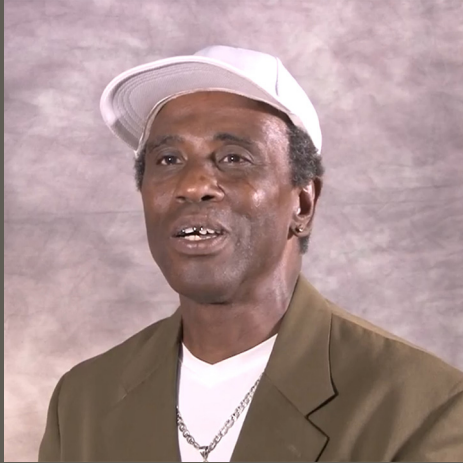Dallas, TX

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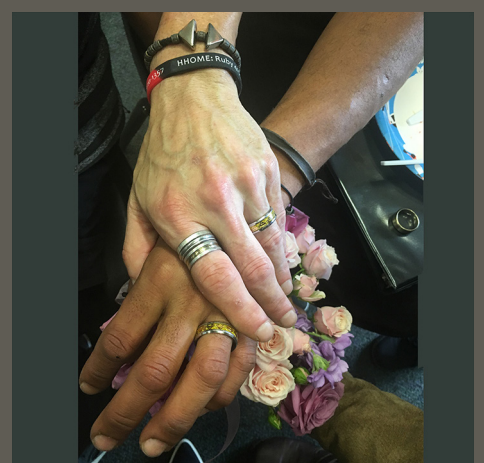
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Pasadena, CA

Portland, OR

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San Francisco, CA

Building a Medical Home for Multiply Diagnosed HIV-Positive Homeless Populations

An implementation guide to achieve the goals of the HIV Care Continuum for people living with HIV who have co-occurring mental health and substance use disorders and are experiencing homelessness

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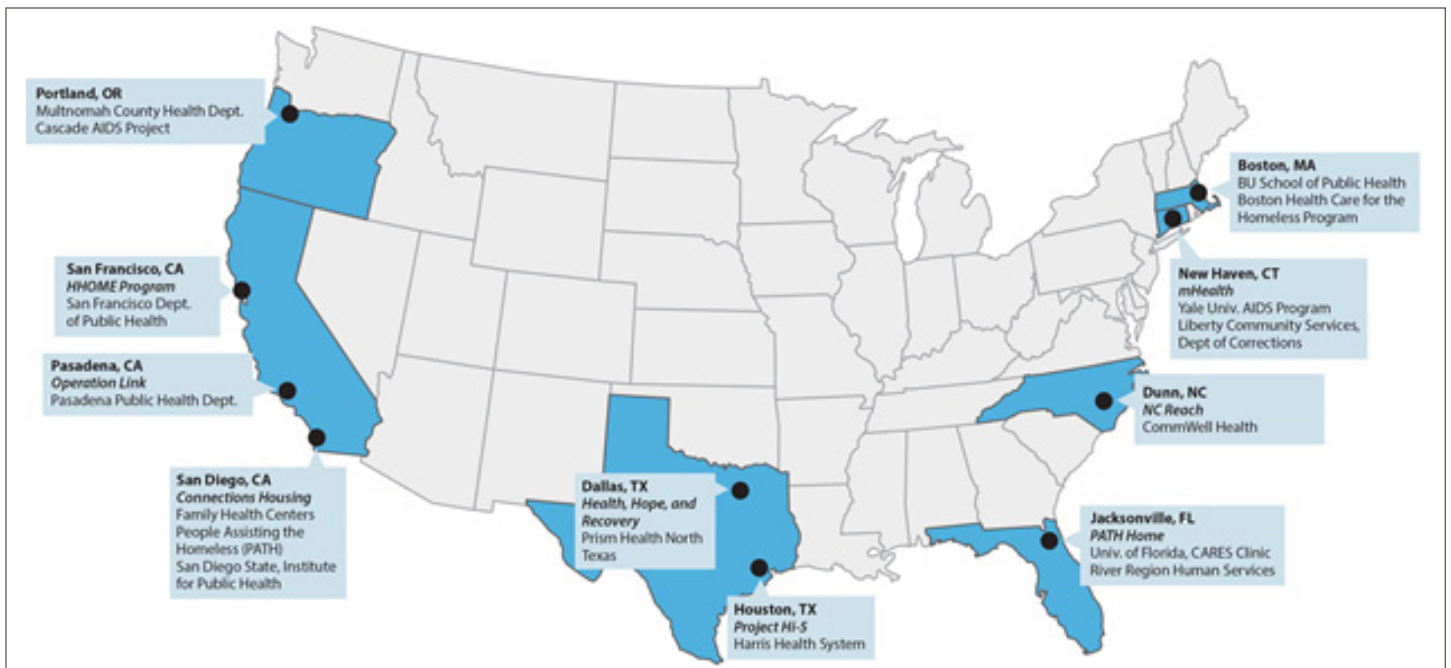
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BUILDING A MEDICAL HOME FOR MULTIPLY DIAGNOSED HIV-POSITIVE HOMELESS POPULATIONS AT A GLANCE

Main challenge: Reduce the barriers to engagement and retention in HIV care by creating a coordinated system of care including HIV primary care, substance use and mental health treatment, and housing and supportive services.

Focus population: People 18 years or older who are experiencing homelessness, living with HIV, and diagnosed with mental health and/or substance use disorders. The populations included adults from predominantly racial/ethnic minority communities.

Description of the model: The nine medical home models had the following characteristics in common:
• Partnerships between HIV and housing providers
• Integrated behavioral health and HIV services
• A patient navigator who worked intensively one-on-one with clients to reduce barriers to care and improve access to HIV care, housing and support services.

The role of patient navigator* varied in position title by project. This member of the team was in addition to the traditional HIV case manager and served the key function of bridging the services system to get client needs met. Based in the HIV health care team or a housing partner, the patient navigator worked with clients and interacted with all members of the team to meet health care, housing, or other social service needs to achieve HIV and housing goals. Caseloads among patient navigators were generally about 25 – 30 clients.

*Sites varied in what this position was called. We are using the generic term "patient navigator" in this manual. Sites called them network navigators, peer navigators, care coordinators, SPNS case managers, or service linkage workers. More about their role can be found in the article Sarango et al. "Role of Patient Navigators in Building a Medical Home for Multiply Diagnosed HIV-Positive Homeless Populations" at https://www.ncbi.nlm.nih.gov/pubmed/28079645

Content of intervention: Navigator key tasks included accompaniment to medical and behavioral health services, assistance with housing search and plans, assistance with transportation, education about services, and HIV care and treatment. A smaller percentage provided support with employment (11%) and obtaining benefits.

Intensity of services: On average, clients received 3 encounters per month across the sites with a range of 2-11 encounters per month. The average length of program intervention was 18 months, with a range of 1-22 months. A majority of encounters were made in a medical clinic setting but high proportion (35%) occurred "out in the community "-- in the streets, shelters, client's home, or a community agency.

Staff background and training: Staff qualification varied by organization structure and approach. In some cases persons with a licensed social work degree filled this role, and in others a peer (person living with HIV, person with a history of homelessness) was essential to the model. In all cases, persons with experience with the community, HIV, homelessness, substance use and/or mental health disorders were critical to the project.

A total of 60 hours of training was provided to intervention staff (care coordinators, service linkage workers, patient navigators, peer navigators and supervisors). Key topics and competencies included:

• Motivational interviewing techniques
• Strategies for managing crises and de-escalating aggressive behaviors in clients
• Harm reduction
• Trauma-informed care
• Advocating for clients who are difficult to house such as persons with a history of sex offense
• Understanding vicarious trauma
• Self-care techniques

Other important topics included supporting HIV medical adherence, supporting clients with mental health disorders and making appropriate referrals, Hepatitis C and other co-morbidities, supporting clients to maintain housing.

