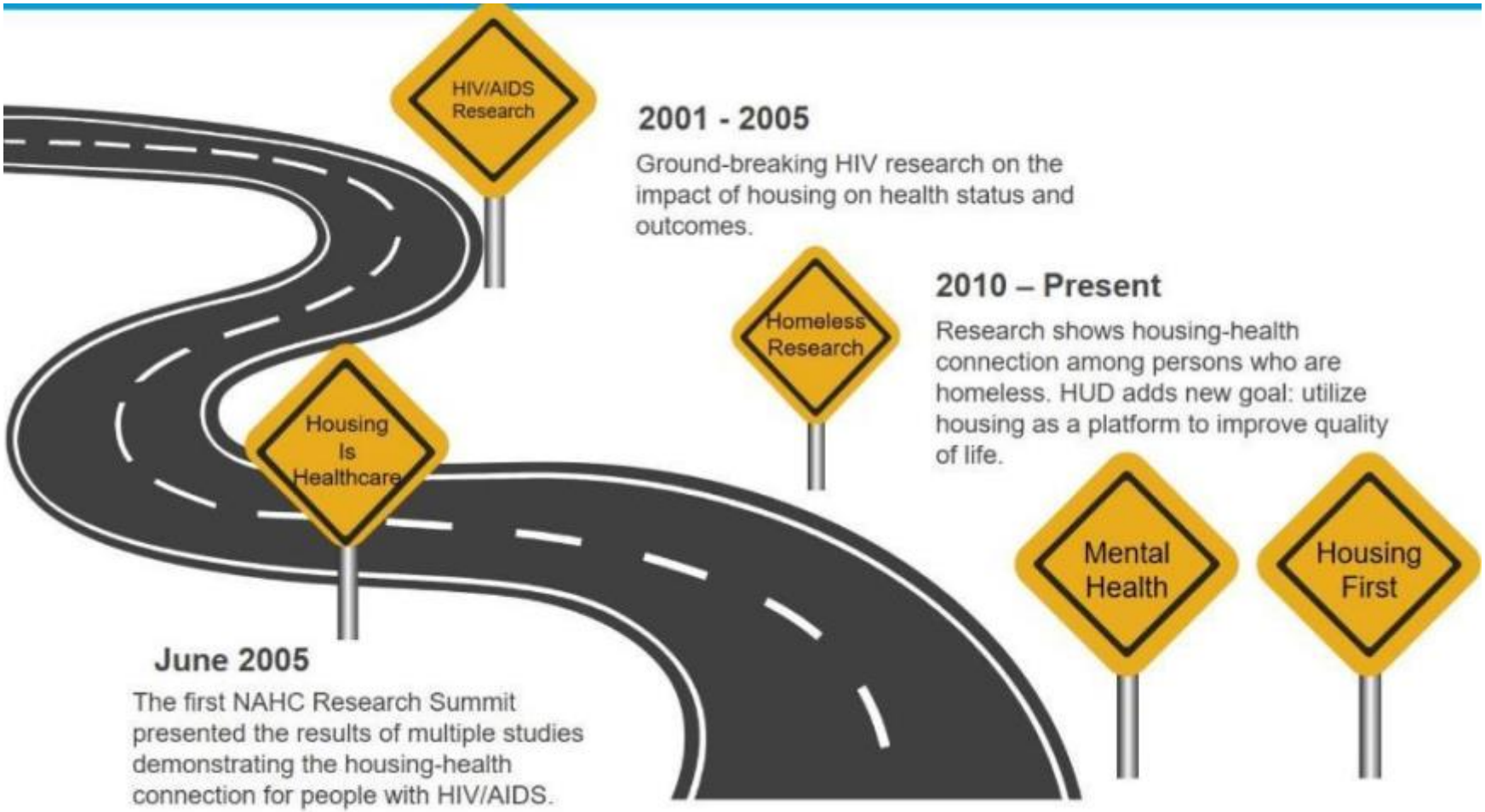
Housing and Healthcare: What is the Connection?

