VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Design for the Margins: HIV Care at the Intersections of Homelessness, Substance Use Disorder, and Incarceration

Boston Health Care for the Homeless Program

Jennifer Brody, MD, MPH, AAHIVS, Director of HIV Services

Natasha Vargas, LCSW, Outreach Social Worker

Sabra Johnson, Medical Case Manager/Re-Entry Specialist

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM

Disclosures

- Jennifer Brody, Sabra Johnson and Natasha Vargas have no relevant financial or non-financial interests to disclose.
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Learning Outcomes

At the completion of this activity, participants will be able to:

- Identify structural vulnerabilities for homeless people living with HIV who use drugs and have been incarcerated
- Apply the principle of "design for the margins" to HIV programming and consider equity implications for your own program.
- Identify key engagement and retention strategies for homeless people living with HIV who use drugs and are involved in the carceral system

Agenda

- Provide a brief overview of Boston Health Care for the Homeless (BHCHP)'s HIV program
- Describe intersecting structural forces that create hypervulnerabilities for homeless people living with HIV
- Using a patient case, discuss BHCHP's programmatic response to a new cluster of HIV in homeless people who use drugs and experience incarceration in Boston, MA
- Review the principle of "design for the margins", and discuss how to operationalize this strategy using a racial and social justice framework
- Describe core components of BHCHP's HIV team model
- Discuss program outcomes, lessons learned and ongoing challenges
- Q and A

A Case: Mr. TC

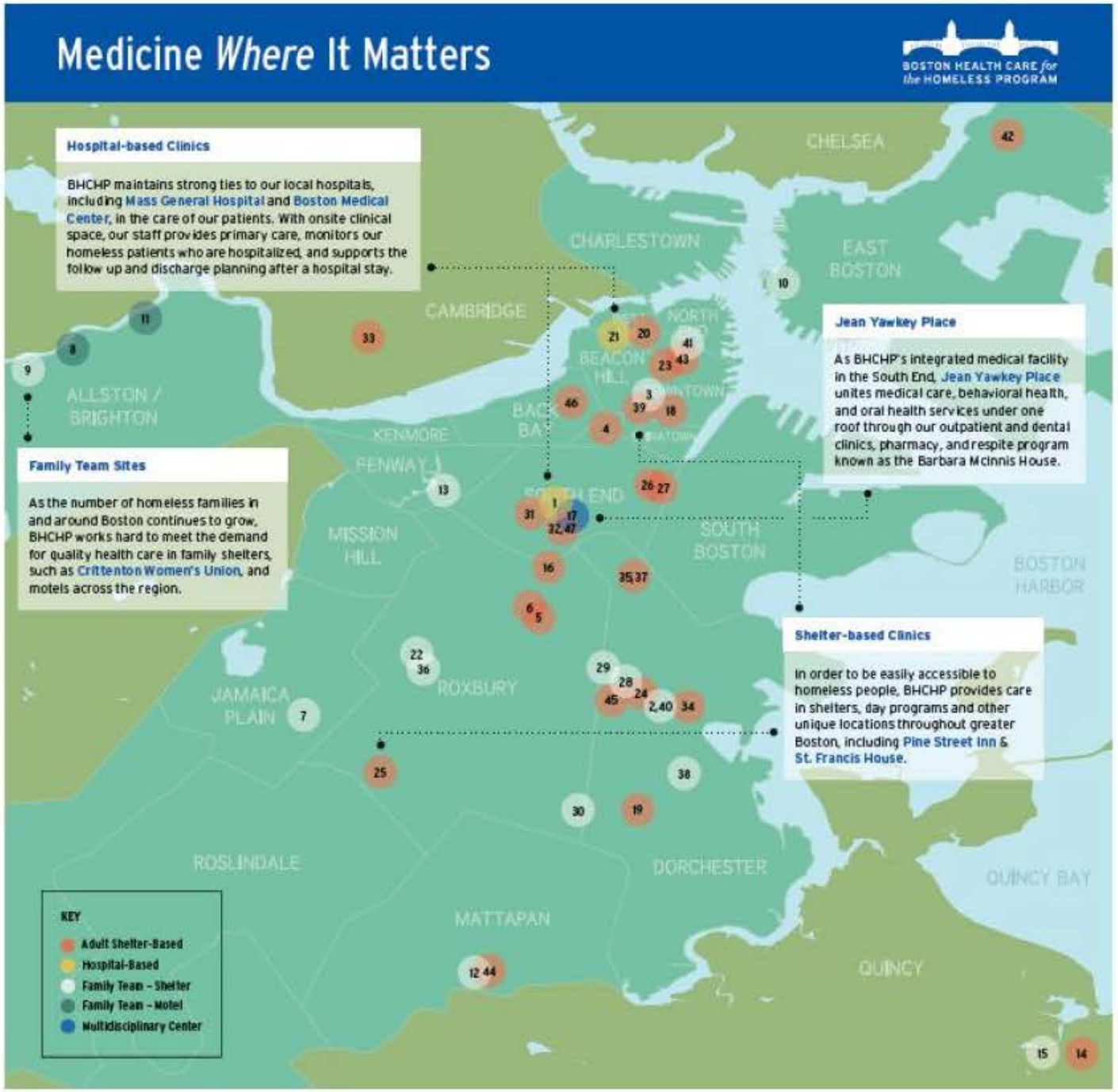
- Mr. TC is a 26 yo man with a past medical history of hepatitis C, polysubstance use disorder (IV methamphetamines and opioids including fentanyl), currently street homeless, with a history of incarceration and a minimal prior engagement with the medical system. He was referred to BHCHP for HIV primary care after receiving a positive rapid HIV test at a nearby syringe services program. Last opioid related overdose was 1 month prior to presentation. He identifies as White.

BHCHP: Delivering Care Since 1985

- Founded 30 years ago by the Robert Wood Johnson Foundation and Pew Charitable Trusts
- Maintains strong partnerships with the Boston medical community, homeless service organizations, and city and state government
- Provides care to more than 11,000 homeless men, women and children every year, making it the largest program of its kind in the country
- Has grown into a national model of care, emulated in cities throughout the U.S.

Medicine *Where* It Matters

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM



1 Boston Medical Center
2 Bridge Home
3 Bridge Over Troubled Waters
4 Cardinal Medeiros Center
5 Casa Esperanza Men's Program
6 Casa Esperanza Women's Program
7 Casa Nueva Vida
8 Charles River Hotel
9 Crittenton Women's Union
10 Crossroads Family Shelter
11 Days Hotel
12 Entre Familia
13 Families in Transition
14 Father Bill's Place
15 Friends of the Unborn
16 Hope House
17 Jean Yawkey Place
18 Kingston House
19 Kit Clark Adult Day Health
20 Lindemann Mental Health Center
21 Massachusetts General Hospital
22 Nazareth Residence
23 New England Center For Homeless Veterans
24 Pilgrim Shelter
25 Pine Street Inn at Shattuck
26 Pine Street Inn Men's Clinic
27 Pine Street Inn Women's Clinic
28 Portis Family House
29 Project Hope
30 ReVision House
31 Rosie's Place
32 Safe Harbor
33 Salvation Army
34 Shepherd House
35 SOAR
36 Sojourner House
37 Southampton Street Shelter
38 St. Ambrose
39 St. Francis House
40 St. Mary's Center for Women & Children
41 Temporary Home for Women and Children
42 The Eighth Pole at Suffolk Downs
43 The Night Center
44 Transitions
45 Women's Hope
46 Women's Lunch Place
47 Woods Mullen Shelter