Management and integration: A project director or coordinator was assigned to supervise the SPNS intervention staff (navigators). This person was also responsible for connecting with partners and overseeing the multisite evaluation. This person provided administrative and supportive supervision, oversaw documentation of tasks, balanced caseloads, and assisted with community partners. Six of the nine sites had a formal system of clinical supervision provided to staff on a monthly basis as a group to help with managing different client cases and addressing self-care needs when working with clients. The integration of the navigator into the team varied across sites. All project staff met for weekly updates with clients and in some sites regular meetings were held with the health care team as part of team huddles. All staff had direct communication via email or phone call with sites when participation in team huddles was not realistic.

Financing: The average cost per person per year was $2,713 (range $1,254-4,225 across sites). Costs were calculated based on 715 (range 46-122 per site) people living with HIV served from September 1, 2015 - August 31, 2016. All costs were wage and price adjusted in 2016 dollars. The sources of funding for the intervention were cooperative agreements through grants awarded to each site from the Health Resources and Services Administration, HIV/AIDS Bureau.

The calculated costs included:

• Salary and fringe benefits for intervention staff and supervisors
• Materials and consumables for non-research related activities
• Transportation cost for staff and clients
• Staff and client communication costs (including pre-paid cell phones for clients)
• Other direct costs to provide client services such as costs for obtaining client IDs and agency overhead rates

Medical and behavioral health provider salary was included only if it was a direct charge to the grant. Data were gathered from administrative reports provided by the agency at the close of the fiscal grant year reported to HRSA. Other agency costs incurred for the intervention from non-SPNS related sources were gathered but omitted in final cost calculation due to missing data and lack of standardization in calculation of costs across sites.

June 2017 all grantee meeting

INTRODUCTION

The Challenge: Care and Treatment for People who are Homeless and Living with HIV

It has long been known that antiretroviral therapies (ART) improve the health of people living with HIV/AIDS (PLWHA) and more recent studies demonstrate that they also help in reducing transmission rates (Bulterys, Dalai, & Katzenstein, 2010; Cohen, Chen, & McCauley, 2011; Skarbinsky et al., 2015). People who are homeless are disproportionately affected by HIV (National Coalition for the Homeless, 2009). Furthermore, people living with HIV who are experiencing homelessness are more likely to delay entering care, have poorer access to HIV care, and are less likely to adhere to antiretroviral therapy (Leaver, 2007, Kidder, 2007, Stewart, 2005). Those who additionally face mental health and substance use challenges have complex medical and social service needs, but are least equipped to navigate the fragmented system of services to access the care they need. Barriers to care often include inadequate insurance, mistrust of the health care system, stigma surrounding HIV and homelessness, a lack of available community resources, lack of transportation, food insecurity, unresolved legal issues, interpersonal violence, frequent interactions with the criminal justice system, or a lack of legal identification. When faced with clients who are living with HIV and experiencing homelessness, HIV case managers may not have the capacity to support these clients adequately because of large caseloads or lack of training in areas related to the barriers this population faces in their lives.

About the SPNS Initiative: Building a Medical Home for Multiply Diagnosed HIV-Positive Homeless Populations, 2012-2017

Against this backdrop, in 2012 the Health Resources & Services Administration (HRSA), HIV/AIDS Bureau through its Special Projects of National Significance

(SPNS)* funded a national five-year initiative with the goal of building a medical home for those who are homeless or unstably housed, living with HIV, and who face co-occurring challenges of mental health or substance use disorders. Nine clinics and community-based organizations and one evaluation and technical assistance center (ETAC) were funded to implement and evaluate innovative service delivery models for this population. The two main goals of the models were to:

1) increase engagement and retention in HIV care and treatment by developing medical homes; and
2) improve housing stability.

While each model was tailored to the environment in which it existed and the needs of the specific population served, the nine models shared several components. They all developed partnerships between HIV and housing providers. They integrated behavioral health and substance use services into HIV care. Additionally, they all created a role of care coordinator/patient navigator who worked one-on-one with clients to access the resulting networked system of services among HIV care, behavioral health and substance use care, housing, and other community services. To measure achievement of project goals, the nine programs conducted a longitudinal multisite evaluation study of the models. For more information about the initiative, visit http://cahpp.org/project/medheart/

The Center for Advancing Health Policy and Practice at Boston University and Boston Health Care for the Homeless collaborated to serve as ETAC for the nine clinical sites. The ETAC provided technical assistance throughout the initiative, served as a central repository for resources and information, designed and oversaw the collection of data, and disseminated findings.

About the Nine Demonstration Sites

The nine sites represented 8 urban areas and 1 rural area. All provide access to comprehensive HIV primary care either directly or through dedicated partnerships with a clinical provider. In developing their models, all sites recognized that their highest acuity patients--those who were most challenging to engage in care or were at most risk of dropping out of care-- were diagnosed with substance use and/or mental health disorders and were in unstable housing situations or experiencing homelessness. The demonstration sites represented public health clinics, outpatient hospitals, comprehensive HIV clinics, mobile health clinics, or federally qualified health centers. See the chart on pg. 14 for an overview of the sites' models. For site-specific information please see each site's manual at: http://cahpp.org/project/medheart/models-of-care

Purpose of This Manual

This manual is intended for organizations that serve people living with HIV who are experiencing homelessness and have a mental health or substance use disorder. It provides information and resources and draws on lessons from the nine sites with regard to:

1. Setting up a program within your agency
   • Working with external partners
   • Recruiting staff
   • Training and supervising staff
   • Developing referral mechanisms
   • Developing policies and procedures
2. Finding and engaging people in care
3. Providing services
4. Evaluating program activities and conducting quality improvement, and
5. Sustaining program services.

It is hoped that organizations who plan to strengthen the provision of services to this population can build on the ideas and resources outlined here to create a model best suited to the needs of their community.

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* Special Projects of National Significance (SPNS) programs are charged with the development of innovative models of HIV treatment, in order to quickly respond to emerging needs of clients served by Ryan White HIV/AIDS Programs. SPNS advances knowledge and skills in the delivery of health and support services to underserved populations diagnosed with HIV infection. Through demonstration projects such as those described in this manual, SPNS evaluates the design, implementation utilization, cost, and health-related outcomes of treatment models, while promoting dissemination and replication of successful interventions. Learn more at https://hab.hrsa.gov/about-ryan-white-hivaids-program/part-f-special-projects-national-significance-spns-program

August 2014 navigator training

SETTING UP THE MEDICAL HOME MODEL

Underlying Principles and Evidence-Based Practices

Patient Centered Medical Home (PCMH)

The models at the nine demonstration sites all adapted the patient-centered medical home (PCMH) framework to develop a model that would provide comprehensive, accessible, patient-centered, and coordinated care to people who are experiencing homelessness and living with HIV. The PCMH framework relies on a multidisciplinary team of providers and focuses on the "whole person." (American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, & American Osteopathic Association. 2007)

Housing First

The nine sites also drew on the Housing First approach when setting up their models. Housing First calls for connecting individuals quickly and successfully without pre-conditions of sobriety or treatment for mental health

disorders. Persons are housed and supportive services are then provided to an individual to connect them to treatment. The idea is that all individual are "housing-ready" and have the right to safe, affordable, and permanent housing. Providers in turn must provide supportive services to find and help people maintain housing as well as connect them to services as needed. More about Housing First programs can be found here: https://www.huduser.gov/portal/publications/hsgfirst.pdf.[1] Prism Health North Texas (PHNTX) staff noted that adoption of the Housing First model and a closer collaboration among housing providers in Dallas had a positive impact on their ability to get clients into permanent housing. (See Prism Health North Texas's manual, Health, Hope and Recovery, pg. 9 at http://cahpp.org/HHR-Prism-Health.pdf)

The Resources that accompany this manual, on the web at http://cahpp.org/project/medheart/resources, include links to underlying theoretical models used by several of the demonstration sites in developing their model.

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[1]Abt Associates July 2007. The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness. Prepared for US
 Department of Housing & Urban Development.