Housing and Health Outcomes



Housing and Health Outcomes

HIV and Homelessness -

- Up to 70% of all people living with HIV/AIDS (PLWHA) experience homelessness or housing instability in their lifetime
- 3%-14% of all homeless persons are HIV+ (10x the rate in the general population)

Housing and Health

- Studies show that among persons at high risk for HIV infection due to injection drug use or risky sex, those without a stable home are more likely than others to become infected

- PLWHA who are homeless are *less likely* to
  - Report good or excellent health
  - Take HIV medication
  - Adhere
  - Have CD4 > 200
  - Have undetectable viral load

HIV & Homelessness

Ryan White HIV/AIDS Program 2012 Client Housing Status	
Unstably Housed	4.1%
Temporarily Housed	12.8%

HOPWA STRMU 2014/2015 Client Housing Status	
Unstably Housed	2%
Temporarily Housed	55%

50% of PLWHA **will** have some form of a housing crisis in their lifetime.

Housing IS an Intervention

Housing improves access to care, maintenance of care, and health outcomes along the care continuum

Stable, affordable housing is a strong predictor of well-being, employment, and education attainment

National HIV/AIDS Strategy cites housing as a critical structural intervention necessary to HIV prevention and care

Housing Impacts Health Outcomes

Housing Instability

1. Delayed diagnosis
2. Increased risk of acquiring and transmitting
3. Delayed entry into care
4. Delayed use of ART
5. Less likely to be virally suppressed

Housing Stability

1. Reduced risky behaviors
2. Increased rates of care visits
3. More likely to return to care
4. More likely to receive ART
5. More likely to be virally suppressed
6. Reduced use of ER and public resources

Housing & Health System Integration

How Can We Navigate to Achieve:

- Systems that connect and work together?
- Better partnerships?
- More housing resources?
- Access to care and supports?
- Reduced homelessness?
- Improved health outcomes?

Working Together for Better Client Outcomes: What are the Roadblocks?

- **Lack of connection to decision makers—especially state Medicaid offices**
- **Lack of connection between providers serving the same population(s)**
- **No community forum for working across systems**
- **Not enough access to mainstream resources**
- **Accessing and sharing client information**
- **Establishing working relationships with** healthcare providers and hospitals
- **Funding restrictions**
- **Data-sharing and methods for documenting outcomes**
- **Lack of affordable housing**

