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

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Disclosures

Presenters have no financial interest to disclose.

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http://ryanwhite.cds.pesgce.com
Map of SPNS Study Sites

HRSA/SPNS Initiative: Building a Medical Home for HIV Homeless Populations

- Portland, OR
  Multnomah County Health Dept.
  Cascade AIDS Project

- San Francisco, CA
  San Francisco Dept. of Public Health

- Pasadena, CA
  Operation Link
  Pasadena Public Health Dept.

- San Diego, CA
  Connections Housing
  Family Health Centers
  People Assisting the Homeless (PATH)
  San Diego State, Institute for Public Health

- Dallas, TX
  AIDS Arms, Inc.

- Houston, TX
  Harris Health System

- Newton Grove, NC
  Tri-County Health Council
  CommWell Health Care Inc.

- Boston, MA
  BU School of Public Health
  Boston Health Care for the Homeless Program

- New Haven, CT
  Yale Univ. AIDS Program
  Liberty Community Services
  CT. Dept. Corrections

- Jacksonville, FL
  PATH Project
  Univ. of Florida, CARES Clinic
  River Region Human Services

Indicates site in stigma sub-study
Indicates site not in stigma sub-study
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

- SF General Hospital PHAST & Social Service
- Homeless Outreach Team/Placement
- Project Homeless Connect
- HIV Prevention: LINCS
- Housing and Urban Health Direct access to Housing & Respite
- API Wellness Drop -In
- Forensic AIDS Project (Jail)
- SFDPH Primary Care Clinics

HHOME Team
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

- Shared Patient
- Parallel Systems
- Co-Location
- Integrated Care

- RN Care Coordination
  Provider Communication-Health Info. Exchange

- Administrative Communication
  Patient Referral

- Consultation

- Teams, Huddle, Shared Registry, Screening, Case Conferencing
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.
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)

Rreevaluate 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?