Working with Stakeholders to Set Up the Medical Home

The introduction of a new project inevitably has an impact on all areas of the organization that work with the clientele being served. To ensure success, it is crucial that the "champions" of the new model take the time to explain it to all stakeholders within the organization. Staff at many of the demonstration sites held meetings to outline the new model, detail its implications for the organization's work flow, and listen to and address any concerns expressed by colleagues in other organizations. Links to presentations used to share the new programs are included on the Resources webpage.

Here are some ways you can help prepare stakeholders within your organization for when you implement your intervention:

Advocate and explain the role of the navigator as part of the care team

All the sites were Ryan White organizations accustomed to serving people living with HIV. However, prior to this project, their existing staff did not have the time to serve people living with HIV with complex needs, given caseloads of greater than 80 clients. To focus on people living with HIV with high-acuity needs, the role of the navigator was a new staff addition, and navigator staff activities were examined against the activities of existing staff to ensure any overlap or friction points were addressed. Sites developed job descriptions so that all staff had a common understanding of who was responsible for which tasks pertaining to clients. Links to examples of job descriptions from several sites are included on the Resources webpage.

In addition to job descriptions, the supervisor of the staff was charged with ensuring the integration of the navigator to the care team. Highlighting the new project via all agency staff meetings and providing regular updates to the Board members of the agencies were also critical to secure buy-in for the project.

> "Any time you introduce a new intervention and a new classification of staff, you need to realize that it can have an impact on your overall operation. Introducing navigators affects the jobs of everybody else in the clinic. You need to look at each role and say what is this role vis-à-vis the navigator?
>
> - Jodi Davich
>   Multnomah County
>   Health Department

Train HIV providers to identify and work with people who are experiencing homelessness or unstable housing

In some cases, an increase in number of clients who were experiencing homelessness indicated a need for additional training of providers in best practices for working with these individuals. Staff were trained to better identify people who were experiencing homelessness, since individuals often did not reveal their housing status in a medical appointment, and were taught strategies for caring for this vulnerable population.

Train your colleagues who work with the people who are experiencing homelessness about HIV and the importance of treatment

For providers accustomed to working with clients who are experiencing homelessness but not as familiar with the challenges of living with HIV, training in HIV care and treatment was called for. See the section on training below for more about efforts to cross-train providers. At Harris Health in Houston, one strategy to improve access to care and treatment for people living with HIV who are experiencing homelessness was to train the clinic team at the Health Care for the Homeless (HCH) Program in HIV care. Using resources from the AIDS Education and Training Center, HCH nurse practitioners were trained in HIV care and treatment and how to support patients as they adhere to their HIV medication.

Work with agencies that provide additional services your clinic doesn't offer

To provide the full range of services required to provide care to this population, many HIV care organizations partnered with organizations experienced in housing clients who are experiencing homelessness. Some sites developed additional partnerships with organizations providing behavioral health and substance use treatment services. Four sites—Multnomah County Health Department and Cascade AIDS Programs, Family Health Centers of San Diego (FHCSD) and People Assisting the Homeless (PATH), Yale and Liberty Community Services, and UF CARES and River Region Human Services—formed specific contractual arrangements to obtain housing and health care services for clients and formalized relationships that were started due to an unmet need recognized by their Ryan White Planning Councils or HUD Continuum of Care Committees in their area.

In other cases, the partnership was a new working relationship developed as a result of the SPNS initiative. For example, CommWell Health used SPNS dollars to initiate quarterly meetings among housing, health care, and other community services to achieve the goals of the project. The table on the next page lists the collaborations formed among organizations to provide comprehensive services. Links to samples of memoranda of understanding used to formalize partnerships are included on the Resources webpage.

Serve on local HIV and housing committees to break down the silos of the care system

Beyond these primary partnerships, all demonstration sites identified private sources beyond HOPWA/HUD and Ryan White partners to leverage local resources and provide robust comprehensive services to clients in the new model. They reached out to potential partner organizations to introduce the initiative. The San Francisco Department of Public Health organized a series of partner meetings to bring the city's rich resources for serving people experiencing homelessness to introduce the new SPNS program HHOME and coordinate care. The goal of the meetings was to share how HHOME would build upon existing programs to reach the most medically fragile, establish memoranda of understanding to recruit and refer clients, stabilize their care, and finally transition them to other HIV and homeless programs. CommWell Health in Dunn NC adopted a similar approach to holding regular partner meetings. The sidebar on pg 17 describes how CommWell Health's initial meeting of local service providers developed into a standing meeting that has led to collaborations and a greater pooling of resources that will continue beyond the end of the demonstration model.

Pasadena's Public Health Department's Operation Link managers encouraged their peer care navigators to sit on existing committee meetings in their Service Planning Areas (SPA) to help coordinate referrals and services for people living with HIV who are experiencing homelessness. The peer care navigators were members of the SPA 3 committee, HIV Providers Committee, and the Coordinated Entry System Committee, a meeting of local housing providers. Peer care navigators attended these monthly meetings which assisted Operation Link to obtain clients for the program as well as find housing opportunities for people living with HIV who were experiencing homelessness.

Overview of the nine SPNS Medical Home Models

The table below summarizes the number of clients served and key components of the medical home models

Demonstration sites	#served 1,338	Setting	Patient navigator role	Collaboration with housing agencies	Provision of mental health services	Provision of SU treatment
CommWell Health **Dunn, NC**	80	• Federally qualified community health center • PCMH certification • On-site comprehensive HIV care services	• Network navigator with dual roles in addressing HIV and housing; continuum of care coordinator	• Coordination with county HOPWA and HUD officials; local housing providers	• Co-located mental health counseling by licensed professional; prescription of psychiatric medications	• Co-located substance use counseling by licensed professional; residential treatment centers on site
Family Health Centers of San Diego **San Diego, CA**	254	• Federally qualified community health center • PCMH certification • On-site comprehensive HIV care services	• FHCSD case manager (HIV-focused) and PATH care navigator (Housing-focused) coordinate efforts on behalf of clients	• Formal partnership with PATH San Diego-a comprehensive housing service provider including a facility with 173 interim beds, 16 special need 1-bedroom units; also provides comprehensive job training and support services	• Co-located mental health counseling by licensed professional; prescription of psychiatric medications	• Co-located substance use counseling by licensed professional; medications for addiction treatment
Harris Health System **Houston, TX**	240	• Clinic/program associated with large hospital system • PCMH certification • On-site comprehensive HIV care services	• Dual roles in addressing HIV and housing provided by 3 licensed professional medical case managers, and two service linkage workers	• Coordination with county HOPWA and HUD officials; local housing providers. • Provision of emergency housing	• Mental health services are available through the Harris Health System, coordinated with primary and specialty HIV care, case management and substance use treatment. • Behavioral health providers are available at Harris Health's HIV clinic as well as by referral. Mental health providers who are part of Harris Health's Health Care for the Homeless staff are available to meet with clients at external locations	• Substance use services are available through the Harris Health System, including primary and specialty HIV care, case management and behavioral health. • Behavioral health providers are available at TSHC as well as by referral

Demonstration sites	#served 1,338	Setting	Patient navigator role	Collaboration with housing agencies	Provision of mental health services	Provision of SU treatment
Multnomah County Health Department **Portland, OR**	148	• Public health department • PCMH certification • On-site comprehensive HIV care services	• Network navigators (HIV-focused) and CAP housing case manager (housing-focused) coordinate efforts on behalf of clients	• Formal partnership with Cascade AIDS Project (CAP), a community-based provider of HIV, housing and advocacy services for PLWHA. Provides direct housing assistance including rent, utilities, and emergency needs. Provision of emergency housing	• Co-located mental health counseling by licensed professional; prescription of psychiatric medications	• Co-located substance use counseling by licensed professional; residential treatment on site or MOU; medications for addiction treatment
Pasadena Public Health Department **Pasadena, CA**	107	• Public health department • On-site comprehensive HIV care services	• Peer care navigators have dual roles in addressing HIV and housing	• Linked with city housing authority; Coordination with city and county HOPWA and HUD officials; local housing providers	• Peer care navigators link clients to care at the Andrew Escajeda Comprehensive Care Services (AECCS) Program, which is managed by Wesley Health Center and located in the same building as Operation Link. Operation Link staff work closely with AECCS staff to help clients access all available services including mental health	• Peer care navigators link clients to care at the Andrew Escajeda Comprehensive Care Services (AECCS) Program, which is managed by Wesley Health Center and located in the same building as Operation Link. Operation Link staff work closely with AECCS staff in assisting the client to access all available services including substance use treatment
Prism Health **Dallas, TX**	157	• Comprehensive HIV/AIDS service organization • On-site comprehensive HIV care services	• Licensed professional care coordinators addressed HIV and housing issues	• Coordination with city and county HOPWA and HUD officials; local housing providers. Provision of emergency housing	• Integrated mental health counseling by licensed professionals; prescription of psychiatric medications by psychiatric providers	• Utilization of motivational interviewing and harm reduction strategies to help individuals move toward engaging in treatment for substance use; referral to external SU treatment providers