Participant Exercise

Identifying major barriers in your community

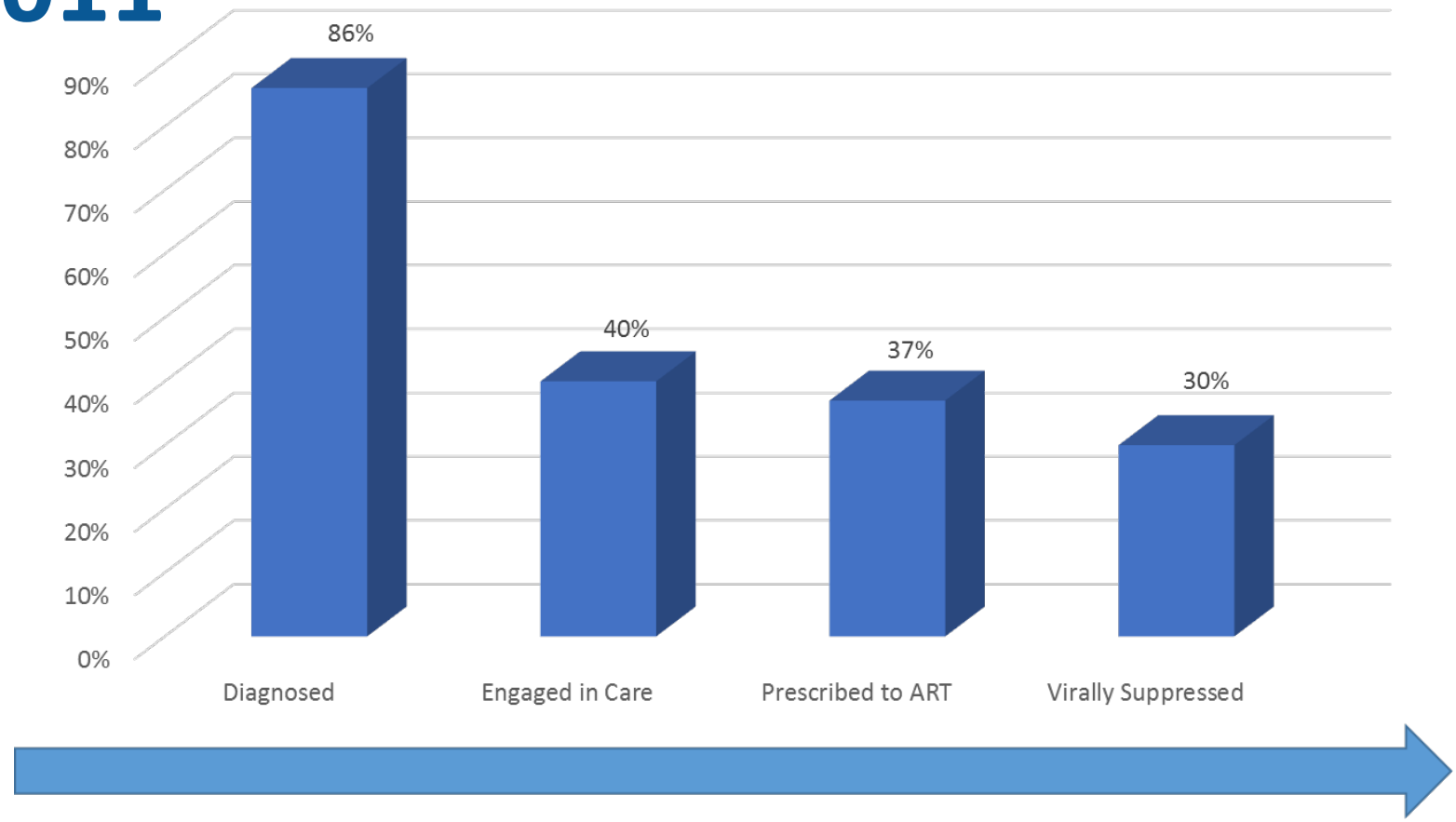
Best Practices and Strategies to Improve Housing and Health Integration for Better Health Outcomes

HIV Housing Care Continuum

- **HIV Housing Care Continuum Initiative**
- A multi-agency federal initiative to support the National HIV/AIDS Strategy goals of:

1. Reducing HIV incidence
2. Increasing access to care and optimizing he outcomes
3. Reducing HIV-related health disparities

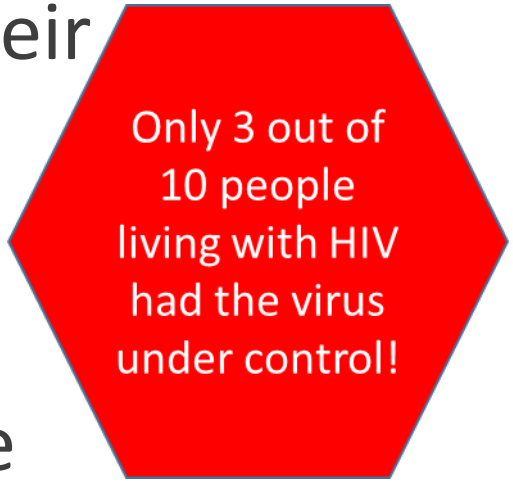
The U.S. HIV Care Continuum, 2011



What Does this Show?

