HRSA
Health Resources & Services Administration

Unstable Housing, Substance Use, and Serious Mental Illness

2020 National Ryan White Conference on HIV Care and Treatment

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Vision: Healthy Communities, Healthy People

Disclosures

- Serena Rajabiun, Lisa McKeithan, Kate Bennett, Jasmine Agostino, Carolyn Yorio, Susan McIlvain, and Nicole Chavis have no relevant financial or non-financial interests to disclose.

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Learning Objectives

- Improve RWHAP Part A-F recipients' understanding of how unstable housing, substance use disorder (SUD), and serious mental illness (SMI) affects HIV health outcomes.
- Highlight innovative strategies to improve viral suppression rates in clients experiencing a combination of HIV, unstable housing, SUD, and SMI.
- Highlight which portfolio of services can work to improve HIV health outcomes in clients experiencing unstable housing, along with SUD and SMI

Health Resources and Services Administration (HRSA) Overview

- Supports more than 90 programs that provide health care to people who are geographically isolated, economically or medically vulnerable through grants and cooperative agreements to more than 3,000 awardees, including community and faith-based organizations, colleges and universities, hospitals, state, local, and tribal governments, and private entities

- Every year, HRSA programs serve tens of millions of people, including people with HIV/AIDS, pregnant women, mothers and their families, and those otherwise unable to access quality health care

HRSA's HIV/AIDS Bureau (HAB) Vision and Mission

Vision

Optimal HIV/AIDS care and treatment for all.

Mission

Provide leadership and resources to assure access to and retention in high quality, integrated care, and treatment services for vulnerable people with HIV/AIDS and their families.

HRSA
Ryan White HIV/AIDS Program

HRSA's Ryan White HIV/AIDS Program

- Provides comprehensive system of HIV primary medical care, medications, and essential support services for low-income people with HIV
    - More than half of people with diagnosed HIV in the United States – nearly 519,000 people – receive care through the Ryan White HIV/AIDS Program (RWHAP)
- Funds grants to states, cities/counties, and local community based organizations
    - Recipients determine service delivery and funding priorities based on local needs and planning process
- Payor of last resort statutory provision: RWHAP funds may not be used for services if another state or federal payer is available
- 87.1% of Ryan White HIV/AIDS Program clients were virally suppressed in 2018, exceeding national average of 62.7%

Source: HRSA. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2018; CDC. HIV Surveillance Supplemental Report 2018;21(No. 4)

Unstable Housing, Substance Use, and Serious Mental Illness

- **Overview of Unstable Housing, Substance Use, and Serious Mental Illness in the Ryan White HIV/AIDS Program (RWHAP)**
  - Jasmine Agostino, Public Health Analyst, Homeless and Housing Workgroup (HHWG)
- **The RWHAP Response**
  - Nicole Chavis, Public Health Analyst, HHWG member
- **What are the issues and solutions?**
  - Serena Rajabiun, University of Massachusetts
- **Programs that work!**
  - Lisa McKeithan, CommWell Health, North Carolina
  - Kate Bennett, Cincinnati Health Network; Susan McIlvain; and Carolyn Yorio

Overview of Unstable Housing, Substance Use, and Serious Mental Illness in the Ryan White HIV/AIDS Program (RWHAP)

Why are Housing Concerns Important to the RWHAP?

- For persons who lack a safe, stable place to live, housing assistance is a proven cost-effective health care intervention.
- Stable housing has a direct, independent, and powerful impact on HIV incidence, health outcomes, and health disparities.
- Housing status is a more significant predictor of health care access and HIV outcomes than individual characteristics, behavioral health issues, or access to other services.

Taken from the US. Housing and Urban Development Publication, *HIV CARE CONTINUUM The Connection Between Housing And Improved Outcomes Along The HIV Care Continuum (2013).* Available for download at https://www.hudexchange.info/resources/documents/The-Connection-Between-Housing-and-Improved-Outcomes-Along-the-HIV-Care-Continuum.pdf

Clients Served by the Ryan White HIV/AIDS Program, by Housing Status, 2018—United States and 3 Territories[a]

5.3%
7.7%
87.0%

N=501,478

- Stable
- Temporary
- Unstable

[a] Guam, Puerto Rico, and the U.S. Virgin Islands.

Clients with HIV Infection Attributed to Injection Drug Use Aged ≥13 Years Served by the Ryan White HIV/AIDS Program, by Housing Status, 2018—United States and 3 Territories[a]

Housing status	Percentage
Stable	79.4%
Temporary	10.8%
Unstable	9.9%

N=29,479

Data represent clients who reported injection drug use as their transmission risk category; data may not reflect current behavior.
Data do not include male-to-male sexual contact *and* injection drug use nor sexual contact *and* injection drug use among transgender clients.
[a] Guam, Puerto Rico, and the U.S. Virgin Islands.