Demonstration sites	#served 1,338	Setting	Patient navigator role	Collaboration with housing agencies	Provision of mental health services	Provision of SU treatment
San Francisco Department of Public Health **San Francisco, CA**	106	• Department of health/community social service program: drop-in clinic. mobile service street, shelter, stabilization room, and hospital	• Peer navigator (HIV-focused) and housing case manager coordinate efforts on behalf of clients	• Department of health direct access to housing, housing authority and local housing providers. DPH emergency stabilization rooms	• Co-located mental health counseling by licensed professional; prescription of psychiatric medications	• Co-located substance use counseling by licensed professional, linkage to detox and residential treatment, medications for addiction treatment
University of Florida Jacksonville, CARES Clinic (UF CARES), **Jacksonville FL**	167	• Clinic/program associated with large university-based system • PCMH certification • On-site comprehensive HIV care services	• Peer navigator at UF CARES (HIV-focused) and peer navigator at River Region (housing focused) coordinate efforts on behalf of clients	• Formal partnership with River Region Human Services, a comprehensive housing, mental health and substance use service agency	• Provided by partner River Region Human Services. Co-located mental health counseling by licensed professional; prescription of psychiatric medications	• Provided by partner River Region Human Services. Co-located substance use counseling by licensed professional; residential treatment on site or by MOU. Medications for addiction treatment
Yale University **New Haven, CT**	79	• Clinic/program associated with large university-based system • PCMH located in a mobile medical clinic and an office setting	• Peer navigator at Liberty Community Services has dual roles in addressing HIV and Housing	• Formal partnership with Liberty Community Services who provides supportive services and housing options for people experiencing homelessness and living with HIV, mental illness or addiction	• Co-located mental health counseling by licensed professional; prescription of psychiatric medications	• Co-located substance use counseling by licensed professional; medications available for treatment; residential treatment by referral

Connect with private landlords

One important area of consideration was developing relationships with potential landlords. This is of particular importance because clients may have a criminal record (convicted of high level of sexual offense and selling methamphetamines) that makes it challenging or disqualifies them from benefitting from housing resources such as HOPWA funding, HUD housing, or section 8 vouchers. The demonstration sites have found that landlords are often more willing to house a client if they know an organization staff member is advocating for the client on an ongoing basis and can facilitate a solution if a housing-related problem arises. See the sidebar on pg.

38 *The Value of Building Housing Relationships* for an example of how Prism Health North Texas worked with a landlord to prevent a client from being evicted.

Create partnerships with the community you want to serve

In addition to engaging with stakeholders who can provide needed services and resources (such as housing), it is also important to constantly engage with the community you are serving. To do this, consider establishing a community advisory board (CAB) consisting of people living with HIV who are experiencing homelessness. Engage with them regularly to identify service gaps and

NC-REACH model leads to new coalition of service providers

CommWell Health staff involved in the NC-REACH program held an exploratory meeting in March 2014 with 15 housing providers to identify the needs of the communities they serve and share available resources and services. As a result of this first meeting, an updated community resource list was created to improve coordination across agencies.

In May, a second meeting of 19 housing providers – including most of those who had attended the earlier meeting – took place. At this meeting, community members suggested forming a coalition or partnership. NC-REACH staff asked each agency to partner with them by helping connect clients enrolled in the NC-REACH program to housing and supportive services. The NC-REACH staff would in turn help agencies connect clients to needed medical services. By the end of the meeting, the group had defined the coalition's goals and objectives:

Goal: Develop a collaborative of housing providers and partners to connect clients living with HIV with housing and medical care.

Objectives:

1. Identify local housing resources for people living with HIV
2. Build sustainable collaborations with local housing providers and partners to increase options available for clients living with HIV
3. Leverage collaborations with new housing partners and providers to obtain transitional and stable housing for clients living with HIV

By September 2014, quarterly meetings had been established and organizations began increasing the number of referrals to each other's services. Participants expanded beyond housing providers to comprise about 40 coalition members, including private landlords, people from faith-based communities, local detox centers, and representatives from agencies such as Veteran Affairs, the Red Cross and United Way. By the end of the NC-REACH program, 16 coalition meetings had been convened, with meeting sizes ranging from 20 to 45 people. The benefits have extended far beyond housing options for clients. Organizations have a better understanding of many aspects of clients' unmet needs. As they learn more about each other's services, they have begun to collaborate more closely to address those challenges.

More info: CommWell Health's manual NC-REACH is at http://cahpp.org/CWH-NC-REACH.pdf

The Community Housing Coalition has been very informative and vastly increased collaboration among service providers within the community.

needs. At the HHOME Project in San Francisco, a client advisory panel met monthly to discuss topics and plan educational and social activities. An HHOME client initiated a program to help his peers learn about and visit different places in the community. The goal was to get his fellow peers more active in their community with the goal of reducing their substance use.

Developing New Policies or Adapting Existing Policies for Staff to Achieve and Support Client Goals

A critical step prior to launching the program was examining existing tools and policies at each site so the model could provide medical and support services to people living with HIV who are experiencing homelessness or unstable housing. Each site assembled and developed tools and resources. Below are some steps taken by the nine sites to develop policies, tools and resources to better identify or obtain services for people living with HIV who experience homelessness.

Design acuity tools for identifying clients and developing appropriate care plans

Each site required a tool to measure clients' service needs and acuity as they entered the medical home and at 3-month intervals as they progressed in their care. The ETAC researched existing validated instruments to provide recommendations for a tool that would measure acuity of needs in areas including health, HIV care adherence, mental health, substance use, housing, legal status, income, social support, transportation, and nutrition. Each site adapted these recommendations to suit the requirements of their model and community. In some cases this took some trial and error until the "right" tool was implemented. For example, the initial acuity scale adopted by Prism Health North Texas's Health, Hope, and Recovery project was not adequately sensitive to appropriately assess changes in the client's acuity level. Therefore, the care coordinators adopted the Transitional System Acuity Scale tool (included in the Resources section at http://cahpp.org/wp-content/uploads/2017/04/Prism-HHR-Transitional-System-Acuity-Scale.docx) that assesses acuity in 14 areas of need.

