# INTEGRATION OF CARE COMMITTEE

January 11, 2006
9:50am-11:35am
GMHC, 119 W. 24th Street

## M I N U T E S

**Members Attending:** J. Grimaldi, MD (Co-chair), T. Troia (Co-chair), R. Canosa, C. Craig, E. Greeley, K. Huang-Cruz, E. Levine, J. Matsuyoshi, L. Morrison, D. Ng, R. Quattrochi, A. Richardson, J. Shields, B. Starks-Ross, S. Caba (ex-officio)

**Staff Present:** D. Klotz, I. Gonzalez, J. Park, D. Wong, S. Bailous, R. Shiau, C. Silva, R. Molina

**Guest Present:** Angela Aidala

---

### I. Meeting Opening/Minutes

Dr. Grimaldi opened the meeting. After introductions, the minutes of the November 9, 2005 meeting were approved with no changes.

### II. Planning for Services: Special Populations

Dr. Grimaldi reviewed the list of special populations drafted by the Needs Assessment Committee (NAC). Members raised concerns about the list, noting that there are many permutations that may include or exclude worthy special populations. Mr. Shiau explained the process the NAC used to develop the list, starting with the six HRSA-designated populations from the FY 2006 New York EMA Title I grant application, along with other HRSA populations and the list developed by IOC at the previous meeting. They also considered data that Dr. Aidala presented on delayed care seekers and the unconnected. NAC will be collecting data on these populations and aggregate it for the IOC and Priority Setting & Resource Allocation Committee's use in planning.

### III. Housing and HIV Care and Prevention

Dr. Aidala presented on the role of housing (and the lack thereof) in HIV care and prevention, and the implications for housing as a structural intervention to reduce the spread of HIV as well as to increase the health and longevity of HIV-infected persons. Housing is a contextual factor within which we live our lives and a manifestation of more global structural factors, but

also a more accessible point of intervention. Using data from the CHAIN study and a national SPNS/HOPWA study measuring those who are homeless, unstably housed and stably house, we found that 40% to 60% of all PLWHA have lifetime experience of homelessness or housing instability. The prevalence of HIV/ AIDS is approximately 10 times higher among persons who are homeless or unstably housed than among persons with stable, adequate housing. 49% of the NYC cohort was homeless or unstably housed during the year they were diagnosed with HIV and 60% experienced unstable housing or homelessness at least once during the study period. Rates of housing need remain fairly constant over time.

Significant differences in drug and sex risk behaviors are associated with current housing status, with the homeless at greater risk than the unstably housed, and both of these groups at greater risk than the stably housed. Unstable housing leads to discontinuous care, e.g., recent breaks in care, dropping in and out of care and/or changing providers often. Homeless or unstably housed individuals are less likely than other PLWHAs to be receiving medical care that meets minimum clinical practice guidelines. Homelessness/unstable housing is one of the most important barriers limiting the use of antiretroviral combination therapy. High viral load, recent opportunistic infection, and hospitalization for HIV related disease are associated with homelessness/unstable housing.

The question the data raises is: Does housing status influence individual risk behaviors and medical care outcomes, or are findings evidence of self-selection of "risky persons" into conditions of homelessness? The latter posits a "risky person model", where an individual's personality dispositions or character "traits" may lead them to drug use, risky sex and illegal activities which would have both health (increased risk for HIV infection) and housing (limited economic resources to purchase conventional housing) consequences. An opposing model says that broader processes of inequality and exclusion lead to the deterioration of housing situations and neighborhood environments for members of excluded groups. In this model, economic marginalization triggers social exclusion and negative psychosocial states. Individuals can find themselves in contexts marked by pervasive risk, competing needs, few personal resources, and few community resources –situations that can that, in turn, lead to unstable housing (one lacks financial resources, faces housing discrimination) as well as risky behaviors.

The "risky person model" assumes behavior follows person, e.g., the formerly homeless who receive housing will continue to engage in risky behavior and continue to remain marginal to systems of care. Rather, while data shows that HIV positive persons with housing problems are more likely to engage in sex and drug risk behaviors and are less likely to be engaged in appropriate medical care, analyses over time show improvement in housing situation is associated with reduction in risk behaviors and positive change in medical care outcomes. For example, people with improved housing are 6 times more likely to be on HIV medication.

Dr. Aidala said that IOC members should consider the context of housing problems, not just the state of homelessness. For example, if a person had medical care before an HIV diagnosis, they are more likely to stay in after being stably housed. Women with children without housing will not focus at all on their own health care. Think of the populations likely to find themselves in a risky context and where to intervene to move people out of that context of risk.

Discussion on the service categories to be re-bid in 2007 will begin at the next meeting. Members were asked to review the grid showing the service categories as well as the priority setting grid distributed at the previous meeting. We will consider what places people at greater risk for not accessing/falling out of care and how we can direct services to address disparities.

## IV. Public Comment

M. Ducret stated that City housing eligibility policies are enforced inconsistently, and that City policies can prevent access to care, particularly by not allowing people to continue seeing their current medical providers when given new housing.

There being no further business, the meeting was adjourned.