Strategies to Build a Patient-Centered Medical Home for Multiply Diagnosed People Living With HIV Who Are Experiencing Homelessness or Unstable Housing

As described in this supplement issue of *AJPH*, homeless and unstably housed people living with HIV (PLWH) who are codiagnosed with mental illness or substance use disorders face extraordinary barriers to health care. The patient-centered medical home (PCMH) is a promising model that promotes provision of additional support services for PLWH. Although some HIV care studies have embraced the medical home label, they lack information on specific characteristics or standardized guidelines for HIV-specific PCMHs.[1]

The particularly complex needs of multiply diagnosed PLWH experiencing homelessness or unstable housing may require a unique PCMH model. Therefore, as part of Building a Medical Home for Multiply-Diagnosed HIV-Positive Homeless Populations, an initiative of the Health Resources & Services Administration's Special Projects of National Significance Program,[2] we sought to identify key strategies for creating medical homes for this population through in-depth interviews with 83 PCMH staff members. Interview questions were based on the PCMH comprehensive, patient-centered, coordinated, accessible, and systems-based approach to quality care.[3] Our aim was to better understand how these key PCMH components were operationalized specifically for this population. Here we offer a summary of our findings (selected quotes are presented in Table 1).

CORE SERVICES

Interviewees highlighted the importance of including combined medical care and sociobehavioral services as part of the PCMH model. All involved agencies integrated mental health, substance use, case management, navigation, and social service assistance, including linkage to housing, into their HIV primary care models. PCMH teams included primary care providers and specialists such as psychiatrists, social workers, case managers, patient navigators, and substance use treatment providers. Most sites included additional on-site specialty services, such as dental care, pharmacy services, hepatitis C treatment, and insurance eligibility assistance.

USE OF NETWORKS

Interviewees underscored the need to work across departments within PCMHs and across multiple systems in the community to coordinate needed services. Formally, partnerships were established by means of memoranda of understanding specifying referral systems, confidentiality agreements, and data sharing protocols. Furthermore, many sites joined community-wide coalitions (e.g., with local governmental agencies and HIV commissions) through which they could advocate for the most critical and challenging-to-access services: housing and behavioral health treatment.

Relationship building and management were also achieved informally. Team members with intimate knowledge of community resources were critical liaisons between patients and the community. Interviewees emphasized the importance of having contacts at substance use and mental health service agencies, often the most challenging services to access owing to limited availability and insurance coverage. Coordination of housing services was also facilitated by communication between navigators and housing providers in the community.

RAPPORT AND TRUST BUILDING

Building trust between the navigator and the patient was necessary to better understand patient needs and coordinate services accordingly. Trusting patients felt more comfortable disclosing important information. Good rapport between patients and staff also facilitated patient involvement in care, as well as education, coaching, and modeling. Having established a relationship, navigators could teach patients how to advocate for themselves and

ABOUT THE AUTHORS

At the time of writing, Mariana Sarango was with the Boston University School of Public Health, Boston, MA. Carole Hohl is with the Boston Health Care for the Homeless Program. Nelson Gonzalez is with the Harris Health System Health Care for the Homeless Program, Houston, TX. Angelica Palmeros is with the Pasadena Public Health Department, Pasadena, CA. Mary L. Powell is with the Yale University AIDS Program, New Haven, CT. Melissa Hirschi is with the University of Memphis Department of Social Work, Memphis, TN.

Correspondence should be sent to Mariana Sarango, MPH, Bouvé College of Health Sciences, Northeastern University, 360 Huntington Ave, INV 320, Boston, MA 02115 (e-mail: sarango.m@husky.neu.edu). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

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TABLE 1—Special Projects of National Significance Staff Perspectives on Key Strategies for Creating Medical Homes for People Living With HIV Who Are Experiencing Homelessness or Unstable Housing

Strategy	Selected Quote
Use of assessment tools and care planning	The care plan is a good tool to help us guide where the client wants to go next. It is their perception of where they're at and what they think they need to get them to the next step.—Patient navigator
Meeting patients where they are	We spend a lot of our time meeting clients at the shelter. For me, it's been a lot at the hospital lately, or at Starbucks or Taco Bell or McDonald's, where I'll meet with a client to talk about what we need to do to help them with services.—Case manager
Core services	[The team includes] myself, the housing staff, the medical case manager, maybe a therapist or case manager that's connected to mental health. . .. [We're] making sure that the substance abuse and the mental health is being treated, adhered to; we're making sure that the medical piece [and] medication is being adhered to; we're ensuring [the housing piece], such as the savings and learning different life skills and coping skills when you move out. . .and the importance of how all three of [these kinds of staff] work together to stabilize housing.—Patient navigator
Development and use of networks	We can't know everything. Aging and Disability Services is. . .a huge system. I know some parts of it that are relevant to my work with folks, but I also have some people there that I really trust and so if something comes up that I don't know the answer to, I can call them and say "Here's the scenario. What should we do?" That stuff is really important.—Case manager
Rapport and trust building	That's so important, building the relationship with [the patients], that they can trust you, that [you're] not gonna go out and tell anybody else what's going on. Or you sit down with them, whether it's under the bridge, whether it's to the park, and they feel that you can connect with them. . .that they feel that they can trust me, that I'm gonna be there for them.—Patient navigator
Use of technology and technological tools	We're officially locked in our schedule an hour a day for telemedicine visits and the team is booking telemedicine visits. . .. So far it's great. We love it, the patients love it. . .. So it saves the patient transportation time, we can talk about a lot of things over the phone without having to do a physical exam. So that is yet another new option that we didn't have before.—HIV physician

help them develop necessary skills ranging from medication adherence to managing living in an apartment.