Harris Health and its intervention team developed a 6-item measure for case managers to track progress with a client's housing situation over time. This housing scale is included on the Resources webpage at http://cahpp.org/wp-content/uploads/2017/09/Harris-Health-housing-acuity-scale.docx

At SFDPH, the tool developed for the HHOME program is now widely used by other agencies in the city. A link to this acuity and chronicity assessment is available on the Resources webpage at http://cahpp.org/wp-content/uploads/2017/12/SF-Acuity-and-Chronicity-Assessment-Tool.pdf. Because the same tool is used to measure acuity across agencies, when HHOME clinical staff meet with hospital and community clinic partners to review mutual clients, they have a shared understanding of the client's acuity. For more information, see San Francisco's HHOME program implementation manual at http://cahpp.org/HHOME-SFDPH.pdf

Links to sample acuity tools used by individual demonstration sites are included on the Resources page at http://cahpp.org/project/medheart/resources

Establish internal and external referral processes

Referral processes and forms were created for both internal systems at the agency (other departments, affiliated hospitals and emergency rooms) and with community agencies, such mental health service providers, substance use treatment agencies, and police departments, to refer potential clients to the program. For example, at Harris Health System in Houston, because of the vast network of departments and services within the system, the program had to set up a coordinated system to receive referrals from Thomas Street Health Center (TSHC, the main HIV primary care providers), the TSHC walk-in clinic, Houston Health Care for the Homeless (HHH), Harris Health System hospitals, affiliated emergency rooms, and other local in-network hospitals. All Harris Health entities including the Health Care for the Homeless Program shared a medical record which facilitated referrals, but they also had staff members at the emergency departments to do HIV testing and to identify people who were experiencing homelessness and were

not in care. In addition, they could track people lost to care via the Homeless Management Information System (HMIS). Several sites used this system.

In addition to working within the internal Harris Health System, the project also established referral processes with key stakeholder groups external to Harris Health who may have interactions with people living with HIV who experience homelessness. For example, when the Houston Homeless Outreach Team (HOT) of the Houston Police Department identified a homeless HIV-positive individual who was in need, they immediately contacted the Hi-5 case management team and provided a location where the Hi-5 service linkage worker could meet the client to begin service delivery.

At Multnomah County, HIV health care providers were an important referral source to the care team because they might have first-hand knowledge that a client was struggling with housing or other social needs. The clinic established a system that the medical team could use to refer clients for two types of navigation assistance: short-term, one-time only and/or intensive, longer-term navigation. The medical team would have a conversation with the client to determine the client's interest in connecting with a navigator and to identify the client's navigation service goals. Once the client expressed interest, the medical provider would connect with the navigator during morning huddle and then the navigator would reach out to the client. In some cases the connection was made that day during clinic. A link to Multnomah's navigation referral process document is included on the Resources webpage. (http://cahpp.org/wp-content/uploads/2017/04/Multnomah-Navigation-Referral-Process.docx)

Co-locating a navigator at homeless agencies on a regular basis was another strategy to identify and obtain referrals for people living with HIV who may need more intensive support. In Houston, service linkage workers accompanied staff at SEARCH, a local non-profit homeless program, monthly to find people who are on the street, HIV positive, and out of care. The partnership with SEARCH also connected the service linkage worker to housing services for clients. Service linkage workers were also stationed at a day shelter, Beacon one day per week to conduct HIV testing and provide on-site assistance to homeless HIV-infected clients.

Links to referral forms from several sites are included on the Resources webpage.

Develop an integrated care plan for the client

Having one integrated care plan that can be used by the care team is essential to: 1) help clients achieve their self-identified goals and 2) facilitate communication among the care team members (navigators/care coordinators, case managers, medical providers, and behavioral health care providers) about services needed and provided. SFDPH developed a weekly meeting client plan template (http://cahpp.org/wp-content/uploads/2017/10/SF-Client-Plan-Weekly-Meeting-Template.docx) which was reviewed each week and set the priorities for each member of the team to work on with an individual client for the coming week. At the weekly team meeting, the care plan for each client was reviewed and updated so that each team member understood his or her role in helping the client meet the goals.

Establish a policy for staff mobility and safety outside the clinic

In many of the medical home models, staff, including patient navigators and sometimes providers, were not limited to working within the clinic. They often accompanied clients to appointments and meetings and met with them wherever the clients were most comfortable—on the street, in encampments, or in coffee shops, for example. The demonstration sites examined existing policies around staff working outside the organization's facilities and in some cases developed specific protocols to ensure the safety of staff and clients. Multnomah County's navigators carried a cell phone for field safety. Whenever they left the clinic to meet a client in the field, a "status update" email was sent to all staff (including supervisors). A protocol was established for checking in after a field visit. In addition to the formally assigned supervisor, navigators were given access to all supervisors at the HIV Clinic and at CAP so that in an emergency, navigators could get real-time support even if the assigned supervisor was unavailable. Clinic staff worked together to develop and implement a formal situation debrief process that supported navigators and other clinic staff following disturbing, difficult events. The crisis staff debrief guidelines are included

among the Resources here: http://cahpp.org/wp-content/uploads/2017/05/Multnomah-Crisis-Staff-Debrief-Guidelines.doc. Other sites set up policies that staff were required to go into the community in pairs for safety. In San Francisco, where most of their work was done in the community, the staff saw clients in pairs.

Establish transportation guidelines for staff to support

Access to transportation is a barrier to obtaining HIV medical care for many clients and especially for people living with HIV who may be experiencing homelessness. The organization's policies regarding staff driving clients to appointments played a major role in some of the medical home models. In the rural setting of CommWell Health in North Carolina, it is not uncommon for clients to travel as long as an hour or more to make a medical appointments, and if staying in a shelter it could be as many as 40-50 miles to the nearest facility. Thus, the ability of navigators to transport clients is an important job requirement, and a tool to build a relationship of trust between client and navigator. Other agencies may have rules against staff transporting clients due to liability concerns and thus other strategies were implemented to assist clients with making appointments. For example, at UF CARES, a shift in transportation policy in year 4 of the project led to unintended consequences in the way staff worked with clients and supported them to attend appointment. (See the sidebar on the right.)

Set up the transition process

The SPNS demonstration projects were designed to be a shorter term, intense approach intended to stabilize clients as they work toward accessing and maintaining their own care. The goal was to link and engage or re-engage the client with the HIV care team. The SPNS navigators were not to replace a traditional HIV medical case manager but to serve as a support to the entire HIV care team in helping reduce barriers to care and address unmet needs. Each site developed its own protocol for determining at what point a client is ready to transition to the next stage of his or her care and how to help a client make the transition to the organization's standard of care. Establishing the criteria for when a client could

Shift in transportation policy means adjustments for The Partnership for Access to Treatment and Housing (PATH Home) model

In the fourth year of the PATH program, the University of Florida changed its transportation policy: employees could no longer drive clients to appointments. Transporting clients had proven an excellent way for peers and case managers to build trust with clients. "You have all that time to talk with the client and learn different things about [them] because they are relaxed. They get to know you as a person, not just as somebody else that gets paid to do what they do," explained Joseph Mims, PATH Home program manager. "It showed us stepping outside of this medical role, and it let clients know how much we care that they make it to their medical appointments."

With one email announcing the transportation policy change due to liability, staff could no longer offer a ride to clients. To overcome this unexpected barrier, the navigators assisted clients with navigating the local bus system by outlining the bus trips and meeting clients at destinations to ensure arrival, providing bus passes, and encouraging people to use Medicaid transportation.

"There were logical reasons for this policy change, but we didn't realize how much this shift in the landscape can affect our program," said Alma Biba, PATH Home program clinical quality assurance coordinator. "Weathering the change called on all the resilience and flexibility that our staff and clients could muster."

be "transitioned" and no longer needed services was a challenge, but each site set up some criteria. Some examples are:

- Being virally suppressed in a specified time frame
- Retained in care and having a specified number of appointments

- In a stable, safe housing situation and/or paying rent for at least 3 months
- Having a social support identified

Links to several tools for transitioning to standard of care, including forms, process descriptions, graduation certificates, sample client letters, and checklists are available on the page at http://cahpp.org/project/medheart/resources

Find space and resources for staff to meet and communicate regularly with clients, the care team and providers

When planning the medical home model, it is important to keep in mind the logistics of introducing new employees and clients to your agency. Do the navigators/care coordinators have a place where they can work quietly with clients? Is the space welcoming to the new employees and new clients? Some important items for new staff include:

- Space or private offices or space for navigators and clients to work
- Cell phones
- Laptops or tablets to track and document work with clients in real time, access the web and resources

Recruiting and Hiring Staff

As mentioned previously, to address the needs of people living with HIV who are experiencing homelessness and build the medical home, each site identified from existing staff or hired new staff members to work intensively with the focus population. At all sites, this role was determined to be beyond the scope of the traditional

Don't start from scratch—resources are available

Links to the tools described throughout this manual, as well as a wide range of other tools and resources developed for each site's medical home model, are included on the Resources webpage that accompanies this manual. Many of these tools were developed before the first client entered the program and were adjusted as the organizations gained experience and improved their processes.