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Viral Suppression among Clients with HIV Infection Attributed to Injection Drug Use Aged ≥13 Years Served by the Ryan White HIV/AIDS Program, 2018—United States and 3 territories[a]

Group	Viral suppression (%)
IDU overall N=20,672	86.4
20-24 years N=106	68.9
25-29 years N=426	72.3
30-34 years N=691	75.7
35-39 years N=1,079	77.3
40-44 years N=1,300	79.1
No health care coverage N=2,039	77.8
Temporary housing N=1,988	79.4
Unstable housing N=1,574	71.8

RWHAP overall (87.1%) N=359,101

≥5 Percentage points lower than IDU overall

Viral suppression (%)

IDU, injection drug use.
Data represent clients who reported injection drug use as their transmission risk category; data may not reflect current behavior. Data do not include male-to-male sexual contact and injection drug use nor sexual contact and injection drug use among transgender clients.
N represents the total number of clients in the specific subpopulation.
Viral suppression is defined as ≥1 OAHS visit during the calendar year and ≥1 viral load reported, with the last viral load result <200 copies/mL.
[a] Guam, Puerto Rico, and the U.S. Virgin Islands.

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Turning to Research….

"HIV prevalence for individuals receiving mental health services was about 4 times as high as in the general population"

- Blank, M. B., Himelhoch, S. S., Balaji, A. B., Metzger, D. S., Dixon, L. B., Rose, C. E., et al. (2014). Multisite study of the prevalence of HIV with rapid testing in mental health settings. American Journal of Public Health, 104(12), 2377–2384

"Greater chronicity of depression increased the likelihood of failure at multiple points along the HIV care continuum. Even modest increases in the proportion of time spent with depression led to clinically meaningful increases in negative outcomes"

- Pence, B. W., Mills, J. C., Bengtson, A. M., Gaynes, B. N., Breger, T. L., Cook, R. L., et al. (2018). Association of increased chronicity of depression with HIV appointment attendance, treatment failure, and mortality among HIV-infected adults in the United States. The Journal of the American Medical Association Psychiatry. https ://doi.org/10.1001/jamapsychiatry.2017.4726 (Published online February 21, 2018)

"Likewise, mental illness and substance abuse are known predictors of both homelessness and unstable housing and health outcomes."

- Aidala, Angela A et al. "Housing Status, Medical Care, and Health Outcomes Among People Living With HIV/AIDS: A Systematic Review." American journal of public health 106.1 (2016): e1–e23. Web.

The Ryan White HIV/AIDS Program Response

Program Implementation: Housing Provision

Flexibility allowed to address the housing needs. These service categories are listed on the HAB webpage in Policy Clarification Notice (PCN) 16-02: Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds

- **Housing Services:** transitional, short-term, or emergency housing assistance as well as housing referral services (assessment, search and placement) and housing advocacy services for clients.
  - ✓ Individualized housing plan updated annually
  - ✓ Can be incorporated within another core or support service
- **Emergency Financial Assistance:** limited one-time or short-term payments to assist with an urgent need for essential items or services necessary to improve health outcomes, including utilities and housing

Program Implementation: Behavioral Health Services

Mental Health Services

- Outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients with HIV

Substance Abuse Outpatient Care

- Outpatient services for the treatment of drug or alcohol use disorders. Activities under Substance Abuse Outpatient Care service category including screening, assessment, diagnosis, and/or treatment

Substance Abuse Services (Residential)

Treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder

PCN 16-02: Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

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Program Implementation: Ancillary Services

Implementing programs to address homelessness should include either directly funded or leveraged support services to address trauma, substance use, mental illness, health literacy, special health needs, etc. Some relevant service categories or activities may include:

- Medical Case Management
- Non-Medical Case Management – focus on accessing services such as employment and education centers and permanent housing
- Mental Health Services
- Peer Navigators
- Support Groups
- Specialized medical care

Demonstration and Evaluation – Special Projects of National Significance (SPNS)

SPNS

- Supports the development of innovative models of HIV care in response to emerging needs of clients served by RWHAP
- Implements and evaluates effectiveness of models, and promotes replication of successful interventions

Building a medical home for multiply diagnosed HIV positive homeless individuals, 2012 – 2017

- Employed models of care focused on the development of sustainable linkages to mental health, substance abuse treatment, and HIV primary care services for homeless or unstably housed people with HIV
- Interventions adopted a set of organizational structures characterized by integrated or co-located strategies for service provision

