WEBINAR VIDEO TRANSCRIPT
SPNS/IHIP Webinar
Homelessness and HIV
June 2018

ANGEL JOHNSON: Hello everyone. My name is Angel Johnson. And I will be moderating today's webinar on Improving Help Outcomes, Moving Patients Along the HIV Care Continuum. This is the second webinar in a four-part series brought to you by the HRSA Special Projects of National Significance Program, SPNS.

As you can see on the agenda, I will provide a brief overview about the SPNS Project of National Significance Program, SPNS, and the Integrating HIV Innovative Practices project, or IHIP. We will then hear from two presenters—actually, three presenters—who will be discussing their SPNS intervention.

Our first speaker today will be Dr. Manisha Maskay from Prism Health North Texas, Dallas, Texas. Dr. Manisha is the Chief Program Officer of Prism Health North Texas, formally AIDS Arms, Inc. In Dallas, Texas. She has over 40 years experience in public help, medical nutrition therapy, health education, and promoting behavioral change and has been recognized for her leadership and contributions to public health and academic medicine.

Angelica Palmeros is a social worker and division manager at the City of Pasadena Public Health Department. She currently oversees the social and mental health division, which includes HIV/STD services, mental health programs, substance abuse prevention and treatment, homeless services, and other special initiatives.

Also, from the city of Pasadena, we have Precious Jackson. And she has worked in the field of HIV for more than 20 years. She has worked with several CBOs in the capacity of treatment adherence coordinator and women's program coordinator. Ms. Jackson brought her skills and talents to the City of Pasadena, Pasadena Public Health Department as a peer navigator for the SPNS medical home for homeless HIV-positive initiative in 2013.

Following the presentations, we will open the lines for Q&A. The SPNS program is funded through Part F of the Ryan White HIV/AIDS Program and provides opportunities for the developing, implementing, and assessing innovations designed to meet national goals to end the HIV epidemic and address the evolving nature of our health care delivery system. The SPNS program remains current by addressing emerging issues in HIV care in populations most affected by HIV.

The SPNS program advances knowledge and skills to support improvements in health care delivery, evaluates the effectiveness of SPNS models in increasing access to care, and promotes
dissemination and replication of successful models of HIV care. Now, currently 57 grant recipients are providing clinical and support services to over 9,000 individuals living with HIV. The SPNS Demonstrations Models contribute to the advancement of public health knowledge and innovations designed to move people living with HIV along the HIV care continuum and ultimately achieve viral suppression.

The SPNS program funds initiatives along all stages of the HIV care continuum, from diagnosing and linking individuals to care to medication adherence and viral suppression and supporting individuals at system-level change to achieve desired outcomes. Initially, SPNS program was challenged by finding ways to effectively disseminate information about successful SPNS models of care and the lessons learned to help other providers replicate these interventions. However, through the IHIP project, SPNS effectively promotes, markets, and disseminate strategies to support optimal implementation of these models, resulting in more informed providers, a stronger workforce, and ultimately healthier patients. And as stated earlier, it also helps to advance and support federal priorities and strategies. The IHIP strategies used to disseminate SPNS models includes developing implementation tools and resources, such as manuals, intervention guides, and pocket guides to encourage replication, engage in stakeholders in the dissemination of information to increase reach of these tools and providing capacity building assistance to support the replication of SPNS' intervention model.

Capacity building assistance includes the IHIP Listserv that notifies recipients of new resources, training, and other upcoming events; knowledge exchange with our partner organization to raise awareness and help promote this information; webinar trainings on best practices and developing and disseminating SPNS-focused publications; and peer-to-peer sharing of best practices, like the IHIP webinar series; and presentations at various conferences and grant recipient meetings to introduce these models and associated resources.

The TARGET Center is the Ryan White technical assistance clearinghouse where you can find IHIP resources. And that's at http://www.careacttarget.org/ihip. There you find a broader overview of IHIP as well as previously highlighted SPNS interventions and IHIP technical assistance material, from jail linkage and oral help to opioid treatments, engaging hard-to-reach populations and more.

Here, I list the IHIP resources that are available on the TARGET Center. Please keep in mind that as tools and technical assistance resources become available, they will be posted to the TARGET Center. So we encourage you to visit the TARGET Center, if you haven't, and become familiar with it and what it offers.

