HUMAN SERVICES DEPARTMENT
COMMUNITY PARTNERSHIPS DIVISION
115 S Andrews Avenue, Room A360 • Fort Lauderdale, Florida 33301 • 954-357-8647 • FAX 954-357-8204

BEHAVIORAL HEALTH NETWORK MEETING

Date: August 17th, 2018 @ 2:00PM
Location: Ryan White Part A Program Office
115 S. Andrews Ave., A-337
Ft. Lauderdale, FL 33301

Facilitator: Clinical Quality Management Staff
quality@brhpc.org
(954) 561-9681 ext. 1250

AGENDA

I. Welcome & Introductions

II. You Asked, We Listened!

HOPWA Presentation—Christopher Leonard, *HOPWA Representative*

- Overview of HOPWA Program/Accessing HOPWA resources

Homelessness and Mental Health

- Discuss assisting homeless clients with behavioral health issues
- Share processes and solutions currently used by Providers
- Discuss additional solutions and available resources to assist clients

III. Case Study

- Broward House
- AHF

IV. Meeting Date Poll

- Complete and submit meeting date poll

V. Complete Meeting Evaluation

VI. Adjournment

Next Meeting Date: November 16th, 2018
Please see staff for a Governmental Parking Garage Validation ticket

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BEHAVIORAL HEALTH NETWORK MEETING
Friday, May 18, 2018 at 2:00 P.M.
Ryan White Part A Program Office, A-337
115 S. Andrews Ave., Ft. Lauderdale 33301

Minutes

PROVIDERS PRESENT
C. David Shelton (AHF)
Damon Jones (AHF)
Elizabeth Johnson (SBHD)
Gary S. Hensley (Sunserve)
Katy Yankie (Sunserve)
Stephanie Miller (Broward House)
Jamie Powers (Broward House)
Hugo Rocchia (Care Resource)

PROVIDERS ABSENT
BCFHC

GUEST
None

PART A RECIPIENT STAFF
Leonard Jones
Edith Garcia
Neil Walker

CLINICAL QUALITY MANAGEMENT (CQM) SUPPORT STAFF
Kelsey Holloman
Charnelle Bacchus-Powers
Linda Anyaduba

I. Welcome/Introductions
CQM Staff welcomed everyone and individual introductions were made.

II. Icebreaker
Staff introduced an icebreaker, chain stories. The Network was separated into three groups. The goal of the icebreaker was to have the Providers learn more about each other and their similarities by telling short stories about themselves. Staff concluded by noting the goal of chain stories was to highlight we are all more alike than different. Staff also mentioned that providers, Staff, and the Recipient might be from different agencies, but we are working towards the same goals and share solutions to similar issues.

III. Presentation: CQM Program and Network Meeting Overview
CQM staff provided an overview of the CQM Program. The presentation went over the CQM Plan and program goals, the roles of the Quality Assurance and Quality Improvement teams, and the Quality Management Committee and Networks. The presentation went on to discuss the difference between quality assurance and quality improvement, the CQM work plan, and the core medical and support

services. The Access to Care schedule is created by the Recipient staff and disseminated by the CQM staff to all providers. The presentation also reviewed the structure and logistics of the Network meetings.

Staff noted case studies serve as a way for feedback to be provided and can be modified to serve as a useful tool for behavioral health providers. Staff asked Providers for suggestions to improve the template for the Network. A provider inquired about the purpose of focusing on viral loads. Staff responded to the provider by noting viral load is always a focus for clients in the Part A system as viral load impacts all aspects of patient health and care. The recipient noted the focus is to consistently make sure Ryan White Part A clients' viral load is suppressed. A member added, a client who is not engaged in mental health, might need the encouragement of seeing viral load progression. The member also stated they encourage their staff to have the conversation about viral load because they might not be well versed about the details. It's important to look at the medical component to check in to see how they are doing with their health. The recipient clarified the goal of the case study is to identify barriers, challenges, success stories, system failure and share resources within the network. There are a number of agencies that clients will interact with on the way to recovery, and there is an opportunity to address and ensure viral load suppression at each Part A service provider. Ultimately, the Network provided multiple suggestions to include in the Case Study template including: diagnoses, symptoms, history, medications, interactions with psychiatrists, how long presenting problem has been going on, and compliance to instructions/advice given to clients by their therapists. Staff will make these amendments and distribute the Case Study to the Network. AHF and Broward House volunteered to present a Case Study at the next Network meeting on 8.17.18.

IV. Survey

Providers completed a survey about the topics they would like to see discussed at upcoming meetings throughout the year.