Resources

- For more information about the SPNS Program: https://hab.hrsa.gov/about-ryan-white-hivaids-program/part-f-special-projects-national-significance-spns-program
- For information about specific interventions: https://targethiv.org/ihip

Addressing homelessness, mental health and substance use in people with HIV

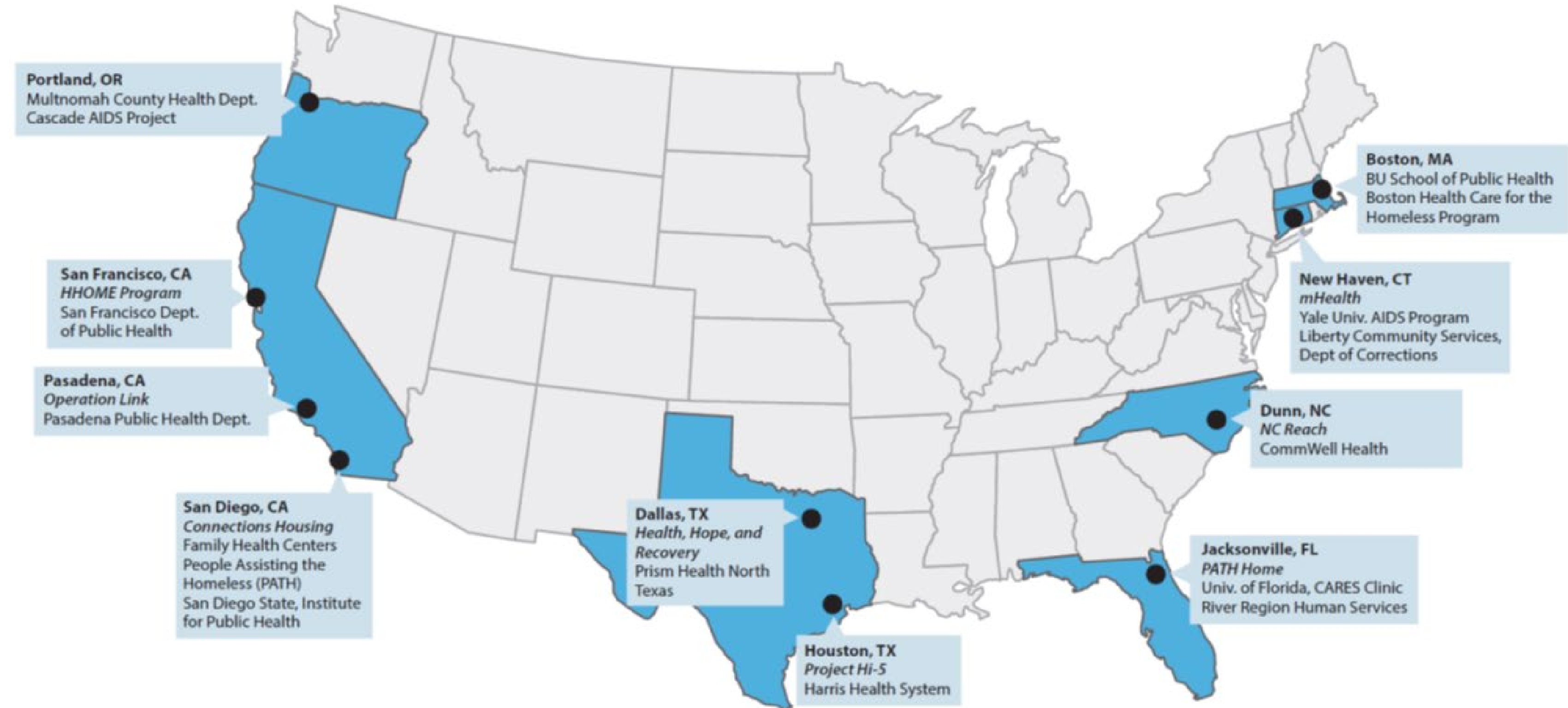
Lessons from the HRSA/SPNS Initiative Building a Medical Home for Multiply Diagnosed HIV-Positive Homeless Populations

Serena Rajabiun, PhD

University of Massachusetts, Lowell

Initiative goals

- Increase engagement and retention in HIV primary care
- Improve viral suppression rates
- Obtain stable housing



Intervention model

- Patient-centered medical home (PCMH) framework
    - Comprehensive, coordinated, accessible, quality care