Not shown:
- Alleyways, park benches, under bridges
- Asian Task Force Against Domestic Violence *(Boston)*
- Colonial Traveler *(Saugus)*
- Finex House *(undisclosed location)*
- Holiday Inn *(Brockton)*
- Home Suites Inn *(Waltham)*
- New England Motor Court *(Malden)*
- Paul Sullivan Housing *(varied)*
- Super 8 Hotel *(Brockton)*
- Town Line Inn *(Malden)*

*as of June 2015

30 YEARS
VIRTUAL
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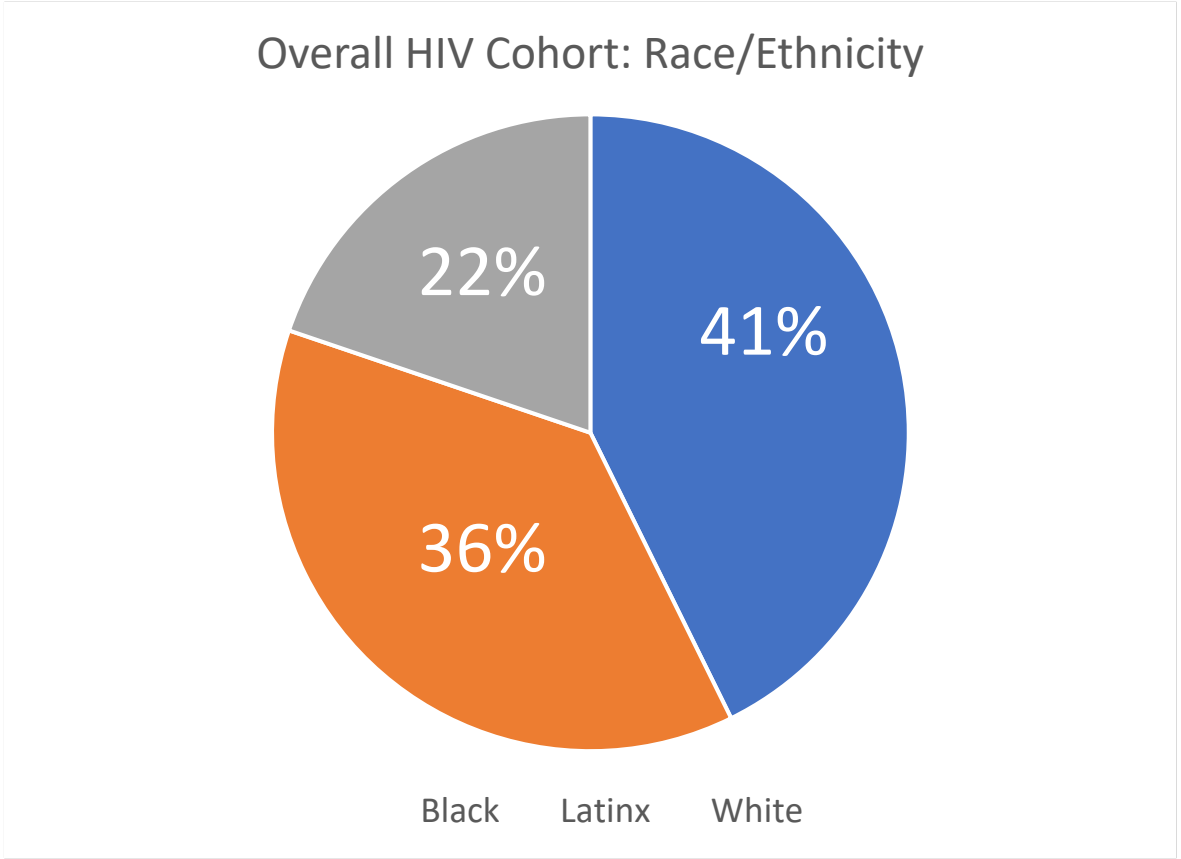
BHCHP HIV Team Overview and Funding

- Multidisciplinary primary care for approximately 300 people living with HIV, experiencing homelessness or unstable housing in the Greater Boston Area
- Funded by Ryan White Part A, C, Massachusetts Department of Public Health (via Part B funding).
- Some of BHCHP wide interventions are funded by Substance Abuse and Mental Health Services Administration (SAMHSA), as well as foundations and private sources.

BHCHP HIV Program Demographics

- 77% People of Color
  - 22% monolingual Spanish speakers
- 72% men, 24% women, 4% transgender
- Avg age 51 years
- Most common mode of transmission: injection drug use (42%)
- 84% with prior or active substance use disorder (SUD)
  - 46% active opioid use disorder
- 75% with diagnosed mental illness
- 10% with incarceration of >30 days in last 12 months
- 100% homeless-experienced (77% homeless/unstably housed; 23% stably housed)



Boston HIV Cluster

- Rise in cases of HIV among homeless people who inject drugs (PWID) in Boston beginning in November 2018.
  - Approx 90 new diagnoses 11/2018-2/2020
- BHCHP has diagnosed/been linked to 24 newly HIV infected homeless PWID since 2018 (19 in last 6 months).
- Many diagnoses occurred during hospital admissions for drug related health care issues (not via screening programs)

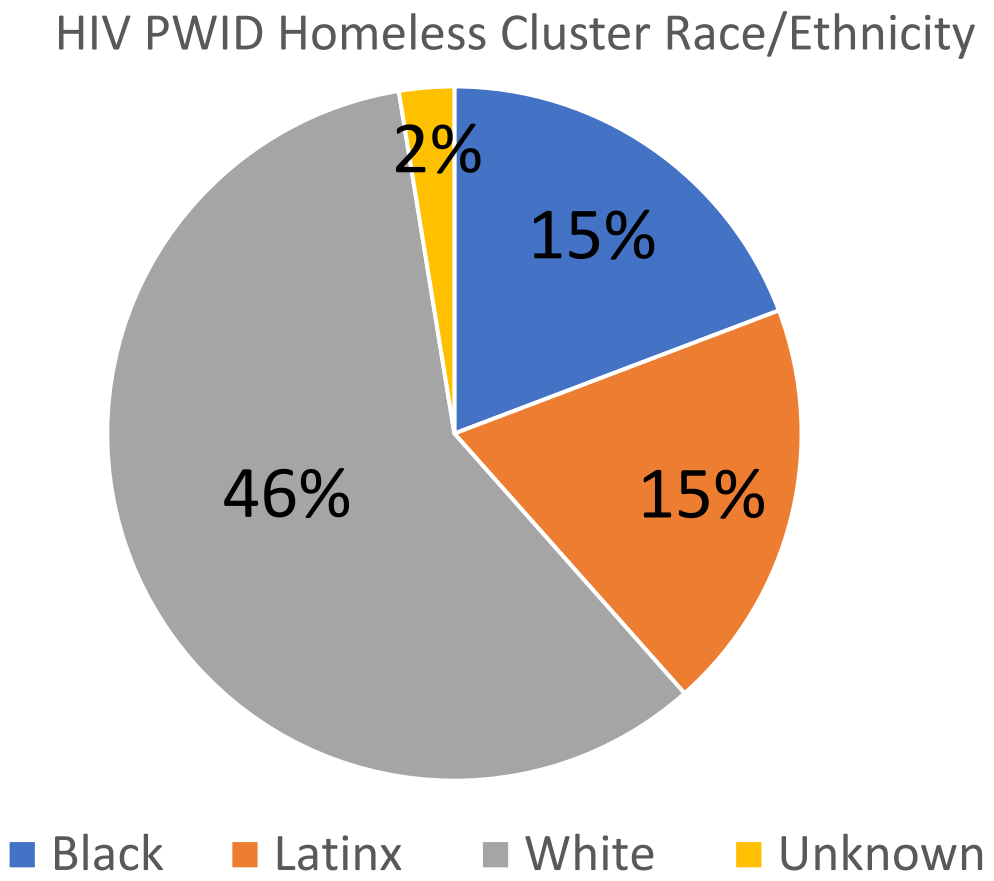
(*Photo: Boston Globe*)