- 14% (approximately 1 in 7 people living with HIV) were unaware of their infection

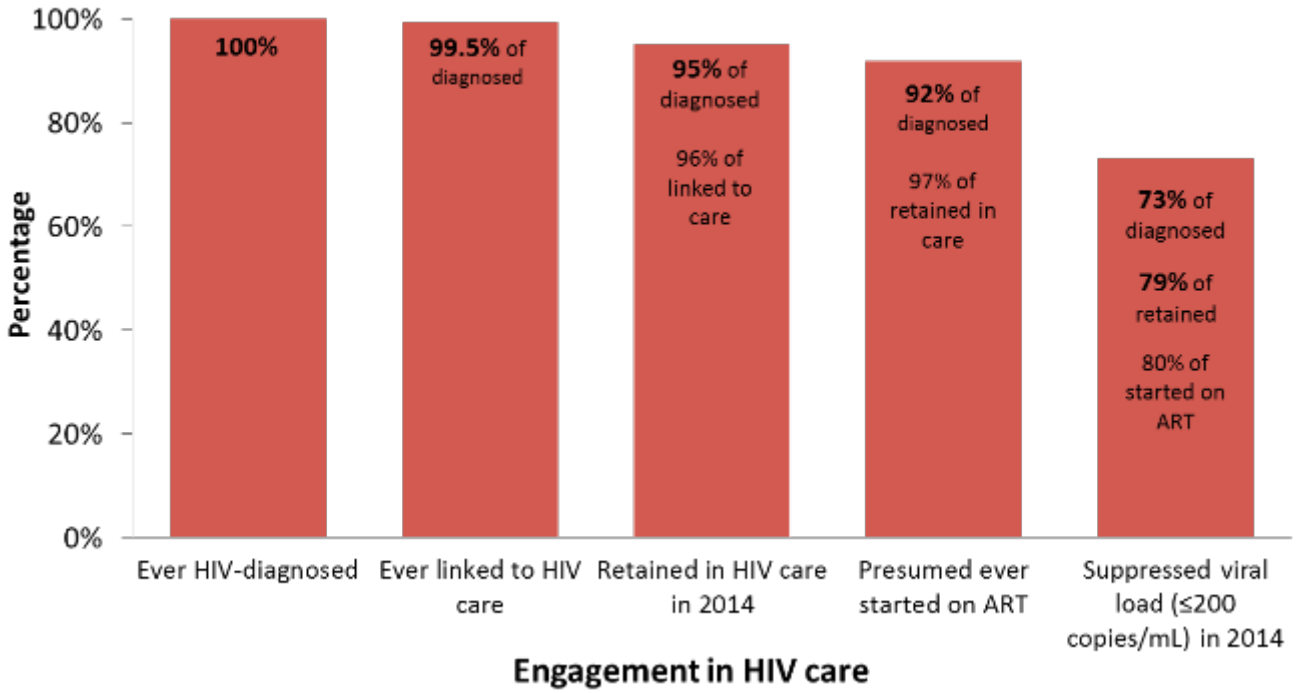
- People living with HIV are dropping off at every subsequent stage in the continuum
  - 40% were engaged in HIV medical care
  - 37% were prescribed ART
  - 30% had achieved viral suppression



How Is It Being Used?

- Further integration of HIV prevention and care efforts
- New approaches to addressing barriers to HIV testing and treatment
- Measure progress toward goals
- Identify gaps in services and develop strategies to address these gaps
- Implement system improvements and service enhancements
- Used by state and local health departments, community-based organizations, health care providers, and people living with HIV

Results: NYC HOPWA care continuum (35,087 HOPWA enrollees in NYC in 2014)



IHHP SPNS Competition Grants

HOPWA awarded $8.8 million for 6-8 one-time awards:

- SPNS projects to help advance understanding and improve the delivery of housing and care for low-income persons living with HIV/AIDS (PLWHA)