And as I prepare to turn things over to Dr. Maskay, I want to provide you with some information on staying connected. If you have questions about any of the information shared during today's webinar or anything related to the replication of SPNS interventions, please send your inquiries to SPNS@hrsa.gov. For additional information on tools and resources and to sign up for the IHIP Listserv to receive the latest announcements about IHIP resources and webinar
So now without further delay, I'm going to turn things over to today first presenter, Dr. Manisha Maskay from Prism Health North Texas. Immediately following Dr. Maskay, you'll hear from Angelica Palmeros and then Precious Jackson for City of Pasadena. Dr. Maskay.

MANISHA MASKAY: Thank you. Good afternoon, everyone. Thank you so much for joining us today. And I’m delighted to share some key points about the Prism Health North Texas Health, Hope, and Recovery Program. I shall briefly go through the intervention model, how we build capacity, the implementation process, lessons learned, sustaining the program, and provide some recommendations and resources.

So Prism Health North Texas was previously AIDS Arms, Incorporated. We are a community-based organization in Dallas, Texas, and provide care to a 12-county area. We provide HIV medical care and comprehensive psychosocial support services through two clinics, including care coordination, behavioral health, and other necessary care.

For Health, Hope, and recovery, the population of focus was people living with HIV, age 18 and older; diagnosed with mental health and/or substance use disorders; homeless, at risk for homelessness or fleeing from domestic violence. Our goals were to increase engagement and retention in HIV medical care and treatment and to improve housing stability.

So as mentioned before, Health, Hope, and Recovery functions within Prism Health North Texas's integrated model of care for people living with HIV. And this includes HIV primary medical care, integrated behavioral health care, case management and psychosocial support services, risk reduction counseling and guidance. We have co-located pharmacy services. And we have an empowerment program for people living with HIV in the community. And it's provided at a separate center not connected with the clinics or any of our other sites.

In terms of implementation, the program is an intensive, represented, care coordination, and behavioral intervention model. It's provided by three full time social workers. We're knowledgeable about treatment of HIV, as well as mental health and/or substance use disorders and knowledgeable about necessary community resources. Here, we're providing care to people with complex needs.

And very importantly mobile, they are able to meet with clients at places and at times convenient to the client. And this really does include the spectrum, whether it is under bridges, at a McDonald's, at a hospital, or any place that is appropriate and safe, but very comfortable for the client. They are able to advocate effectively for clients with housing, behavioral health, medical, and other social service providers and also able to build bridges to necessary care.
The implementation process also placed a very strategic focus on strengthening and sustaining partnerships with multiple entities. Even though as an organization we've always paid attention to partnerships, we decided that for this particular program and the population of focus it was critical to do a lot of strengthening.

So that includes the Metro Dallas Homeless Alliance, which brings together over 85 providers of permanent housing, shelters, and other support services; individual permanent housing providers, including the City of Dallas and others; the rental property managers and owners. So we focused on building strong, collaborative relationships with property managers and owners, so that they were more likely to provide housing for clients. Shelters, motels, we do provide some amount of emergency housing. And so it was important to have motels which would support that. Mental health/substance use disorders, treatment providers; hospitals and medical providers; and also respite care providers.

As with any program, we did have challenges—most importantly, the inadequate availability of affordable permanent housing. This, of course, is true in many, many metropolitan areas. And it’s definitely a factor in North Texas. There is resistance to and inadequate adoption of Housing First principles. Actually, this area was late coming into Housing First in any case, but it’s still very challenging.

There are changing rules and interpretation of program requirements related to eligibility for housing assistance and other services; increasing requirements related to documents needed to establish eligibility, as well as the frequency of updates; stigmatizing attitudes and behaviors from providers, ranging from housing and psychosocial support providers to many others; and finally, an inadequate understanding of the needs of people living with HIV, who are co-diagnosed with mental health and/or substance use disorders and are experiencing homelessness.

We learned many lessons—what was the importance of ongoing and rigorous process evaluation—and I’ll speak a little bit more about that later—ongoing attention to establishing nurturing and sustaining relationships with community partners and stakeholders. We also learned that where each component of the care process is critical, the care coordinators are truly the glue.