Resources webpage: http://cahpp.org/project/medheart/resources

The Med-HEART team has also drawn upon the experiences of navigators who work to house their clients to create a housing toolkit titled *Finding Home: Tips and tools for guiding people living with HIV toward stable housing*. This toolkit provides ideas and resources to organizations to increase access to stable and permanent housing for people who are experiencing homelessness or unstable housing, living with HIV, and who may have persistent mental illness or substance use disorders.

Finding Home housing toolkit and resources: http://cahpp.org/project/medheart/housing-toolkit

Planning for increased walk-in traffic

As more homeless clients were engaged in care, they started spending more time in the clinic—and tended to show up daily or several times a week. The clinic's approach to triage was not adequate to handle the increase in walk-in traffic. Front desk staff was trained to ask if clients needed to be seen for a medical appointment, case management, or both, and were directed to different areas depending on the answer. We built out a triage room off the waiting area for use by the nurse so clients would not have to be put into an exam room unless needed. We rearranged the clinic lobby space to add a big table for clients to use to reorganize their belongings or fill out paperwork. We also made charging stations for phones and laptops available.

The Consumer Advisory Board requested the development of drop-in programs to provide newly engaged-in-care clients with social support. As a result, we developed a weekly program called "Here for You," drop-in art therapy classes, and a book group for clients who struggle with methamphetamine use.

- Staff at Multnomah County Health Department

Ryan White medical case manager. Required qualifications and staffing roles for the intervention depended on the organization's model. For example at Multnomah County Health Department, the navigator was hired by the housing partner and attended HIV health care team meetings as the navigator played a dual role addressing HIV and housing needs. At Family Health Center of San Diego (FHCSD) and People Assisting the Homeless (PATH), an HIV case manager was hired at FHCSD to work on health and other social service-related activities and coordinated with internal FHCSD medical and behavioral health care, while at their housing partner PATH, a navigator was hired to focus on finding and coordinating housing within the PATH housing system.

Other staffing models included hiring a medical and/or behavioral health clinician (nurse, prescribing nurse practitioner, social worker) and peers to provide care to clients directly in the community. Yale had a psychiatric nurse practitioner on their van; Pasadena had a Registered Nurse as part of their mobile team, and San Francisco Department of Public Health had a nurse, a physician, a social worker, a case manager and a peer working on the streets.

Some common qualifications and skills across staff included:

- Experience working with vulnerable populations, e.g., people with substance use disorders, mental health disorders, or homelessness, people with incarceration history
- Lived experience
- Adaptability/flexibility
- Knowledge and experience with social services in the community or key contacts to refer clients (i.e., provide screening and referral for substance use treatment)
- HIV knowledge
- Language capacity (need depends on the community)
- Personal readiness (especially for peers)
- Knowledge and familiarity of the community and services

Links to staff position descriptions from several sites are included on the Resources webpage.

Training Staff to Support People Living with HIV Who Are Experiencing Homelessness

Provide training in core competencies to serve people experiencing homelessness

All of the demonstration sites provided extensive training to patient navigators/care coordinators both before they assumed their duties and as ongoing in-service training. Below we highlight key topics to train staff who will work with people living with HIV who are experiencing homelessness.

Conduct an initial core training of intervention staff on core competencies

It is recommended that frontline staff receive a minimum of 40 hours of training on subject matter training including HIV, addressing substance use and mental health challenges, and trauma-informed care, with refresher trainings on a regular basis. Training on topics such as self-care and maintaining boundaries with clients is also important to support navigators in coping with the intensity and unpredictability of the work and help prevent burnout. Areas of training generally included:

- HIV viral life cycle and supporting treatment adherence
- Addressing stigma and discrimination
- Trauma-informed care
- Motivational interviewing techniques
- Protecting patient privacy and confidentiality (including HIPAA)
- Home visit and workplace safety
- Finding and accessing community resources
- Addressing substance use with clients
  o Medication assisted therapies (for prescribing providers)
  o Harm reduction
- Mental health first aid
  o Understanding mental health disorders
  o Making appropriate referrals and follow-up with clients for services
  o Crisis intervention
- Addressing other co-morbidities such as Hepatitis C, tuberculosis, and diabetes
- Documenting services provided for clients

Key positions for team members

Role	Description	Key Qualifications
Network Navigator	• Connect client with services • Attend team meetings, HIV, health care, and housing meetings • Accompany clients to medical and other social service appointments • Document activities • Access and record data in housing case management system, Ryan White case management systems and electronic health record • Communicate and advocate for clients with a variety of professionals (medical providers, housing agencies, funders, etc.) • Other skills as identified by agencies	• Experience with the community and geographic area • Preferred knowledge of the service system in the area • Ability and willingness to advocate for clients • Ability to build trusting relationships • Preferably experience with persons experiencing homelessness, substance use or mental health disorders • May be a peer (a person with lived experience in HIV, homelessness, and/or substance use • Bachelor or master's degree in social work • Familiarity with computers
Case Manager	Similar to above • Ability to work well in both a team-based environment and independently. • Basic computer literacy, ability to comply with department needs and expectations (i.e., electronic medical record documentation, obtaining background information and reports on patients, following up on appointments, etc.). • Basic counseling skills, such as reflecting, active listening, and paraphrasing. • Basic organizational skills, attention to detail, time-management skills, and motivation to meet deadlines and achieve goals. • Demonstrated ability to be culturally sensitive and respect diversity. • Excellent interpersonal and customer service skills. • Excellent written and verbal communication skills.	• 1 year of work experience providing human services to high risk, medically underserved, or relevant community health populations required. • Ability and means to travel as needed in a timely manner. • Bachelor's degree in Social Science field, Public Health, Health care Administration, or closely related field required. • Or equivalent combination of education and experience that provides the skills, knowledge and ability to perform the essential job duties, and which meets any required state or federal certification requirements.
Behavioral Health Provider	• Conduct screening and evaluation of mental health and substance use disorders • Provide substance use and mental health counseling • Provide medication assisted therapy • Provide referrals for specialty care	• Licensed provider for counseling (LCSW, MFT, LiCSW) • Prescribing provider (Nurse practitioner, psychiatrist)
Health Care Provider	• Provide primary, mental health and addiction medicine care • Train team on all aspects of medical and behavioral health/addiction medicine • Provide medical advocacy • Assess vital signs and chief complaint by the client, registered nurse, and any other recent medical evaluator • Review past medical history, social history, health-related behaviors, current medications, allergies, and other medical history • Conduct a full physical examination • Review available labs and imaging • Coordinate with any provider that has recently cared for patient • Complete the medical portion of the acuity scale, including utilization patterns, chronic and acute medical issues, and heath literacy • Perform client-centered care and formulate a treatment plan with input from the team	• Current state medical license • Experience providing health care to high risk, medically underserved or relevant community health populations required • Experience in a medical home setting and working with case management staff

Links to staff position descriptions from several sites are included on the Resources webpage at
http://cahpp.org/project/medheart/resources

- Self-care and boundaries
- Addressing intimate partner violence
- Motivational interviewing techniques
- Vicarious trauma
- Housing-related topics
    - o Eligibility requirements for HUD/HOPWA and other programs
    - o Use of Ryan White funds for housing-related services
    - o Supporting clients with the application process (ID and documentation requirements)
    - o Walking a client through the housing search
    - o Life planning and budget skills

Provide continued education training opportunities for intervention staff through topic-specific trainings and agency-wide trainings

Additional training offered at individual sites included topics such as cognitive behavioral therapy, alternatives for managing aggressive behavior, and other topics as needed. For example, the Multnomah County Health Department manual (http://cahpp.org/Medical-Home-Multnomah.pdf pg. 15) describes a situation involving a client at Multnomah County Health Department that led the organization to provide additional training about intimate partner violence. Please consult each site's manual for details about the training their staff received.

