2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

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Using Demonstration Project Findings to Build Sustainable Multi-level Integrated Care Models within Ryan White Systems

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Disclosures

Presenter(s) have **no** financial interest to disclose.

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Learning Objectives

The learner will be able to:

- Identify practical strategies for system-wide integration of best practices
- Review potential challenges and solutions to system-wide integration
- Identify and discuss opportunities for sustaining the delivery of integrated care

Prism Health North Texas

- Key goals:
  - Prevent HIV
  - Test those at high risk for HIV/STIs
  - Engage/retain PLWH in medical care
  - Help PLWH achieve viral suppression, optimal health
- Serves 12 North Texas counties
- Services provided at several sites
  - 2 health centers – primary HIV medical care and integrated behavioral health care with a co-located pharmacy at one site
  - Mobile and onsite – case management, psychosocial support services, testing and risk reduction counseling
  - HIV Empowerment Center – all PLWH in community

Prism Health North Texas –
Special Projects of National Significance (SPNS) Supported Initiatives

Health Hope and Recovery (2012-18)

- Building a Medical Home for Multiply Diagnosed HIV Homeless Populations
  - Increase engagement and retention in HIV care and treatment
  - Improve housing stability

Viviendo Valiente (2013-19)

- Culturally Appropriate Interventions of Outreach, Access and Retention among Latino/a Populations
  - Increase HIV testing
  - Increase engagement in care
  - Increase retention in care

SPNS Initiatives Support

The Health Hope and Recovery project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number H97HA24956 (Special Projects of National Significance (SPNS) Initiative Building a Medical Home for Multiply Diagnosed HIV-positive Homeless Populations, in the amount of $1,560,860) awarded to AIDS Arms, Inc. No percentage of this project was financed with non-governmental sources. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

The Viviendo Valiente project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under H97HA26497, Special Projects of National Significance (SPNS) Culturally Appropriate Interventions of Outreach, Access and Retention Among Latino/a Populations Initiative, in the amount of $1,489,500. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Definitions

- Integrated care
  - Comprises of shared systems and facilities that provide seamless care, involves in-depth appreciation of roles and both patients and providers have the same expectations of the system. Ultimately, integrated care should become a single merged practice. *(Adapted from A Standard Framework for Levels of Integrated Healthcare and Update Throughout the Document. SAMHSA-HRSA Center for Integrated Health Solutions, March 2013)*
- Sustainable care model
  - The extent to which new formats for working and improving outcomes becomes the standard, the thinking and attitudes supporting them altered and systems surrounding them transformed. (*Adapted from MedspeakUK)*
- Healthcare service delivery system
  - A configuration of organizational networks and technology focused and organized around the mental and physical health needs and expectations of people and community. *(Adapted from: The World Health Organization and the Institute of Medicine)*

Sustaining Programs Beyond Grant Funding

1. Identify key findings
2. Translate for meaningful implementation
3. Integrate into the system of service delivery
4. Implement ongoing processes

Identify Key Findings

- Key findings may be identified through monitoring and evaluation, at multiple stages of implementation and levels of a service delivery system.
- Evaluation should be conducted to learn about the effectiveness of program strategies and to measure outcomes – not for the sole purpose of reporting to funders.
- In order to identify key findings:
  - Develop a monitoring and evaluation plan
  - Monitor fidelity and outputs
  - Evaluate program outcomes