V. Questions/Suggestions

A provider requested handouts with images/tables be set as landscape for easy reading. In discussing issues with Provide Enterprise (PE), a provider mentioned their agency can only see initial client viral load information, but cannot see updated viral loads. The provider noted this issue might be an issue with PE account user settings as they are only providing mental health services in the Ryan White Part A system. The Recipient suggested the issue may be able to be remedied by addressing it with PE staff who will be in Broward next week. The recipient encouraged all providers to confer with their agencies to schedule a agency-specific training block with PE staff next week. Broward County and Staff sent e-mails to providers on the subject with information. Providers will need to contact Susan Malek in the Recipient's office to schedule the training. The training will be held at the Recipient's office and will be address and all provider/agency-related PE issues.

A provider suggested the Network discuss moving the Behavioral Health Network meeting date/time to an alternate day of the week; however, after a vote it was determined there was a split on a date/time which worked best for the majority of providers. Staff agreed to distribute a poll to providers with flexible date/time options that may work best for the network. Staff concluded all meeting parties are open to the network meeting date/time.

VI. Adjournment

The meeting was adjourned at 3:29pm.

Next Meeting Date: 8/17/18

Parking Lot

- None.

Action Items

- Case Study: Broward House and AHF will complete the Case Study template and return to Staff at quality@brhpc.org by August 3rd, 2018.
- Staff will distribute a poll to providers with alternative dates and times for the Behavioral Health Network to meet.

City of FORT LAUDERDALE

City of Fort Lauderdale
Housing & Community Development

Housing Opportunities for Persons with HIV/AIDS

HOPWA- 101 Presentation

1. Overview
2. Client Eligibility
3. Housing Stability Plans
4. Support Services
5. Eligible Activities

The Statutory purpose of Housing Opportunities for Persons with AIDS, also known as HOPWA, is to provide states and localities with the resources and incentives to ***devise long term strategies*** for meeting the housing needs of low-income persons living with HIV/AIDS and their families.

To reduce the risks of homelessness for this population and increase access to appropriate healthcare and other support.

Housing subsidies should not be viewed as permanent housing subsidy.

To develop and implement individualized comprehensive housing stability plans to help HOPWA clients achieve housing stability ***without long-term dependence*** on HOPWA assistance:

- Enable assisted households to establish or better maintain stable living in an environment that is decent, safe and sanitary
- Reduce the risk of homelessness
- Improve clients' access to medical care and linkages to supportive services associated with HIV/AIDS.
- **Clients who have documented medical conditions may require long term dependence**.

COFL Goal #1

Stabilize housing by providing housing assistance and supportive services for low-income HOPWA eligible clients to reduce the risk of homelessness.

COFL Goal #2

Move low-income HOPWA households **towards self-sufficiency**[1] through the use of HOPWA housing subsidy[2] and supportive services in the reported fiscal year.

This is accomplished through the development and implementation of an individualized comprehensive housing plan.

[1] Self-Sufficiency is defined as households who moved off HOPWA 12 month subsidy through private housing or another subsidy.

[2] HOPWA Housing subsidy is Tenant Based Rental Voucher (TBRV), Facility Based Housing (FAC), or Project Based Housing (PBR) .

COFL Goal #3

Annually, move low-income HOPWA **households off** HOPWA housing subsidy[1] to self-sufficiency[2].

This is accomplished through the development and implementation of an individualized comprehensive housing plan.

[1] HOPWA Housing subsidy is Tenant Based Rental Voucher (TBRV), Facility Based Housing (FAC), or Project Based Housing (PBR).

[2] Self-Sufficiency is defined as households who moved off HOPWA 12 month subsidy through private housing or another subsidy.

COFL Goal #4

Low income persons living with HIV/AIDS and their families will maintain self-sufficiency[1] through the use of HOPWA STRMU and PHP housing assistance program.

This is accomplished through the development and implementation of an individualized comprehensive housing plan.

[1] Self-Sufficiency is defined as households who moved off HOPWA 12 month subsidy through private housing or another subsidy.