HOPWA
Housing Opportunities for Persons With AIDS

Projects supported the goals of the NHAS and HOPWA

- **National HIV/AIDS Strategy (NHAS) Goals:**

1. Reduce HIV Infections
2. Increase Access to Care & Improve Health Outcomes
3. Reduce HIV-Related Disparities

HOPWA Program Goals:

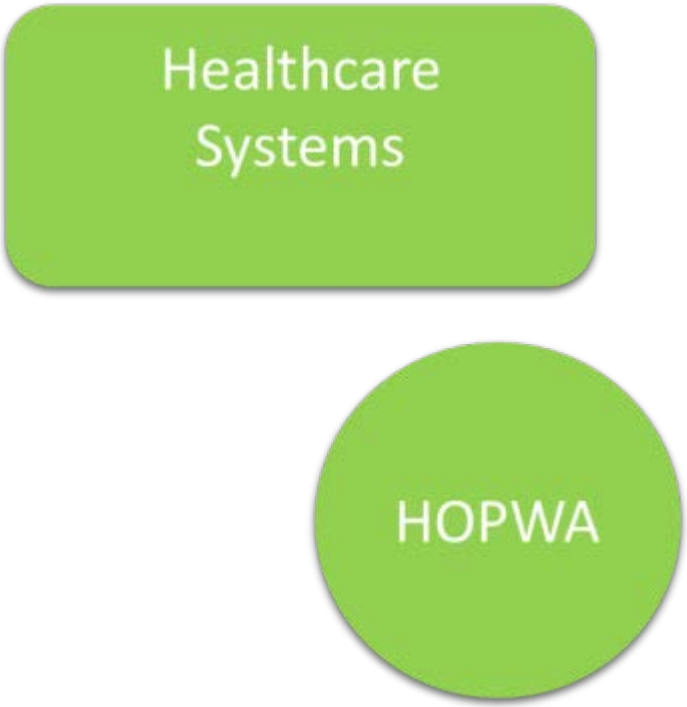
1. Increase Housing Stability
2. Reduce Risk of Homelessness
3. Increase Access to Care & Support

Many of these projects included strategies for system integration…

Portland Housing Bureau

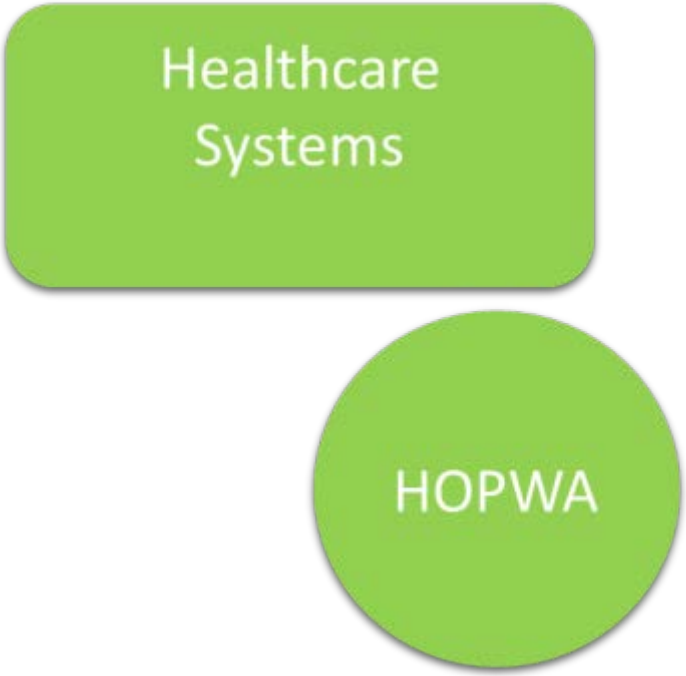
CAP Cascade AIDS Project

- **Strategy: Improve Linkage between Housing and Primary Care Services to Enhance Client-, Program-, and Community-level Outcomes**
- Implement a “medical home” model of integrated behavioral health, physical health, case management and such ancillary services as housing support with Ryan White Part A grantee



