



Building Housing Partnerships to Improve Housing Stability and Increase Health Outcomes

Friday, October 3, 2014



Presenting Partners

- Jane Fox, Boston University, Boston MA
- James Apt, Boston Health Care for the Homeless Program, Boston MA
- Leigh Evans, CommWell Health, Dunn NC
- Verna Gant, Family Health Centers of San Diego, San Diego CA
- Jodi Davich, Multnomah County Health Department, Portland OR
- Brenda Meskan, SF Department of Public Health, San Francisco CA



Outline

- Introductions and ice breaker (Many Questions)
- Describing housing barriers/challenges and needs
- Description of the initiative and the multi-site evaluation (setting the stage)
 - CommWell Health presentation
 - Family Health Centers of SD presentation
 - Multnomah HD presentation
 - SF Dept of Health presentation
- Tackling challenges and housing partnerships at home
- Report out and wrap up



Introduction & Activity

- Many Questions...



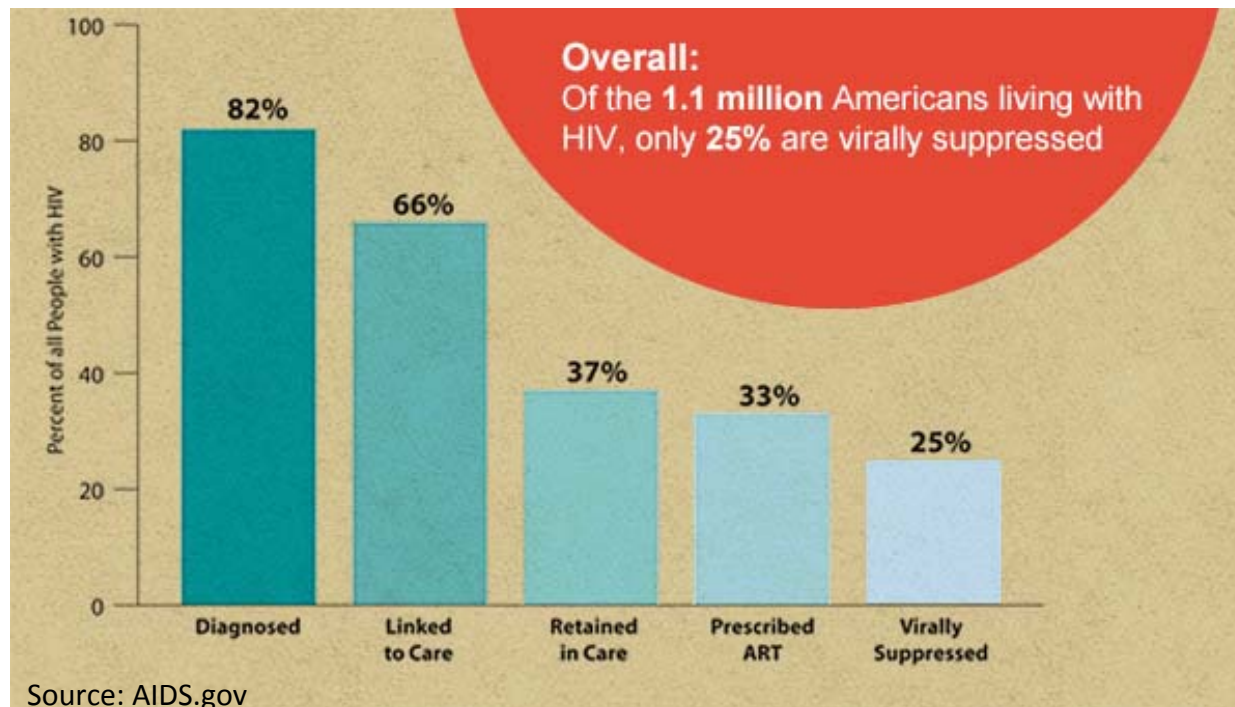
Housing Challenges and Barriers

- What is the current HIV housing situation in your area?
- How accessible is housing for PLWHA?
- How do the various organization (HIV and housing) work together to meet the needs of PLWHA?
- Barriers or challenges?



Background & Significance

HIV Continuum of Care





Background & Significance

– National HIV/AIDS Strategy

- Reducing the number of people who become infected with HIV
- Increasing access to care and optimizing health outcomes for people living with HIV, and
- Reducing HIV-related health disparities



Background & Significance

Homelessness and HIV:

- HIV is 3-9 times more prevalent among homeless individuals than those in stable housing (Kidder et al., 2006)
- Limited or inadequate health care utilization reported among unstably housed persons living with HIV (Aidala et al., 2007).
- Less likely to have ever been prescribed or actively taking HIV antiretrovirals (Kidder et al., 2006).
- More likely to use emergency rooms for HIV care or be hospitalized due to HIV related complications (Arno et al., 1996).



Background & Significance

Behavioral Health, Homelessness and HIV:

- 26.2% of homeless population suffer from severe mental illness problem (HUD, 2010).
- 34.7% of homeless population have substance abuse problem (HUD, 2010).
- Injection drug use accounts for 9% of HIV/AIDS diagnoses (CDC, 2012).