Develop Monitoring and Evaluation Plan

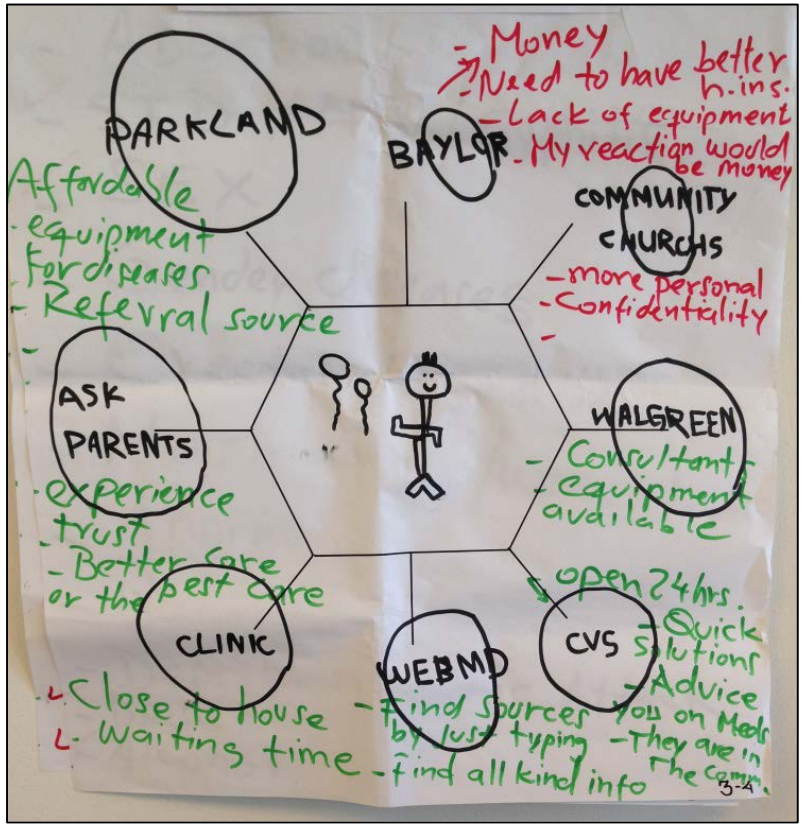
An evaluation plan may include:

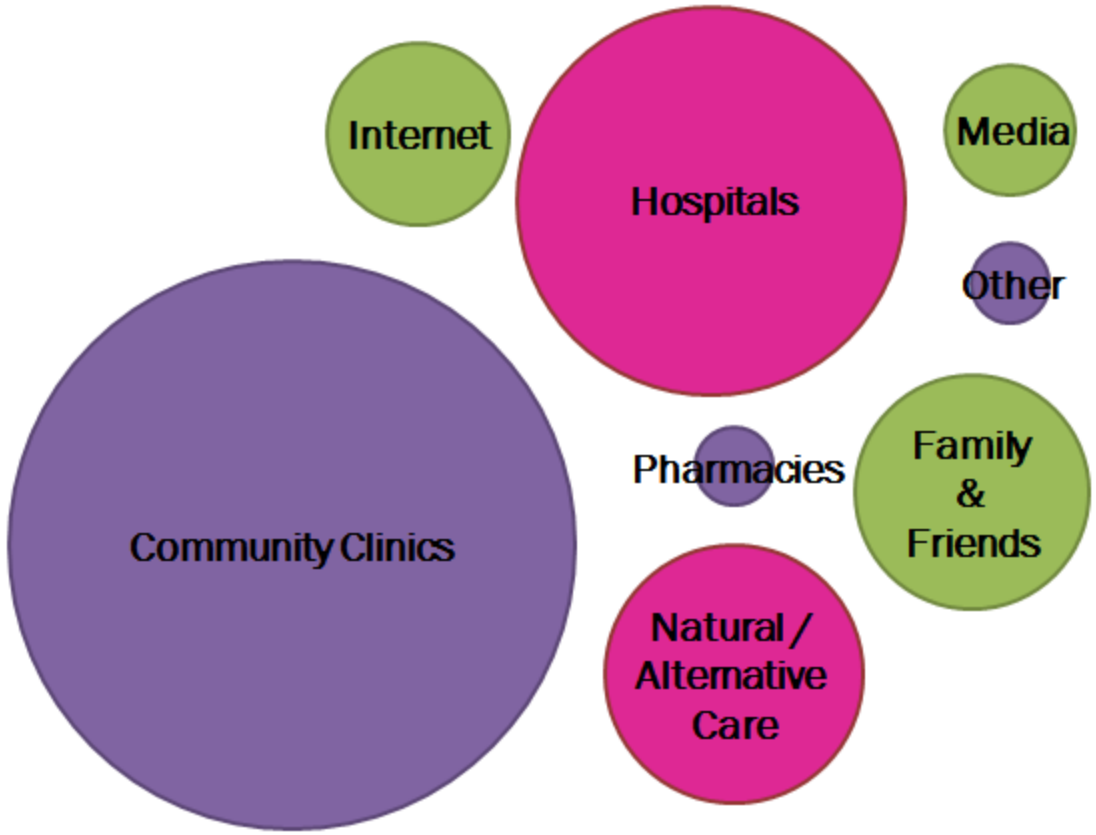
- **Formative Evaluation**
  - What can we learn before implementation? What can we anticipate?
- **Program Monitoring/Process Evaluation**
  - Who, what, when, where?
- **Outcomes Evaluation**
  - Changes in knowledge, attitudes, skills, behaviors, health outcomes and/or other factors