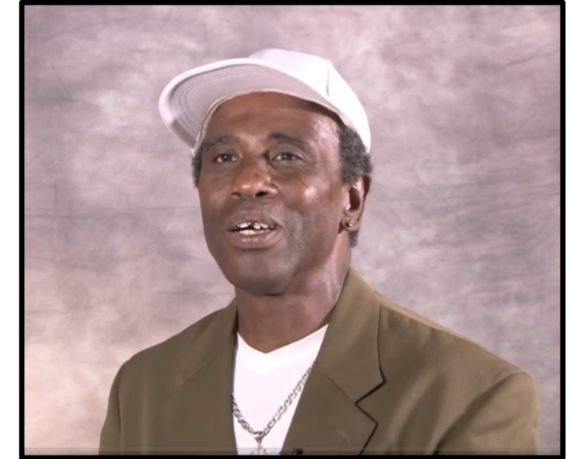
- Integrated behavioral health & HIV primary care and treatment
- Network navigators (e.g. care coordinators, peer navigators, service linkage workers)
- System level coordination (housing, health, behavioral health providers)
- Partnering with housing providers & landlords
- Reuniting with families

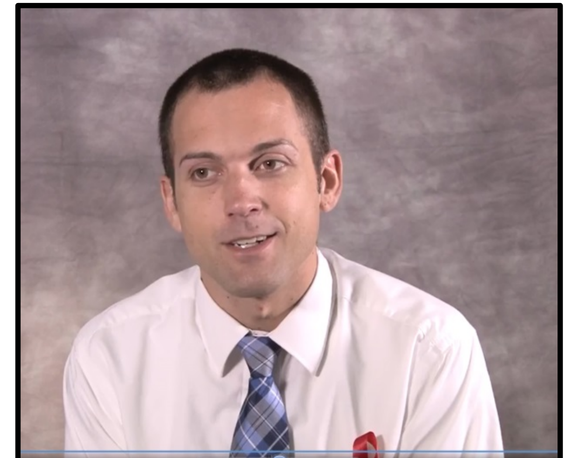
Focus Population

- Persons living with HIV/AIDS who are 18 years of age or older;
- **AND** are experiencing homelessness or unstable housing
  - Literally homeless,
  - Unstably housed,
  - Fleeing domestic violence;
- **AND** have one or more co-occurring mental health and/or substance use disorders

Overview SPNS Participants

- 1,332 clients served
- Gender
  - 75% Male
  - 21% Female
  - 4% Transgender
- Race/Ethnicity
  - 47% African-American/Black
  - 17% Hispanic
- Average (SD) years experiencing homelessness: 6.4 (8.4)