HIV Cluster Demographics

- Near universal HCV exposure, poor health care engagement, high rates recent or current incarceration, drugs used include opioids and methamphetamines

BHCHP Engaged Cluster Cohort (n=13):

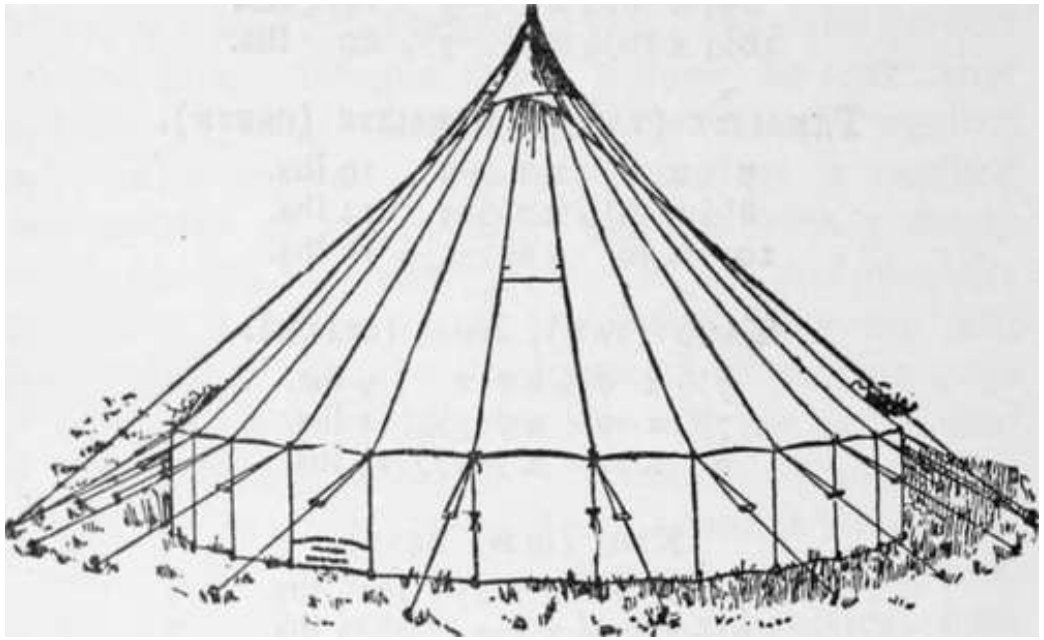
- Avg age 40
- 15% women/85% men
- 100% active OUD



Design for the Margins

- "What we tend to do in this world is design for the middle and forget about the margins…***Actually it's in the margins that we have to concentrate our design.*** If you pay attention to the margin, and design for them, you cover the middle. Like a tent…the further out you stake it, the stronger the structure you get. Why is that? Because people at the margins are living with the failures of the systems…***So when we design to take care of them, we build stronger systems for everyone."***

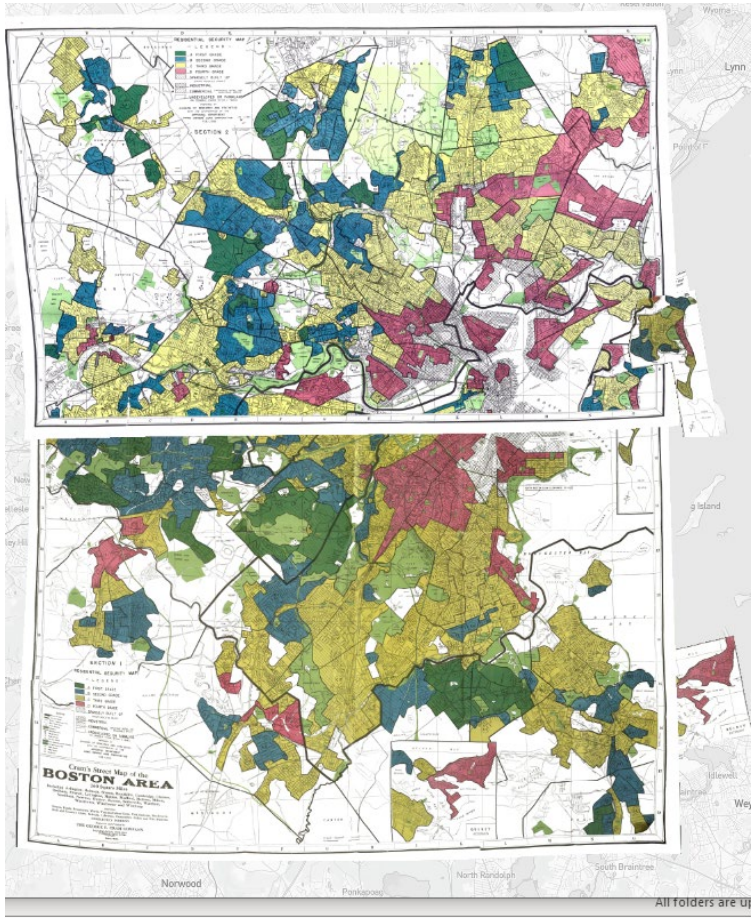
--Ceasar McDowell (Interaction Institute for Social Change)



Built on bell hook's from margin to center theory (Feminist Theory: From Margin to Center 1984)

Underlying Social Justice Principles: Leading with Race

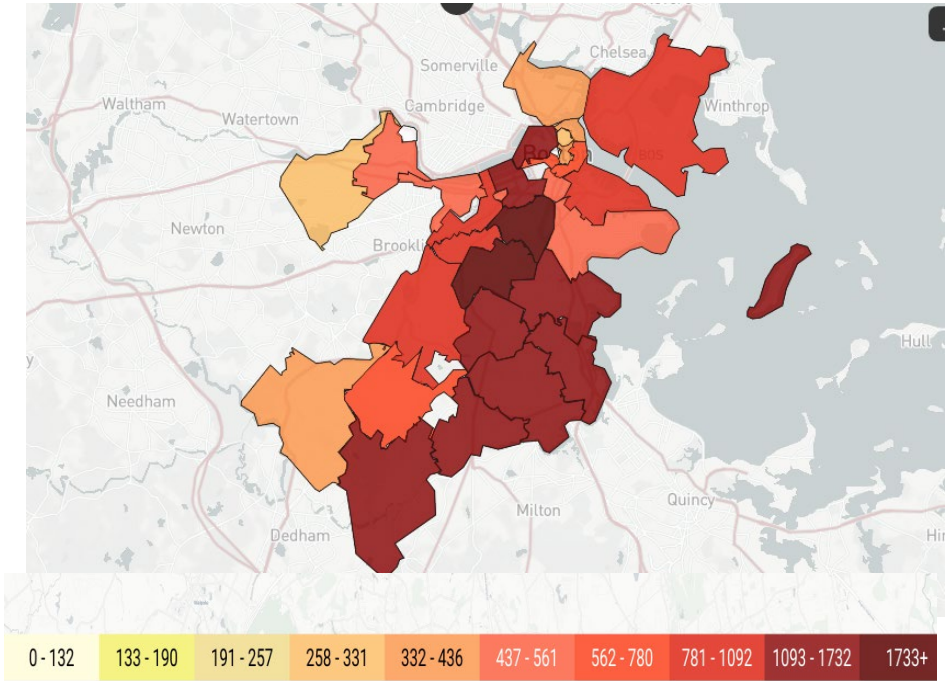
- Homelessness is caused by historical and structural oppression
  - Discrimination in housing, health care, voting, employment, criminal justice, and elsewhere
- These root causes have led to systematic economic disadvantages
  - Long-standing discrimination has limited wealth production among Black Americans and other people of color.
- Black Americans are vastly over-represented in the homeless population
  - 41% homeless but only 13% gen pop.