USE OF ASSESSMENT TOOLS AND CARE PLANNING

Interviewees described the importance of recognizing different levels of need within caseloads to aid in appropriate triaging. Patients with cognitive disabilities, severe mental illness, and substance use disorders faced unique barriers (e.g., shortage of services, nonreadiness to seek treatment) and often required more time-consuming and intensive work. Furthermore, all frontline and clinical staff developed care plans for their patients. However, documentation and storage of care plans were inconsistent in terms of location (electronic medical record, hard-copy storage) depending on who completed the plans. Some teams did not formally share care plans, and thus they were not typically read by the entire team.

"MEETING PATIENTS WHERE THEY ARE"

"Meeting patients where they are" was a central theme that emerged to describe the necessary adaptability and flexibility in provision of services for this population. To improve patients' readiness for behavioral change, staff used approaches such as motivational interviewing, the stages of change framework, shared decision-making, and harm-reduction techniques. Robust training programs that covered such techniques were available to staff across the sites. In addition, training sessions addressing cultural sensitivity, working with PLWH who are experiencing homelessness or unstable housing and other vulnerable populations (e.g., transgender individuals, those with mental illness), and trauma-informed care were found to be helpful.

Another organization-level strategy to "meet patients where they are" was to reduce language and literacy barriers. Sites made an effort to hire staff who spoke the languages common among their patient populations and used translation services as needed. Nevertheless, participants noted that improvements were still needed, such as providing materials at the appropriate reading level and in multiple languages. Several sites were flexible in that they worked with clients to reunify and involve families if desired.

Walk-in and same-day availability as well as flexible and extended hours (e.g., weekend, early morning, evening) were reported as critical to "meeting patients where they are." Appointments with navigators and medical providers appeared to be more flexible in this regard, whereas unscheduled behavioral

health treatment appointments were more difficult to access. In terms of location of services, several sites included a mobile PCMH component that provided medical services in areas accessible to people experiencing homelessness.

Moreover, having a staff person in the field to facilitate navigation of complex systems was necessary. For example, interviewees reported that navigators assisted patients with the process of obtaining proper identification and that before navigators were available, many patients were denied care without proper identification. In addition, navigators were particularly helpful in coordinating services during transition periods because they had the capacity go into the community and provide warm handoffs. Another strategy frequently reported was provision of or linkage to transportation services to help patients get to appointments.

USE OF TECHNOLOGY

Technological tools (e.g., patient portals, Google Voice, texting, social media, telemedicine) were commonly used to engage patients in care. Appointment reminders via telephone calls were standard, and navigators commonly used texting to communicate with patients. Some sites even helped patients obtain cell phones. Furthermore, team members communicated via texting, calling, and e-mail to coordinate immediate services. For general information sharing with team members, electronic medical records or other service documentation systems seemed to be preferable. "Flagging" capabilities were useful to communicate tasks requiring information that needed to be shared in a timely manner.

The ability to share calendars in the electronic medical record was also reported as helpful for service coordination. Electronic medical records were valuable for monitoring quality as well, as they were used to create reports through which medical providers could track patient outcomes. Finally, several sites reported having access to community-wide databases that track patients who are experiencing homelessness or living with HIV, which helped to locate out-of-care patients and avoid duplication of services across agencies.

NEXT STEPS

The PCMH model has demonstrated its potential for improving health outcomes in the general population and among populations with chronic illnesses.[4–7] In this study, we explored strategies used to create a PCMH for people who are experiencing homelessness or unstable housing and have co-occurring mental illness or substance use disorders. The HIV PCMH has already emerged as a model to address the needs of PLWH across several states.[8] To ensure that this model is appropriate for all PLWH, it will be necessary to consider the complex needs of those with HIV who are also experiencing homelessness or unstable housing and have been codiagnosed with behavioral health disorders.

Our description of the strategies used to create these PCMH models (along with the outcome evaluation findings presented in this supplement) represents an important area of preliminary research. Future research should further establish an evidence base regarding the efficacy of PCMH models for PLWH who experience homelessness or unstable housing. Such evidence will be useful for policymakers who aim to develop performance and accreditation guidelines that are meaningful and effective even for the most vulnerable PLWH. AJPH

Mariana Sarango, MPH
Carole Hohl, PA-C, MHS
Nelson Gonzalez, DHA, MPH
Angelica Palmeros, MSW
Mary L. Powell, DNP, PMHNP-BC
Melissa Hirschi, PhD, LCSW

CONTRIBUTORS

M. Sarango assisted with data collection and led and contributed to all aspects of coding, data analysis, writing, and editing. C. Hohl and M. Hirschi contributed to coding, analysis, writing, and editing. N. Gonzalez, A. Palmeros, and M. L. Powell contributed to analysis, writing, and editing. All of the authors contributed to the conceptualization of the article, contributed to discussions of its substance, and reviewed drafts.

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