Person-centered Care for Vulnerable Populations: A Case Study

Department of State Health Services
FUNdamentals Session
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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

Section 1
Jefferson Tower Homeless Shelter activity

Section 2
What are the needs of the homeless population?
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

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

Any External Stigma related to Homelessness, Mental Health/Substance Use Disorders, %
- Baseline: 13.7%
- 6 Month: 20.5%
- 12 Month: 38.9%

Any External HIV Stigma, %
- Baseline: 57.8%
- 6 Month: 61.4%
- 12 Month: 81.0%

Source: Maskay et al. AJPH.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
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.

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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Participant Discussion
One Client’s Path to Success

Video
Thank you!