Building a Medical Home Initiative (2012-2017)

- Funded by Health Resources & Services Administration/ Special Projects of National Significance (HRSA/SPNS)
- 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



Initiative Goals

- Improve timely entry, engagement and retention in HIV care and supportive services
- Build and maintain sustainable linkages to mental health, substance use treatment and HIV primary care
- Increase access to stable/permanent housing
- Create a medical home for HIV positive multiply diagnosed homeless/unstably housed populations



Target Population

- 1. Persons living with HIV/AIDS who are 18 years of age or older**
- 2. Persons who are homeless or unstably housed**
 - Literally homeless;
 - Lacks a fixed, regular, and adequate nighttime residence
 - Unstably housed
 - No lease, ownership interest or occupancy agreement in permanent and stable housing) in the last 60 days; or
 - Persistent housing instability as measured by two moves or more in the preceding 60 days; and
 - Expected to continue as such for an extended period of time.
 - Fleeing domestic violence
 - Fleeing or attempting to flee domestic violence, has no other residence and lacks the resources to obtain permanent housing.
- 3. Persons with one or more co-occurring mental health or substance use disorders**

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



<http://medheart.hdwg.org/>



Intervention Model

- Building a medical home for HIV positive homeless population
 - Housing partnerships
 - Behavioral health partnerships
 - Systems integration
- Use of network navigator/care coordinators



Study Design Overview

- Methodology
 - Longitudinal study with data collection at baseline, and follow-up points at 3,6,12, and 18 months
- Data collection instruments
 - Client interviews
 - Medical chart review
 - Intervention encounter form



Study Design Overview

- Evaluation measures
 - Outcome measures
 - Clinical: Changes in CD4 and viral load, HIV primary care visits, behavioral health visits, quality of care, HIV and housing case management visits (Suggest to delete above)
 - Increased retention in care
 - Increased viral suppression
 - Improve housing stability
 - Improved health related quality of life
 - Other intermediate outcomes:
 - Reduction in barriers to care & unmet needs for services
 - Improved HIV treatment adherence
 - Increased patient experience with care
 - Improved access & use to mental health & substance use treatment
 - Process measures
 - Number and duration of encounters with intervention staff, activities with intervention staff, types of encounters
 - Building a medical home: patient quality of care measures (for homeless), self-management and end-of-life plan
 - Qualitative supplement: in-depth provider and staff interviews



Building Housing Partnerships

Site: CommWell Health

Presenter: Leigh Evans



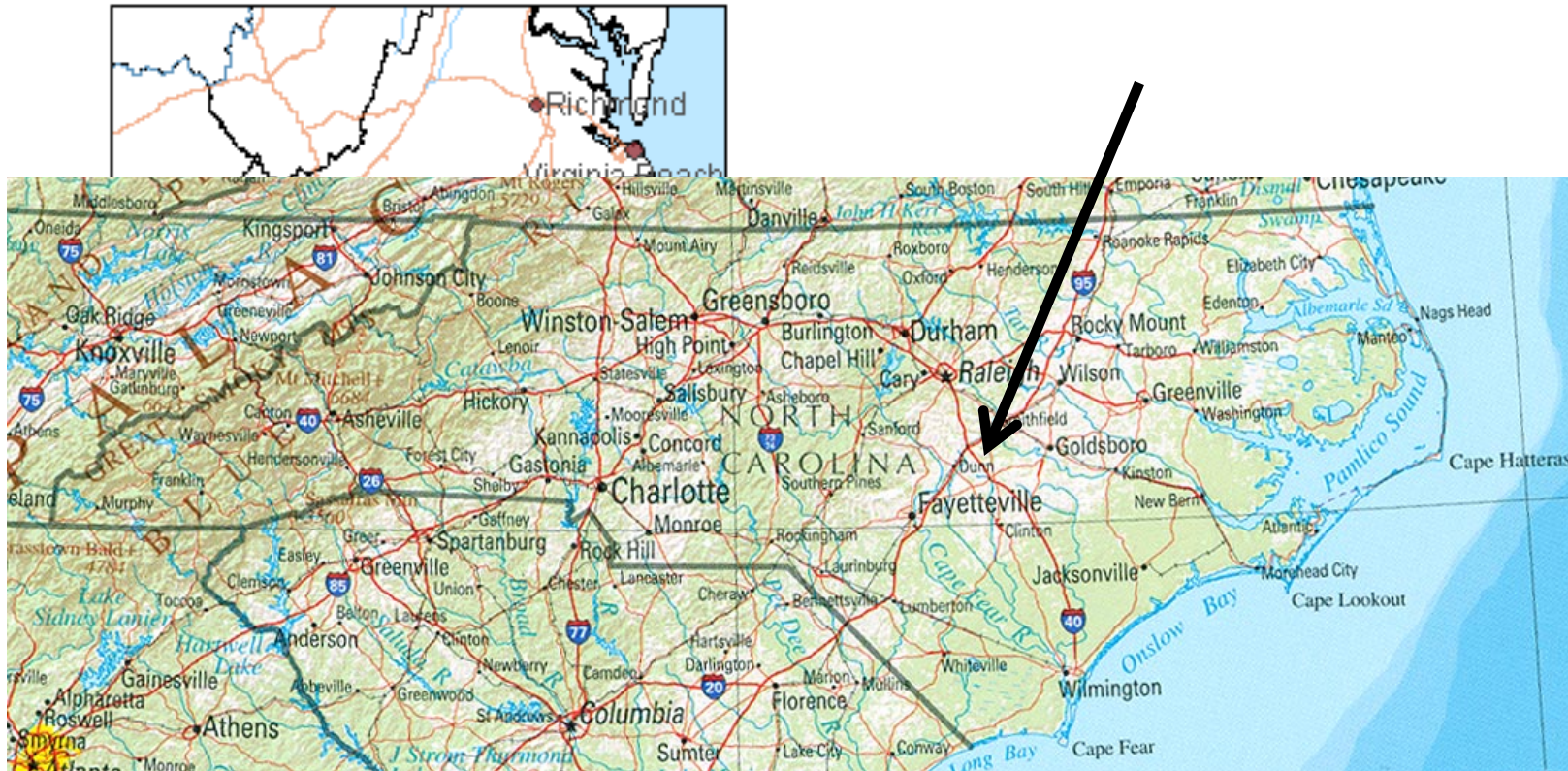
Program

- Model:
 - Care coordination provided by HIV Nurse
 - Network Navigator
 - Intensive housing coordination
- Target Audience:
 - HIV+ homeless/unstably housed, some farmworkers
- Innovation
 - Coordinated, intensive service provision spanning across departments and local service providers

