HIV and Homelessness in Baltimore

3/15/22

HEALTH CARE for the HOMELESS

Poverty in Baltimore

In Baltimore, poverty is pervasive:

- Nearly 1/2 of residents live below 200% of the federal poverty line
- 1/4 of residents live at or below the federal poverty line
- More than 1/2 of poor residents live in deep poverty, meaning they live at or below 50% of the federal poverty line
- More than 1/3 of children in Baltimore City live in poor households
- Disproportionately impacts communities of color

Homelessness is an experience, not a characteristic. It is directly related to economic disparities.

The economic landscape in Baltimore makes homelessness likely for so many.

Homelessness In Baltimore

- Annual “Point in Time” counts measure the number of sheltered and unsheltered individuals experiencing homelessness
- The count, required by Housing and Urban Development (HUD), attempts to measure the number of people experiencing homelessness in a community on a given night in January
- In 2020, this number was 2,193 people, including 298 who were unsheltered, or sleeping on the street/place not meant for habitation
- This count, however, only accounts for 19% of the approximately 11,800 people receiving homeless services

Demographic Trends in the PIT Data

- Black or African American people make up approximately 63% of the population of Baltimore, but account for 71% of the people experiencing homelessness
- 64% of people experiencing homelessness in the survey identified as men
- 40% of the women and 39% of men surveyed were between the ages of 35-50 making this the most common age group

For more information…

- The full PIT Data Report is available here: https://journeyhome.wpengine.com/wp-content/uploads/2020/08/2020-PIT-Count-Report-1.pdf

Demographic Data at Health Care for the Homeless (HCH)

- Annually, HCH compiles a Uniform Data System (UDS) report for HRSA, which looks at demographic, health and financial data for health centers
- Our 2021 UDS indicates the following trends in housing:
  - 14% of clients report staying in an emergency shelter
  - 8% of clients report staying on the street or a place not meant for human habitation, and
  - 56% of clients report doubling up

The Intersection of Homelessness and HIV

Baltimore City HIV Statistics

- Four people are diagnosed with HIV every week in the Baltimore, with non-Hispanic black men representing 81.5% of those cases (Maryland HIV Progress Report 2020).
- Baltimore City has significantly more people living with HIV per 100,000 population than the state and country.
- The Baltimore-Towson metro area recently ranked 4th in the United States for adolescent HIV diagnoses (Decker et al., 2015).

Relationship between Homelessness and HIV

- Studies estimate that 3.3% of individuals experiencing homelessness in the United States are HIV positive, compared with 1.8% of the stably-housed population (Denning, MD, MPH & DiNenno , PhD, 2022).
- People who are homeless experience higher rates of HIV infection, have a more difficult time staying in HIV care and adhering to HIV medications, and experience worse health outcomes as a result of HIV infection. ("Homelessness linked to HIV infection and low rates of viral suppression - San Francisco AIDS Foundation", 2022)

Relationship between Homelessness and HIV Cont.

- One study shows that people who sleep in a shelter are twice as likely to have tuberculosis if they are HIV-positive (National Alliance to End Homelessness, 2006).
- Homelessness makes it more difficult to adhere to complex medication regimens.
- Source: http://www.nationalhomeless.org/factsheets/hiv.html

What is clear?

Homelessness is caused by poor health, causes poor health, and exacerbates existing health conditions

Health Care for the Homeless Overview

HCH Mission

- HCH is a nonprofit (501c(3)), Federally Qualified Health Center (FQHC). HCH works to prevent and end homelessness for vulnerable individuals and families by providing quality, integrated health care and promoting access to affordable housing and sustainable incomes through direct service, advocacy, and community engagement.

Demographic Data at Health Care for the Homeless (HCH)

The 2021 UDS indicates the following trends:

- 46 % of our clients are uninsured as compared to 18% in 2014
- 34% of our clients as Hispanic, a significant increase 25% in 2019
- For the first time, the majority of our clients are female identified (54%)
- Nearly 2% of clients have a HIV diagnosis
- 50% of our clients identify as Black or African American

Services Provided

- HCH clinics deliver pediatric, adult, and geriatric medical care including care for HIV, behavioral health services including substance use treatment, and supportive services such as case management, outreach, and community health workers
- Six Locations: Downtown/Fallsway, West Baltimore, Baltimore County, Mobile clinic, Medical Respite Program, and a dental program
- HCH Housing Services – provides supportive services through several permanent supportive housing programs and rapid rehousing programs

Health Home

HCH operates a patient-centered medical home or health home for clients engaged in care.