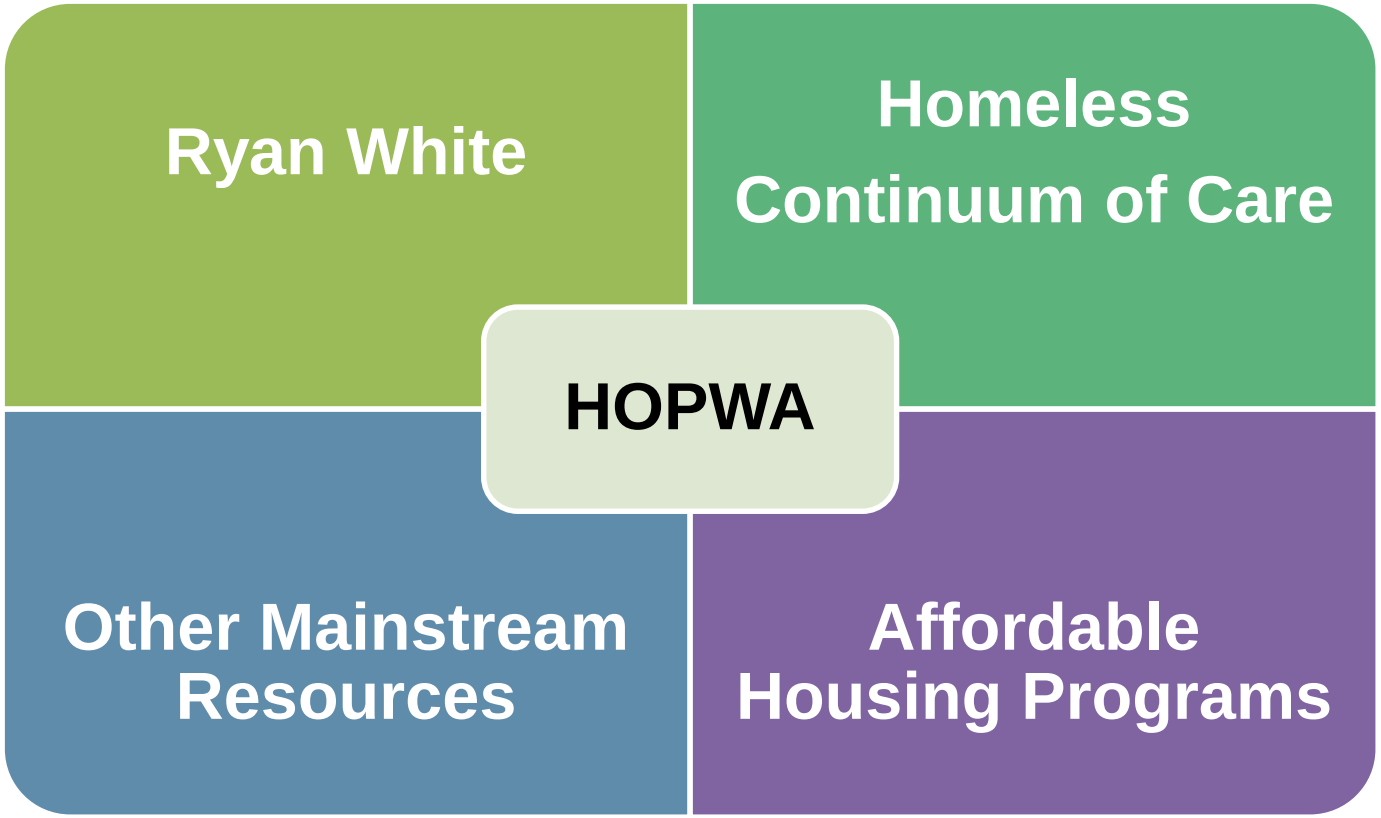
[2] HOPWA Short Term Utilities, Mortgage and Rent (STRMU) and Permanent Housing Placement (PHP).

- Code of Federal Regulations – HUD 24 CFR 574: HOPWA
- Can address a wide range of housing needs
- One of several solutions for housing someone with HIV disease
- People living with HIV are considered by HUD to be persons with special needs
- Not a homeless program
- Designed to work with existing housing resources
- Other HUD programs are also potentially available to PLWH/A's
- HOPWA helps persons living with HIV/AIDS overcome key barriers to stable housing - affordability and discrimination
- Should not be used to supplant Ryan White services

CONFIDENTIALITY

24 CFR 574.440

HOPWA regulations require that grantees and project sponsors ensure the confidentiality of both the name of any individual assisted by HOPWA and any other information regarding individuals receiving assistance.


Ryan White
Homeless
Continuum of Care
HOPWA
Other Mainstream
Resources
Affordable
Housing Programs

Be HIV positive	• Lab results- Western Blot/Viral Load
Income must fall within Federal	• Income of ***ALL*** applicable household members is

5. ***Permanent Housing Placement (PHP)*:** assists with move in assistance with rent/deposits/utility connection.

6. ***Supportive Services*: *Housing Case Management*** Consists of housing service plans that establish or better obtain, maintain a stable living environment in housing that is decent, safe, and sanitary. Assists with completion of STRMU/PHP applications

7. ***Support Services: Legal:*** Consist of legal services for landlord evictions, discrimination related to housing, unit safety/habitability and landlord/tenant issues.