Develop Monitoring and Evaluation Plan

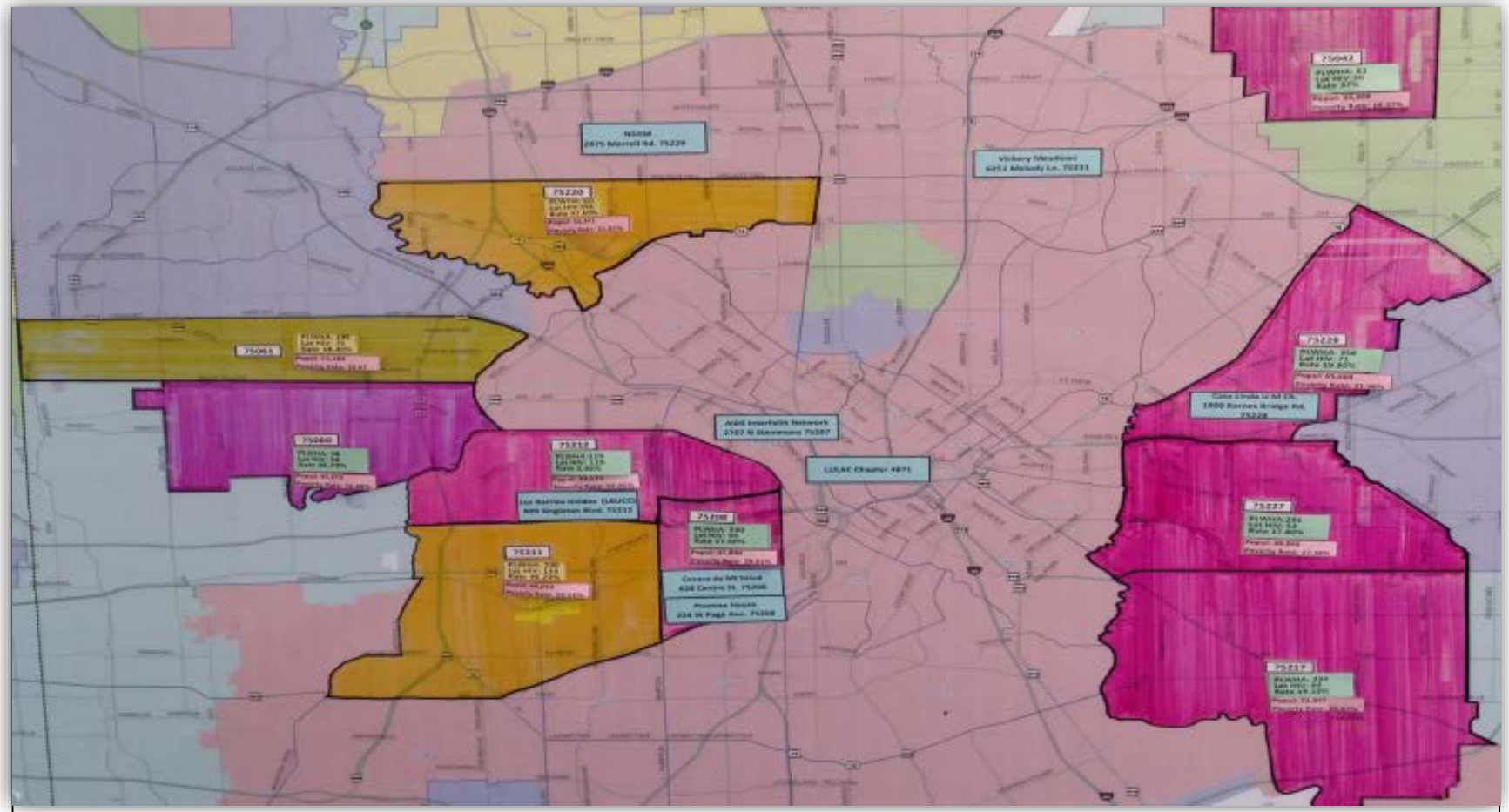
- **Formative Evaluation**
  - *Examples: Consumer survey and focus groups, stakeholder survey, literature review*
- **Program Monitoring/Process Evaluation**
  - *Examples: Client satisfaction surveys*
- **Outcomes Evaluation**
  - *Examples: Changes in behavior, knowledge, health parameters, etc.*

