



# Person-centered Care for Vulnerable Populations: A Case Study

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**Manisha H. Maskay, Ph.D., Chief Program Officer  
Justin Vander, Director  
Community Partnerships & Digital Media**

# Learning Objectives

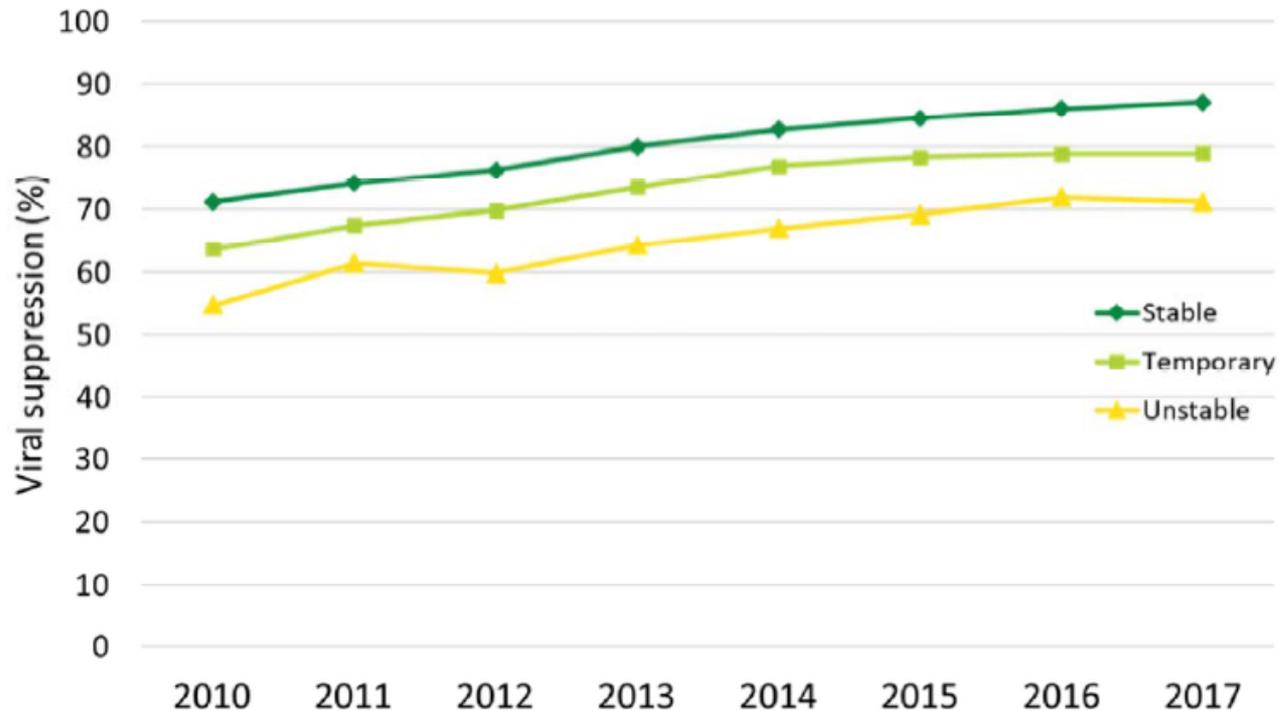
- Describe key components for developing and implementing models of care for vulnerable populations.
- Identify at least *two* elements to improve individual client level outcomes.
- Describe strategies to sustain critical program elements.

# Case Study - a focus on PLWH with complex needs

- PHNTX, one of 9 sites tasked with
  - Developing/implementing a model of care for people living with HIV (PLWH), co-diagnosed with mental health and/or substance misuse disorders, experiencing homelessness
  - Disseminating key development/implementation action steps and study findings through multiple platforms
- Demonstration project/study supported by the Health Resources and Services Administration, HIV/AIDS Bureau, Special Projects of National Significance, 2012-2017.