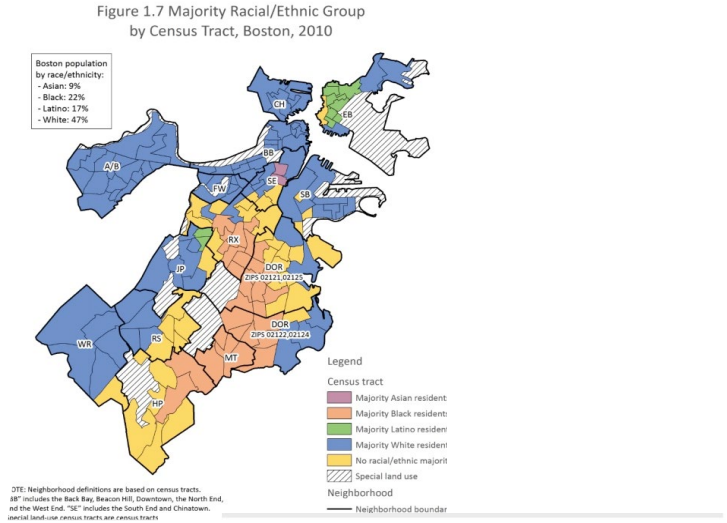
Home Owners Loan Corporation (HOLC).
Residential Securities Map of Boston, Circa 1938.
Mapping Inequality: www.dsl.richond.edu

Mapping Inequity in Boston

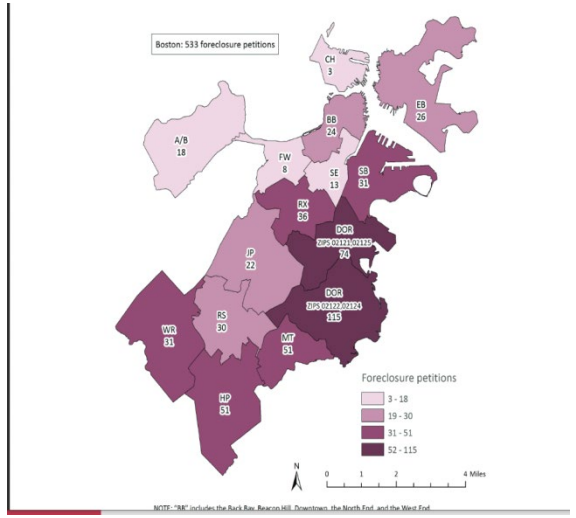
Rate of HIV per 100,000 people in Boston in 2018

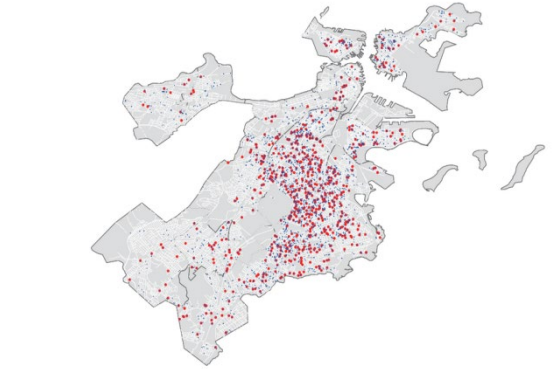


Majority Racial and Ethnic Group by Census Tract 2010



Home Foreclosure Petitions 2016





Jail Admissions in 2013 by Home Address

(Boston Public Health Commission: The Health of Boston 2016-2017; The Geography of Incarceration, Boston Indicators Project. 2016; AIDSVu)

Prevalence of Homelessness among PLWHA

***At least* 50% of PLWHA** with lifetime risk of housing instability

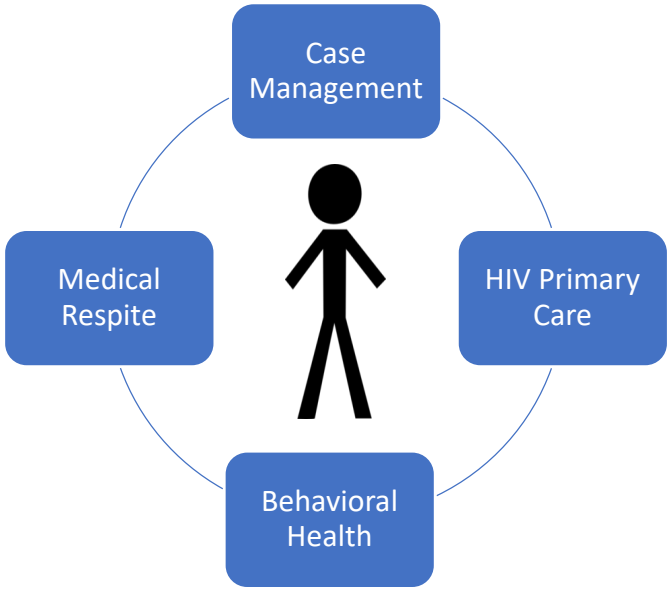
- 9% of PLWHA in US were homeless in 2017
- 32% of US Veterans with HIV experience homelessness
- More than 50% of those recently released from incarcerated settings were homeless

The interlocking and mutually reinforcing structural vulnerabilities that predispose someone to contracting HIV are the very same as those that predispose someone to experiencing homelessness—structural racism, poverty, gender and sexuality-based discrimination, incarceration, trauma, mental illness and substance use disorder and related stigma, as well as other forms of systemic exclusion.

(DHHS NHAS Progress Report 2017; National Alliance to End Homelessness, 2006; and National AIDS Housing Coalition, 2008; National Low-Income Housing Coalition, 2008; HUD HIV Care Continuum, Moving Forward, Nov 2014; HUD 2020 Summary of Resources)