- Provides resources to develop and operate community residences and other supportive housing for up to 365 days.
- With facility based housing, the expectation is that participants will be in need of some level of supportive services in order to maintain stability and receive appropriate levels of care.
- General housing operations (e.g., maintenance, security, insurance, utilities, furnishings, equipment/supplies).

- Housing for clients that require supervision and assistance with daily living activities
- Requires clients pay portion of their income as rent
- Assist client in achieving self-sufficiency through development of individualized housing stability plans:
  - Identify client housing instability
  - Create objectives and goals for independent living
  - Provide supportive services

- Rental assistance for eligible persons or families to live in apartment units.
- Rental subsidy stays with housing facility/units.
- *Household income not required*; however, income must be obtained within designated time period.
- Requires clients pay portion of their income as rent and cannot exceed fair market rent standards provided by HUD.

- Assist client in achieving self-sufficiency through development of individualized housing stability plans:
  - —Identify client housing instability
  - —Create objectives and goals for independent living
  - —Provide supportive services

- Independent housing- portable monthly rental subsidy that stays with client not the unit in housing of their choice within the Broward County. Lease is in the client's name.

- The subsidy covers the difference between the HUD Fair Market Rent (or other rent standard) and the tenant's contribution.

- Requires clients pay portion of their income as rent.

- Assist client in achieving self-sufficiency through development of individualized housing stability plans:
  - —Identify client housing instability
  - —Create objectives and goals for independent living
  - —Provide supportive services

STRMU is intended to:

- Provide **short-term interventions to help maintain stable living arrangements** for households experiencing a financial crisis and the potential loss of housing.

- Only be used in response to "**emergency need**":
  - Sudden loss of income not due to quitting job unless medically documented;
  - Reduction of income due to recent hospitalization or illness;
  - Extraordinary and unexpected health care cost; and
  - Due to the above issues, client faces eviction or utility shut off.

STRMU is intended to:

- Support for ***emergency financial assistance*** for payment of rent, mortgage and utilities.
- ***Time-limited*** housing assistance designed to prevent homelessness and increase housing stability.
  - Assistance is provided to help homeowners and renters remain in their current place of residence.
  - STRMU ***cannot*** be used to assist a client with locating a housing unit, security deposits, first months rent, or other move-in support.
  - *Designed as a short-term intervention*. Other types of assistance (rental assistance or residency in community facility) should be used for clients with ongoing needs.

- STRMU payments ***must not be used to relieve the household responsibility*** of their rent, mortgage or utility payments ***in the absence of ability to pay.***

- Assist client in maintaining self-sufficiency through development of individualized housing stability plans:
  - —Identify client housing instability;
  - —Create objectives and goals for independent living; and
  - —Provide supportive services

PHP is intended to:

- To assist eligible clients with move in assistance and cost associated with obtaining permanent housing:
  - Application fees and credit checks;
  - First months, Last months and security deposits (not to exceed two months rent);
  - Security deposits are program funds that are returned to the program when the assisted client/tenant leaves unit;
  - One time utility connection fees and processing cost; and
  - Needs based program and should be used sparingly.

- Assist client in *obtaining* permanent housing.
- One time payment for first/last month rent only.
- May provide a one time utility connection.
- ***Ensure client's financial resources can sustain living in the housing unit.***
- Assists clients in completing PHP applications.
- Clients must receive supportive services.
- Agency reviews and approves completed applications.

- Consists of housing service plans that establish or better maintain a stable living environment in housing that is decent, safe, and sanitary, reduce the risk of homelessness, and improve access to healthcare for ***clients who are not receiving FAC, PBR or TBRV services.***
- Assist clients in completing STRMU and PHP applications.
- Ensure client is receiving adequate and appropriate housing.

- Assist client in achieving/maintaining self-sufficiency through development of individualized housing stability plans:
  - —Identify client housing instability
  - —Create objectives and goals for independent living
  - —Provide supportive services

- Serve clients who were terminated from FAC, PBR, TBRV, STRMU or PHP HOPWA Programs.

Provide legal advice and/or direct legal representation to clients only for the following issues:

1. Foreclosure;
2. Eviction;
3. Three Day Writ;
4. Unit Habitability and Safety issues;
5. Land Lord and Tenant issues on executed contracts; and
6. Review unsigned lease for HOPWA clients prior to signing.