It was important for all of us to know that every step taken may not in fact yield success. It does take many steps to get expected results. And failure often presents opportunities. It was incredibly important for us to pay attention to staff needs, not just their own needs but also in terms of what they requested with regard to supporting their clients in terms of food, emergency housing, clothing, assistance with getting documents, storing documents, et cetera.

It was also important to provide fairly significant support related to helping them to take care of themselves. So we had a—have actually, this is ongoing—a PhD-level psychologist who meets with our care coordinators and case managers on a regular basis to help them with their self-care. And also proactive and strength-based supervision and guidance.
Another lesson was that although Prism Health North Texas had, in fact, served the population of focus for many years, this initiative provided us with substantive information about what is necessary to optimize health outcomes for people living with HIV who have mental health and/or substance use disorders and who are homeless or unstably housed.

So in terms of sustaining the program, it is important to recognize that it must be intentional and start at program inception. It should be almost the first part of program implementation. For us, key components were ongoing process evaluation to determine which components are essential for optimal outcome; rigorous documentation; capacity building to enhance organizational ability to care for the population of focus; transition of care to a specialized case management team with the necessary skills to serve the population of focus; as I mentioned before, active participation and Metro Dallas Homeless Alliance, as well about the partnerships; and strategic fundraising to help support the necessary services that may not have funding from other sources.

We continue to have barriers as the area becomes more and more gentrified. And that's because of migration and other reasons. There is increased demand, more people experiencing homelessness. There is an inadequate supply of affordable housing. And it seems like—and actually, it's a fact—that there are increased requirements related to documentation to establish eligibility for services.

I wanted to sort of wind up more with our successes. We serve a total of 157 clients. 120 of them enrolled in the multi-site study. Staff recorded close to 6,000 encounters with clients over a three-year period.

75% of our clients achieved stable housing. And 85% of them achieved viral suppression, which is a viral load of less than 200 copies per milliliter compared to only 43% at baseline. This was incredible.

Other successes include that we were able to acquire the Housing Management Information System to help expedite client access to permanent housing. We are not holding providers, so this actually wasn't something we had thought about before. But this has been incredibly helpful to get our clients housed.

Ongoing education and technical assistance for internal and external direct service and support staff—our needs and challenges homeless of clients; Housing First principles; trauma informed care; best practices for providing person-centered care for homeless individuals; motivational interviewing, strength-based solution-focused counseling techniques; and emerging trends related to regulations and requirements for documentation to establish eligibility for services. We are now almost a go-to organization in terms of getting this type of technical assistance. So that's really wonderful in terms of being able to sustain our work.

Our key recommendations are in terms of developing a program such as this. So people who actually have the most complex needs, it's important to maintain structure and organization.
while remaining flexible and nimble. Even though this sounds counterintuitive, it's actually really key to the success of such a program. It's important to keep the key stakeholders informed on an ongoing basis, very important to accept failures as an opportunities for learning and improvement, and learning from successes as well as challenges, and finally to build capacity as part of overall program implementation.

In terms of resources, the manual is available for anybody who would like to start such a program. It's available on our website as well as cahpp.org. And we are available to answer any questions related to developing this program and resolving some of the challenges. Thank you. And with that, I am going to turn it over to Angelica.

ANGELICA PALMEROS: Hello. This is Angelica Palmeros. And we'll present on the City of Pasadena's Operation Link project. One of the things is that our project model overview is an intensive case management system navigation program for individuals who obviously were experiencing homelessness, living with HIV, diagnosed with mental health and/or substance use disorders.

We had Peer Care Navigators work with clients to find established medical homes throughout the Los Angeles County and they were accessible or nearby where they were getting their services on either primary care, behavioral housing, and care coordination services. The goals of the project were to provide peer support and advocacy for clients who were experiencing homelessness and, again, were diagnosed with a mental illness and/or a substance use disorder.

The other one was to assist the clients to increase adherence to treatment, so we could improve the medical status in their health. And we implemented something called the, for us, the mobile care-coordinated services, basically meeting where the clients are at, either be at the streets, the shelters, in order for us to bring them into services and link them. So those were are our offices on wheels, and also advocating for clients to have housing.

For us, being in Los Angeles County, we're at Pasadena Public Health Department. We're local to this city. And we're in a huge county, which is Los Angeles. And in working, we offered services to the San Gabriel Valley.