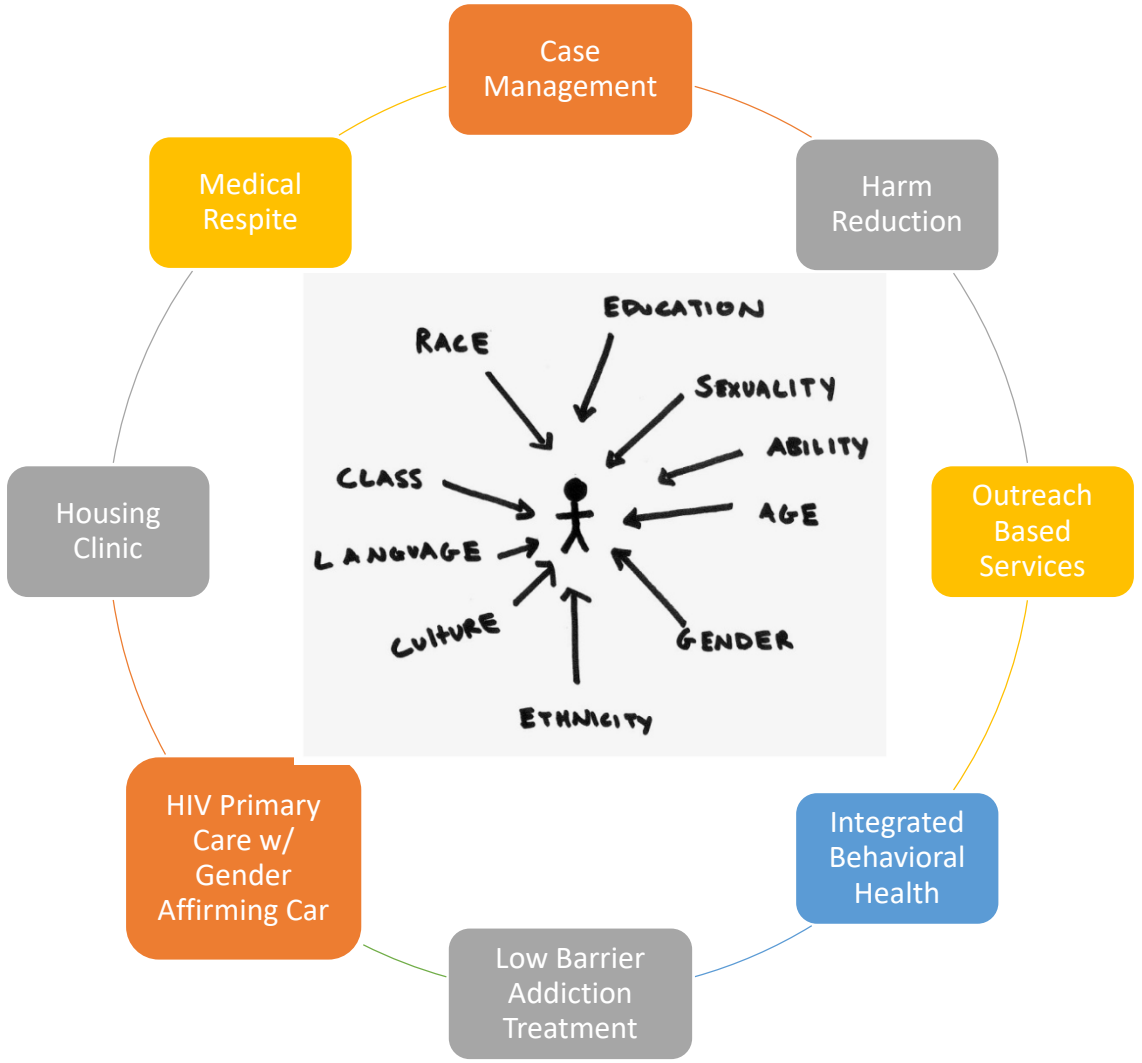
HIV Care Model Evolution

BHCHP Model 5 years Ago



Designed for the Margins

Guided by Social/Racial Justice Principles



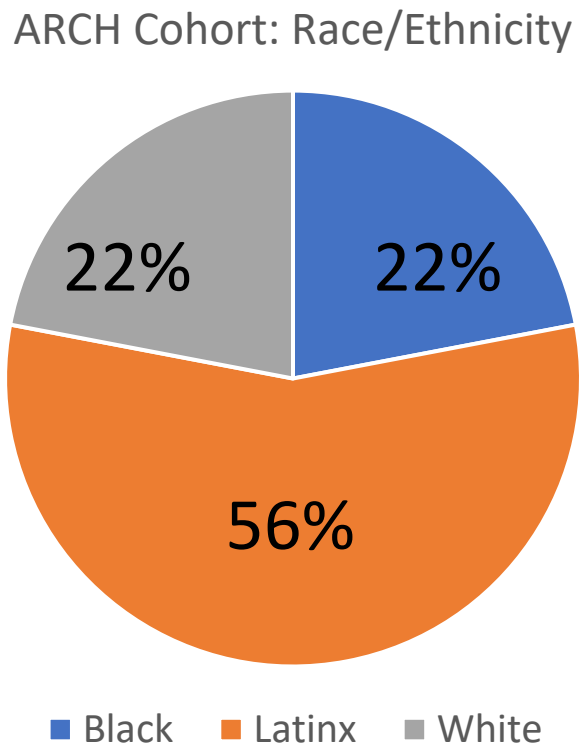
Kimberle Crenshaw. "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. U. Chicago Legal Forum 1989

Building Capacity for Intensive, Tailored Outreach

- Patients with detectable viral loads/not engaged in care are prioritized for intensive outreach-based clinical and case management services
  - All 4 **HIV nurse case managers** have outreach capacity (12 hours per week).
  - All **HIV providers** have 1 session per month dedicated to outreach
  - 5 full time **Medical Case Managers** with outreach capacity for activities including accompaniment to housing, legal, social service appointments
  - Highest acuity patients are referred to the Active Retention in Care and Health (ARCH) Program

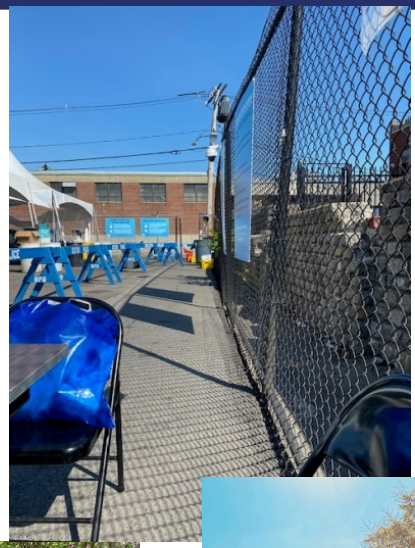
ARCH Program

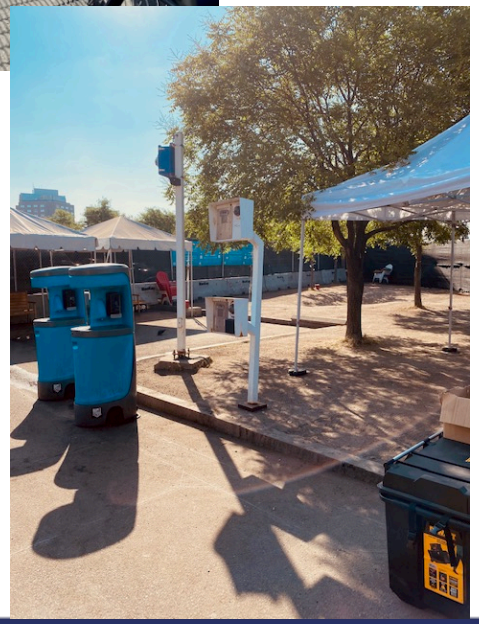
- 27 of our highest risk patients, all virally detectable and/or difficult to engage in care at intake
- Demographics
  - 30% monolingual Spanish speaking
  - 67% male, 33% female
  - 82% w/ lifetime incarceration
  - 67% were literally homeless at the time of intake
  - 93% with active SUD



ARCH= Outreach, Outreach, Outreach + Non-contingent care

- Outreach Social Worker Led
  - Supported by outreach nurses
  - Bilingual/Bicultural Staff
- Non-judgmental, non-contingent expressions of care/dignity/respect
- High intensity outreach
  - Streets
  - Drop in spaces for those experiencing homelessness and using drugs
  - Syringe services programs
  - Encampments
  - Court
  - Shelters





Engaging Mr. TC

- Mr TC and his partner were found to have transmitted multidrug resistant HIV, they were placed in a motel for stabilization and received daily visits from the outreach social worker and nurses. Trust was established through ongoing weekly outreach visits at couple's encampment. Collaborated with syringe service providers to coordinate outreach and ensure engagement and retention and medication adherence support. Provided accompaniment to important medical, social service, housing and legal appointments. Visited patient in the hospital. Provided crisis intervention counseling. His HIV viral load became undetectable within 1 month.

