Harlem United’s Maintenance in Care Program

“Breaking Down Barriers to Care”

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Integrated Care Model

Supportive Housing Programs
- Case Management, Primary Care Support, Treatment Education, Mental Health Services, Substance Use Counseling, Advocacy, Structured Socialization
- HRA Housing (Scatter-Site)
- Women’s Housing (Scatter-Site)
- HUD Housing (Scatter-Site)
- Transitional Housing (Scatter-Site)
- Emergency Congregate Housing (Foundation House North & South)
- Permanent Congregate Housing
- Building Bridges Mental Health Program
- Vocational Education Program

Prevention Services
- Black Men’s Initiative Individual, Group and Community Level Interventions targeting Men of Color Who Have Sex With Men
- Youth Development for Health, for Young Men of Color Who Have Sex with Men
- FROST’D @ Harlem United
  - Harm Reduction ♦ Syringe Exchange ♦ HIV/HCV Testing and Linkage to Care and Treatment ♦ Overdose Prevention
  - Testing Services
    - Rapid HIV testing: Risk and Zone Based approaches ♦ STD and Hepatitis C Screening ♦ Innovative Recruitment Strategies ♦ Connection to Healthcare ♦ ADAP & Medicaid Enrollment ♦ Uptown Health Link: HIV Awareness and Prevention Services for Upper Manhattan ♦
    - Peer Training Services

Federally Qualified Health Center & Related Services
- Dental Clinic
- Supportive Housing Programs
- Prevention Services
- Supportive Housing Programs

Adult Day Health Center West
- Medical Care, Adherence Support, Nutrition Counseling, Substance Use Counseling, Structured Socialization, Pastoral Care,

Adult Day Health Center East
- Fully Bilingual (Spanish/English) Case Management, Treatment Education, Support Groups, Harm Reduction Counseling, Auricular Acupuncture,
- Primary Care Support

Healthcare for the Homeless
- Healthcare & related services for the homeless in Central & East Harlem

COBRA Case Management
- Assessment, Intensive Case Management, Advocacy, Crisis Intervention

Evening Food & Nutrition
- Nutritional Assessment and Support, Treatment Education, Psycho-Social Support

Mental Health Services
- Crisis Intervention, Individual and Group Psychotherapy, Medication Management, Expressive Therapies
Learning Objectives

- Provide methods on how to outreach hard to engage clients into care
- Educate community based staff/consumers on the importance of meeting people where they are in terms of healthcare
- Provide techniques on how to reduce barriers to healthcare

Maintenance in Care
Program Goal & Objectives

Goal: Reduce HIV-related morbidity by assisting PLWHA out of care or with sporadic care to access and engage in HIV medical services and specialty care.

Connect or re-connect individuals to HIV primary care provider within 60 days of enrollment

For clients who could not be connected to care within 90 days of enrollment, connection with supportive services (e.g. substance abuse treatment, mental health services, and housing)

Maintain client engagement (i.e., minimum of 3 visits per 14 months) with HIV primary care provider and/or medical specialty care
Who is Eligible

Return to Care:
- Persons lost to follow-up (out of care) for 9 months or longer or with a pattern of sporadic primary care attendance (fewer than 3 primary care visits in a 14 month period).

Maintenance in Care:
- Persons at risk of dropping out of primary medical care due to adverse circumstances such as loss of benefits, homelessness or imminent homelessness; or co-morbidities such as an acute mental health episode or severe mental illness, or active drug use.
Program Services

- Medical driven case finding
- Outreach
- Brief assessment of need
- Goal driven service plan, demonstrating need for enrollment
- Quarterly re-assessment and service plan update
- Accompaniment and other strategies for getting patients to their scheduled appointments
- Information and education
- Referral for services which are necessary for engagement in primary care, and follow-up on referrals
Selling Point to Other Agencies

- An MOU between Harlem United and the referring agency will be developed, clearly stating that all clients will be returned to the referring agency’s primary care program. This will enable us to form partnership, so that we can work together to reduce health disparities and connect & re-connect hard to engage clients into care.
How to Outreach Hard to Engage Clients into Care

- Take time to listen to what they are saying
- Allow them to be themselves

- Do not make promises you can not keep
- Do not miss your appointments—keep your word

- Most times they receive bad news when going to their primary care provider
- Their anxieties are real to them
Techniques on Reducing Barriers to Healthcare

**Substance Users**
- Learn what is their drug of choice and educate on harm
- Schedule appointments when you know they are sober

**Children in the Family**
- Learn children school schedules
- Schedule appointment while children are in school

**HIV/AIDS Disclosure Issues**
- Ensure that confidentiality is kept
- Honor identified ways of contact
- Do not force your values on your clients
Contacts Made
Kevin is a 32 year old male diagnosed with HIV five years ago. He contracted the virus via heterosexual contact. He has not returned to his primary care provider for two years because every time he attended his appointment his CD4 levels were reducing. He knows he should receive primary care but is afraid of what his doctor will tell him.

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<tr>
<th>What techniques will you employ to address this issue?</th>
<th>How will you deal with Kevin if he tells you he drinks all night long but wants to go to the doctor?</th>
<th>How would establish a relationship with Kevin?</th>
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Questions

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