- Most clients are referred from the HCM programs

Behavioral Health Network Case Study

(Provide any information (behavioral health or medical) relevant to client case being presented)

Behavioral Health Diagnosis:	Schizophrenia paranoid type, Bipolar D/O, Major Depression, Substance Abuse Dependence (Alcohol, Crack Cocaine)
Length of Behavioral Health Diagnosis:	Early 20's; currently
Presenting Behavioral Health Symptoms:	Upon admission she was placed under BA due to responding to internal stimuli and impulsive behaviors which put her and others in her treatment community at risk of harm.
Medications (medical and/or behavioral health related):	Upon admission: Chronic Arthritis, severely underweight, long history of lack of self-care, digestive issues, dental needs, optical needs. During treatment client was provided with case management services to assist with linkage to: HIV medical treatment, gastroenterologist, obgyn, dental care, pulmonologist, optical. She underwent eye surgeries, extensive testing for heart and gastrointestinal issues, all teeth were extracted and received dentures.
Viral Load (include history of viral load, if relevant):	12/21/2017- VL: 4,380,000 and CD4: 299 1/12/18- VL: 985000 CD4: none reported 2/12/17- VL: 2320 CD4: none reported
Length of Time in Care:	Admitted to IDT programming on December 1st 2017.
Other Relevant Medical Conditions:	Addressed Above.
Other Barriers to Care:	Chronic Homelessness, Lack of support system (no family/sober supports), Hx of non-adherence to medical and mental health treatment, extensive substance abuse history (crack cocaine/alcohol); extensive history of trauma and feelings of abandonment.

Client History (including presenting issues to be discussed):

Current issue(s) to be discussed include:

1. Housing placement for a client who is able to live independently in that she can cook for herself, and maintain her personal hygiene; however, needs assistance

managing Medicaid/Medicare services, needs reminders to take her medications, and needs assistance with ensuring medications are filled properly to ensure she does not run out.

2. Client has Medicare/Medicaid, and we have been granted Override for SA services rendered; however, due to client's complications with her medical needs and the slow start of engagement into her treatment program, she continues to need further assistance to develop IL skills. *What programs are available in the community to assist with meeting these needs that are covered through Medicare/Medicaid?*

Client Treatment Plan and Compliance with Treatment Plan:

Current treatment plan goals read as follows:

1. "I would like to have my time at Broward House extended so that I am ore prepared to live on my own once I leave" Client will increase the use of independent living skills so that she can successfully transition to transitional housing, AEB: identifying 3 sober supports within the community, independently demonstrating med compliance (mental health and psychiatric), demonstrate ability to maintain personal hygiene, seek safe and stable housing. (Most Recent)
2. "I want to live my life without drugs" Client will increase the use of coping skills around drug use as evidenced by obtaining negative drug screens weekly. *Since December 2017, client has tested negative on all drug screens with the exception of one relapse on 3/3/18.*
3. "I want to manage my mental health and have a greater understanding of my symptoms so I don't go back to using." Client will improve compliance towards mental health treatment, AEB: identifying symptoms she experiences of mental health diagnosis, identifying coping skills around mental health diagnosis, attend all scheduled psychiatric appointments, and take all medications as prescribed. *Client has been compliant with psychiatric treatment as she takes her medications when prompted by nursing staff, has gained more insight into her mental health symptoms and is able to identify episodes of mania/depression, attends psychiatric appointments as scheduled. Client continues to struggle with taking psychiatric medications without prompting, especially when experiencing manic episodes or increased levels of paranoia.*
4. "I want to manage my HIV." Client will improve health outcomes, AEB; improvement in lab (CD4 and VL), adherence to medication, and attending scheduled medical appointments. *Client has demonstrated improved compliance to medical care, as her VL has improved over the past two lab draws. CD4 count was unable to be reported during this staffing. Client takes medications when*

prompted by nursing staff. She had demonstrated the ability to advocate to ensure her medical needs are addressed, with care counselor (CM) team.

Interactions with Behavioral Health Provider: Upon admission client presented with increased paranoia, often claiming that ARTAS case manager (who linked her with care) kidnapped her and then abandoned her in our treatment center. Client was resistant to engaging into care; however, was also experiencing multiple medical complications which prevented her from focusing her attention on engaging in her treatment program. During this time client was able to make progress towards abstaining from the use of drugs/alcohol. Our staff assisted with motivating her to take care of her hygiene, eat three meals (or more) daily, and begin improving her compliance with medical care. After the client began feeling better, and addressing her concerning medical needs, she became increasingly engaged in the treatment community. Client is currently an active member in her treatment community, speaking from her experiences and sharing that her willingness to accept treatment has made all the difference in her ability to make emotional, spiritual, and physical improvements in her life.

