What's Going on @SPNS

HRSA Ryan White & Global HIV/AIDS Programs

AN UPDATE FROM THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH RESOURCES AND SERVICES ADMINISTRATION, HIV/AIDS BUREAU, SPECIAL PROJECTS OF NATIONAL SIGNIFICANCE

SPRING 2016

Addressing the Complex Health Care Needs of HIV-Positive Homeless Populations

"HIV-positive and homeless clients often have complex behavioral issues and experience multiple dimensions of stigma surrounding an HIV-positive diagnosis."

—Serena Rajabiun, Senior Evaluator and Principal Investigator, Evaluation and Technical Assistance Center

According to a study published in a report by the Department of Housing and Urban Development (HUD), housing status is a stronger predictor of HIV health outcomes than individual characteristics such as gender, race, age, sexual orientation, drug and alcohol use, mental health status, and receipt of social services.[1] These findings demonstrate that housing alone may improve the health of people living with HIV (PLWH) and that housing plays a significant role in HIV prevention. Furthermore, persons experiencing homelessness are at an increased risk of acquiring HIV, with rates of new infections as high as 16 times the rate in the general population.[2]

The combination of HIV and homelessness is especially challenging because homeless people are less likely to take medications needed to improve health outcomes.[3] In addition, when antiretroviral therapy is prescribed, adherence can be particularly difficult for homeless patients because of the necessary focus on meeting daily challenges for food, shelter, and clean clothing.[4] Moreover, the study conducted by HUD revealed that at least half of Americans living with HIV experience homelessness or housing instability following a positive HIV diagnosis.[5] Therefore, being homeless can increase one's risk of getting HIV, and having HIV increases the risk of becoming homeless.

The Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program (RWHAP) provides funds to ensure that PLWH and their families have access to medical care. The Special Projects of National Significance (SPNS) Program provides grant funding through RWHAP to organizations that design and develop innovative health care interventions to improve health outcomes, engagement, and retention in care among PLWH. Specifically, the mission of the SPNS Program is to provide support to organizations that implement innovative health care models for HIV-positive individuals who are homeless or unstably housed and who may require coordination of health care services for substance abuse treatment and mental health.

According to HRSA's 2014 Ryan White Client Level Data Report, published on December 24, 2015, by the HIV/AIDS Bureau (HAB) and HRSA, the highest percentages of temporarily or unstably housed adults were those ages 20–24 (18.1%, 5.9% respectively), 25–29 (16.3%, 5.9%), and 30–34 (14.6%, 5.5%) years. (Table 1; percentages presented in the table are column percentages, while those presented here are row percentages).[6]

2014 Ryan White Client Level Data Report[7]

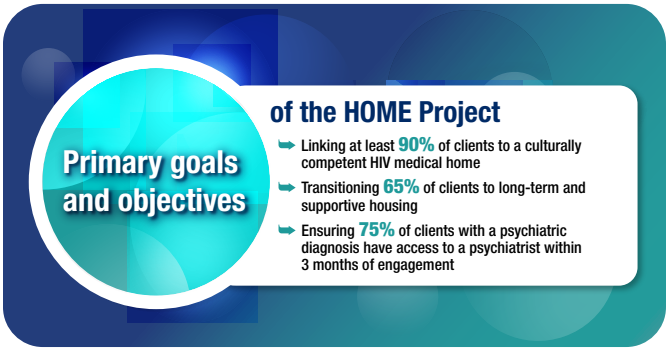
Table 1

Age Group (years)	Stable Housing		Temporary Housing		Unstable Housing	
	No.	%	No.	%	No.	%
< 13	5,579	1.4	638	1.1	53	0.2
13–14	658	0.2	65	0.1	4	0.0
15–19	3,641	0.9	609	1.1	136	0.6
20–24	15,993	4.0	3,801	6.7	1,240	5.5
25–29	28,729	7.2	6,013	10.6	2,173	9.6
30–34	32,780	8.2	6,001	10.6	2,238	9.9
35–39	36,594	9.1	6,030	10.6	2,353	10.4
40–44	45,773	11.4	6,884	12.1	2,823	12.5
45–49	62,472	15.5	8,887	15.6	3,766	16.6
50–54	69,701	17.3	8,591	15.1	4,034	17.8
55–59	50,639	12.6	5,353	9.4	2,350	10.4
60–64	29,337	7.3	2,625	4.6	1,036	4.6
≥ 65	20,150	5.0	1,353	2.4	453	2.0
Total	**402,046**	**100.0**	**56,850**	**100.0**	**22,659**	**100.0**

Targeting Homeless HIV-Positive Individuals Through Mobile Outreach and Engagement

The City and County of San Francisco's HIV Homeless Outreach Mobile Engagement (HOME) Project is one of 10 grantees that received funds through the RWHAP. The HOME project targets homeless individuals who are HIV positive, have not been engaged or retained in care, and face complex multiple co-morbidities, such as substance abuse and mental health challenges. In 2015, the HOME Project received 40 referrals from the San Francisco General Hospital Emergency Departments, HIV/AIDS clinic, and the City and County of San Francisco's navigation service for HIV-positive patients. Of the 40 patients referred to the HOME Project, 30 patients met the medical and psychosocial acuity requirements and were accepted into the program and subsequently linked to care. It is a requirement for patients to have a detectable viral load in order to be accepted into the HOME Project.