Formative Evaluation Example –
Community Assessment





Formative Evaluation Example –
Mapping



Viviendo Valiente - **Dallas County Map: Priority Zip Codes for Outreach**

Program Monitoring

- Also referred to as ‘Process Evaluation’ or ‘Implementation Evaluation’
- Monitor fidelity and outputs to determine:
  - Utilization of strategies/techniques by providers
    - What barriers and facilitators impact providers’ use of strategies/techniques? Knowledge, resources, etc.
  - Alignment to program goals and objectives
    - Are efforts developed and implemented with the specified goals and objectives in mind?
  - Reach among priority populations/communities
    - Is the intended population being reached?
    - What elements are most effective at reaching the priority population? Venues, zip codes, referral sources, client satisfaction, etc.

Program Monitoring Examples –
Client Satisfaction, Fidelity to Specified Interventions

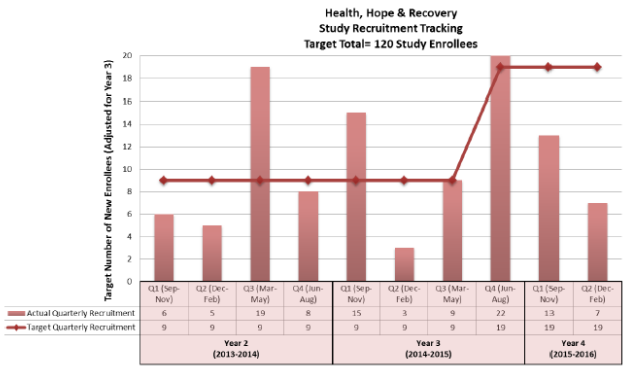
Client Satisfaction Survey Cumulative Results (n=34)						
#	Question	Strongly Agree	Agree	Do not agree or disagree (Neutral)	Disagree	Strongly Disagree
1.	My Promotor(a) de Salud meets me at places that are convenient (easy) to me.	94%	3%	3%	0%	0%
2.	My Promotor(a) de Salud shows respect for my culture and background?	94%	6%	0%	0%	0%
3.	My Promotor(a) de Salud has helped me to have a say in my care and treatment.	88%	12%	0%	0%	0%
4.	My Promotor(a) de Salud helps me to achieve my health goals.	91%	6%	3%	0%	0%
5.	My Promotor de Salud speaks to me in the language I am most comfortable with.	97%	3%	0%	0%	0%
6.	My Promotor(a) de Salud has taught me how to do things for myself.	76%	12%	3%	0%	6%
7.	I am able to share my concerns with my Promotor(a) de Salud.	88%	9%	3%	0%	0%
Overall Client Satisfaction= 97% (Overall satisfaction= Percentage of *"Strongly Agree"* or *"Agree"*)						

VV Client Feedback Survey: Version 1.1
Created 06.17.2015 | Updated 01.17.2017

Score		Strength Based Counseling						
Assess if the following components were addressed:	**1** Inadequate	**2**	**3** Adequate	**4**	**5** Very Adequate	**N/A**	**Comments**
Assessment Positive attribute(s) of client in three life domains (life skill, relationships and health) are identified.	1	2	3	4	5	N/A	
Goal Setting Statement(s) from client are documented describing their own goals.	1	2	3	4	5	N/A	
Working Relationship Success of mutually agreed upon goals developed by client and Promotor is documented.	1	2	3	4	5	N/A	
Appropriate Use of Strengths Based Counseling	1	2	3	4	5	N/A	