So for those who know LA, they would know that the eight service provider areas were divided. And we chose service provider area three, which is our San Gabriel Valley. And we're located in that area.

In our target population that we were looking, obviously, was our San Gabriel Valley, again, individuals experiencing homelessness, living with HIV, diagnosed with mental health or substance use, and also looking at newly released into the community treatment programs, shelters, and/or incarceration. So we were recruiting in different areas. Los Angeles County really have 90,000 individuals experiencing homelessness. And as you see in the slide, there's a
series of numbers that identify who—for severely persistent mental illness, addiction. I mean, so it's a huge, huge area to cover.

Our staffing—so this is what the project looked at in having. For this model Operational Link, we have the project director, project coordinator. We embedded the clinical supervisor, the Peer Care Navigators, the RN case manager and our project assistance.

You'll see that we actually looked at if this program was to be implemented and if it was to be used in other places, could they adapt it to their needs of the organization, to the client. A lot of it sometimes is tied to funding. But what is the best way one can deliver these services to the client.

As you see, we have an area that we call the enhanced Peer Care Navigation model, which would include an RN case manager and a clinical supervisor to support the peer navigators. So those were some variables that can be changed and not have both, but have one, or have an entire team. And that would depend on the fund available to the organization or the program. So we wanted to look at those things as well to help implement or adapt it and still keep some of the fidelity of the model.

Obviously, in this case, our peer navigators were looking at clinics, housing, mental health, substance abuse, and including transportation, because mapping out transportation was very important. Especially in LA County, it's very geographically large and going to one city to another sometimes with two or three buses. So we wanted to make sure that we looked at that as well for our clients.

We have our Operation Link client flow chart just to give you an idea of the process we went through in there recruitment, the screening, those who did consent to participating in the study, and then what our follow-up and data collection was. So we were looking at our peers who were conducting outreach. And also, at the time, we didn't have—the City of Pasadena Public Health Department did have a medical home at the beginning of the project.

And we were also recruiting through our own program. But we were also going to the streets to serve the broader area. And we were looking at newly diagnosed or others that just walked or our partners had sent. So the project assistant would screen. If client decided not to participate in the project, they would still receive the services. They were just not, obviously, counted.

The project assistant then, if the client decided that, you know what, I will participate, then the client was aware that they would get the services, and we would be following up with them conducting interviews 3, 12, and 18 months. And also, the nurse would conduct chart reviews during the same period, the 6, 12, 18, and 24 months. And now, I'm going to hand it over to Precious Jackson so she can describe the Peer Care Navigators.

PRECIOUS JACKSON: Hi, everyone. I'm Precious. And so I'm going to be talking about the Peer Care Navigators. And I was one of the peers, and actually I'm still a peer. Our program was
based on three evidence-based models which served as the framework—critical time intervention, seeking safety, and illness management and recovery.

The development of our role as Peer Care Navigators was it came with a benefit with assisting the case managers, because sometimes, the case managers, as you all know, sometimes cannot leave the office. So to have Peer Care Navigators on staff made it much easier and helpful, because we had the ability to go out into the streets and find the clients.

So we identified and work with each service provider needed to address the client's issue. And we did that on purpose, because we wanted to make sure that we didn't double dip or overlap. So like, some case manager, they would do housing, they would do medical, or they would do other supportive services. So we would divide what we were going to do to make sure that the client needs were met.

We coordinated appointments from across providers to ensure a treatment, which was consistent with the framework and the proposed project. We provide intensive follow-up. The Peer Care Navigators will follow up with the client on a weekly basis, depending on how acute the client's situation was. So if the client was like in high acuity stage, we will follow up sometimes every two days, every week, or every day.

So the peer aspect provides empathy, first-hand experience with HIV/AIDS, homelessness, substance abuse, and/or mental illness. This was also really important, because it helped the clients to open up, and to know that they weren't alone, and that if they could see a peer doing what they strive to do, then it gave them hope and it also empowered them. So that's pretty much what the peers did. We empowered our clients to give them the ability that they can.

As for the next slide, as for their recruitment, we utilized our mobile unit for a little bit. But for the most part, we did a lot of foot outreach. We went out in the parks. We went to all of the clinics that provided HIV services. We put our flyers in other health clinics. And we also partnered with other homeless organizations, because all of the service providers would see most of the clients that we were looking for.