Re-Entry Case Management

- Added Re-Entry Specialist/Medical Case Manager Role 1 year ago given high prevalence of incarceration among people experiencing homelessness and living with HIV and high rates of loss to follow up post-release.
- Follow approximately 20 patients with recent incarceration/or currently incarcerated.
- Broad aim is to provide tailored , intensive case management for people with recent incarceration during the re-entry period, and to maintain relationships and coordination of care during incarceration

Key Elements of Re-Entry Case Management

- Building relationship and earning trust
- Visits within the walls of jail/prison
- Serve as advocate in courts
- Coordinating services and discharge planning with corrections staff
- Connecting patient to key services – PCP/Mental health /addiction treatment services /housing
- Understand and address issues that contributed to incarceration to avoid recidivism
- Keeping patients connected to services during and after incarceration
- Helping patient rebuild relationship with family/children if desired

Returning to Mr. TC: Incarceration and Re-Entry

- When Mr. T.C. became incarcerated after being a patient on the team for approximately 1 year he was transitioned to re-entry case management. He had a long history of severe SUD since he was a teen. This was an enormous barrier to engaging in medical care. It was critical that we build a relationship with him and help him think about life differently while he was in jail, so that he was able to believe in himself again. TC knew that he had a team that cared about him, that was there to support him through his struggle. TC was very thankful that he had someone that came to the jail once a week to help him with his release plan. He was open to going to a drug treatment program while in the past he wasn't. He told us that because of the visits in jail, he began to look at things differently. He had a much more open mind to reconnecting to care, to pursuing addiction treatment.

Nurse Case Management

- Enhanced patient education/counseling
- Intensive care coordination/case management
- Nurse Adherence Group Intervention
  - Intensive medication adherence monitoring, education and support via frequent visits

    - Pill boxes/blister packed medications

    - Directly observed therapy (DOT) both in clinic and in ***outreach settings***

    - 4 months ago started daily, street-based DOT for HIV therapy for small subset of cluster patients (5-7 individuals)

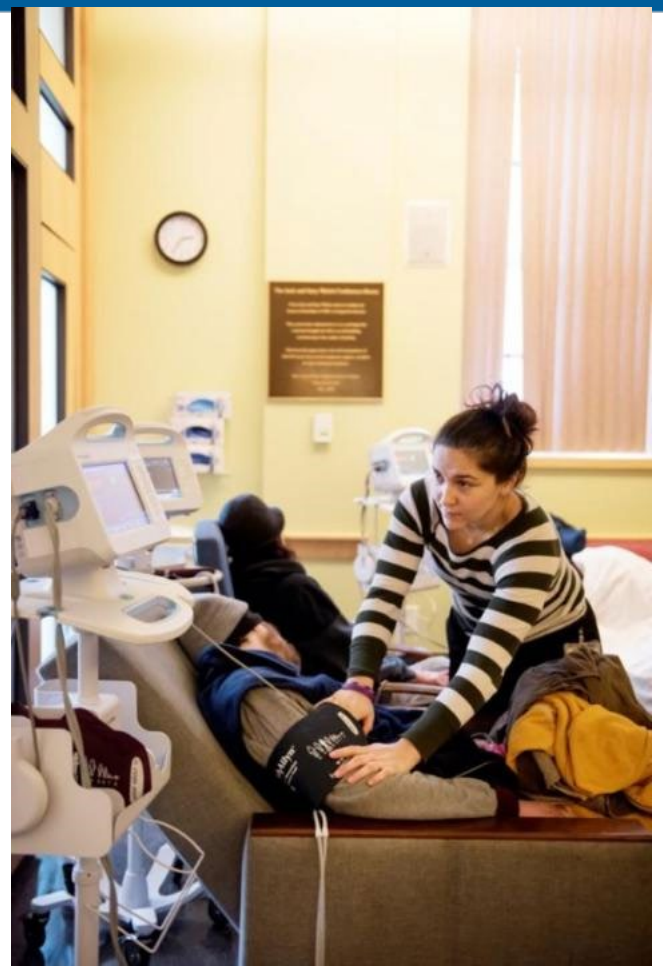
Low Barrier Addiction Treatment

- Expanded capacity for same day buprenorphine inductions for patients with opioid use disorder
  - All HIV team providers have buprenorphine waivers, 3 providers with Addiction Board Certification
  - HIV Nurses cross trained to support buprenorphine follow up care
- Care Zone Mobile Unit provides buprenorphine, syringe services, PrEP, HIV testing, and HIV treatment for homeless people with SUD.

Integrated Harm Reduction Services

- Program-wide cultural sensitivity/trauma informed care trainings for all staff around SUD
- Naloxone at on site pharmacy by standing order
- Safe Place for Observation and Treatment (SPOT)
  - Walk in sedation unit
- Reverse motion detectors in bathrooms to prevent overdoses

SPOT Program



Services Offered

- Medical monitoring
- Treatment of overdose
- Harm reduction services
- Connection to primary/behavioral health care and addiction treatment
- Naloxone distribution
- PrEP/PEP and ART DOT and med storage
- HIV screening

Staffing Model

- Registered nurse specializing in addiction
- Harm reduction specialist builds relationships and links people to treatment
- Peers who are in recovery offer support
- Rapid response clinician (MD/NP/PA) available for emergency

Housing as HIV Treatment

- Research studies (including 2 RCTs) have shown that provision of housing to PLWHAs:
  - Improves likelihood of receiving and adhering to ART
  - Improves HIV specific health outcomes (preserved CD4 counts, fewer OIs, improved virologic suppression, improved survival)
  - Decreases ER visits and hospitalizations
  - Decreases annual medical costs
  - Leads to a reduction in high risk sexual and drug use behaviors

(Aidala, et al. 2016; Buchanan et al., 2009; Wolitsky, et al. 2010; Kidder, et al. 2008; Schwarcz, et al. 2009: Aidala and Sumartojo, 2007; Des Jarlais, et al., 2007; Geman et al., 2007; Stanic, et al. 2019)