Geographic location

- Rural, southeast North Carolina

North Carolina



Geographic location



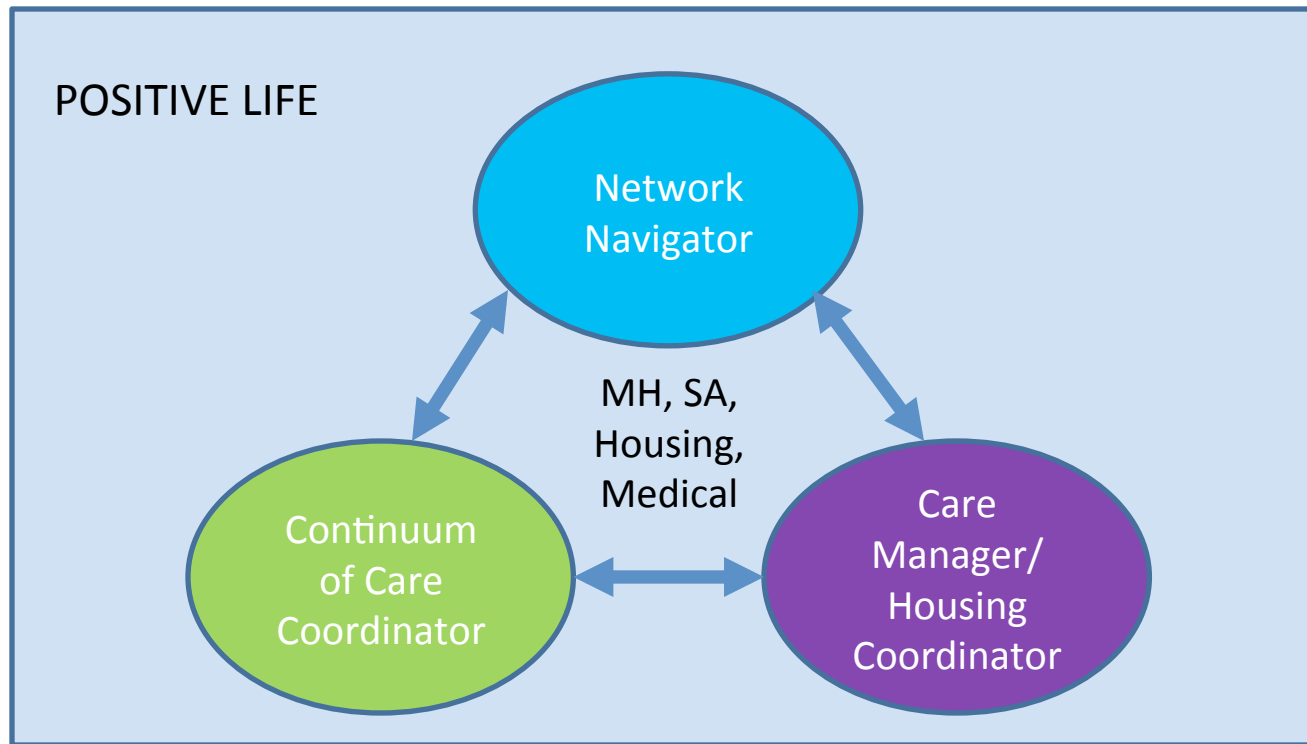
CommWell Health



Transportation



Program Model



Positive Life Team



SPNS Team





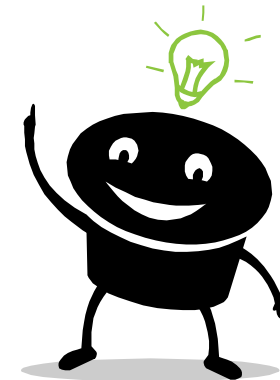
Housing Partnerships

Barriers to housing

- Limited resources- housing units, transitional housing
- Services for homeless but not HIV+
- Red tape- background checks, drug screens
- Cost for emergency shelters

Strategy

- Convene local housing providers
- Pull them together to:
 - Introduce program
 - Learn about resources



Housing Partnerships

- What was meant to be a 1 time meeting turned into:
 - Forum for local housing providers
 - Quarterly meetings
 - Development of shared goals and objectives
 - Venue to share resources
 - 2-way street: connecting clients to housing and medical

Housing Partnerships

- Successes
 - Good representation at housing meetings
 - Information sharing
 - Willingness to collaborate
- Challenges
 - Time and energy for outreach
 - Too many meetings
- Other challenges/successes
 - Stigma
 - Structural barriers
 - Resources do exist!!