Behavioral Health Network Case Study

(Provide any information (behavioral health or medical) relevant to client case being presented)

Behavioral Health Diagnosis:	Borderline Personality Disorder Dysthymia (Severe) Generalized Anxiety Disorder Alcohol Use Disorder(In early remission) Binge Eating Disorder
Length of Behavioral Health Diagnosis:	12 June 2018 21 May 2018 8 Feb 2018 8 Feb 2018 20 July 2018
Presenting Behavioral Health Symptoms:	At the time of admission, the patient reported difficulty coping with ETOH dependence, increased levels of anxiety, and a recent attempt at suicide. The patient reported being BA'd and released on Feb 19. The patient reported additional difficulty coping with loneliness, loss of his home, chronic health conditions, strong cravings to drink, and the death of his partner in 2016.
Medications (medical and/or behavioral health related):	Restoril ; Cymbalta ; Vistaril ; Lyrica ; Biktarvy ; doxycycline
Viral Load (include history of viral load, if relevant):	Suppressed and undetectable. The patient demonstrates compliance with scheduled medications.
Length of Time in Care:	The patient has been a patient of care at AHF since 2013. The patient became enrolled in OP care in March of 2018.
Other Relevant Medical Conditions:	Obesity, GERD, decreased libido, current smoker, reports of musculoskeletal pain, reports of joint related issues.
Other Barriers to Care:	The patient reports having inadequate access to medical care and poor satisfaction with caretakers, with exception to behavioural health clinician. The patient demonstrates poor professional boundaries, AEB flirtatious engagement and lewd comments during sessions towards behavioural clinician. The patient reported difficulty with obtaining access to disability. The patient demonstrates a tendency to engage in med-seeking behaviours. The patient demonstrates significant tendency to exaggerate somatic, behavioural, and medical related issues grossly out of proportion to medical evidence. The patient demonstrates significant resistance to caretaker recommendations.

Client History (including presenting issues to be discussed):

The patient is a 51yo Caucasian cisgender homosexual male who is continuing to seek OP mental health services to address his depression and anxiety and prevent relapse on ETOH. The patient's early upbringing was notable for abandonment related issues. The patient's father left and became estranged from the family when he was two years of age. The patient reported his father had a history of ETOH abuse. The patient is estranged from his siblings and has minimal contact with his mother due to interjection from his sister. The patient reported he is the "black sheep" of the family and that his brother and sister are the "successful ones – the golden children." The patient reported a history of physical and emotional abuse from his first step-father. The patient reported his mother was supportive, when she could be. The patient reported a history of verbal abuse from his siblings. The patient reported a history of bullying between middle and high school.

The patient reported having a low self-image and self-esteem. The patient reported he struggled with his weight on numerous occasions. The patient is currently diagnosed obese and demonstrates issues with poor appetite and binge eating. The patient's binge eating is driven by strong cravings for sugar and happens predominantly after awaking from naps and sleep schedules. The patient reported difficulty coping with his HIV status and how he contracted it. The patient reported attempting to engage in intravenous drug use while under the influence of alcohol and pursuing a sexual encounter. The patient currently does not discuss any issues with his HIV and demonstrates medication adherence.

The patient reported a legal history consisting of three DUI's, his most recent being in April of 2018 for DUI. The patient reported relapsing on ETOH, failing to adhere to schedule medication recommendations, due to increased feelings of depression and stress. The patient obtained legal representation to have his charges lessened and reported he was placed on house arrest. The patient was required to participate in police monitoring until his scheduled court date. The patient reported an extensive history of misdemeanor driving charges, his most recent being in April for excessive speed in a school zone during school hours. The patient has demonstrated poor acknowledgment, acceptance, and responsibility of his behaviour AEB statements referring to police as "dicks, pricks, assholes," and police being "out to get me because they know me." The patient continuously denies fault and engages in persecutory thinking patterns despite awareness of locations of traffic signs and school zones and reporting being a resident in his neighborhood for "years."

The patient is currently unemployed and is seeking assistance with being placed on FMLA and disability, despite sufficient evidence supporting disabilities he claims. The patient has been reported and demonstrated verbally combative behaviours with practitioners on numerous occasions. The patient has repeatedly demonstrated poor adherence to medical recommendations and continuously claims "These doctors don't know what they fuck they are doing. And XXX is a prick. I'm not going to him anymore. I tell him I have anxiety and he gives me Vistaril. What the fuck is that going to do. Give me the real stuff that works." The patient has demonstrated med-seeking behaviours and consistently engages in verbal altercations with his medical treatment team to obtain desired diagnoses. The patient has participated in numerous assessments and physical exams which lack evidence to support his somatic claims. The patient has also demonstrated passive aggression as AEB by his declination to report current concerns and issues to his providers and sharing them with behavioral clinician instead. The patient has acknowledged poor compliance with treatment recommendations and engages in denial patterns to support his maladaptive thought processes.

