

HEALING HANDS



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Network to Study HIV and Homelessness

To address the special considerations and challenges that primary care providers may face in caring for homeless individuals with HIV, the HCH Clinicians' Network is undertaking a project focusing on HIV and homelessness, under the direction of John Song, MD, MPH, MAT. Dr. Song is a Fellow in General Internal Medicine at the Johns Hopkins University. He is also a volunteer physician at HCH Baltimore.

Supported by the HIV/AIDS Bureau and the Bureau of Primary Health Care, the project will draw from the experience of HCH clinicians and their clients, from published and ongoing studies, and from expert opinion.

The resulting white paper will be presented at the National HCH Conference in May 1999. The paper will address considerations primary care providers should take into account when caring for homeless persons living with HIV, and recommend how optimally to apply current treatment guidelines to these patients.

HIV infection exacerbated by homelessness deserves special attention for the following reasons:

- **Epidemic prevalence:** Studies indicate that the prevalence of HIV among homeless people is between 3-20%, with some subgroups' having much higher burdens of disease.

- **High morbidity and mortality:** HIV-infected homeless persons are believed to be sicker than their domiciled counterparts. For example, they tend to have higher rates and more advanced forms of TB, and higher incidence of other illnesses such as Bartonella. Another study has demonstrated that more homeless people die of AIDS than other HIV-infected populations.

- **Barriers to care:** Homeless people with HIV may face many barriers to optimal care. Injection drug use and lack of insurance, common among homeless people, have been shown to negatively affect health care utilization, level of medical care and health status.

- **Challenges to adherence:** Adherence to complex medical regimens may be more difficult if one does not have stable housing or access to basic subsistence needs such as food. As it is believed that decreased adherence is the single best predictor of protease inhibitor failure and the primary cause of medication resistance, this problem has grave personal and public health implications.

A Network task force on HIV and homelessness is being formed to assist Dr. Song in compiling and analyzing information about effective treatment methods and perceived barriers to appropriate HIV care for homeless individuals.

Dr. Song is seeking information about any research conducted by HCH projects – published or ongoing – related to HIV and homelessness. Persons interested in participating in this project in any capacity and/or in sharing research information are invited to contact him at (410) 614-1135 phone; 502-6952 fax; jsong@welchlink.welch.jhu.edu.

What Works: Advice from the Field

“**BE FLEXIBLE** – You can't run a traditional HIV clinic for homeless people,” says Dan Ramey, LCSW, clinical social worker with Stones River Medical Consultants in Hermitage, Tennessee. “Homeless clients typically depend on emergency care because their lives are in continual crisis. They don't seek help early because they aren't used to regular medical care and don't think they'll get it.”

“**BE PROACTIVE** – Evaluate functional level, psychological status and eligibility for all health and social service benefits.”

“**BE AN ADVOCATE** – Those who work with HIV-infected homeless persons need to value them, appreciate the difficulty of their constantly changing life situation, and persistently question the authority structure about the best way to deliver services to them.”

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Clinicians Compare Notes on HIV Care for the Homeless

RURAL PERSPECTIVE

Heartland Cares is a Title III program in Paducah, KY, serving 32 rural counties in far western Kentucky and southern Illinois. The agency operates a primary care center and a continuum-of-care program for persons with HIV including homeless clients. Emergency shelter, available for two males and two females at a time, is followed by transitional housing for 24-30 months of in-depth assessment and comprehensive, medico-psychosocial services. The residential care program is part of a proposed demonstration project to compare clinical outcomes and cost-effectiveness in a therapeutic community vs traditional housing.

"In our area, newly infected HIV clients are more likely to be under 25 years of age, female with at least one child and African American," reports Director Richard Fortenbery, RN. "Most contract HIV through sexual contact with males self-described as heterosexual, many with a history of drug abuse, tattoos and/ or body piercing – risk activities fairly common in the youth culture. About half are infected in urban areas, half in rural areas."

Fortenbery advises clinic administrators to broaden their patient base: "The more broadly based a program can be beyond serving persons with HIV, the less likely it is to be opposed on philosophical grounds by local politicians, particularly in conservative rural areas." For that reason, Heartland Cares partners with agencies serving

diverse clientele with similar needs. In early 1999, the program will expand to serve other disabled persons in need of temporary shelter and comprehensive care, including victims of domestic violence.