So we did homeless shelters. We did parks. We did churches. We also put our flyers in transitional living communities, community centers. We provided food and hygiene kits, because we found that majority of the people that were homeless they didn't have the basic needs, like a toothbrush, toothpaste, soap, a towel.

So we partnered with a local church, right, Angelica? Yeah, we partnered with a local church. And they were able to provide us our supplies for the hygiene kits, which really came in handy. And that's a way to build rapport and build trust with the client. And we outreached to other community organizations, HIV providers to assist with the recruitment.

During the implementation phase of the program, it was very important for Peer Care Navigators to have supervision with a licensed MFT. Because sometimes, as a woman who is
living and thriving HIV myself and who experienced homelessness, to encounter a client who was experiencing that, sometimes I would take that home. So to have supervision to be to talk about that, that helped me to relieve and to understand that, in order for me to do the work that I need to do, I needed to be able to release that part of the work that I do, which can be emotional and mentally stressful sometimes.

With the licensed MFT, we were in group. We did individual sessions. And they also led case conferences as well. And then on board, we had our RN case manager, which she provided medical insight on cases and took the lead on any medical adherence or medication management issues. Even our RN, she will go out with us sometimes to the client. If it was a necessity for her to go out to meet with the client, she will go out too.

Sometimes, with our clients, we had to do a contract to ensure that we weren't going to do all of the work, because it's a two-way street. So I do my part, and then the client do they're part. And so we had a contract to ensure that, in order for the client's need to be met, the client need to participate in this process.

And that went very well. Some people were like a little resistant to it. But you know, between my partner in crime, we was able to get it done. OK, now I'm going to turn it over to Angelica.

ANGELICA PALMEROS: I'll be discussing some of the implementation barriers. As we mentioned at the beginning, we decided to use the mobile unit. And as many projects when we start, we think of all these really innovated approaches and we think—we go out with the mobile unit, people are going to come. Well, no, that did not happen.

So that was a barrier that we realized that it wasn't getting our clients, and we weren't getting the information out. So that was something we learned early, early on in the study. And we removed that as one of our approaches. It was just better for us to just get informed by our partners where and when and do warm handoffs and meet the client where they were at.

We also, at the time—a huge barrier we experienced just at least, and I think this doesn't quite always happen to many organizations, but for us it did—we had a [INAUDIBLE] medical home for a long period. But due to the Affordable Care Act and other factors of the city, we weren't able to continue to sustain our medical home. So in that process also, we transferred our clinic to our Wesley Health Centers. There was a lot of advocacy. And the great part about this partnership was that they stayed in the same building, they occupied the same offices, and they're just right here next to us as well.

So there was no disruption to clients in terms of getting to know another place, getting to find out. The other important piece of this transition, I think, was that there was a community advisory board, a consumer board, that helped us, and that was the clients too. So it was a really, really great partnership.
However, during that time, looking at Operations Link new approach or, I would say, idea, the interesting thing is that we had been working with other medical facilities, that we just smoothly transitioned into now working with many, many other medical homes. And so it didn't really disrupt our delivery of services. Precious will be discussing the implementation challenges.

PRECIOUS JACKSON: We had a little challenge by some HIV providers, because they thought that we were stealing their clients. [LAUGHS] And I'm sure the service providers that are listening, I'm sure you guys can relate to that. But so we had to have like an intervention with Angelica and other higher-ups to let them know that, no, we're just adding an addition. It's not about stealing. It's about just enhancing the client's needs.

And another challenge that we faced was the lack of affordable housing in the City of Pasadena. And that was because a lot of the landlords were not willing to take the Section 8 vouchers. So we had to get a little creative and find housing outside of Pasadena. But by stepping out the box and thinking outside the box, my other peer coworker, we were able with the house majority of our clients.

Some were able to find housing on their own. And then we were able to help clients find housing together. But most of the clients were housed–just a few were housed in Pasadena, but majority were housed outside of Pasadena.

Another challenge that we faced was the lack of housing opportunities for the undocumented clients. So as you all know, LA has a lot of undocumented individuals. So some of the clients that were undocumented, they had to end up paying for their housing on their own through shared housing. And we also experienced with our clients, most of them lack just basic life skills training. So as peers, we had to do a little training.