I could go on but……

Client Treatment Plan and Compliance with Treatment Plan:

Patient's Challenge I: "I want help with my panic attacks. My heart races and I have some numbness in my left arm."
Objective: The patient will demonstrate three relaxation techniques to reduce anxiety.
Intervention: Didactic exercises in individual session
Interventionist(s): David
Frequency: PRN - Biweekly
Target Date: 18 July 2018
Status: Partially successful.

Patient's Challenge II: "I have depression."
Objective: The patient will learn and develop three ways to elevate his moods when met with feelings of depression and negative circumstances.
Intervention: Psychoeducation, process in individual session
Interventionist(s): David
Frequency: PRN - Biweekly
Target Date: 18 Sept 2018
Status: In progress. The patient demonstrates continued codependent behaviors and presents with reluctant and resistant behaviors to therapist recommendations. The patient's borderline traits also present significant obstacles to desired treatment results. The patient's progress and status will be reviewed with RW-A case management for possible referral to higher level of care.

Patient's Challenge III: "I want to see you weekly if I can."
Objective: The patient will adhere to scheduled appointments and therapist will provide support as needed.
Intervention: Attendance of scheduled sessions and adherence to therapy policies; follow-up if necessary
Interventionist(s): David & Robert
Frequency: PRN - Biweekly
Target Date: 18 Sept 2018
Status: In progress. The patient demonstrates poor compliance with scheduling. To date, patient has missed four scheduled appointments, without prior notification and with consistent claim to not having received confirmation of a scheduled appointment despite setting the appointment with staff himself. The patient is also insistent that he be given immediate priority to see behavioural clinician but does comply with rescheduling policy.

Interactions with Behavioral Health Provider:

The patient demonstrates significant difficulty with becoming engaged in therapy, despite constant therapist redirection and education on how to effectively benefit from OP mental health services. Borderline traits are apparent and significant during most encounters. The patient demonstrates poor personal and professional boundaries as evidenced by unwanted remarks towards behavioural clinician. The patient has stated on numerous occasions "I like coming to therapy because the eye candy is helpful." The patient consistently engages in verbose, pressure, and circumstantial speech related patterns and depending on intensity of BPD traits responds poorly to therapist retort. The patient has completed some treatment plan goals but continues to engage in avoidant behavior and poor adherence to therapist recommendations. The patient responds best to Solution Focused therapy and MI.

THE IMPORTANCE OF
VIRAL LOAD MONITORING

Viral load monitoring is one of the most powerful and multifaceted HIV prevention and treatment tools available.

Monitoring stimulates consciousness of health, increased personal health engagement, motivates ART adherence, and provides a measure for programmatic success.

ENGAGE
SERVE
RETAIN

A SYSTEMS PERSPECTIVE

Engaging clients in discussions about monitoring viral loads is also an essential asset of care continuum retention and gauging program efficiency–poor engagement has been associated with inadequate medical adherence, and viral load outcomes.

In the United States, as many as 50% of individuals with HIV are not retained in care services.

Roughly 33% of HIV transmissions stem from PLWHA who have been diagnosed, but are not retained in care and not virally suppressed.

The Part A Program is above average among U.S. programs in retaining patients within the care continuum.

- Expansive viral load monitoring, RW copay structure, broader formulary, and comprehensive care have been cited as contributors to the program's proficiency.

As we endeavor upon quality improvement within the program and reinforce the comprehensiveness of care and services across agencies, monitoring viral loads of clients will be a collaborative effort in prevention and retaining clients in care.

GET CARE BROWARD TREAT HIV BEAT HIV

BROWARD COUNTY FLORIDA

1. Irvine, M. K., Chamberlin, S. A., Robbins, R. S., Kulkarni, S. G., Robertson, M. M., & Nash, D. (2017). Come as You Are: Improving Care Engagement and Viral Load Suppression Among HIV Care Coordination Clients with Lower Mental Health Functioning, Unstable Housing, and Hard Drug Use. , (6), 1572–1579. http://doi.org/10.1007/s10461-016-1460-4

2. Colasanti, J., Kelly, J.,Pennisi, E., Hu, Y., Root, C., Hughes, D., del Rio, C., Armstrong, W.S. (2016). Continuous Retention and Viral Suppression Provide Further Insights Into the HIV Care Continuum Compared to the Cross-sectional HIV Care Cascade. , (5). 648–654.