Maintaining Partnerships

- Maintaining good relationships
 - Quarterly meetings
 - Continued outreach
 - Representation at larger housing coordination meetings
 - Coordinating housing and other things like medical services, employment assistance

Shared goal: to help clients access the services and programs they need



Resources

– Local Housing Inventory

LOCAL SERVICES INVENTORY FOR COMMWELL SPNS MEDICAL HOME PROJECT															
GENERAL INFORMATION			SERVICES PROVIDED												
Name of Center	Key contact person	Location	Shelter	Housing assist	Substance use	Mental Health	Case Mgmt	Primary Medical Care Assistance	Meals Assistance	Domestic Violence	Financial Assistance	HIV prevention	Social support	Other (specify)	Notes
Adult Health Clinic Harnett Co. Health Dept.	Debra Hawkins 910-814-6198	307 W. Cornelius Harnett Blvd Lillington NC	No	No	no	Yes	yes	Yes	no	No	no	Yes	no	N/A	
Alliance of AIDS services-Carolina	Stacy Duck 919-834-2437	324 S. Harrington st. Raleigh, NC	No	Yes	Yes	Yes	Yes HIV	Yes	Yes	No	Yes	Yes	Support	n/a	n/a
Beacon Rescue Mission	John Cooke 910-892-5772	207W. Broad Street Dunn, NC	Yes	yes	no	Yes	no	no	yes	yes	no	no	no	n/a	Homeless shelter
Betsy Johnson Regional Hospital	910-892-1000	800 Teighman Dr. Dunn NC	No	No	Detox by	Yes	no	Yes	no	No	no	Yes	yes	N/A	detox thru ER only
Carolina Outreach	Rhonda Nordin 910-438-0939	907 Hag St. Fayetteville NC	No	No	Yes	Yes	Yes	No	No	No	No	Yes	Yes	N/A	
Cape Fear Valley Behavioral Health services	Laura Taylor 910-615-3753	3425 Melrose Rd Fayetteville NC	No	Yes	yes	yes	yes	yes	no	no	no	yes	yes	n/a	
City Rescue Mission	Gladys Thompson 910-323-0446	120 North Cool spring st.	Yes	yes	no	Yes	no	no	Yes	yes	yes/ case by	no	yes	n/a	Female only cost \$50.00/
Community Health Interventions	Elazzoa McArthur 910-488-6188	2409 Murchinson Rd Fayetteville NC	No	No	no	no	yes	no	no	no	yes	yes	yes	n/a	
Christian Faith Ministries	Tabatha Franklin 919-776-8474	705 Chatham St. Sanford NC	Yes	No	no	no	no	no	Yes	No	No	no	Yes	n/a	Homeless shelter
Cumberland County Health	Phyllis McLeMore 910-433-3600	1235 Ramsey St. Fayetteville NC	No	No	yes - by referral	Yes	no	Yes	no	No	no	Yes	n/a	N/A	
Cumberland Interfaith	Denise Jiles 910-826-2454	113 Stein St. Fayetteville NC	No	yes	no	no	no	no	Yes	no	no	no	no	n/a	In county only
Good Neighbor House for women	Karen Earp 919-934-3639	Smithsfield NC	Yes	Yes	no	no	yes	no	yes	yes	no	no	yes	n/a	Female only mandatory drug screen. Out of
Healing Place of Wake County	Dennis Tripp 919-838-9800	1251 Goode St. Raleigh NC	Yes	Yes	no	no	Yes	no	Yes	yes	No	no	Yes	n/a	County case manager cost \$7.00/day
Hope Center	Evelyn Campbell 910-920-4723	913 Person St. Fayetteville NC	Yes	yes	yes	yes	yes	no	yes	no	no	yes	yes	n/a	
House of Fordham Shelter	Linda Burroughs 919-736-7352	412 N. William st. Goldsboro NC	Yes	Yes	no	no	no	no	Yes	No	no	no	y	N/A	no cost
New Life Mission church/shelter	Pastor Grace Kim 910-864-4678	303 Maloney Ave. Fayetteville NC	Yes	No	No	No	No	No	Yes	No	No	no	Yes	n/a	
Potter's Wheel Ministries	Manager John	147 Faith Ln. Mount Olive NC	Yes	Yes	No	No	Yes	No	Yes	No	No	No	Yes	n/a	
Port Crisis Center, Human Services	252-413-1637	203 Government cir. Greenville NC	No	No	yes/detox	Yes	yes	Yes	no	No	no	Yes	yes	N/A	Detox facility
Project Homeless Fayetteville PD	Officer Stacey Sanders Community	467 Hag St. Fayetteville NC	No	liason only	no	no	no	no	liason	liason	no	no	yes	N/A	homeless liason



Building Housing Partnerships



Presenter: Verna Gant



Program Model

Identify HIV positive homeless or unstably housed dually diagnosed individuals and assist them with establishing the following services:

- Select and maintain a Primary Care Medical Home
- Housing resources/referrals
- Behavioral health services (licensed therapist, psychiatrist)
- Outpatient substance abuse support
- Provide intensive case management support



Family Health Centers of San Diego

Program Focus: Identification of Dually Diagnosed HIV+ Homeless Individuals within the County of San Diego (Central and Downtown San Diego)





Family Health Centers of San Diego

Program Innovation through partnership of Connections Housing, People Assisting the Homeless (PATH) and Family Health Centers of San Diego

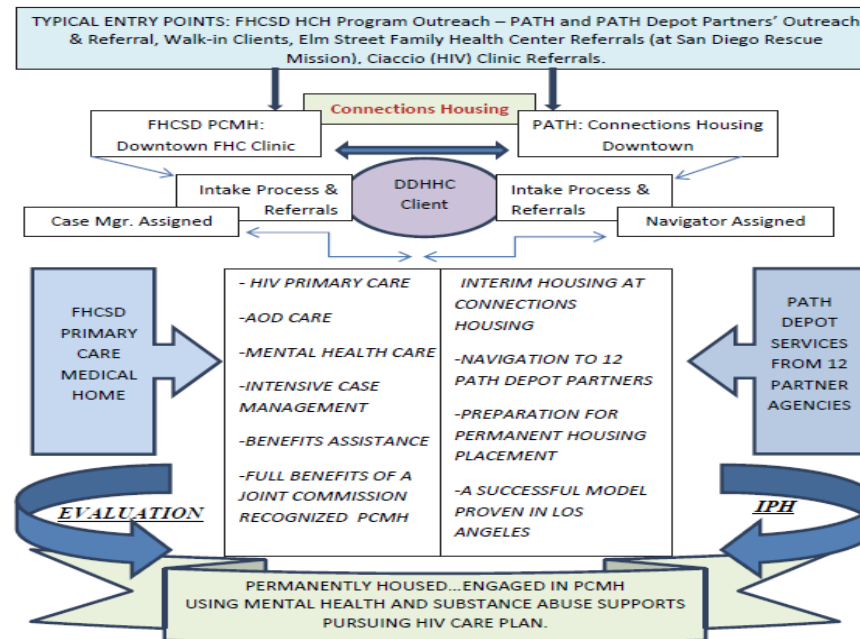
-Creation of strong street-familiarity among downtown homeless residents with integrated resources available through interim/long term housing through a one-stop shop (housing, health care, comprehensive social services).