# Rationale

## Viral Suppression, Clients Served by RWHAP, by Housing Status, 2010–2017—U.S. and 3 Territories



Credit: *RWHAP Client HIV Care Outcomes: Viral Suppression, by Housing Status - 2017* [PPT, 1.6MB]

# Prism Health North Texas *formerly known as AIDS Arms, Inc.*

## **Mission**

Advancing the health of North Texas through education, research, prevention, and personalized integrated HIV care.

# Prism Health North Texas

- Provides integrated care and services:
  - Outreach to and testing for those at high risk for HIV/STIs
  - HIV/STI prevention and treatment - risk reduction, education and counseling services
  - Pre-exposure prophylaxis (PrEP) for HIV prevention
  - Linkage to medical care and psychosocial support services
  - Primary HIV medical care and integrated behavioral health care
  - Psychosocial support services to promote health equity, retention in care, treatment adherence
  - Effective 2019: primary medical care, transgender care
- Works to address specific needs of marginalized populations
- Collaborates with partner agencies to ensure respectful care for clients.
- Service area - North Texas

# Key Components of Initiative

- Integrated within PHNTX person-centered care model
- Intensive care coordination and behavioral intervention provided by three FTE social workers:
  - Skilled in providing care to people with complex needs and co-occurring disorders
  - Mobile: able to meet with clients at places and times convenient to them
  - Able to advocate effectively on behalf of clients with housing, behavioral health, medical and other providers
  - Able to build bridges to necessary care
  - Persistent

# Partnerships

- Strategic focus on strengthening/sustaining partnerships with:
  - Providers of relevant services including housing
  - Rental property managers/owners
  - Shelters
  - Motels
  - Mental health/substance use disorder treatment providers
  - Hospitals and medical providers
  - Respite care providers
  - Community members
  - Others essential to promoting successful client outcomes

# Critical Elements for Success: Client Level

- Comprehensive assessment of client needs
- Collaborative development of care plans
- Regular meetings with clients based on **acuity** and **need**
- Expedited access to medical and behavioral health care
- Care-team case conferences
- Focus on client strengths and resilience
- Flexibility in addressing clients' needs
  - Food, water, clothing, hygiene packs, sleeping bags, tarps, restaurant gift cards, other as necessary
  - Assistance with obtaining and storing documents
  - Emergency housing
- Ongoing process and outcome evaluation

# Critical Elements of Success: Service Delivery

- Responsiveness to needs of frontline staff, supervisor(s)
  - Clinical supervision
  - Professional support to address self-care, compassion fatigue, other concerns
  - Active support of requests related to improving care processes
- Ongoing process and outcome evaluation

# Sustaining Necessary Services

- ***Intentional*** - starting at program inception
  - Ongoing evaluation to determine essential components for achieving optimal outcomes
  - Rigorous documentation
  - Capacity building to enhance organizational ability to care for priority population
  - Strategic fundraising

# Capacity Building

- Subscribing to/utilizing the Homeless Management Information System (HMIS) to expedite client access to permanent housing
- Ongoing education and technical assistance for internal and external direct service and support staff on:
  - Challenges faced by clients experiencing homelessness
  - Trauma informed care
  - Best practices for providing person-centered care
  - Motivational interviewing, strength based and solution focused counseling techniques
  - Emerging trends related to regulations and eligibility requirements

# Capacity Building – Example

## Working with the Homeless Population

AIDS Arms, Inc.

June 9, 2016

**Brought to you by:**

**Health Hope and Recovery** - Benjamin Callaway,  
Luis Moreno, Miata Everett, Raymond Castilleja Jr. and  
Justin Vander

**Case Management** - Trang Mai and Gilbert Moreno



# Capacity Building - Example



## Health, Hope & Recovery

Ben Callaway, LMSW, Charles Peterson, LMSW, Luis Moreno, BSW  
AIDS Arms, Inc.