The best part of this program was the graduation. And we would provide a certification of completion. And so once the clients were housed, we did a graduation. And we would go to their homes, and we would present them with their certificate of graduation and also kind of like a little housewarming gift thing.

And that was like the most highlighting thing that I looked forward to, because a lot of clients, they were just so happy. Because most of them when they moved into their place, they didn't have anything. So we would have to like coordinate with other housing providers that provided appliances and stuff like that. And then we had little housewarming gifts that we would give them.

And they were really appreciative of that. They were like, man, we didn't expect this. And that was like the highlight of the program.

Once the client was at self-manage and all team members, including the client, agreed that the client was ready, because they were able to adhere to their medical and behavioral health care,
they were able to obtain stable housing, they had the ability to demonstrate basic life skills, they had the ability to follow up on referrals independently, and they were able to navigate the systems independently. So that was the highlight of our program. The graduation was just—that was my favorite part.

And our successes, we were able to enroll 102 people. We had 67 to graduate by the standard of care at the end of SPNS grant. 59% were virally suppressed at 12 months. 80% were linked into medical care at 12 months.

75% were housed at 18 months. And so we continue to use this model. And we continue to use care navigator/case manager at the local libraries. And I will turn it back over to Angelica.

ANGELICA PALMEROS: So some of the things that are lessons learned, we created a much greater understanding of the needs of the population experiencing homelessness in Pasadena and the surrounding areas. And that includes the challenges, because the challenges were with the client. So we faced them together.

Highlighted the necessity of intensive case management and peer support for individuals who are experiencing homelessness. They're living with HIV, and, obviously, they're diagnosed with a mental health or a substance use disorder. And through the original case load goal, we had 40.

And then we realized that because most of these clients had a lot of highs need in their acuity levels were really high, the realistic goal for a peer, we looked at it, was 28 cases. Obviously, we graduate and we take on new clients. But that was our number.

Need to meet homeless clients where they feel safe, I would say, and comfortable. Safety is a big issue for our clients. And I think it's very important to make them feel safe and also validate where they feel safe. Need to take in account all client's needs before choosing housing, location, and access to medical needs.

I think the reason for this was that we wanted to make sure the client was a willing partner to want to go to these places, where would they see themselves going, because that was part of the adherence. If they had difficulties in the areas that we were placing them, then the likelihood of dropping out of care again and then not reaching out for help, that was a higher risk. So we tried to make sure that that was all—I can't talk—that we get strategies on that.

So our next slide is on sustainability. Part of the project was to see how we could continue this program. And so what we had is that we maintained the Operation Link model in its framework and in the delivery and also the process. So now, we have to through our Library Case Management or navigator approach. And it's open to all individuals experiencing homelessness.

I think one of the important things here is why. Because as a public health department and through this research, our clients were not only faced with HIV, but other heart conditions,
diabetes. We’re talking about health issues. And so this really opened the door so that clients can be also looked in that way of all of their medical conditions.

And again, providing intensive care to the client and linkage, and this is patients at our Pasadena Central Library and two other additional that we go when called. We also were awarded the Grant for Benefiting the Homeless Individual through SAMHSA, which is a team of social workers, case managers, and paramedics to provide case management and linkage to care. So we’re really excited about that project, because this is working with the first responders, and again, the HRSA assistance.

PRECIOUS JACKSON: OK, The recommendations that we recommend is the need to enhance life skills partnerships to improve transition from homelessness to the demands of day-to-day life demands, like paying bills, meal preparation, money management; increase the coordination of case conferencing among partner agencies; provide peer support through clinical provision and trainings to support professional development and growth; and also important linkages prior to graduating for ongoing support, such as medical, mental health, and substance abuse. And we have a list of resources.

ANGEL JOHNSON: Thank you. Thank you all very much. And thanks to all our presenters. Those were all very informative presentations. And before we open the line for Q&A, we would greatly appreciate it if you would please make note of the link on the screen and use this to give us your feedback on today’s webinar. And as we said earlier, we will also be emailing this link to all our registered participants, so that you will have an opportunity to respond and to give us some feedback.

Now, I’m going to ask the operators to please open the line for any questions and if we have any questions that were put forth through the chat box.

UNIDENTIFIED OPERATOR: Someone would like to know more about the library linkage and how that process worked.