URBAN PERSPECTIVE

Clinicians at Chicago Health Outreach frequently treat patients with co-occurring HIV, TB, mental illness and substance use disorders. "These clients have specific needs for specialized follow-up with case management," says community health nurse, Carol Hammell, MPH, BSN. "They need help with proper nutrition and refrigeration of medications, and with managing complex requirements and schedules for taking them. Some clients have to take 20 or more pills a day." Those who don't qualify for Medicaid may have difficulty getting medications funded. Getting lab fees paid for viral load testing is even more of an issue.

Hammell and her colleagues are engaged in HIV prevention with female prostitutes. They encourage these women to make safe-sex decisions, provide condoms often hard for clients to obtain, and help them work on negotiation skills. Hammell says she "definitely believes in harm reduction." "Our clients need to be seen for more than antiretroviral therapy prior to treatment. They also need assistance in making complex treatment decisions and in negotiating public assistance programs." ■

Advice from the Field *continued from page 1*

Outreach, Education & Advocacy

Homeless people don't know how to negotiate the conventional medical system; accessing services gets even more complicated under managed care. HIV patients need to be seen immediately, but managed care rewards delays to determine if care is necessary, and may also limit coverage of case management services.

Dan Ramey's solution is multicultural advocacy. As a case worker, he continually educates clinicians and clientele about current managed care policy, helps providers negotiate the reimbursement system, explains service access to clients and helps them get transportation to the nearest clinic or pharmacy. "It's important to have advocates for the homeless always at the table when State Medicaid managed care programs are being designed and implemented," Ramey con-

tends. "Cost-effectiveness and public health are two arguments people are willing to listen to."

Outreach saves money for HMOs because homeless patients with HIV are expensive when treated on an emergent basis. One MCO paid three months of boarding room costs when a patient agreed to use an outpatient clinic, saving an enormous amount in hospitalization costs.

Outreach is also an investment in public health. Many homeless people with HIV also have TB and drug use disorders. Bare-bones coverage that excludes outreach and case management services will inhibit disease containment and result in rapid depletion of Medicaid, Medicare and other public health dollars.

Continuum of Care

St. Joseph Mercy Care Services in Atlanta operates a primary care clinic that subcontracts for on-site case management and substance abuse services. "Most of our homeless HIV patients have co-occurring substance use disorders and/or mental illness," says Velinda DeForge, MS, RN, ACRN.

"During the past six years, we've tried different models of recovery. What works best is a continuum of care, including a drop-in service at an adjacent church for crisis intervention and client education; a voluntary educational support group for new HIV clients; a six-week, intensive day treatment program for clients who are ready – with behavior contracts, spot-check urine tests and monitored attendance at group sessions – prior to transitional housing." ■

Magda Barini-Garcia Moves to HIV/AIDS Bureau

After five years as Associate Director of the Division of Programs for Special Populations at the Bureau of Primary Health Care (BPHC), Magda L. Barini-Garcia, MD, MPH became Chief Medical Officer of the HIV/AIDS Bureau – also part of the Health Resources and Services Administration (HRSA) – in July.

Magda is best known to HCH clinicians as the Network's (former) Project Officer in the BPHC, the federal agency that improves access to health care for underserved populations by funding primary services at community, migrant, homeless, school and public housing health centers and through the National Health Service Corps.

In her new role at the HIV/AIDS Bureau, Dr. Barini-Garcia will focus on the clinical impact of the AIDS Education and Training Center (AETC) Program on health status and quality of care for people with HIV/AIDS. She will also serve as an advisor to the Network's project on HIV and homelessness.

The HIV/AIDS Bureau administers the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, enacted by Congress

in 1990 and reauthorized in 1998. One of several components of the CARE Act, the AETC Program is a national network of 15 centers that conduct targeted, multidisciplinary education and training for health care providers. Designed to increase the number of clinicians engaged in effective HIV/AIDS care and prevention, the AETC Program has trained more than 700,000 providers since 1991.