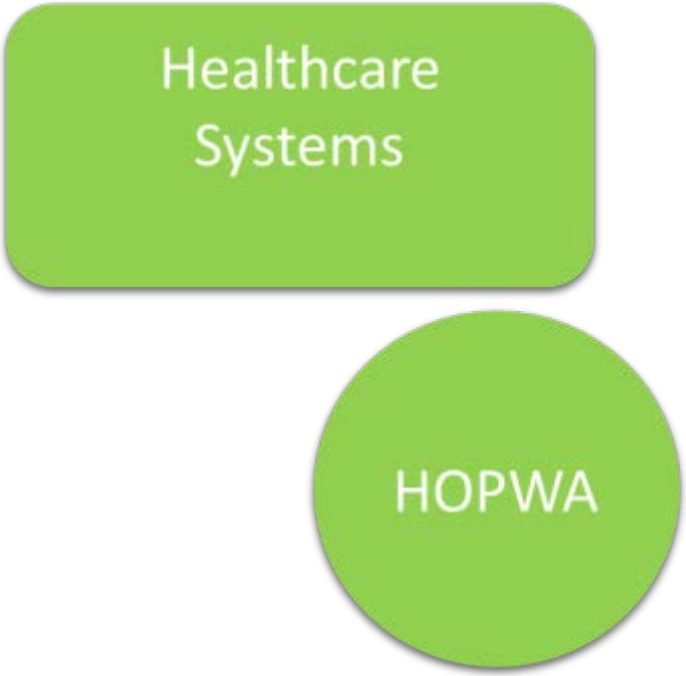
City of Dallas

- **Strategy: Promote the Intersection of Housing and Health through Community-Wide Workshops**
- Developed a learning curriculum designed to
  1. Increase awareness of HIV and Ryan White services among non-Ryan White providers,
  2. Increase awareness of housing resources among Ryan White and non-Ryan White providers,
  3. Increase the health focus for HOPWA case managers and the housing focus for Ryan White case managers



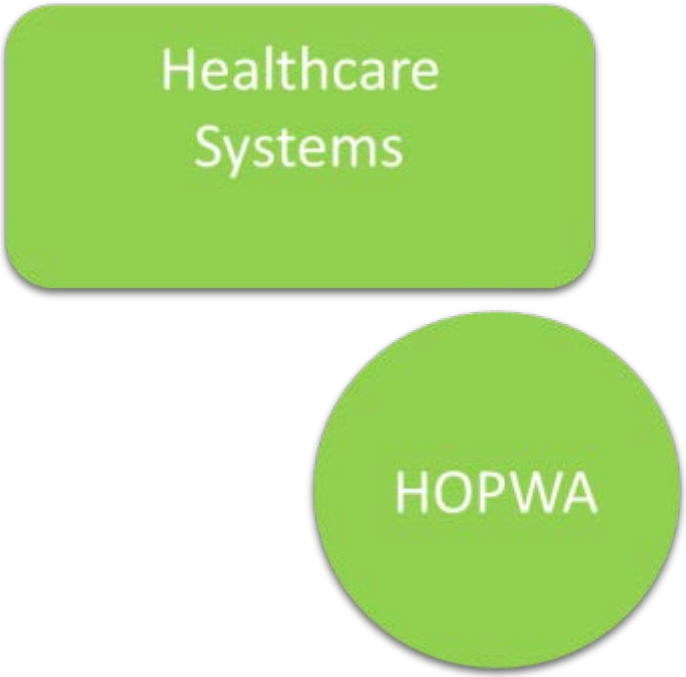
Justice Resource Institute

- **Strategy: Increase Collaboration to Address Disconnected Mental Health and Substance Abuse Treatment**
- Accompany clients to counseling sessions
- Worked with a Boston Medical Center psychologist to meet clients at JRI offices for initial counseling sessions
- Accompany the service provider to clients' apartments if they were severely depressed and/or not functioning
- Advocate for opportunities for youth to meet with a clinician for a few minutes and focus the session on problem-solving or crisis management