3. Schwartz, S. R., Kavanagh, M. M., Sugarman, J., Solomon, S. S., Njindam, I. M., Rebe, K., Quinn, T. C., Toure-Kane, C., Beyrer, C., Baral, S. (2017) HIV viral load monitoring among key populations in low- and middle-income countries: challenges and opportunities.

Survey for Subsequent Meeting Time and Day

☐ Wednesday (11/14/18) 9:30 a.m. – 11:30 a.m.

☐ Wednesday (11/14/18) 2 p.m. – 4 p.m.

☐ Wednesday (11/14/18) 3 p.m. – 5 pm.

☐ Friday (11/16/18) 9 a.m. – 11:30 a.m.

☐ Friday (11/16/18) 2 p.m. – 4 p.m.

SHORT

TERM

RENT

MORTGAGE

UTILITY

Remember this:

- ***Verifiable loss** (reduction in, or loss of income that can be proven)*
- ***Verifiable need***
- ***Verifiable income***
- ***Establish and maintain housing plan***

DO N
THE

Beneficiary Eligibility

Definition/Purpose

Short-Term Rent, Mortgage, and Utility (STRMU) assistance is an eligible activity under the HOPWA program. STRMU is ***time-limited*** housing assistance designed to prevent homelessness and increase housing stability due to unexpected illness or loss of income. HOPWA Agency may provide assistance for a period that does not exceed ***the established lifetime cap.*** The amount of assistance varies per client depending on funds available, Client's housing cost needs, and program guidelines. STRMU funds are limited and no two situations are ever identical. For this reason, the Housing Case Managers must conduct an individual assessment of the client's situation and develop a plan of action (Housing Plan). Financial assistance decisions are made based on the data collected and client's risk of homelessness . STRMU payments are not to be used to relieve the household responsibility of their rent, mortgage or utility payment in the absence of their ability to make self-sufficient payments in the future.

All financial payments are made directly to the vendor (i.e., Mortgage Financial Institution, Landlords, Florida Power & Light (FPL)).

HOPWA Program Eligibility

Households must meet the following criteria to be eligible for assistance under the HOPWA program:

- Low-income (Total House hold income at or below 80% of area median income, see www.huduser.org);
- Documented HIV/AIDS status of at least one household member (confidentiality must be maintained); and
- Must have proof of Broward County residency for 6 consecutive months.

STRMU Eligibility

Provide ***short-term interventions*** to help maintain stable living arrangements for households currently living in housing that does not have a rent, mortgage, or utility subsidy, and who are experiencing a financial crisis and the potential loss of housing. Other types of assistance should be used for clients with on-going needs.

- Homeless individuals are not eligible for STRMU assistance. Assistance is provided to help homeowners and renters remain in their current place of residence
- Client must be able to document that he/she has a legal right to occupy the premises or has responsibility for the rent, mortgage or utility payment. Examples of acceptable documentation are as follows:

  Rental payments: Client must be named tenant under valid lease or referenced in lease as occupant of the premises.

  Mortgage payments: Client must demonstrate that he/she is owner of mortgaged real property (mortgage, deed of trust, title insurance policy).

  Utility payments: Client must have account in their name or proof of responsibility to make utility payments copies of money orders, cancelled checks, receipts).

- Client must demonstrate he/she does not have the resources to meet rent, mortgage or utility payments and, in the absence of STRMU assistance, would be at risk of homelessness.
- ***Sudden and unexpected loss*** **of income due to reduction in hours, termination beyond the client's control, but not due to quitting the job unless medical documentation requires such action.**
- Reduction of income due to recent hospitalization or illness; Extraordinary

Eligible Expenses

Rent, and mortgage assistance

- Must be reasonable and represent actual housing costs.
- Unlike other forms of HOPWA assistance, tenants are not required to pay a portion of their income towards the rent or mortgage payment. However, if they are able, clients should pay a portion of their housing costs as any portion paid by the tenant does not count against the ***lifetime STRMU Cap.***

Late fees

- Late fees and other penalties may be paid if, in the event of nonpayment, the household is at risk of eviction or loss of housing..

Utility assistance

- Electricity (FPL)
- Water and Sewer
- Natural gas / propane (for household use)

Ineligible Expenses

- Security deposits and first month's rent STRMU assistance is designed to help homeowners and renters stabilize in their current place of residence; therefore, security deposits and first month's rent are not eligible costs under STRMU. However, these costs are eligible as permanent housing placement costs;
- Moving assistance;
- Household supplies and furnishings;
- Automobile expenses; and
- Telephone expenses.

Program Requirements

- Client must sign participation agreement;
- Client must understand that funds are capped and are limited; and
- Client must have a viable plan of action for housing stability and self-sufficiency