The primary goals and objectives of the HOME Project include linking at least 90 percent of its clients to a culturally competent HIV medical home, transitioning 65 percent of clients to long-term and supportive housing, and ensuring that 75 percent of clients with a psychiatric diagnosis will have access to a psychiatrist and receive a closely monitored psychotropic regimen within 3 months of engagement. In addition, the HOME Project aims to ensure that at least 50 percent of chronic substance users in the Project are actively enrolled in a medical substance abuse treatment plan within 3 months of engagement.



The HOME Project deploys a mobile multidisciplinary, multi-agency team that serves a caseload of about 20 to 25 of the hardest-to-serve individuals with severe needs in San Francisco. The HOME Project's team has provided services to multiply diagnosed HIV-positive homeless populations, including refugees, political asylees, immigrants, and undocumented individuals. The Project employs two medical social workers, a part-time psychiatric registered nurse, a homeless peer navigator, and a homeless outreach social worker. According to Janell Tryon, Evaluation Associate for the HOME Project, "Our preliminary findings indicate having access to a registered nurse on our interdisciplinary team is one of our most successful interventions, because increased nursing care and visits are positively correlated with viral suppression."

Furthermore, this innovative mobile outreach engagement program provides clients with the option to have a medical social worker accompany them to medical appointments. In addition, the HOME Project offers language interpretation and risk-reduction counseling to clients as needed. The Project also assists clients in building their own support networks, which can increase adherence to medication and improve long-term health outcomes. A key component of the HOME Project includes delivery of antiretroviral HIV medications and conducting in-the-field medication adherence assessments. Another great feature of the HOME Project is its ability to send a rapid response team to the emergency room, which ensures that patients are enrolled in an HIV treatment program upon receiving an HIV-positive diagnosis. Deborah Borne, Principal Investigator for the HOME Project, revealed, "The majority of our homeless patients are not only homeless but also have severe mental health challenges, which makes it difficult to provide treatment if they are unable to sign a consent form." However, despite the enormous challenges of treating some of the hardest-to-serve individuals with severe needs in San Francisco, the HOME Project has achieved a 40 percent viral suppression rate, from a zero percent suppression rate upon entering into the HIV treatment program. The HOME Project's success is strengthened by maintaining close contact with individuals in the community and by forming a relationship of trust. Mobile team members continually meet to coordinate care and participate in weekly case conferences to help link clients to community resources, agencies, and organizations with funding sources that work with and on behalf of individuals who are homeless and living with HIV/AIDS.

Utilizing the Patient-Centered Medical Home Model (PCMH) to Provide Integrated Health Care

The CommWell Medical Home Works (CWMH) also received grant funding through the RWHAP. The program was developed to meet the challenge of providing housing to the most disadvantaged homeless HIV-positive population in rural southeast North Carolina. This community-based program provides medical services to underserved PLWH who are homeless and unstably housed migrant farm workers, African Americans, Latinos, and American Indians. According to Lisa McKeithan, SPNS Project Manager for the CWMH, "One of the greatest challenges that our clients face in rural areas includes limited access to high-quality medical care and transportation to and from appointments." The CWMH provides transportation for their clients, as well as comprehensive medical care, dental, pharmacy, and behavioral health services for up to 24,750 individuals each year. The primary goals and objectives of CWMH include promoting and improving timely entry, engagement, and retention in HIV care

and psychosocial and supporting services for PLWH who are homeless or unstably housed. Furthermore, CWMH strives to improve the experience of HIV care and treatment by integrating high quality acute and chronic disease management in a planned, coordinated, culturally competent, and patient-centered manner.

The CWMH model creates ongoing opportunities for patients and their families to actively be involved in their treatment plan by participating in the decision making, including seeking feedback through evaluation tools to ensure that patients' expectations are achieved. The continuous input from patients helps the CWMH enhance access to care through such systems as open scheduling and extended hours. The CWMH employs a principal investigator, a project director, a data manager, a care manager, a housing specialist, a continuum-of-care coordinator, a network navigator, a lead evaluator, and an evaluation consultant.