A health home delivers ***person-centered, whole-person*** care that is ***evidence-based,*** uses ***data*** and listens to ***clients to continuously improve*** the care we deliver.

The interdisciplinary team is comprised of medical, nursing, behavioral health, case management, community health workers, and administrative support; all working together to meet the needs of the client.

HCH and Ryan White

- HCH receives Ryan White A and B/state special funding to provide supportive services specific to our clients living with HIV
- Ryan White A
  - Oral Health
  - Non Medical Case Management
  - Housing
- Ryan White B (or State Special)
  - Health Education and Risk Reduction (HERR)
  - Outreach
  - Housing

Ryan White A – Oral Health

Oral health services delivered specifically to clients living with HIV which includes:

- Developing Dental Care Plans
- Documenting a clients dental and health history
- Oral health education
- Oral health procedures such as extractions, periodontal procedures, scaling and root planning

Services are provided at one of three sites by dentists, dental assistants and a dental hygienist; high need for population and those with HIV are prioritized

Ryan White A – Non-Medical Case Management

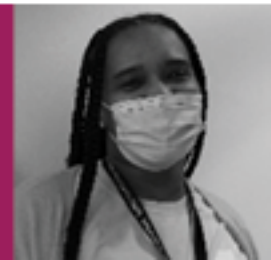
This includes activities such as:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan that is re-evaluated and updated every 6 months;
- Continuous client monitoring to assess the efficacy of the care plan;
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Case managers work with clients to address social determinates of health and document visits, assessments, and treatment plans in our electronic health record

Ryan White B - HERR

These activities include:

- Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients' partners and treatment as prevention
- Education on health care coverage options (e.g.., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage)
- Health literacy
- Treatment adherence education
- Provided by the Case Management team for clients with a higher level of need than Non-Medical Case Management

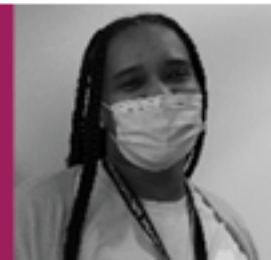


Ryan White B - Outreach

Activities include:

- Identification of people who do not know their HIV status and linkage into health services at HCH or another location
- Reengagement of people who know their status into health related services

Services are administered by our Community Health Worker and outreach team who proactively maintain communication with clients to link and re-engage

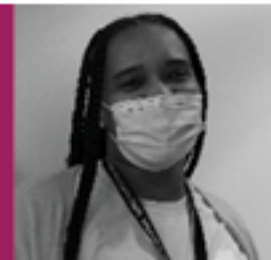


Ryan White A and B - Housing

Activities are provided by Housing Services and Case Management Team

- This includes the provision of transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain care and treatment
- Clients are referred to our transitional housing partner Project PLASE, hotels, and short-and-medium term market rentals such as room rentals and apartment units

Clients are referred via our Housing Services, Connect Team or Case Managers who identify eligible clients, work with the client to create a housing plan, and collect Ryan White eligibility documentation



Additional HIV services at Health Care for the Homeless

1. Funding for permanent housing and supportive services (HUD HOPWA-C)
2. Funding for HIV testing (BCHD – CDC)
3. Ending the HIV epidemic funding with a focus on PrEP and education (HRSA)

HIV Outcomes at HCH

- In 2021, HCH tested 2386 clients for HIV including 1918 lab and 468 rapid tests
  - This represents a 71% screening rate
- HCH has maintained a 100% linkage rate for the past three years for client with a new diagnosis
- Reached 149 individuals in 2021 providing Ryan White HIV-related services
  - Provided 1600 bed nights of temporary shelter to people living with HIV
  - Provided 101 clients with nonmedical case management in 440 encounters
  - Provided outreach to 53 clients in 157 encounters