River Region Human Services, Inc.
Rebuilding Families, Restoring Communities

- **Strategy: Enhance Coordination and Integration of Housing and Primary and Behavioral Health Services**
- Developed an integrated case management system that addressed and linked clients to primary and behavioral health services
- Partnered with Ability Housing of Northeast Florida and University of Florida Center for HIV/AIDS Research, Education and Service in the Partnership for Access to Treatment and Housing HRSA SPNS 5-year initiative to build a medical home



Healthcare and Housing (H2) Systems Integration Initiative

- An initiative of HUD—SNAPS and OHH– and federal partners to enhance integration and collaboration between housing and healthcare systems

- H2 Goal: To maximize care coverage for people who are homeless and/or low-income and living with HIV/AIDS, and to increase the coordination of comprehensive healthcare and supporting services with housing.

H2 Initiative Assumptions

Housing is a key determinant of health

People who are homeless are at greater risk for poor health

Health issues are likely to increase as the homeless population ages

HIV is correlated with homelessness

Homelessness is correlated with high health care costs

PSH improves health outcomes and reduces health care costs

What H2 Communities Have in Place

Leadership group

Cross-system involvement by key stakeholders

Initial Action Plan with prioritized strategies

Individualized Plan components:

- Enrollment
- Engagement
- Integration
- Data-driven interventions
- Resource maximization

H2 Case Examples/Studies

A growing body of research shows supportive housing can improve health outcomes and lower system costs:

- Illinois saw a 39% reduction in total cost of services for 177 residents in its PSH programs two years after moving in, including services from Medicaid, mental health hospitals, substance use treatment centers, prisons and county jails, and hospitals. Mainstream service costs decreased by almost $5,000 per person.
- In Denver, a longitudinal analysis of system costs of 19 PSH residents revealed 34% fewer emergency room visits, 40% fewer inpatient visits, 82% fewer detox visits, and 76% fewer incarceration days.

H2 Case Examples/Studies

Numerous studies have shown the correlation between homelessness and high health care costs:

- Connecticut study: Of the first 30 participants in Frequent Users Systems Engagement (FUSE) program, 58% had been homeless for more than two years; 71% had ever received mental health services; and 81% had ever received substance abuse services.
- New York study: Homeless patients are six times more likely than patients with stable housing to name an emergency department as their usual source of care or to report no usual source of care.
- California study: approximately 45% of high utilizers of emergency departments are homeless.
- 2014 University of New Mexico study found 13% decrease in emergency room costs and 83.8% decrease in hospital inpatient costs after study group members were housed for a year, compared to the prior year.

H2 Case Examples/Studies Continued

Chicago Example:

- Heartland Health Outreach (a Health Center) collaborates with Mercy Housing Lakefront to provide on-site health clinics in PSH
- Links tenants seen in those housing-based clinics to Heartland Health Outreach's main clinic for ongoing care and treatment.
- These services are Medicaid- reimbursable if clients are enrolled in Medicaid.

Integrating housing and healthcare – an organizational model:

AIDS Resource Center of Wisconsin (ARCW)