### Program Design

**Strategies & Techniques:**

- Cognitive Behavioral Therapy (CBT)
- Solution Based Therapy (SBT)
- Strength-Based Case Management (SBM)
- Motivational Interviewing (MI)
- Harm Reduction
- Audly Driven Standards of Care

**Duration of Intervention:**

- 18-Months Intensive Case Management

**Implementation Team:**

- Program Director
- Care Coordinators

### Comprehensive/Team Based Care

- Health, Hope and Recovery (HHR) team attends clinical team meetings as needed.
- Care Coordinator meets with the medical provider and/or the behavioral health team when necessary or communicate by phone or email.
- Care plans developed together by Care Coordinator and/or team.
- entered into the electronic health record (EHR)
- available for review to the medical and behavioral health providers.
- Behavioral health provided onsite when indicated.
- Clients requiring substance abuse treatment and/or treatment of complex mental health disorders referred to external providers.

AIDS Arms does not plan to pursue PCMH certification at this time.

### Access

- Patients may access medical and behavioral health providers on a walk-in basis for urgent needs.
- Patients may access the Care Coordinator without an appointment for urgent needs.
- Patients are able to communicate through text messages or by leaving a voicemail.
- All patients have 24/7 access to a medical provider on call.
- Bilingual staff and translation services are available to all clients for medical and case management services.
- All staff receives ongoing training regarding providing culturally and linguistically appropriate services tailored to the unique needs of each client and following CLAS standards.

### Care Coordination

- Tracking of Referrals and Labs:** Referrals are tracked with an excel spreadsheet that denotes date, source of referral, business status, start of medical care upon entry to program. Labs are examined via manual chart review.
- Communication with Behavioral Health:** The Behavioral Health Case Managers and Care Coordinator communicate via work email, office phone, and text messages on cell phones.
- Electronic Health Records (EHR):** AIDS Arms, Inc. uses an integrated EHR.

### Medical Outcomes Among Emergency Housing Participants (n=82)

Category	Percentage
All Medication Adherence	100%
Adherence to HIV Medication	85%
Adherence to TB Medication	85%
Behavioral Health Care	63%
Primary Care	54%

### Integrated Care & Services at AIDS Arms, Inc.

### Quality Assurance & Performance Measurement

The Quality Assurance & Performance Measurement Plan for Health, Hope & Recovery utilizes the PCMH Cycle Plan, On-Study, Act to ensure continuous improvement and ensure quality. All quality assurance activities are conducted either monthly, quarterly, or on an ongoing basis. A PDCA cycle has been developed for all program strategies and techniques.

**Permitted Reports:**

- Monthly Dashboard Reports
  - Population Description
  - Recruitment Progress
  - Retention Rates
  - Missing Status
  - Retention in Medical Care
- Quarterly Process Evaluation Reports
  - Peer Review Results
  - Supervisor MI Observation Aggregate Results
  - Curative Prior Year Results

The consumer advisory board serves the entire agency and not a specific program. It provides guidance regarding development of the client satisfaction survey, recruitment materials and educational programs, and provides assistance with other activities as needed.

### Conclusion

AIDS Arms is moving forward in a strategic manner to build a medical home for patients and already has many of the key components - behavioral health, social health, dermatology, etc. The agency is exploring options related to finding a medical partner that will provide specialty care for individuals who do not have health insurance or have Medicaid and who need treatment for complicated medical problems such as cancer, heart disease, liver disease, etc. Unfortunately, the only resource for these individuals is an overburdened County Hospital system. Whereas, this is where patients are referred, it is not an ideal partner in terms of "conceiving" a medical home framework.

### Recruitment & Retention

**Clients Recruitment, as of August 25, 2015:**

- Total H-H-R clients served = 128
- Total clients enrolled in study = 88
- Total clients active in study = 75
- Total clients transitioned to standards of care = 12

**Client Retention, as of June 26, 2015:**

- > 3-Month Retention Rate: 73%
- > 6-Month Retention Rate: 67%
- > 12-Month Retention Rate: 57%
- > 18-Month Retention Rate: 47%

### Disclosures

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number 49T420059, a Special Agent of National Significance. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of our agency or any endorsement be inferred by HRSA, HHS or the U.S. Government.