Program Overview

From the mountaintop, FHCSO's care integration and coordination proposed looks like this:



- By leveraging FHCSO's HCHP infrastructure we will facilitate *timely* entry to care.
- By leveraging FHCSO's Coordinated HIV Services Center grants & contracts we will *maximize and optimize* the use of *existing resources* for HIV+ individuals.
- Through FHCSO's mental health and substance abuse grants & contracts, we will connect clients with *evidence-based care* and *give clients support against potential relapse*.
- Through PATH's expertise in housing, we will *connect clients* with a permanent home.
- Through evaluation, we hope to create a *compelling case for replicating the project* elsewhere.



Building Housing Partnerships

Within the County of San Diego, Family Health Centers of San Diego (FHCSD) focused on increasing housing partnership and referrals through:

- Local HIV Community Agencies
- Community Meetings
- County of San Diego Consumer Meetings



Building Housing Partnerships, Con't

- People Assisting The Homeless (PATH) Family Health Centers of San Diego(FHCSD)-Subcontractor
- Affirmed Housing Group
- PATH Ventures
- Alpha Project For The Homeless
- Solari Enterprise Inc.





Housing Successes

Within San Diego County, the following successes can be highlighted by utilizing the following programs and partnerships:

- Emergency Housing Program
- Transitional Housing Programs
- PATH (Special Needs Units, Interim Units)
- Establishing relationships with Non-Traditional Landlords



Housing Challenges

Within San Diego County there are several housing challenges:

- There is a lack of permanent and affordable housing options
- Clients have limited Income

Address the challenges:

- FHCSD and PATH continue to identify non-traditional HIV stable/permanent housing programs to assist clients with stable housing
- Obtain feedback from the Community Advisory Board and consumers



Housing Challenges, Con't

What are other housing challenges to keep in mind in your community?

- The length and history of homelessness
- Mental health
- Substance abuse
- No or limited income
- The wait list for Section-8 and HOWPA
- Linking and establishing a Primary Care Medical Home



Housing Successes, Con't

Let's hear more on what has worked for San Diego County and Family Health Centers of San Diego:

- Section-8 and HOPWA waiting list
- HOPWA Housing Programs
- Ryan White emergency and transitional programs
- Networking with Property Managers and Landlords



Maintaining Positive Partnerships

Steps to maintaining partnerships that have worked in San Diego:

- FHCSD and PATH continue to foster working relationships with community members and organizations
- Get the word out (again and again)-Conduct quarterly and bi-annual in-services with existing and new partners!
- Foster partnerships with existing Ryan White and HOWPA funded Housing Programs (formal and informal)



Maintaining Partnerships under challenging circumstances

FHCSD has worked to address challenges through-

- Coordination & Communication
- Case Conferences
- Collaboration (FHCSD & PATH)
- Identification of non-traditional HIV stable/permanent housing programs to assist clients with stable housing



Partnership Maintenance

How does FHCSD work with PATH to help our clients achieve their goals?

- Co-location
- Coordination
- Collaboration
- Shared Database
- Shared Partnership





Formalizing Partnerships

Family Health Centers of San Diego works with PATH in the following ways:

- Subcontracted Services
- Co-location-Share office space/resources
- Training & support on the Ryan White Case Management model
- Treatment adherence education and monthly case reviews
- Case review meetings offer an opportunity to provide resources and supports to homeless downtown residents on primary health care, specialty HIV medical care, dental services, mental health, substance use services, enrollment with Managed Care plans, Ryan White and the AIDS Drug Assistance (ADAP).





Resources

Customize Resources for your community, FHCSD has customized the following:

- There is a PATH/Alpha Interim Housing Referral Form-used for screening and intake for housing program.
- There is a Documentation Guide Checklist-which lists documents needed for housing referrals
- Creation of an Eligibility Screening Tool-a guide to determine eligibility for the Special Needs Units at PATH Connections Housing
- ARIES-A shared client database for documentation and record keeping
- Intake Assessment – Includes Mental Health, Medical Health, Substance Abuse, Financial, Disability, DV, etc. to develop an Individualized Service Plan



Housing Resources

FHCSD has created the following tools and resources within our program

- San Diego Housing Commission Forms
- Certification of Homelessness-verification of a client's homeless status
- Certification of Disability-an authorization of special considerations in federally funded housing to a person who is permanently disabled or verification of a handicap



Building Housing Partnerships

Site: Multnomah County HIV Clinic

Portland, Oregon

Presenter: Jodi Davich



Program

- **Model:** Based on Patient Centered Medical Home and Critical Time Intervention
- **Target Audience:** Homeless PLWH Affected with Mental Health and Substance Abuse Disorders
- **Geography:** Portland, Oregon
- **Innovation:** Full integration of network navigators into the primary care medical team through collaboration with primary HOPWA provider, Cascade AIDS Project