Needs of individuals experiencing homelessness

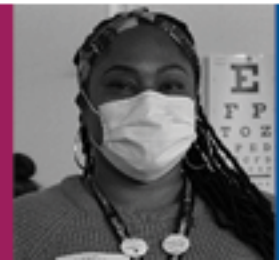
How we determine service needs

1. Client input
   - Client satisfaction surveys
   - Focus groups
   - Consumer Relations Committee of the Board
2. Evaluate internal and external data that demonstrates needs

Client input

Clients report needing

- Health care delivered in a culturally and linguistically appropriate manner
- Timely access to their provider and appointments
- Health care they can understand
- Well coordinated and integrated care
- HOUSING, HOUSING, HOUSING



Health Outcome Data

1. Individuals experiencing homelessness and at our health center are at risk for
   - Higher rates of trauma
   - Higher rates of substance use
   - Higher rates of unintentional overdose
   - Worse health outcomes in chronic disease such as Hepatitis C
   - Worse health outcomes for preventive screenings such as colorectal cancer
2. The need for trauma-informed, harm reduction services are vital to improving behavioral health outcomes.
3. The need for robust and integrated care is necessary to improving health

How HCH addresses these needs

Testing and linkages to care

1. Offer lab and rapid testing to all health center clients
   - Motivational interviewing and trust-building for those anxious to get tested
2. Link clients to case management, community health workers, or peers to help with ongoing engagement in care including assisting with housing, income, and benefits assistance
   - Addressing social determinants of health can help clients focus on all of their needs at a one-stop shop

Retention in Care

1. The use of the Care Team model is effective in communicating and coordinating care around an individuals health and supportive services needs
2. Meetings assess viral load, appointment adherence, medication regimens, and other needs of the clients
   - Use of data, registries, and EMR support to identify clients engaged in care to ensure continued engagement
3. Medical providers have access to case managers, behavioral health, and other staff to ensure care coordination and meeting all of the individuals needs

We see this model as effective in linkage to and retention in care.

Harm Reduction and SSP

1. Intravenous drug use (IVDU) is our primary risk factor for HIV and other infectious diseases
2. To address this, HCH offers an integrated mental health and substance use program (Behavioral Health)
3. We provide medication-assisted treatment (MAT) and behavioral health groups
4. In 2021, we also became a Syringe Services Program (SSP) to reduce the risk of unintentional overdose and other negative health outcomes

Housing is healthcare

Barriers to housing in Baltimore

Cost is a significant barrier in obtaining housing.

Final FY 2022 & Final FY 2021 FMRs By Unit Bedrooms

Year	Efficiency	One-Bedroom	Two-Bedroom	Three-Bedroom	Four-Bedroom
FY 2022 FMR	$953	$1,124	$1,395	$1,809	$2,075
FY 2021 FMR	$917	$1,115	$1,384	$1,793	$2,053

Individuals have to earn 2x the minimum wage or work 82 hours a week to afford a 1-bedroom unit .

Barriers to housing in Baltimore

- 52% of Baltimore residents are at risk of eviction and rent increases (Dinsmore, 2019).
- Baltimore's overall eviction rate is 5.3%, which is 2.3 times higher than the national average. (https://bmorerentersunited.org/evictioncrisis/)
- As of November 2019, more than 14,000 people were on the wait list for public housing (Reed, 2019).
- Individuals who are Black or African American are disproportionately impacted

Housing is Healthcare

- An analysis of 152 studies show that worse housing (i.e., stability, structure, or quality of housing) is associated with poorer access to and engagement in health care and treatments, lower adherence to ARV therapy, worse health outcomes, and higher rates of HIV risk behaviors (Aidala et al., 2016).

- When reviewing hospitalization data for housed clients, individuals who have been housed for one year have fewer visits, fewer re-admissions, fewer ED visits, and reduced costs to hospitals.

HCH and Housing

1. HCH provides housing support to more than 400 individuals or families
2. This is done through rental subsidies, vouchers, project-based housing, housing development, and short-term rental assistance (such as RW)

Thank you for your time!

Questions?

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