Co-located Housing Clinic at BHCHP

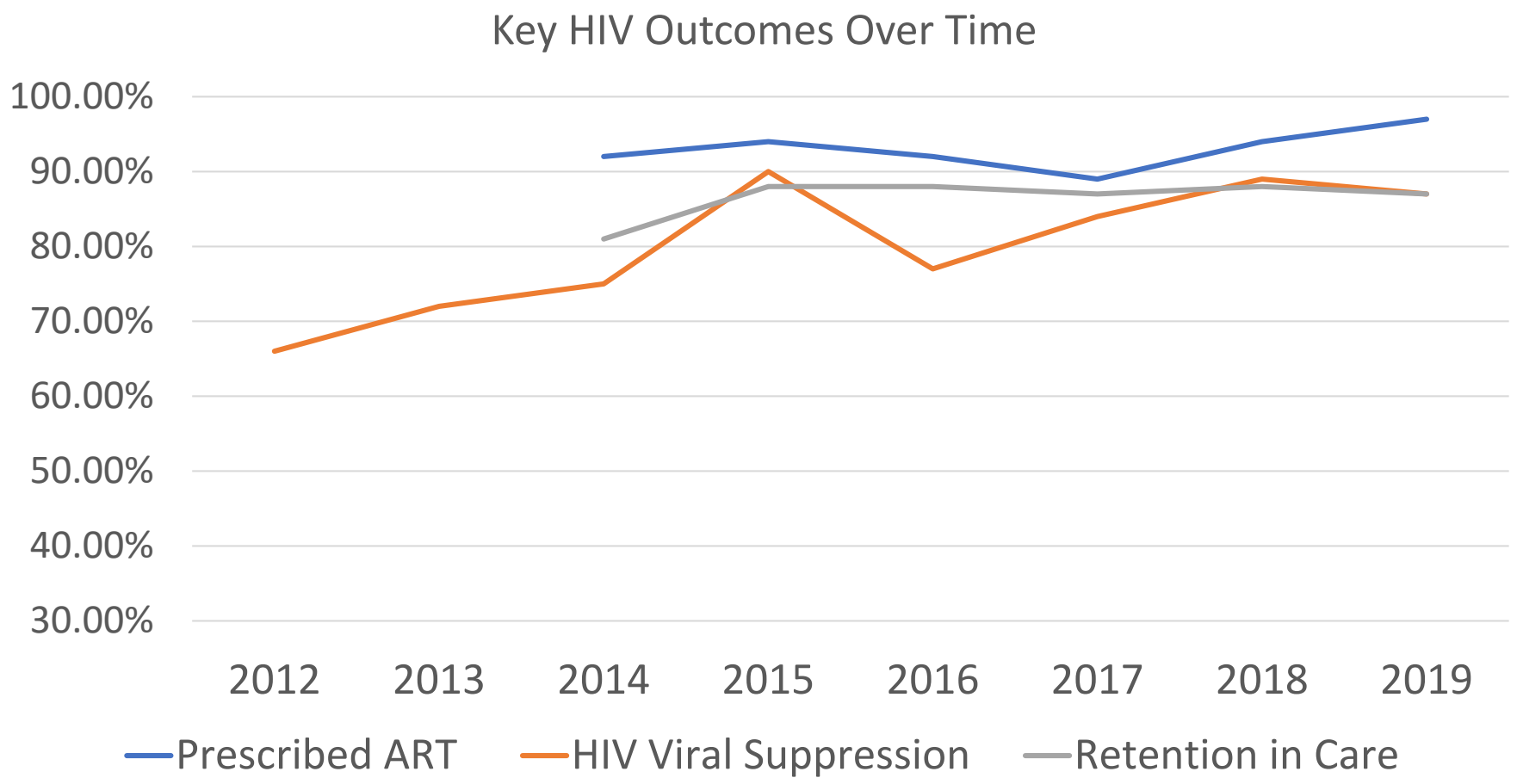
- Invited existing partner agencies already conducting housing search and advocacy locally in Boston to meet with patients at BHCHP on a weekly basis
- Complete housing applications/housing histories onsite
- BHCHP case managers assist with all follow up and work with patients to retain housing, set up home visits once housed
- Housed 36 people in first 2 years of this intervention

HIV Program Outcomes

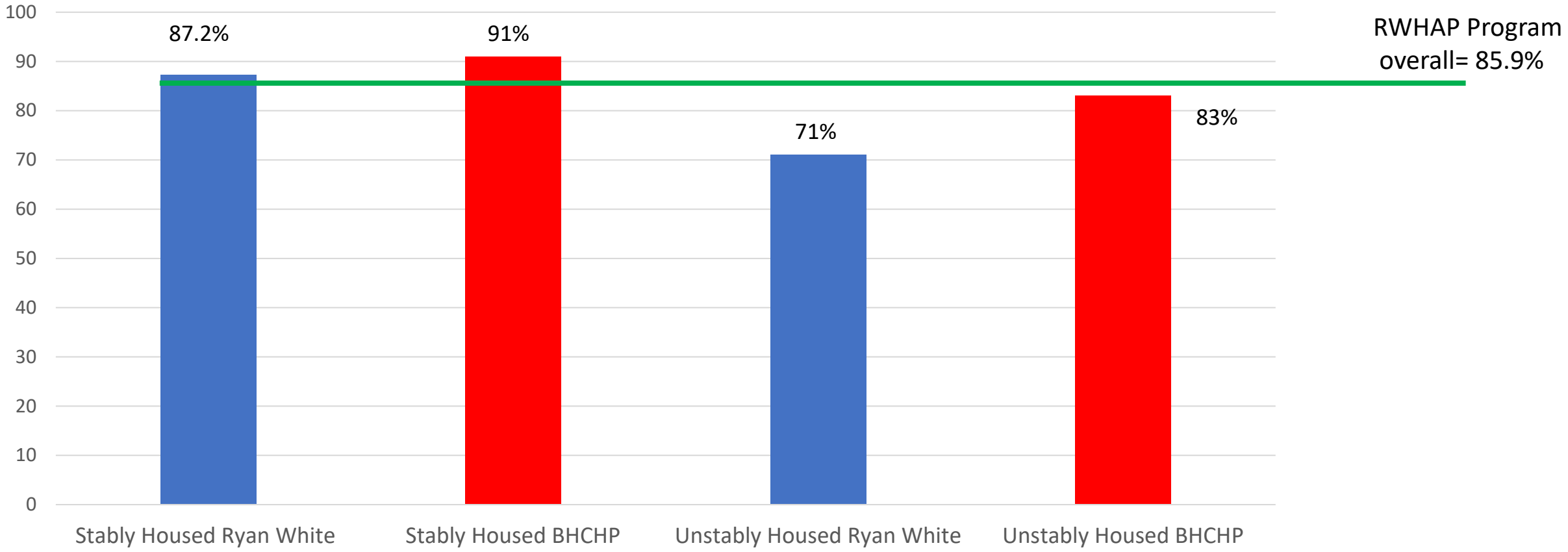
How effective is all this?

- **97%** of patients on ART
- **87%** with HIV viral load suppression
- **91%** retained in care

BHCHP HIV Outcome Measures



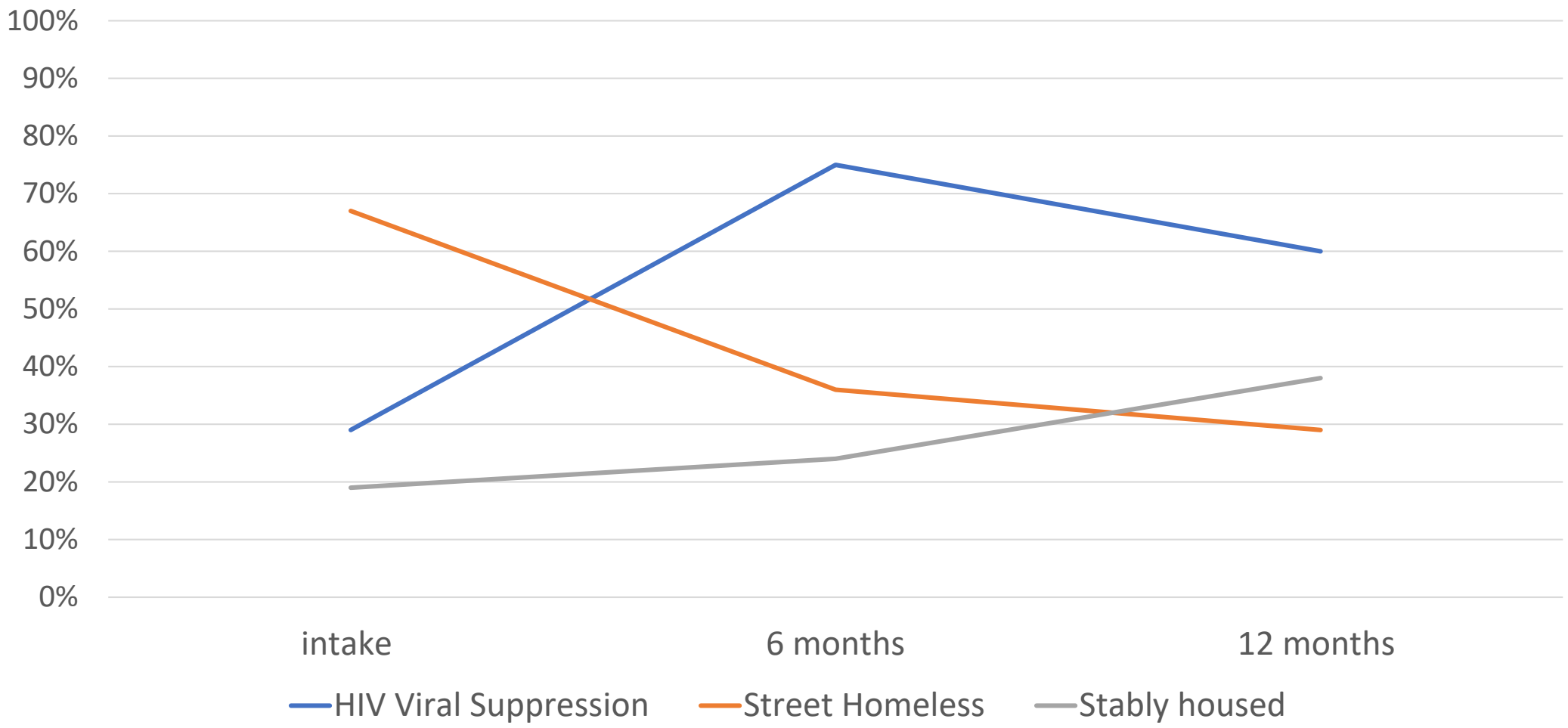
HIV Viral Suppression by Housing Status: Ryan White HIV/AIDS Program Nationally Compared with Boston Healthcare for the Homeless Program