Born and raised in New York City, Magda is a graduate of the NYC public school system and Yale College. She received her medical education at Cornell University Medical College. After completing residency training in Obstetrics/Gynecology, she served as Assistant Director of the Department of Ob/Gyn at Brookdale Hospital Medical Center in Brooklyn.

"I was concerned about the lack of access many women I cared for had to basic prenatal services," she recalls, "and decided to explore public health issues from a systems approach." Subsequently she earned a Master's degree in Public Health Policy and Management at Columbia University's School of Public Health.

These professional interests and accomplishments made Magda a natural to help with the

"The prospect of seeing the community as my patient was intriguing, and I decided to apply my clinical and administrative expertise to policy development—specifically around issues of the underserved."

formation and direction of the HCH Clinician's Network. "As an active member of the Research and Education Committees, she helped clinicians focus on the big picture by enabling us to connect with a variety of experts who could help us reach our goals," recalls former Steering Committee Chair, Karen Rotondo, BSN, RN.

Magda's current work is a natural extension of her long commitment to clinical excellence and public policy related to the special health care needs of underserved, vulnerable populations and the uninsured. ■

Questions & Answers on Antiretroviral Therapy

Carol Hammell, community health nurse at Chicago Health Outreach, posed the following questions for HCH clinicians who prescribe antiretroviral medications for homeless HIV clients. Velinda DeForge, nurse practitioner St. Joseph Mercy Care Services in Atlanta, responds from her agency's experience:

How do you handle antiretroviral medications for clients actively using nonprescription drugs?

"It depends on the individual. We don't begin antiretrovirals if a client comes in drunk. We explain the harm these meds will do without strict adherence to prescribed treatment regimens, and draw up behavior contracts with some clients. Often patients agree they are not ready to begin medication. We counsel those who are ready at length about antiretroviral therapy, let them think about it for a couple of weeks, then begin treatment if they still want it."

What about mentally ill clients with or without substance use?

"If clients don't have the capacity to stay on the regimen, don't put them on it. Some folks, even with cognitive deficits, can do it and do well. One well-integrated patient with multiple personality disorder, still on dual therapy, refuses approved protease inhibitors because she fears their side-effects."

What do you do for clients who have failed regimens?

"We're on the expanded access program for Sustiva and are adding Hydroxyurea for some patients. If clients fail on one protease inhibitor, we put them on two. We haven't had anyone who has completely run out of options yet, but we're crossing our fingers until the latest antiretrovirals are approved."

How aggressively do you begin clients who are seroconverting (newly infected) on antiretrovirals? Do you give meds prophylactically?

"We are aggressively treating clients who are seroconverting, but are not giving antiretrovirals prophylactically." ■

As For Hope

For the most part my story is general.
There was education, success, adulthood,
then bad decisions.
Compiled with other issues, now homelessness.

Good Lord, why did I ever try to live without you?
The Homeless circuit (also called the Trail)
is this hidden world where no one exists
except to those appointed to serve. (Praise God)

When I first arrived on the scene, the fear
was unlike anything I had ever faced.
Shame allowed me no contact with the world I left.
So I had to lay stake wherever I could.

I have slept in Shelters on all sides of town.
I've stood in lines for hours, dodged body lice,
prayed for freedom from airborne viruses
and fought to sleep despite overwhelming body odors.

Please, try this test at home:
First, take off your clothes without touching the floor
with your bare feet.
Then take a shower without touching the walls
of the shower,

(at the same time) listening for the flushing of the toilet which
changes the water temperature of the shower.
Then decide if this is compulsion or safety.

Please repeat this process for several months. Only then will you
feel the full effects of what will follow these words.

In the day-to-day struggle to escape my conditions,
I stumbled upon Hearts' Place.
Where the people smile and welcome you.
Where clean blankets and sheets are plentiful.
Where you can shower in your bare feet
and still feel clean.
Where God's name does not have to be mentioned
to insure his presence.
Where the toughest staff member shows evidence
of compassion.
Where men and women help you
because you need them.
Not because they're obligated.
I believe Hearts' Place is the very hand of refuge...
The very arm of God...
Let us pray for its growth.

John Garner

*member of Dr. John Song's creative writing group
HCH Baltimore, Maryland*

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