According to a report prepared for the Agency for Healthcare Research and Quality (AHRQ), the patient-centered medical home (PCMH) is a promising model for transforming the organization and delivery of primary care.[8] The PCMH can also improve the delivery, quality, and affordability, as well as the patient and health care professional experience.[9] The CWMH offers multiply diagnosed HIV-positive homeless populations a coordinated approach to providing comprehensive health and support services to address complex health needs, which can include behavioral health, mental health, substance abuse, and long-term housing services. Serena Rajabiun, Senior Evaluator and Principal Investigator for the multisite Evaluation and Technical Assistance Center, indicated that the CWMH is a successful PCMH model because of the comprehensive medical, psychosocial, and supporting services offered to PLWH who are homeless. According to Rajabiun, "Having access to behavioral health specialists is a valuable benefit for PLWH and homeless clients, who often have complex behavioral issues and experience multiple dimensions of stigma surrounding an HIV-positive diagnosis." Another value-added benefit provided by the CWMH program is its extensive network and collaborations with local housing agencies, which partner with CWMH to increase housing options for PLWH.

Grantees featured in this article are funded through HRSA's RWHAP. According to a letter provided by President Obama for the event commemorating the 25th anniversary of the Ryan White CARE Act, the RWHAP has helped prevent HIV transmission and has broadened access to affordable, lifesaving treatment for people who need it regardless of who they are or where they come from.[10] The Homeless Outreach Mobile Engagement and the CommWell Medical Home Works health care programs showcase innovative models of care and treatment that will no doubt help to change the landscape in the delivery of HIV care, treatment, and support services for multiply diagnosed HIV-positive homeless populations.

Other News at SPNS

Addressing HIV Care and Housing Coordination Through Data Integration to Improve Health Outcomes Along the HIV Care Continuum—This initiative is a $1.2-million, 3-year joint collaboration with the HRSA's HIV/AIDS Bureau (HAB) and HUD's Office of HIV/AIDS Housing and is currently being administered through HAB's SPNS Program. The purpose of the initiative is to provide technical assistance and capacity building in support of the electronic integration of housing and HIV care data systems in the coordination of housing and HIV care services. This initiative has one Coordination and Technical Assistance Center, and four performance sites are expected to be selected in early 2016. Performance sites will integrate their Ryan White HIV/AIDS Program and Housing Opportunities for Persons with AIDS data systems and will be expected to design, implement, and evaluate the effectiveness of an integrated HIV care and housing data system and enhanced service delivery strategy, including service utilization, cost, impact on health-related outcomes, and dissemination of findings, best practices, and lessons learned.

This initiative, which began in FY 2015 and runs through FY 2017, supports the National HIV/AIDS Strategy: Updated through 2020, charging Federal agencies to strengthen coordination across data systems, both to coordinate the use of data to improve health outcomes and to monitor the use of Federal funds. This project is funded through the U.S. Department of Health and Human Services (HHS) Secretary's Minority AIDS Initiative. This is the first time a pilot project of this nature—integrating housing and HIV care services through data—is being promoted under the umbrella of health information technology.

For More Information

Contact Adan Cajina, SPNS Branch Chief, at 301-443-3180 or acajina@hrsa.gov.

References

1. U.S. Department of Housing and Urban Development. November 2014. HIV Care Continuum. The connection between housing and improved outcomes along the HIV care continuum. Available at: www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/key_resources/housing_and_supportive_services/hopwa.pdf.
2. Ibid., p. 3.
3. Buchanan D, Kee R, Sadowski LS, Garcia D. 2009. The health impact of supportive housing for HIV-positive homeless patients: a randomized controlled trial. *American Journal of Public Health* 99(S3): S675–80.
4. Kirst M, Zerger S, Misir V, Hwang S, Stergiopoulos V. 2015. The impact of a housing first randomized controlled trial on substance use problems among homeless individuals with mental illness. *Drug and Alcohol Dependence* 146: 24–9. doi:10.1016/j.drugalcdep.2014.10.019.
5. U.S. Department of Housing and Urban Development. November 2014. HIV Care Continuum. The connection between housing and improved outcomes along the HIV care continuum. Available at: www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/key_resources/housing_and_supportive_services/hopwa.pdf.
6. Health Resources Services Administration. 2015. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2014. December 24. Available at: hab.hrsa.gov/data/servicesdelivered/2014RWHAPDataReport.pdf.
7. Ibid., p. 24.
8. Peikes D, Zutshi A, Genevro J, Smith K, Parchman M, Meyers D. 2012. *Agency for Healthcare Research and Quality (AHRQ). Early evidence on the patient-centered medical home, p 10. Final Report*. Available at: www.pcmh.ahrq.gov/sites/default/files/attachments/Early%20Evidence%20on%20the%20PCMH%202%2028%2012.pdf. AHRQ Publication No. 12-0020-EF.
9. Ibid., p. 10.
10. Obama B. 2015. Letter commemorating the 25th anniversary of the Ryan White Comprehensive AIDS Resources Emergency Act (CARE). August 18. Available at: hab.hrsa.gov/ryanwhite25/ryanwhitewhletter.pdf.