Staff also took advantage of agency-wide trainings offered within their own organizations, at their partners, or within the community. The Yale AIDS program had access to the training opportunities the university and the Connecticut AIDS Education and Training Center provide. Because of the importance of trauma-informed care in working with the people who are experiencing homelessness, Family Health Center of San Diego enlisted the help of a consultant who provided one-on-one assessments and technical assistance to improve clinical skills around working with traumatized clients. (See the evaluation section for more about this effort.) They also selected Coldspring Center for Social and Health Innovation (www.coldspringcenter.org) to provide department training in this area.

Multnomah County Health Department, through its Capacitation Center, provided and paid for an 80-hour certification course for navigators to become community health workers. Not only was this training valuable in increasing the skills of their workforce, it contributed to make the peer position sustainable beyond the end of the demonstration by qualifying Multnomah for access to funds (see sidebar "Sustaining patient navigators beyond the grant period at Multnomah County Health Department" on pg. 45).

Provide training to other members of the health care team and agency on working with people experiencing homelessness

Navigators are not the only ones who need training and orientation. Other members of the health care team may not be accustomed to working with people experiencing homelessness and also need to be trained so that they are aware of the services provided by network navigators and be prepared to treat a population that is potentially new to them.

Provide opportunities for providers to learn about cultural competency about being homeless and/or HIV positive

At a few sites, project staff provided training to providers and others who were not used to working with people who presented challenges caused by homelessness. This sometimes represented a cultural shift in the organization to make it friendlier to people experiencing homelessness. This "training" could take the form of a project oversight committee that shared data and client success stories with clinic and partner staff or the creation of new protocols and workflows to address concerns. Prior to this project, people seeking care at Thomas Street Health Center in Houston were turned away if they did not have ID's or if they were late for an appointment. The SPNS staff trained the clinic staff around the barriers that people experiencing homelessness may face, and the clinic became much more accessible. At CommWell Health, the network navigators talked with providers about rural homelessness and how it differs from urban homelessness. This gave providers greater insight into the barriers to adherence some of their clients might be facing. (See sidebar "The 'hidden homeless' among us" on pg. 33.)

Include providers in network navigator trainings, either in its entirety or for certain components

At Harris Health, the Thomas Street clinic medical staff received training in working with high-acuity clients who are experiencing homelessness, while Health Care for the Homeless Program staff were trained on an

HIV 101 curriculum developed by the regional AIDS Education and Training Center (The learning materials for this curriculum are included on the Resources webpage.) This cross-training ensured that providers were well-versed in working with clients who presented challenges caused by both homelessness and HIV.

Co-locate providers with different roles with one another so that they can learn from each other about the services they provide.

Co-location was also used as a way of ensuring that staff members had a broad understanding of the medical home model. At Family Health Center of San Diego, the SPNS case manager and the PATH care navigator were co-located at each other's primary facilities at least one day a month. This led to seamless shared case management between the "medical" and "housing" side of the program. Similarly, at the San Francisco Public Health Department, care coordination staff worked with clinical staff in ongoing dyads: Navigator-MD or RN, Case Manager-MD or RN, Social Worker-MD or RN, etc. to provide a broader understanding of client care among the team.

Offer training to supervisors of navigators and care coordinators

Because of the importance of supervision support for navigators (see the next section on pg. 26), a workshop for supervisors on strategies for effectively managing staff can be useful to build a successful model of care. In the SPNS initiative, a 5-week course that met once/week for 1.5 hours was offered to supervisors across the sites.

Topics included:

- Pluses of solution-focused supervision
- Strength-based supervision frameworks
- Your organizational culture
- Motivational interviewing
- Disseminating evidence-based practices
- Reflective supervision as trauma-informed care
- Supervising substance use treatment
- Challenges faced by mental health support workers
- Multiple perspectives in supervision
- Self-care and a healthy workplace
- The unbearable fatigue of compassion

Training webinars for intervention staff:

- An introduction to using motivational interviewing skills: Helping clients identify and set goals
- Treating Hepatitis C among HIV homeless
- Case studies using motivational interviewing (MI) (Multnomah)
- Case studies using MI (UF CARES/River Region)
- Considerations for navigators before housing a client
- What to do when housing is in jeopardy
- Using mobile apps in the field
- Wellness recovery action planning (WRAP) program
- Addressing aggressive behaviors with substance use disorder treatment: A trauma-informed approach to creating safety for everyone
- Motivational interviewing (Part 2): Skills building with site case studies
- Housing advocacy for sex offenders

"The navigator position is unlike others. In an office setting, there is a limited time that you will be with a client who is in your supported environment. But out in the field, you are in the client's surroundings for an unknown, unlimited amount of time. It makes me feel very vulnerable."

- Jamie Christenson, patient navigator at Multnomah County Health Department

- Harm reduction and vicarious trauma
- Harm reduction and life skills for housed individuals
- Transitioning clients from intensive interventions to standard case management
- Helping people obtain and maintain housing focus: Shared housing model
- How trauma affects the brain
- Tenancy support in the context of Housing First
- Brainstorming how to address racism and homelessness through the SPNS initiative
- Delivering bad news to challenging patients while maintaining positive relationships
- Understanding and addressing substance use disorders, Part 1 and 2
- Managing loss and grief

"

I am the direct supervisor for day-to-day activities, the administrative supervisor. But now, we have a clinical supervisor who can take the time to meet regularly with each peer care navigator and be available when there is a need to talk things through. Someone who can help the navigator set appropriate boundaries with clients, who can respond supportively to the unique challenges of the work and each person's particular life circumstances as a peer."

- Erika Davies, Operation Link project coordinator, City of Pasadena

Implement a Formal Administrative and Clinical Supervision System

Working intensively with people facing so many challenges and unmet needs can take a toll on navigators. As the quote on the previous page points out, a navigator can feel very vulnerable when working one-on-one with a client. To make sure navigators get the support they need and prevent staff burnout, the nine demonstration sites put processes in place prior to integrating the navigator into the medical team.

Provide regular supervision: minimum weekly administrative and at least monthly clinical supervision

For staff working with people living with HIV who are experiencing homelessness, consistent formal administrative and clinical supervision can help build a successful medical home.

- **Administrative supervision** focuses on accomplishing the goals of an organization and includes activities such as clarifying roles and responsibilities of navigators vis-à-vis other care team members and promoting effective communication among staff. The administrative supervisor reviews documentation and is responsible for tracking services to ensure that quality care is being delivered and agency policies are being implemented in accordance with standards. Having a dedicated administrative supervisor who oversees and supports the day-to-day operations of the program can ensure that all staff are functioning and communicating well with each other to address client needs and coordinate services and tasks. It can prevent staff burnout, help clients achieve their self-identified goals, and make sure services are documented for reporting to funders.

- **Weekly administrative supervision** is recommended for up to an hour to review case loads and documentation and address any challenges with referrals, team members, or external partners. Ideally administrative supervision should be provided one-on-one, but may be conducted in groups during project team meetings. An administrative supervisor should be a person who

is familiar with HIV and/or the housing service systems, is familiar with the agency's policies, and knows community partners or is willing to spend time out in the community advocating for working with people living with HIV who are experiencing homelessness. Having a clinical degree is not required for this position.

