Increasing Retention in Care for HIV Positive Homeless Individuals: Harlem Model Implementation

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I. Background

•Engagement in Primary care for PLWH/A contributes to better health outcomes

•Unfortunately, structural barriers such as stigma and discrimination prevent PLWH/A from accessing and engaging in care

•One of the emerging models of care coordination that has been frequently advocated is the patient navigation system

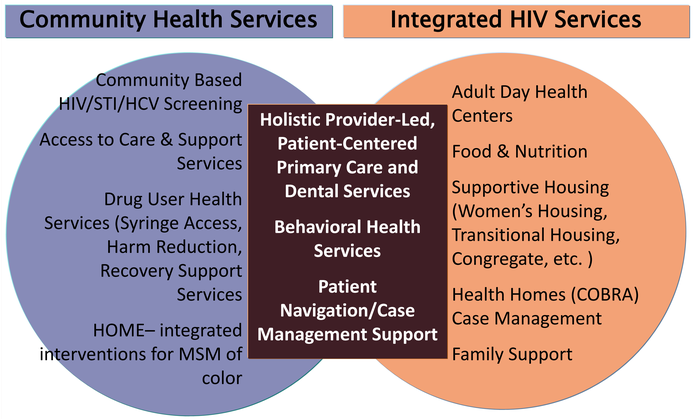
II. Agency Overview

• Harlem United Community AIDS Center, Inc. (HU) is a community based organization (CBO) in New York City, founded at height of first phase of AIDS epidemic in 1988.

• In the past, HU specifically served people living with HIV/AIDS (PLWH/As) who were homeless and/or suffering from mental illness and/or substance use in Central and East Harlem neighborhoods.

• HU received a Federally-Qualified Health Center for the homeless (FQHC-H) designation from the Health Resources Services Administration (HRSA) in 2007, which allowed for expansion of services to homeless individuals regardless of HIV status.

• In 2012, Harlem United received Patient-Centered Medical Home (PCMH) level 3 accreditation which further promotes care coordination and integration of services.



III. Access to Care (ATC) Program

Goals

- To locate and engage out-of-care individuals into care and support services
- To ensure access to and retention in medical care and support services
- To provide support services needed to achieve optimal health outcomes
- To navigate through initial medical care and connect to comprehensive case management

Client Characteristics

- 75% Male, 24% Female, >1% Transgender
- 95% Black & Hispanic
- Primarily 35-54 years old
- 65-75% Homeless/Unstably Housed
- 40% HIV+, 15-20% AIDS diagnosis

Target Population(s)

- HIV Positive and High-Risk HIV Negative Homeless & Unstably Housed Individuals
- High utilizers of emergency rooms and detox facilities
- Undocumented Immigrants (primarily African and Latino)

Program Flow/Services

1. Patient Navigation

2. Supportive Case Management

2A. Psychosocial Assessment

2B. Entitlements

3. Supportive Services (Treatment Adherence, Housing Support)

IV. Outcomes

Sample

•Intervention group (i.e. ATC): HIV+ clients receiving ATC services in 2011

•Comparison group (i.e. non-ATC): HIV+ clients who were not receiving ATC services in 2011

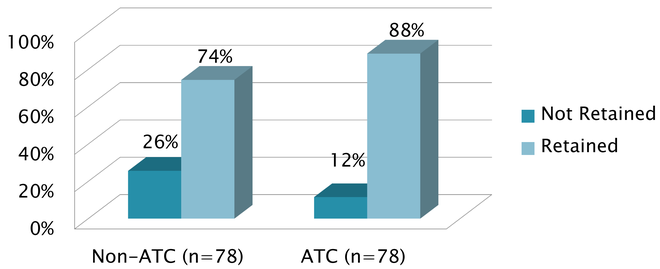
Measures

•Dependent variable: retention in care, ART status

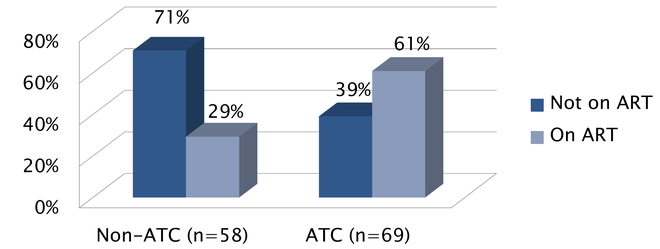
•Independent variable: ATC group membership

Results

Retention rate among ATC and non-ATC clients



ART status among engaged ATC and non-ATC clients



V. Conclusions

•Daily rounds among ATC staff and HU Primary Care ensure effective care coordination

•Ongoing monitoring of chronic no-show clients through our Electronic Medical Record (EMR), eClinicalWorks (eCW), assists in effective outreach and re-engagement activities

•Utilizing a client-centered, harm reduction approach, and motivational interviewing techniques lead to positive outcomes (ongoing staff training/development)

•Low threshold services necessary for target population(s)

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