Viral Load Suppression among clients served by Ryan White HIV/AIDS Program by Housing Status 2017
N= represents the total number of clients in the specific population.
Viral suppression: ≥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.

(HRSA, RWHAP, Dec 2018)

ARCH Cohort Outcomes



Vulnerable Sub-Populations

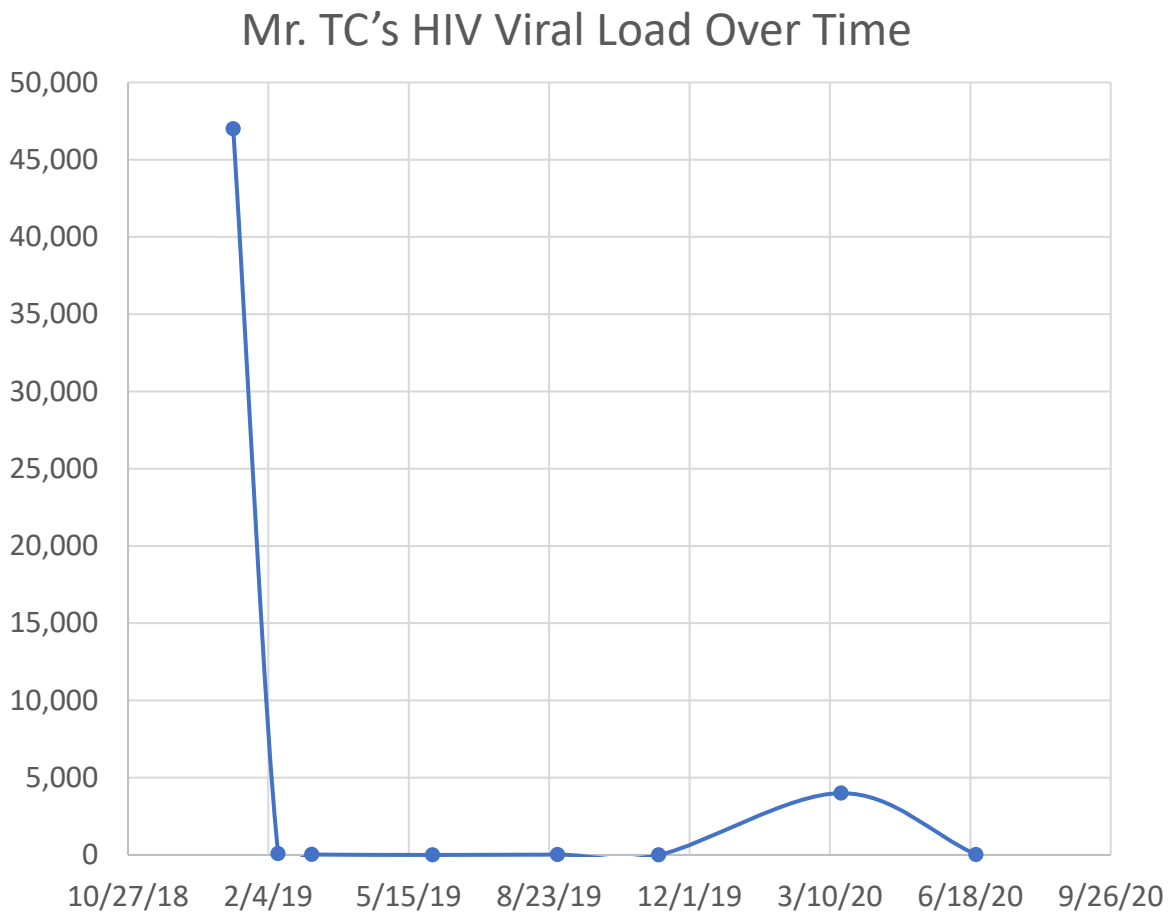
- While some viral suppression equity gaps are closing:
  - Active OUD – 87% (vs 89% no OUD)
  - Black: 92%, Latinx 89%, White 82%

Others remain…

- **2019/2020 Boston Homeless PWID Cluster: 19 patients**
  - 50% (8/16) virally suppressed
    - Includes 5 not yet engaged in care (diagnosed in last 3-6mo)
    - 3 linked to other programs
  - 73% (8/11) virally suppressed of those we have engaged
- **Recently Incarcerated Cohort:** (13 patients)
  - 77% (10/13) virally suppressed

Mr TC Follow Up

Mr. TC recently reengaged in care in the outpatient setting. While he has sustained HIV viral suppression for the majority of the past year, maintaining suppression and engagement in care remains a struggle. He has restarted HIV medications recently. Continues to be street homeless with his partner who is also HIV positive. Re-Entry Case Manager and ARCH Social worker continue to work collaboratively with the patient. With Mr. TC's permission, has allowed the team to contact his mother to help coordinate care and services. Patient is receiving support from our outreach nurse to do weekly HIV medication delivery and DOT support to his encampment on a weekly basis.



Lessons Learned

- Principles of “design from the margins” rooted in racial and social justice, can inspire important transformations in HIV programs to improve care for the most vulnerable patients
- BHCHP redesigned our program to meet the urgent needs of a growing population of street homeless, people who use drugs, with criminal justice system involvement
- Understanding and addressing structural barriers and survival needs (including harm reduction and low threshold SUD treatment) was central
- Centering care on the margins led to improved outcomes for all BHCHP’s patients, not just “the most vulnerable “ on the team.

Ongoing Challenges

- Ongoing criminalization of homelessness and drug use continues to lead to high rates of incarceration in our patients
- Lack of low threshold/supportive housing options for people with SUD and histories of incarceration in Boston
- Rise in methamphetamine use disorder in our patient populations remains very difficult to treat given lack of effective medical therapies
- Insufficient supply high-quality residential treatment programs with appropriate cultural/trauma/language services to meet demand
- **Our advocacy in these areas continues!**

What Questions Do You Have?

Thank You

CONTACT INFORMATION

Jennifer Brody, MD, MPH
Director of HIV Services
jebrody1@bhchp.org

Sabra Johnson
Re-Entry Case Manager
sjohnson@bhchp.org

Natasha Vargas
ARCH Outreach Social Worker
nvargas@bhchp.org

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