Program Monitoring Example –
Dashboards

Health, Hope & Recovery Total Study Population		
Characteristic	**#**	**%**
Total Study Enrollees:	107	89%
Gender		
Male	98	92%
Female	7	7%
Transgender	2	2%
Age		
Mean Age:	38	--
Min Age:	23	--
Max Age:	57	--
Sexual Orientation		
Homosexual (Gay or Lesbian)	68	64%
Heterosexual/ Straight	27	25%
Bisexual	9	8%
Unsure	3	3%
Other	1	1%
Race/ Ethnicity		
Non-Hispanic White	52	49%
Non-Hispanic Black	42	39%
Hispanic/ Latino	11	10%
Two or more races	2	2%
Educational Attainment		
Less than High School	17	16%
High school Diploma/ GED	39	36%
Some College/ < 4-year degree	42	39%
4-Year College Degree	6	6%
Post-college/ graduate	3	3%
Incarceration History		
Jailed	66	62%
Avg # of times jailed	1	--
Prison	28	26%
Avg # of times imprisoned	1.0	--
Age At First Homeless Experience		
Mean Age:	29	--
Min Age:	4	--
Max Age:	57	--
Medical Access		
Medically Insured	37	35%



Subject Retention				
Follow-up Period	Rate on 11/30/15 Reported (Adjusted)	Rate on 12/31/15 Reported (Adjusted)	Target Rate	In Window for Follow-up
3 Month	74% (75%)	68% (74%)	70%	11
6 Month	67% (69%)	56% (71%)		19
12 Month	58% (64%)	55% (57%)		2
18 Month	53% (62%)	46% (59%)		8

*Adjusted retention rates account for clients who are no longer eligible for follow-up. Clients who are currently in the window for follow-up have been excluded from the adjusted rates.

Lost to Follow-up		
W= Withdrew	9	14%
M= Moved	28	43%
L= Arrested/ Avoiding Law enforcement	11	17%
T= Transportation/ Currently Out of the Area	11	17%
NS/ LTF= No Show/ Lost to Follow-up	6	9%
Total Missed:	65	100%

Progress Report- Health, Hope & Recovery

As of 12/31/15

Current Period: *Year 4 Quarter 1*
Total Clients Served by Program: *145 Clients*
Total Clients Enrolled in Study: *107 Clients*
Total Clients Active in Program: *57 Clients*

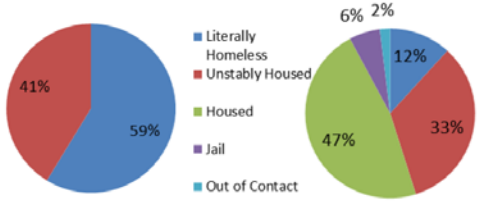
Community Linkage and Education	
Total # of Events	188
Estimated % Reached who were Spanish Speaking	85%
Reached	9,833
Engaged	3,729
Educated	2,989
Total Tested	607
Total Latinos Tested	570

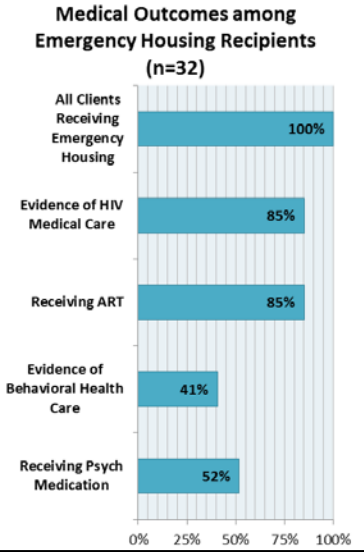
Evaluate Program Outcomes

- Develop outcome measures
  - How will we define success?
- Use evaluation data to:
  - Identify ***effective*** program elements
    - What should be adopted and integrated into the service delivery system for the long-term?
  - Identify ***ineffective*** program elements
    - What should be modified or streamlined?
    - What should be de-implemented?

Program Outcomes Evaluation Example –
Health, Hope & Recovery

Housing Outcomes





Emergency Housing Recipients	#	%
Total	32	100%
Active	6	19%
Discharged	26	81%
Housing Outcome		
Permanently Housed	11	42%
Moved	2	8%
Out of Contact	7	27%
Jail/ Prison	1	4%
Homeless	4	15%
Unstably Housed	1	4%
Gender		
Male	30	94%
Female	2	6%
Transgender	1	3%
Sexuality		
Same-sex/ Gay or Lesbian	22	69%
Heterosexual/ Straight	8	25%
Bisexual	1	3%
Unsure	1	3%
Age		
Min	23	
Max	51	
Average	37	
Race/ Ethnicity		
Non-Hispanic White	16	50%
Non-Hispanic Black	14	44%
Hispanic/ Latino	1	3%
Mixed	1	3%
Incarceration History		
History of Incarceration	22	69%
Jail	16	50%
Prison	6	19%