Housing Partnerships

- **Methodology for building partnerships**
 - Networking, education and outreach
 - Targeting new programs and resources as they emerge
 - Developing MOUs
 - Joining housing coordination groups
 - Inviting housing case managers to join the medical team
- **Successes in identifying and engaging housing partners**
 - Creating new HIV slots in housing programs
 - Housing staff participate in clinic activities



Housing Partnerships

- **Challenges identifying & partnering with housing agencies**
 - Portland lacks housing stock for low income—particularly those with bad rental histories
 - Portland lacks supportive housing and re-entry programs
- **How are you addressing these challenges**
 - Participating in policy and community planning
 - Exploring tiny houses, micro-apartments
 - Approaching faith communities
 - Promoting advocacy within HIV communities



Maintaining Partnerships

- **Working together to serve clients:**
 - Collaborate ways to meet eligibility criteria
 - Help with psycho/social assessments that are needed for specific/special needs housing programs
 - Meet together with client, navigator, housing staff, and medical case manager so everyone is on the same page
 - Create a client driven housing plan that is shared and understood by all parties
 - Stay faithful to agreements—follow through with your duties!



Maintaining Partnerships

- **What do you offer to them in exchange for what they offer to you/your agency?**
 - Real-time help to resolve landlord/tenant problems including moving disruptive clients out, paying large deposits, avoiding formal eviction (which saves landlords money), renting storage units, etc.
 - Assistance with paperwork, housing searches, tenant/landlord relations and home visits



Maintaining Partnerships

- **Working with landlords**
 - Be honest
 - Being available to respond to issues in real time
 - Having a plan to resolve problems
 - Educate landlords about recovery—built empathy—make it human



Maintaining Partnerships

- **Dealing with challenging situations:**
 - Collaborating with housing partners to develop standards for communication and problem resolutions
 - Being responsive to requests (avoid “it’s not my job”)
 - Identifying possible barriers and stumbling blocks for each client prior to initiating a housing search
 - Addressing problems in real time
 - Holding rapid debriefs with service providers to identify what worked and how to improve future efforts
 - Holding all parties accountable (including clients)



Tools/Resources

- Motivational Interviewing (eliciting change talk in clients)
- Deep Listening
- Trauma Informed Care
- Chronic Condition (Disease) Self Management
- Action Plans