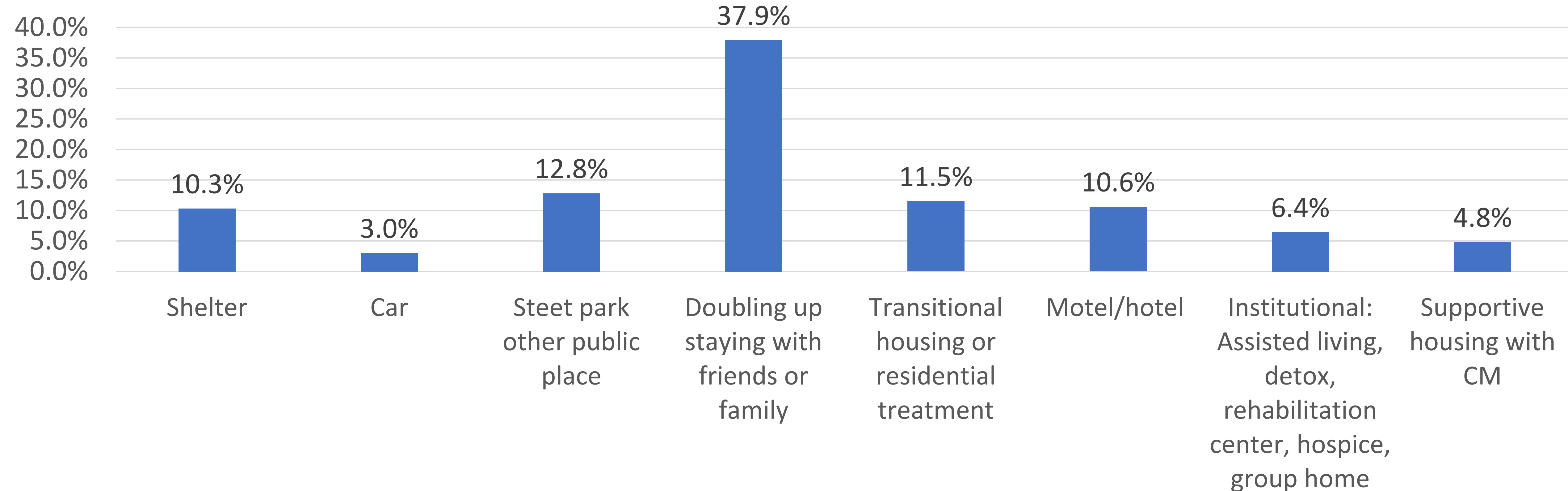


SPNS Participants Characteristics

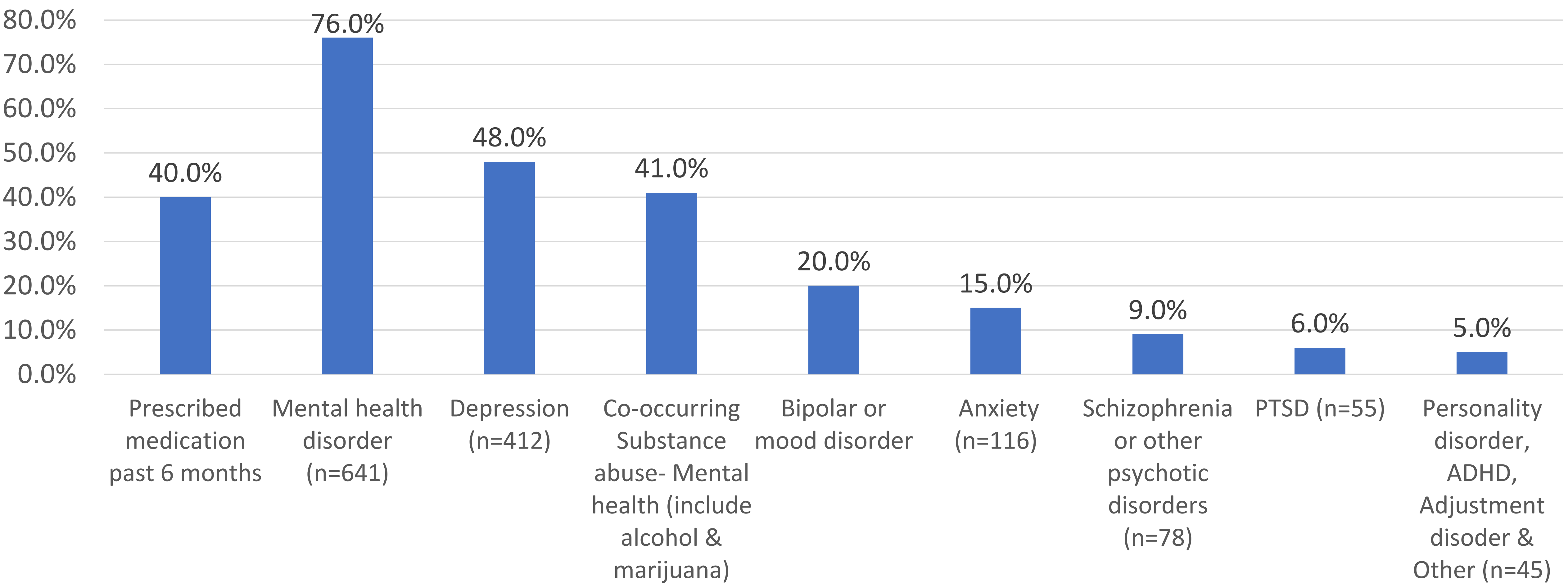
Characteristics	%
Incarceration history	81%
Diagnosed mental health condition*	75%
Experienced sexual assault	40%
Experienced physical injury	44%
Illicit substance use, ever	
High risk (dependence)	24%
Moderate risk (problem)	78%
Food insecure, past 30 days	59%
Out of care, 6+ months	32%
Experienced HIV stigma, ever	>50%

*Includes depression, anxiety, schizophrenia, and PTSD

Housing categories



Participant diagnoses at baseline (n=855)