# Capacity Building - Example

## *A day in the life of staff members providing services to homeless clients ...*

- Text client to remind them of appointment.
- Meet client at shelter to provide a needed items such as sleeping bag, medication box and/or snacks.
- Work in collaboration with shelter staff and client to obtain letter of homelessness for housing eligibility.
- Discuss and assess client's past experiences with medical care including barriers to care such as substance use and mental health disorders.
- Create care plan in collaboration with client utilizing motivational interviewing to identify triggers for substance use and create a harm reduction plan to decrease high risk behaviors.
- Call client to schedule medical and behavioral health appointment.
- Assist client in programming medical appointments in cell phone provided by AAI to increase adherence to medical care.
- Provide education on DART system, bus pass and practical tips for attending medical appointments.
- Help internal and external colleagues learn about the Trauma Informed Model of Care as well as harm reduction strategies.

# Leveraging Resources

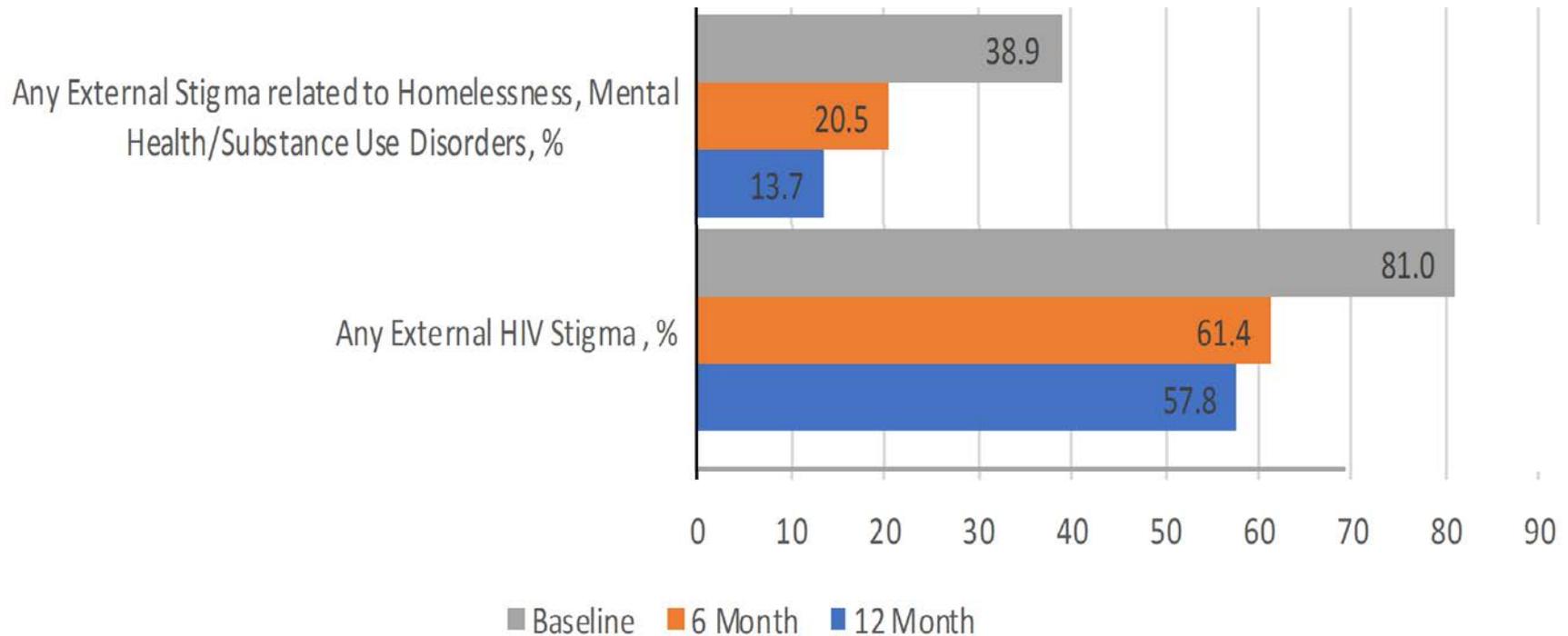
Source	Purpose
Ryan White Parts A, B and C	Intensive non-medical case management/care coordination
Private donors	Emergency housing, support for HMIS subscription fees
Agency general funds	Documentation assistance, packaged snacks, transportation vouchers, assistance with other basic needs
Marketplace insurance plans	Medical and psychiatric care