ANGEL JOHNSON: And that's for Angelica and Precious?

UNIDENTIFIED OPERATOR: Yes.

ANGELICA PALMEROS: Our contact information now is in this slide. And if we don't have enough time to cover any information, you're always welcome to email us or call us. It's going well. We started it a year ago. And Precious has been able to house five clients so far. And again, high acuities we're noticing.

The other part is we worked very well with the librarians on learning trauma-informed approach and also their own issues about working with the homeless and their stigma. So that was two parts—not only working with the client, but having the community understand the individual. So it's still going. It was approved by the council. And we're going strong, right?
PRECIOUS JACKSON: Right.

ANGEL JOHNSON: Thank you, Angelica. Any other questions?

UNIDENTIFIED OPERATOR: There is a chat pod question, Merick Mullen. And he would like to know more about program eligibility, how you found your patients, who we lost to follow-up. Where was there a systematic approach? And can you share the patient contract? Where did you get housing money? And how long did you keep someone on your case load—was it time limited, and what was the average time?

MANISHA MASKAY: This is Manisha. In terms of program eligibility, it really was the people who met the criteria in terms of experiencing homelessness or being at risk of homelessness, living with HIV, people aged 18 and older, and having a co-diagnosis of mental health and/or substance use disorders. The other question was—and I think that various sites have found clients in different ways. But for Prism Health North Texas, interestingly there was lot of self-referral. We had internal referrals from our medical providers, but also external referrals from some of the other hospital systems, and so on.

The other question was, where did you get housing money? So in terms of housing, we used the housing card program, [INAUDIBLE] programs, and so on. The important thing was to be able to establish eligibility for those programs, which is why we ended up getting the HMIS system.

And also for emergency housing, initially the grant for a short period of time, funded it. It helped us to learn how we could provide emergency housing. And again, that’s where that process evaluation piece came in very handy.

And after that, we actually went to a donors. What has been very interesting for us as a community-based organization is that our donors are very interested in supporting emergency housing for our clients. And lastly, case load, well, I didn't talk much about it acuity levels, but we used a validated acuity tool. And for people who were able to go down to an acuity level of one and they maintained that acuity level for a period of time and were relatively stable both in housing and adherence to medical treatment and care, then we graduated them.

ANGEL JOHNSON: Thank you very much. It’s 3 o'clock. I think we need to wrap up. There may be a few other questions. And as we said earlier, if there are questions, all presenters put their information, their resource information, and you can feel free to reach out and ask questions. You can also provide questions to us, and we can get questions to them.

So I think this has been very good. Unless there are any really pressing questions—were there clinician or MDs that were embedded into these teams?

MANISHA MASKAY: Well, Prism Health North Texas, yes, because this whole program was about also creating a medical home. So they were receiving medical care. Our social workers
were licensed. And then in terms of medical care, that's what's provided by physicians and/or mid-level practitioners.

UNIDENTIFIED OPERATOR: Also note, for those who asked about the client contract, there is a link in the chat pod as well to be the resource if you scroll through.

ANGEL JOHNSON: It also looks like someone is asking about an acuity tool and if this was in the manual.

MANISHA MASKAY: For us, it is. For Prism Health North Texas, yes, it's in the manual.

ANGEL JOHNSON: Great.

MANISHA MASKAY: There was one question. I'll just quickly answer it. It was related to how we adapted.

And that was related to the process evaluation that we did. We looked at our outcomes on an ongoing basis and examined the outcomes comparing them to each of the program elements. And the program elements that made the most sense and improved outcomes are what we ended up keeping.

UNIDENTIFIED OPERATOR: Thank you. And Edie has also placed links to the resources for this initiative. There are several acuity tools and models to choose from on that link Edie just provided. And it includes the logic models, several presentations, reference guides, role and project staff descriptions, as well as front line staff role descriptions, as well as trainings. So that link Edie just provided takes you to a wealth of documents and examples to choose from based on the presentations provided today, as well as shared with other projects under this initiative.

ANGEL JOHNSON: OK. Thank you all very much. The next presentation in this series is scheduled for July 11 at 2:00 PM Eastern Daylight Time and will feature two transgender women of color demonstration models. And I want to thank you very much for your participation and for your attendance. If you have any questions, please do not hesitate to contact them at SPNS@hrsa.gov.