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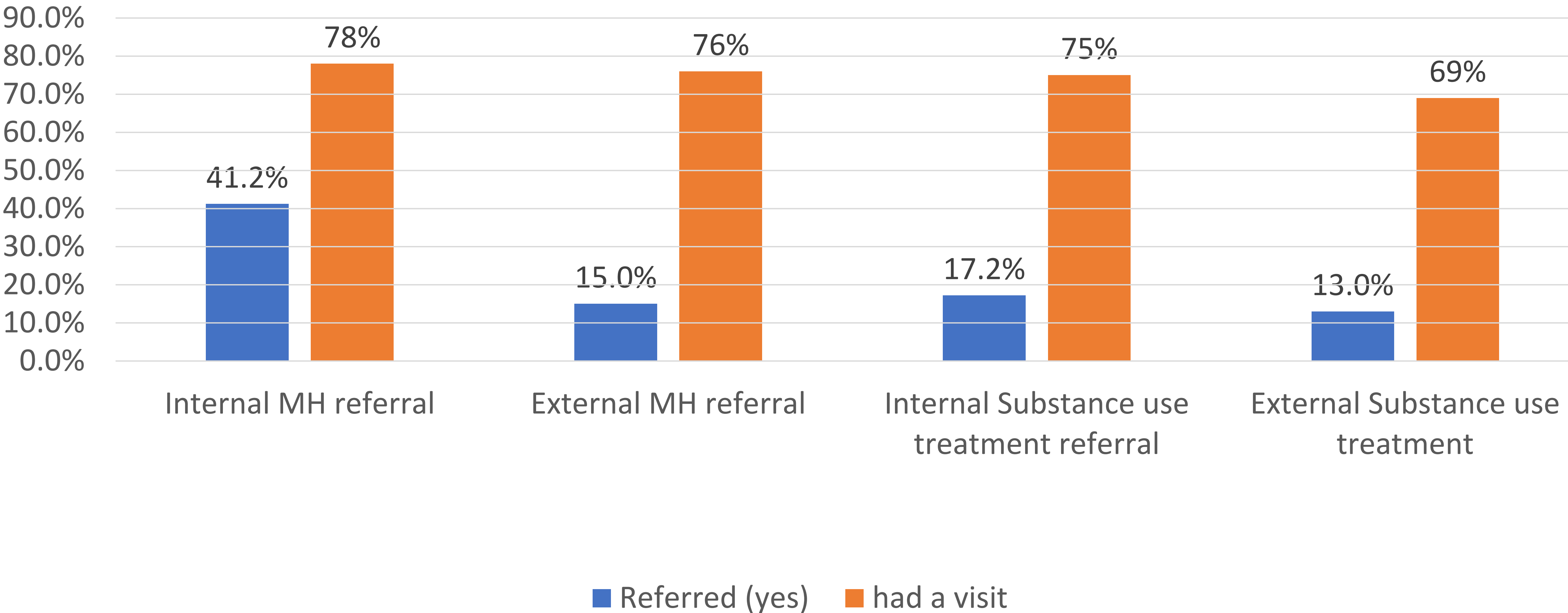
30 YEARS

Referrals made to MH & Substance Treatment



30 YEARS
VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Reduction in Unmet Needs

	Baseline (N=909)	6months (N=629)	12months (N=542)
Housing	55%	45%	41%
Transportation	23%	15%	12%
Substance use treatment	18%	12%	11%
Mental health treatment	21%	10%	15%

Changes in Viral Suppression

	Virally suppressed	Virally detectable
Baseline (n=774)	51%	49%
12 months (n=745)	70%	30%

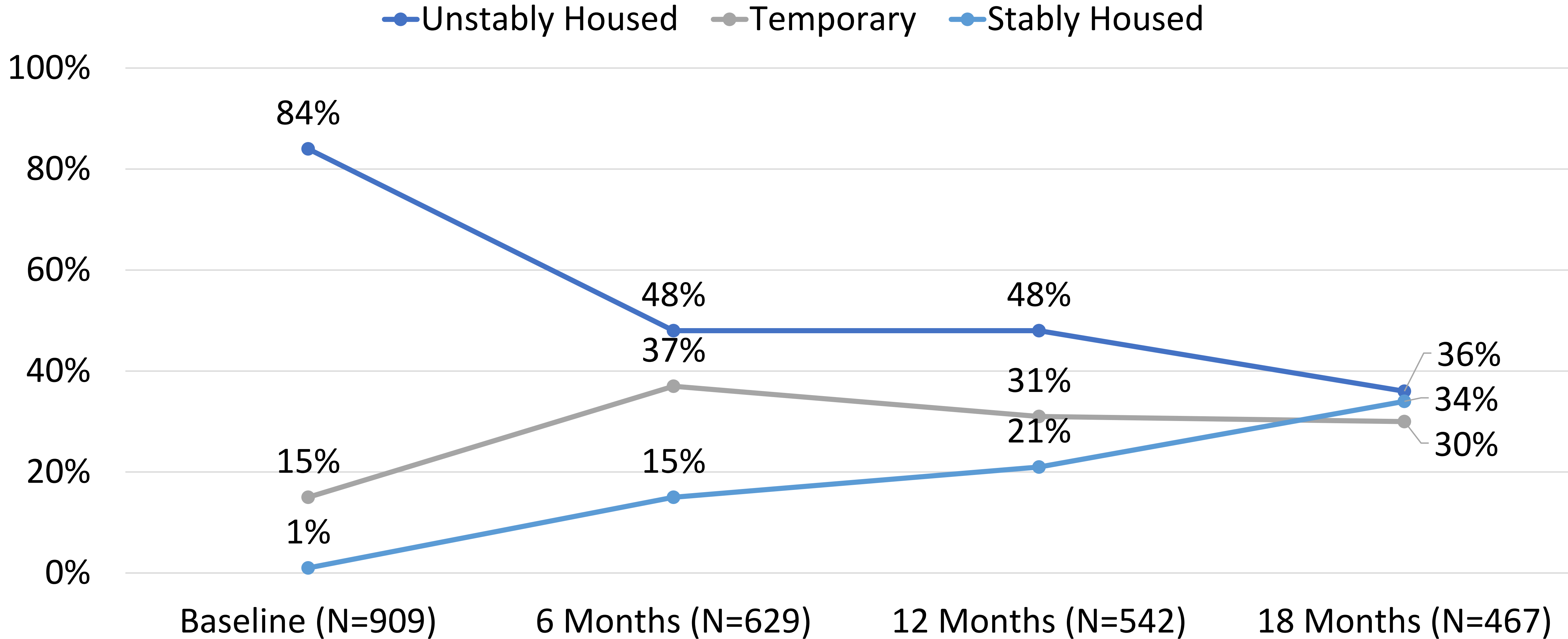
* Lowest VRL Prior to Enrollment (<200 copies/mL), 180 days prior to enrollment to 30 days post enrollment
** Most recent VRL Load (<200 copies/mL) in post 12 month period** 30 to 395 days post enrollment