# Key Outcomes

- A total of 157 clients served
- 120 clients enrolled in multi-site study
  - Staff recorded 5,761 encounters with clients during a 3 year period (Jan 1, 2013 - Feb 1, 2016)
  - 75% achieved stable housing
  - 85% achieved viral suppression compared to 43% at baseline

# Key Outcomes -

## Percentage of Participants reporting Perceived External Stigma (N=548)

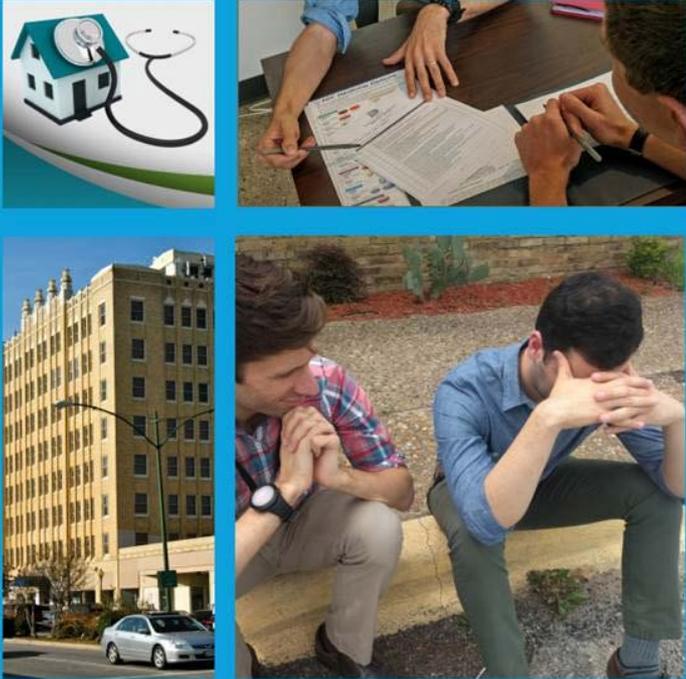


Source: Maskay et al. AJP.108: Supplement 7; 2018; S546-S551.

# Ongoing Needs and Challenges

- Inadequate availability of affordable permanent housing
- Varying levels of adoption of Housing First model
- Increasing requirements related to documents needed to establish eligibility and frequency of updates
- Perceived and actual stigmatizing behaviors from service provider staff and other clients
- Inadequate understanding and acceptance regarding needs of HIV positive individuals with mental health and/or substance use disorders experiencing homelessness

# Resources



**Health, Hope and Recovery**

A project of Prism Health North Texas (formerly known as AIDS Arms, Inc.) - Dallas, Texas

Intensive care coordination to link and retain HIV-positive individuals with multiple diagnoses of mental health and/or substance use disorders who are homeless in a medical home

<https://ciswh.org/wp-content/uploads/2017/06/HHR-prism-health.pdf>

# References

- Sarango M, Hohl C, Gonzalez N, et al. Strategies to build a patient-centered medical home for multiply diagnosed people living with HIV who are experiencing homelessness or unstable housing. *AJPH.108: Supplement 7; 2018; S519-S521.*
- Maskay MH, Cabral HJ, Davila JA, et al. Longitudinal stigma reduction in people Living with HIV experiencing homelessness or unstable housing diagnosed with mental health or substance use disorders: an intervention study. *AJPH.108: Supplement 7; 2018; S546-S551.*

# Acknowledgments

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- Luis Moreno, LBSW
- Justin Vander, MBA

# Participant Discussion

# One Client's Path to Success



[Video](#)

Thank you!