Program Outcomes Evaluation Example –
Health Hope and Recovery

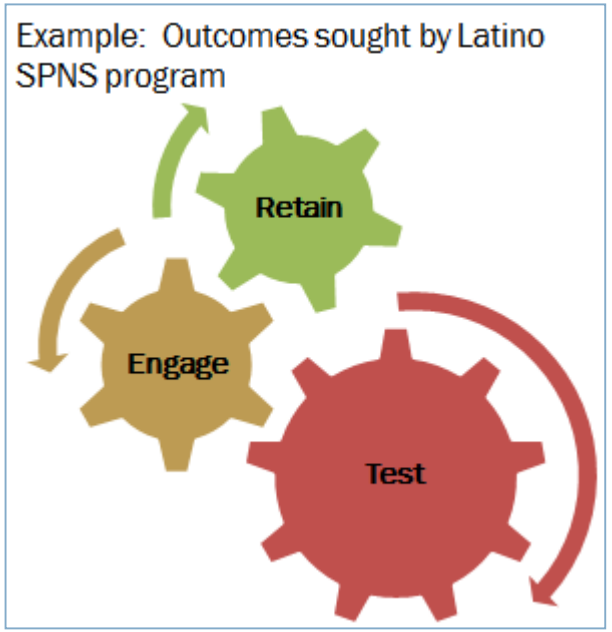
- A total of 157 clients served
- 120 clients enrolled in multi-site study
  - Staff recorded 5,761 encounters with clients during a 3 year period (Jan 1, 2013 - Feb 1, 2016)
  - 75% achieved stable housing
  - 85% achieved viral suppression compared to 43% at baseline

Use of Key Findings

- Identify key findings
- Translate key findings for meaningful implementation by program staff and all stakeholders

Translate for Meaningful Implementation

- Involve providers across disciplines and administrative staff to:
  - Support a fluid care experience for clients
  - Confirm alignment of key findings to agency goals
    - Will integration of key findings support agency goals?
  - Explore and address emerging concerns regarding integration of key findings at the organizational and systems level
    - What are potential barriers and solutions to promote effective integration?



Translate for Meaningful Implementation

- Garner internal support
  - Providers from all disciplines, administrators, board members, advisory groups, key influencers
- Acquire necessary resources
  - Staffing, funds, and time
- Build and sustain community collaboration
  - Promote integration and /or dissemination of key findings
  - Research needs of stakeholder(s) to determine and demonstrate mutual benefits of collaboration

Implementation – Obtain Resources

- Start at program inception – must be intentional
- Inform stakeholders about key program components
  - Successes
  - Challenges
  - Outcomes
  - Needs
- Develop elevator speech to show value
- Add essential components to the organization's budget
- Develop strategic process to leverage existing resources, obtain ongoing funding
- Maintain attention and focus

Ongoing Funding – Examples

Source	Purpose
Ryan White Parts A, B and C	Intensive non-medical case management/care coordination, behavioral health
Private donors	Emergency housing, support for subscription fees for system-wide data bases
Agency general funds/program income	Staffing, documentation assistance, packaged snacks, transportation vouchers, assistance with other basic needs
Marketplace insurance plans	Medical and psychiatric care

Implementation – Partnerships

- Dedicate time and resources
- Place a strategic focus on strengthening/nurturing partnerships with key community and government partners
  - Offer ongoing bi-directional education, technical assistance and information sharing
  - Seek ongoing opportunities to collaborate

Partnerships – Examples

- Traditional partners
  - Mental health/substance use disorder treatment providers
  - Hospitals and medical providers
  - Community clinics
  - Respite care providers
  - Permanent housing and other service providers
  - City, county and state level leadership and staff
- Non-traditional partners
  - Rental property managers/ owners
  - Motels/hotels
  - Curanderos
  - Barber shops/schools
  - Transitional homes
  - Night clubs
  - Recreational centers
  - Key influencers in the community