SF HHOME

Brenda Meskan, LMFT
SF Department of Public Health

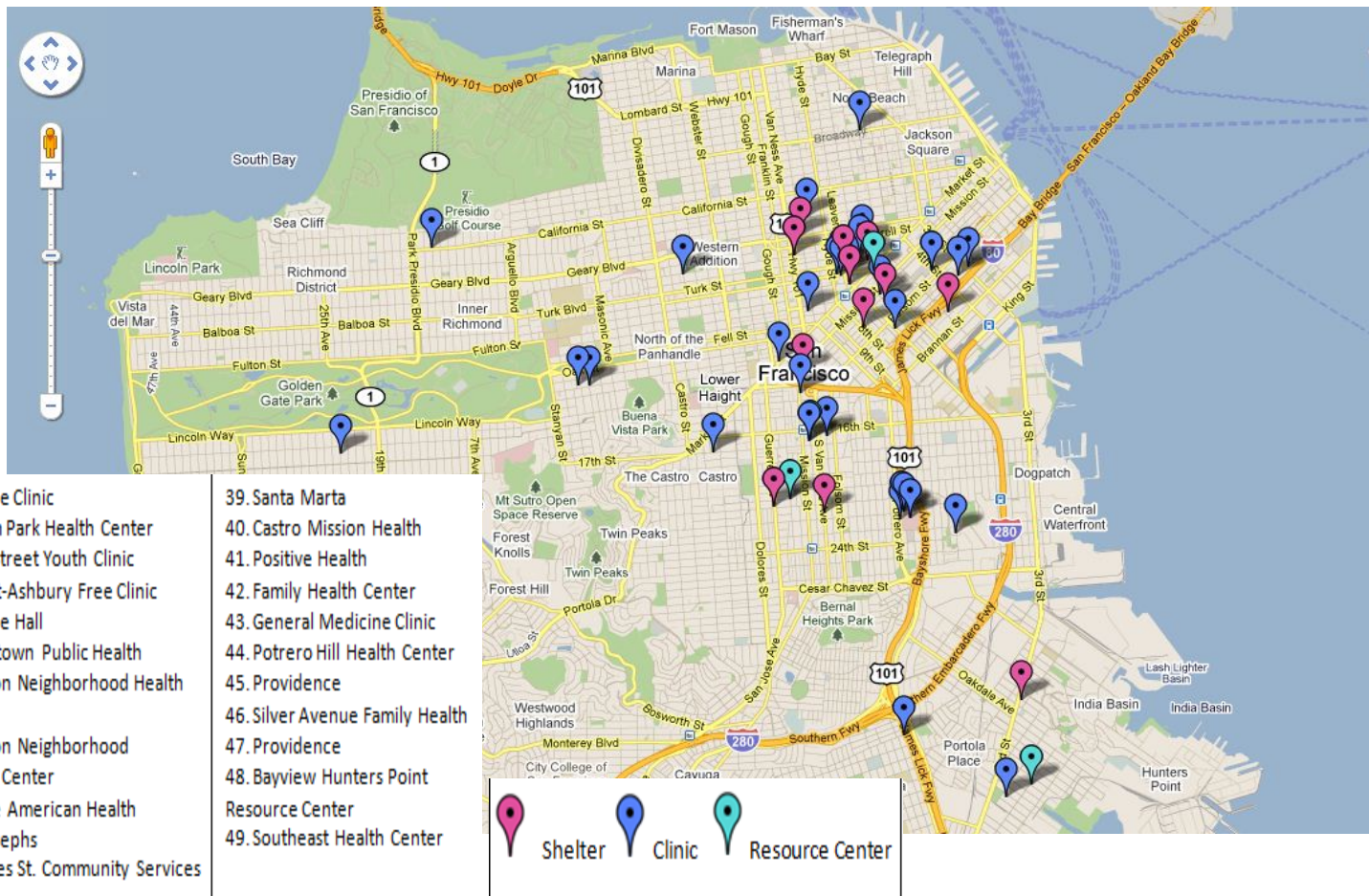


Homeless Health Outreach Medical Engagement HHOME

- Model: Intensive Street Medicine Outreach and Engagement Team
 - Target Audience: HIV positive, multiple diagnosed individuals-chronic homelessness, substance abuse, mental illness, and not connected to Primary Care
 - Street Medicine, Stabilization Units in Single Room Occupancy (SRO) hotels

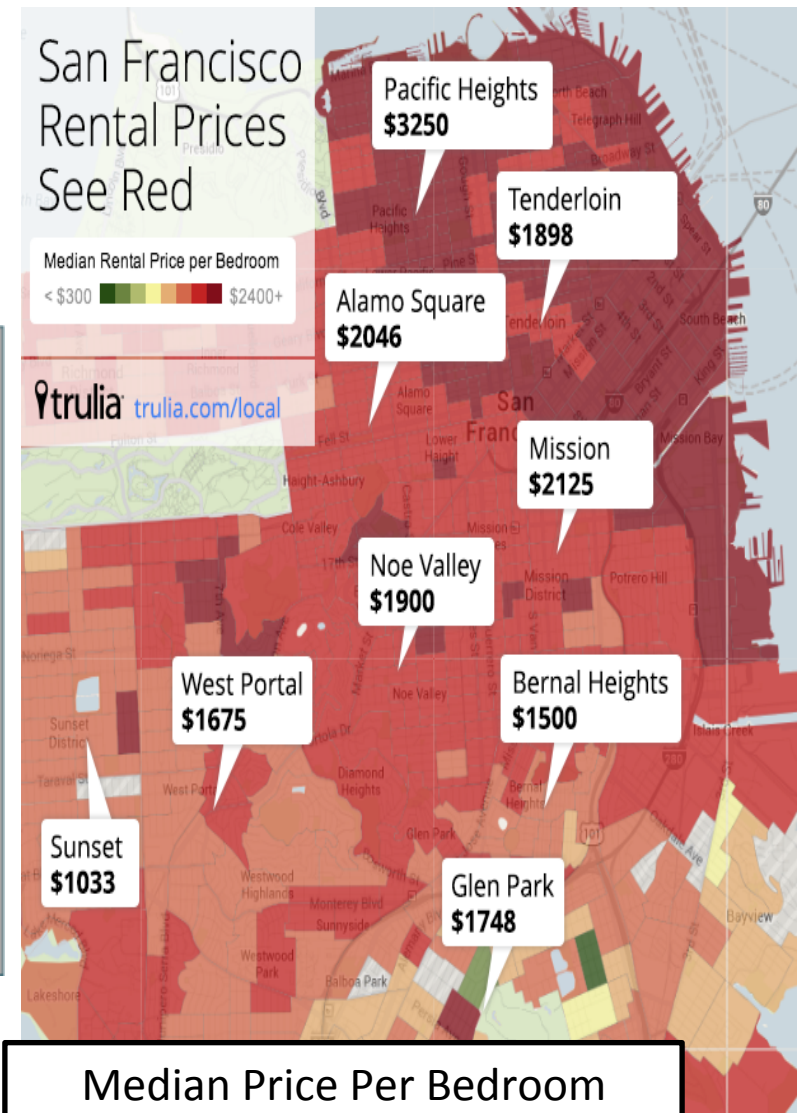
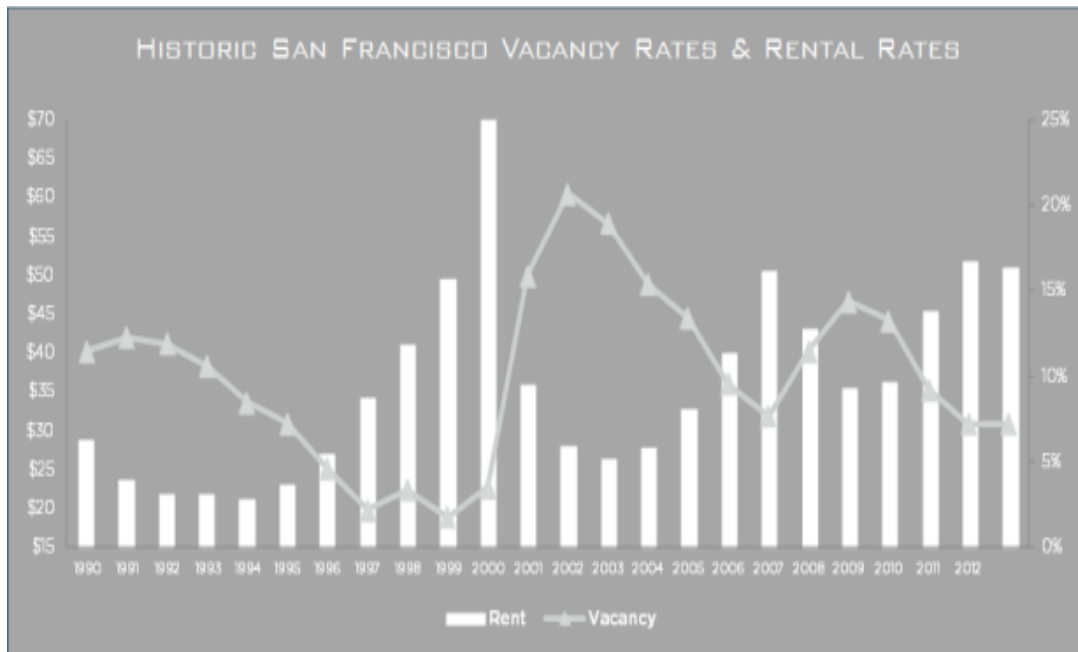