HIV Care Continuum (N = 334)

Category	Percentage
Linked to care	84%
Retained in care	74%
Prescribed ART	90%
Virally suppressed	71%

- **Linked to care:** Person out of care for at least 6 months or newly diagnosed at enrollment and connected in 90 days
- **Retention in care:** 2 HIV medical visits 90 days apart in 12 month period
- **Viral suppression (n=290):** Most recent lab test in a 12 month period, <200 copies/mL

Changes in Housing Status



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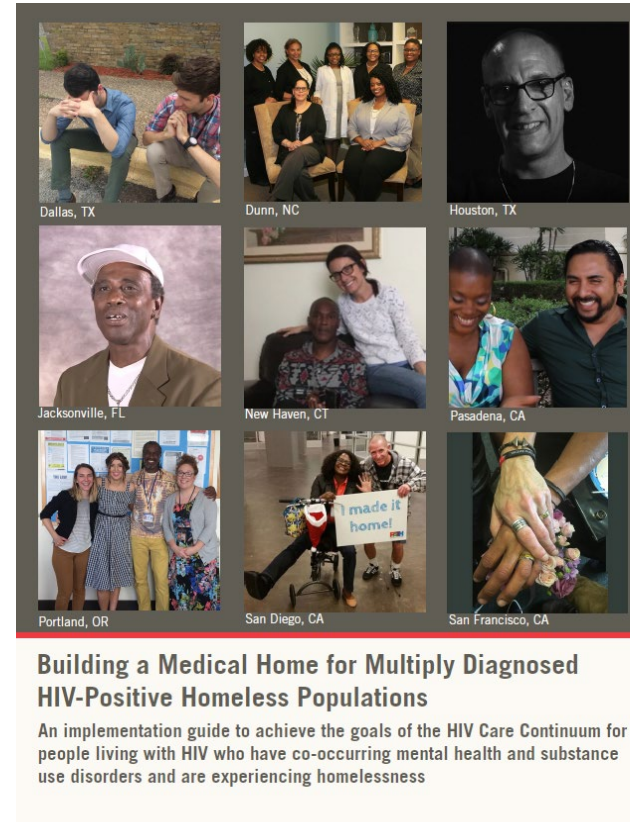
30 YEARS

Key Components for Replication

- Mobile and team-based care
- Open access to integrated services:
  - HIV primary care, substance use treatment and mental health, housing, and social services
- Frequent team huddles and communication
- Acuity assessments and integrated care plans
- Trauma-informed and welcoming culture that understands the needs of people living with HIV and experiencing homelessness

Resources

- Implementation manuals & videos
  - Building a Medical Home for Multiply Diagnosed HIV-Positive Homeless Populations Implementation Manual
- Journal Articles
  - American Journal of Public Health, December 2018



For more information about the Building a Medical Home for Multiply Diagnosed HIV-Positive Homeless Populations Initiative: https://ciswh.org/project/medheart/models-of-care

THANK YOU!

VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

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Unstable Housing, Substance Use Disorder, and Serious Mental Illness Among People With HIV

Lisa McKeithan
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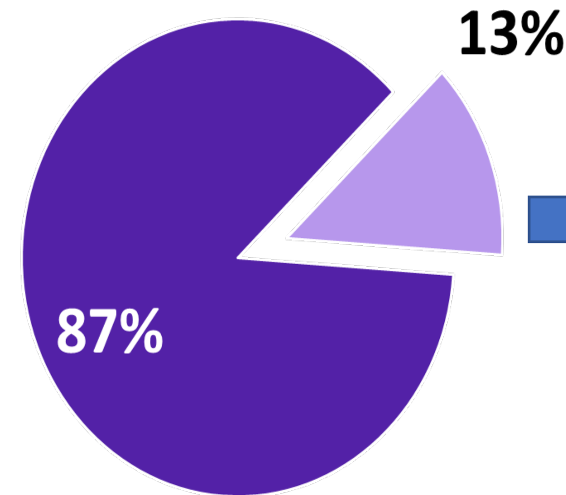
NC REACH: SPNS Program

- Innovation
  - Build and maintain sustainable linkages to mental health, substance abuse treatment, and HIV/AIDS primary care services that meet the complex service needs and ensure adherence to treatment of HIV positive homeless or unstably housed individuals.
    - Network navigators
    - Behavioral health
    - Housing services
    - Comprehensive care coordination team (Positive Life Program)

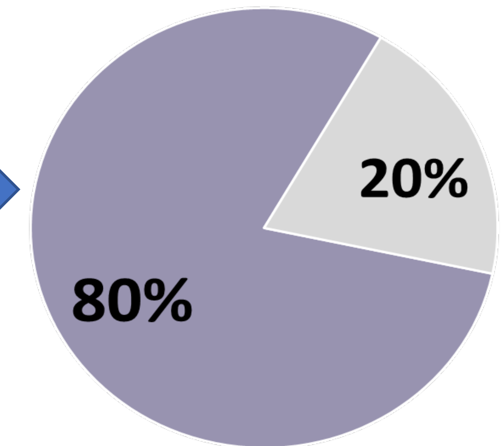
Results

- Total enrolled : 80 clients
- VL suppression: 83%
- Patients transitioned to SOC: 74%
- Patients lost to follow up: 3%
- BH/SA referral and completed one (1) visit: 100%

Viral Suppression at 12 months



HIV Care Status within 180 Days in Patients with Detectable Viral Loads



Network Navigators

1. Provide comprehensive assessment of the patient's needs and determine an appropriate (care) plan
   - *Acuity scale to evaluate housing, mental health, substance abuse, etc.*
2. Offer support services & plans for need/problem resolution
3. Collaborates with HIV Medical Treatment Team
4. Assist with scheduling patients for their appointments and assess transportation needs

Standard of Care

Participate	Develop	Work	Maintain
Participate Team Communication/Weekly Huddles and Meetings with medical provider, BH, & SA counselors	Develop and maintain collaborative relationships with agencies that serve PLWH (i.e. housing, mental health, substance abuse and psychosocial support services)	Work collaboratively with other service providers to develop individual client goal plans and provide intensive support to clients in carrying out their goal plan.	Maintain a strong working knowledge of HIV medical treatment and community resources

Role of Case Managers

- Providing Emotional Support
- Navigation of Systems & Coordination of Services
- Support Retention In Care

Challenges

Individual

- Active/increased substance use
- Untreated mental illness
- Incarceration history
- Trauma
- Stigma
- No or limited income
- Bad credit history
- Frequent visits to ER
- Weak employment history
- Not as adherent to HIV meds
- Comorbidities such as Hep C, diabetes, hypertension, and depression

System

- Lack of **permanent, affordable** housing
- Lack of availability of behavioral health care
- Fragmented system
  - Poor coordination

Lessons Learned…

- Integration of HIV care and housing services in a coordinated intervention
- Reduction of duplication of services, unmet needs and barriers to care
- Community based education about “hidden homelessness”, HIV, ART, prevention, discrimination and stigma
- Establishing relationships with non-traditional landlords
- Reconciliation with family members

Thank you

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Cincinnati Health Network

Greater Cincinnati HIV Collaborative

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RW Part B Program

Program Overview

Barriers to care:

- Homelessness
- Substance use disorders
- Mental illness

Target population parameters:

- VL +200
- PHQ-9 >10
- Lost to follow-up

Interventions Identified:

- Create multi-directional communication channels
- Strengthen agency partnership collaboration

Critical Interventions

- Trauma Informed Care – patients, clients, staff
- Collaborative Care
- Evidenced based psychotherapies
- Housing First model
- Motivational Interviewing
- Harm Reduction
- Addiction Therapies
- Empowering Self care

Questions and Answers

Ryan White HIV/AIDS Program

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