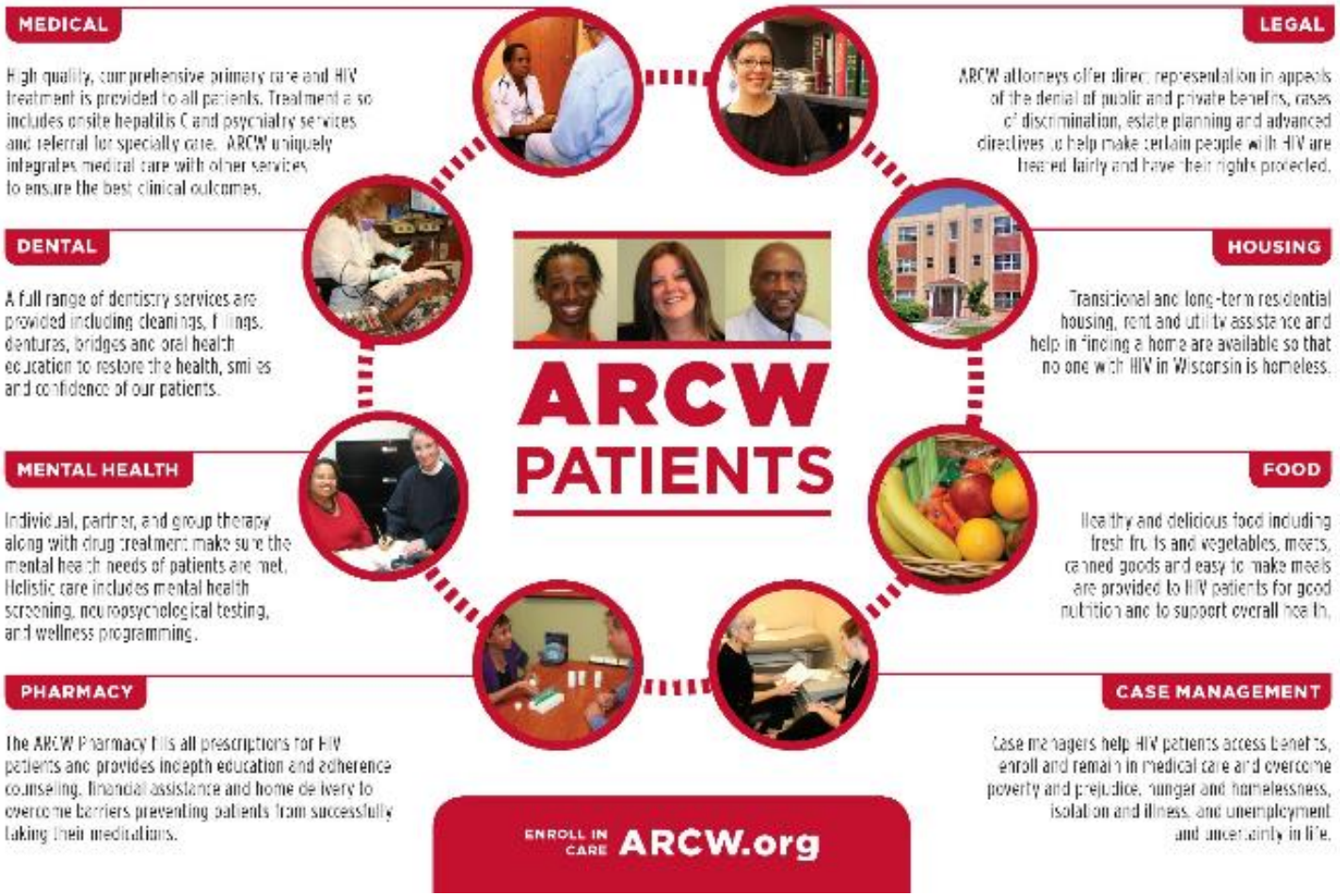
The ARCW Model

Questions the organization has addressed:

- How do we improve the health outcomes of those living with HIV in Wisconsin?
- Where and when do we expand services?
- What do we offer internally vs. referrals to community resources?
- How do we serve clients and patients in rural areas as well as those in urban centers?
- How do we respect the differences in rural living in our service model?


ARCW
PATIENTS

THE ARCW MEDICAL HOME



Exercise Report & Discussion

- Top Barriers Identified
- Discussion:
  - Ideas on how to break down these barriers in your community?
  - What has worked?
  - How can we integrate out systems and improve client outcomes?
- Future Trends

Presenter Contact Information

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