SF Department of Public Health Medical Clinics, Consortium Clinics, & Shelters





Housing Shortage





Building Housing Partnerships

- Find Gatekeepers
- Build Relationships
- Research available housing:
 - Government and local programs
 - Colleagues
 - Reference books/Internet
- Networking/Phone calls, site visits, refer clients
- Be of “service” responding to phone calls, emails, and any requests in a timely manner
- Maintain relationships with housing providers



Navigate the Housing System

- Identifying the HIV specific sites, contacting the sites and inquire about referrals into their programs. Ryan White funded-programs
- HIV specific sites were closed to new referrals; CHIPS waiting list closed in 2001: No lists: Derek Silva Community, Leland House, Peter Claver Community
- Human Service Agency (HSA) has access to housing- Housing Access Team (HAT)/Tenderloin Housing Clinic (THC), and other HSA sites that have an occasional opening
- Direct Access to Housing (DAH) (1700 units) sites for those needing more supportive services on site-case management, nursing, money management





Challenges in Identifying & Partnering with Housing Agencies

- CHIPS- Waiting list
 - Not available for new positives
 - Long waits
 - Clients need additional services
- Stabilization
 - Medical
 - Psych
 - Evictions for nuisance behavior
 - 6 month before eligible to refer back
- HIV specific sites are not w/c accessible
- Lack of affordable housing in SF



Programmatic Challenges

- Response Time
- Assessing Acuity
- Finding the appropriate level of care for clients after stabilization
- Being pulled emotionally. We believe everyone deserves housing.
- Do not want to “burn bridges” with providers handling the referrals-
HONESTY
- Clients that have stabilized are waiting for housing and have
“stepped down” to lower level of care w/ partner agency SF HOT,
undetectable viral load
- Housing Shortage



Preparing Clients for Permanent Housing

- Success in Stabilization Room
- Birth certificate, CA Id, SS card
- Benefits: County Adult Assistance Program or SSI
- Money Management
- Issues to Address: Substance Abuse, legal, psychiatric, adherence
- Partnering with Transitions Placement Team
- Coach/support agencies to care for our clients
- Referral to Health at Home for ARV Daily Observation Therapy
- Referral for In-Home Support Services



CHALLENGES TO HOUSING





Successes







Questions?

Brenda Meskan, LMFT

San Francisco Department of Public Health

Brenda.Meskan@sfdph.org



Breakout Groups

- In the next 3 – 6 months
 - Who would you like to work with in your area to address your housing issues?
 - What do you need specifically from them and what do you have to offer?
 - How will you approach them?
- How would you incorporate them into your organizational work?



For More Information

- <http://medheart.hdwg.org/>



Providing a medical home for people who are homeless and living with HIV

Contact us Login Register

Home About Demonstration sites Resources

Home

About Med-HEART

- What strategies successfully address housing needs of homeless people living with HIV?
- What does it take to keep homeless people in HIV care?
- How can we successfully integrate HIV care, mental health services and substance abuse treatment for homeless people?
- What does it take to create a medical home for homeless people living with HIV?

These are some of the questions the initiative *Building Medical Homes for Multiply Diagnosed HIV Homeless Populations* is designed to answer. This five-year initiative is funded through the U.S. Department of Health and Human Services (HHS) under the Health Resources and Services Administration (HRSA) Division of HIV/AIDS Bureau Special Projects of National Significance (SPNS).

The Health & Disability Working Group at Boston University School of Public Health and Boston Health Care for the Homeless Program® have partnered to establish the Med-HEART (Medical Home-HIV Evaluation & Resource Team) project that serves as evaluation and technical assistance center for the initiative.

Med-HEART will collaborate with nine demonstration sites to evaluate models of care that link HIV-positive homeless individuals with needed services and resources. We will share resources on this site as they become available to help organizations address the needs of this population.

Learn more

- [Building Medical Homes for Multiply Diagnosed HIV Homeless Populations initiative on HRSA \(Health Resources and Services Administration\) initiative web pages](#) [Ⓔ].
- [A profile of this initiative \(called the SPNS Homeless Initiative in the article\) is included in the April 2013 issue of HRSA's What's Going On @SPNS newsletter \[PDF\]](#) [Ⓔ].
- [BUSPH Researchers Awarded 5-Year Grant to Evaluate Medical Home Approaches for HIV-Positive Homeless](#) [Ⓔ] on [Boston University School of Public Health website](#)

Med-HEART is a collaboration between the Boston University School of Public Health's Health & Disability Working Group and the Boston Health Care for the Homeless Program. Funding for Med-HEART is through the Health Resources and Services Administration's HIV/AIDS Bureau Special Projects of National Significance, which is a program within the federal U.S. Department of Health and Human Services.



Recorded Webinars

Recorded webinars for those who work to help clients who are homeless find and retain housing.

News

Webinar: What to Do When Housing is in Jeopardy?

Webinar: You're Housed! Now What? Keeping clients on track once they are housed

New Minority AIDS Initiative Funding Opportunity - May 2014

Housing and Health Connection Recorded Webinar Available

The ACA's Impact And The Implications Of State Choices

[more](#)

Events

Oct. 2-5 U.S. Conference on AIDS