Partnership Agreements

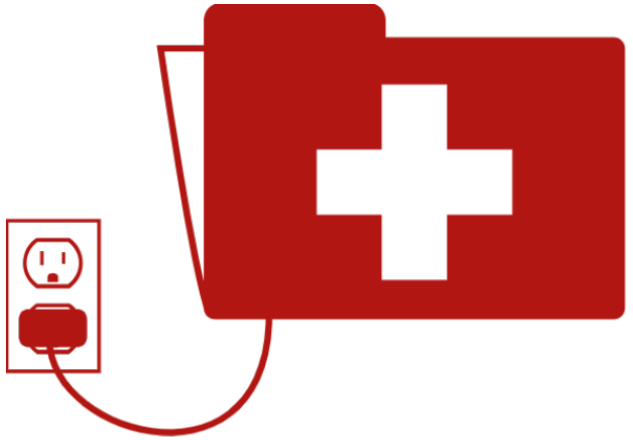
- Base on key needs and essential functions
- Articulate specific expectations clearly
  - Sharing of client level information/data
  - Client confidentiality
  - Timelines
  - Mutual responsibilities
- Revisit regularly
- Evaluate and share outcomes

Implementation –
Integration Into Service Delivery System

- Assess systems thoroughly for capacity
  - Compare requirements against current capacity
- Determine steps for implementation
  - Delineate service delivery
    - What?
    - Where?
- Analyze key points/areas for integration of key elements
  - Key points?
  - Who?
  - Where?

Integration Into Service Delivery System

- Review, modify or develop integrated procedures, protocols and necessary tools
- Decide on necessary requirements for documentation of client information – demographics, care plans, encounter notes, etc.
- Set up electronic health record (EHR) – ensure that key users:
  - Are involved in development/implementation
  - Have access to necessary components
  - Are able to use it effectively to provide integrated, cohesive and coordinated care



Integration Into Service Delivery System - Education

- Education and training
  - Determine needs
  - Develop educational program
    - In person group session(s)
    - Instruction manual(s)
    - Technical assistance processes
    - Evaluation plan
  - Provide education/training sessions
  - Make ongoing technical assistance available
  - Evaluate outcomes
  - Use PDSA (plan, do, study, act) if necessary

Capacity Building

- Ongoing education and TA for direct service and support staff and community partners about:
  - Needs, challenges, strengths and preferences of priority population
  - Best practices for providing client-centered care
  - Communication strategies
  - Trauma informed care
  - Motivational interviewing, strength based and solution focused counseling techniques
  - Emerging trends (regulations/requirements for documentation to establish eligibility for services
  - Strategies for addressing barriers and concerns

Capacity Building – Example A

Working with the Homeless Population

AIDS Arms, Inc.

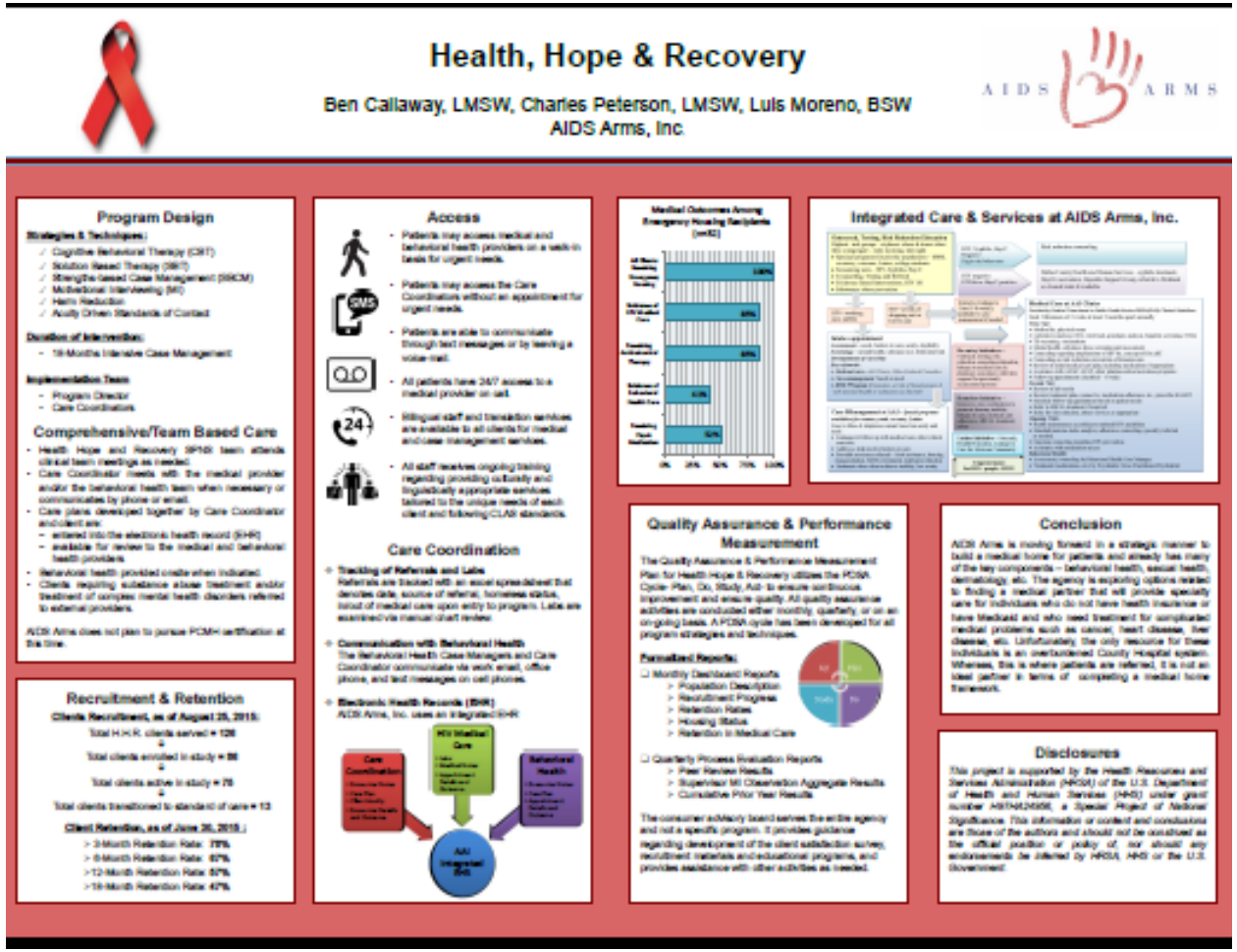
June 9, 2016

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 B



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)
- Strengths-based Case Management (SBCM)
- Motivational Interviewing (MI)
- Harm Reduction
- Acuity Driven Standards of Contact

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 communicates by phone or email.
- Care plans developed together by Care Coordinator and client are:
  - 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.

Recruitment & Retention

Clients Recruitment, as of August 25, 2015:

Total H.H.R. clients served = 126

Total clients enrolled in study = 88

Total clients active in study = 75

Total clients transitioned to standard of care = 13

Client Retention, as of June 30, 2015 :

- > 3-Month Retention Rate: 78%
- > 6-Month Retention Rate: 67%
- >12-Month Retention Rate: 57%
- >18-Month Retention Rate: 47%

Access

- Patients may access medical and behavioral health providers on a walk-in basis for urgent needs.
- Patients may access the Care Coordinators without an appointment for urgent needs.
- Patients are able to communicate through text messages or by leaving a voice-mail.
- 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, homeless status, result 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

Integrated Care & Services at AIDS Arms, Inc.

Quality Assurance & Performance Measurement

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

Formalized Reports:

- ☐ Monthly Dashboard Reports
  - > Population Description
  - > Recruitment Progress
  - > Retention Rates
  - > Housing Status
  - > Retention in Medical Care
- ☐ Quarterly Process Evaluation Reports
  - > Peer Review Results
  - > Supervisor MI Observation Aggregate Results
  - > Cumulative Pilot 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 referrals 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, sexual 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 completing a medical home framework.

Disclosures

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Capacity Building – Example C

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.

Potential Barriers and Solutions

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- **Barrier:** Cultural differences between disciplines
- **Solution:** Regular conversation, feedback

- **Barrier:** Miscommunication
- **Solution:** Developing effective feedback loop and ongoing opportunities for regular communication

- **Barrier:** Inadequate ‘buy-in’
- **Solution:** Regular reminders about organizational values and goals related to providing integrated client-centered care

- **Barrier:** Lack of resources
- **Solution:** Strategic fund-raising for key components

- **Barrier:** Staff-turnover
- **Solution:** Detailed procedures/protocols, educational tools, effective onboarding

Your Turn –

What Strategies Do You Recommend to Ensure Sustainability

1. Identify key findings
2. Translate for meaningful implementation
3. Integrate into the system of service delivery
4. Implement ongoing processes

Thoughts/Questions?

_____

Thank you!