• **Clinical supervision** functions as a psychological support where navigators have an opportunity to discuss how their work with clients affects them. Clinical supervision must be provided by a licensed practitioner (MFT, LCSW, psychologist, psychiatrist) at least monthly. This role is crucial for frontline staff who often serve as the main contact for clients' interactions with the medical home team. At City of Pasadena, turnover among the peer care navigators was high in the beginning. Hiring a clinical supervisor who took the time to meet regularly with each peer care navigator and was available when a need arose to talk through a difficult situation strengthened the support provided to navigators. (See the City of Pasadena's Operation LINK manual, http://cahpp.org/Operation-Link-PPHD.pdf pg. 13)

Training and Supervision at Prism Health North Texas

The diagram below indicates the training and supervision approach used with care in the Health, Hope and Recovery project. Clinical and administrative supervision was provided individually and in a group setting. Care coordinators met biweekly with the clinical supervisor to discuss cases and manage challenges. Biweekly group meetings included case discussions and educational presentations on mental health and substance use disorder treatment. Care coordinators also met biweekly with an experienced PhD-level therapist to discuss concerns and focus on self-care.
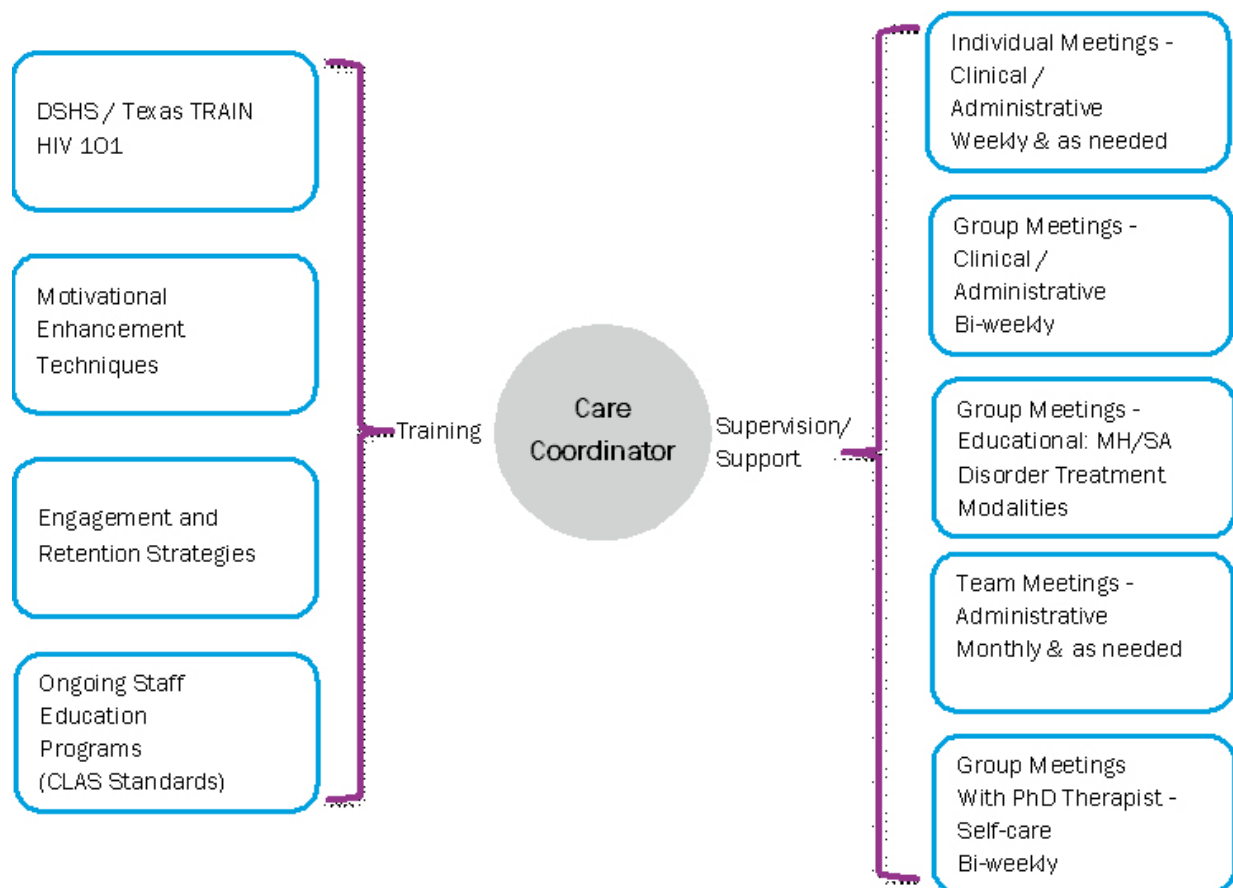
Training and supervision planning for the care coordinator role at Prism Health North Texas.

Dedicated time for each type of supervision is set aside at all the sites, ranging from once a week to once a month, depending on need. At Harris Health, for example, case managers and service linkage workers meet with the administrative supervisor weekly. Each frontline staff member meets individually for one hour with the clinical supervisor on a weekly basis. At UF CARES, administrative and clinical supervision is provided during biweekly combined team meetings, with additional meetings focused on specific challenges as needed.

Provide open-door access to staff and plan for crises

Traumatic and difficult situations come up when working with people who are experiencing homelessness and struggling with behavioral health disorders.

Planning in advance how to support navigators who may face these situations can avoid heartache. Because their clients are often in crisis when they meet with the patient navigator, the demonstration sites generally had an open-door policy for navigators to reach out to providers and other staff at short notice. "Lean on your team" is one of the mantras included in the *Navigator Manifesto* that frontline staff developed to remind navigators that they don't have to handle situations alone (see below). The Resources webpage includes a formalized situation debrief process (http://cahpp.org/wp-content/uploads/2017/05/Multnomah-Crisis-Staff-Debrief-Guidelines.doc) that Multnomah County Health Department staff developed to ensure that navigators receive the support they need when encountering traumatic situations.

> " Senior leaders were asked to make themselves totally available to navigators and to help problem solve. That is what made it successful."
>
> - Jodi Davich, Multnomah County Health Departmentw

The navigator manifesto

Below are some things that patient navigators keep in mind when working with clients. They were collected from a series of webinars in which patient navigators from nine sites nationwide discussed what they have learned from their experiences working with clients. We list the highlights below— go to the Navigator Manifesto at http://cahpp.org/wp-content/uploads/2017/06/navigator-manifesto.docx to read more.

Be your client's "go-to person."
Set realistic expectations.
Educate and empower.
Don't talk about it, BE about it.
Know yourself.
Don't take it personally.
Don't work harder than the client.
Let people learn from their mistakes.
Put yourself first.
Lean on your team.
Celebrate success.
Keep in touch.

Housing case manager conducting outreach in San Francisco

FINDING AND ENGAGING PEOPLE IN CARE

Priority Population

While each organization focused on clients within its area of service, the criteria for eligibility for the medical home model were standard across all sites. Clients all had the following characteristics:

- HIV-positive individuals aged 18 and over who:
  o Are out of care, newly diagnosed, or otherwise not adherent to medical care
  o Have multiple and complex psychosocial issues (such as mental health, substance use, homelessness, etc.) that negatively affect a client's health status.
  o Are homeless or unstably housed, defined as one of the following:
    • Literally homeless: an individual who lacks a fixed, regular, and adequate nighttime residence
    • Unstably housed individual who:
      o Has not had a lease, ownership interest, or occupancy agreement in permanent and stable housing with appropriate utilities (e.g., running water, electricity) in the last 60 days; OR
      o Has experienced persistent housing instability as measured by two moves or more during the preceding 60 days; AND
      o Can be expected to continue in such status for an extended period of time.
    • Individual fleeing domestic violence who:
      o Is fleeing, or attempting to flee, domestic violence;
      o Has no other residence; and
      o Lacks the resources or support networks to obtain other permanent housing.

Beyond this, different organizations focused on specific groups. For example, the Yale mHEALTH model included a strong working relationship with the Connecticut Department of Correction and focused on clients who were transitioning from the criminal justice system and those who were identified by community partners as not being retained in care. CommWell Health had a higher-than-average number of migrant workers because of its agricultural

setting. The City of San Francisco medical home model focused its efforts on individuals who were the most medically fragile—those facing complex comorbidities, not virally suppressed, and who had previously resisted attempts to engage them in housing or HIV treatment.

Identifying Potential Clients

Sites used a variety of methods to find, reach out to, and engage people living with HIV who were experiencing homelessness. The key is to have a multi-prong approach to using information from internal data systems and your health care providers to collaborate with external partners if agreements and permissions are in place.

Community outreach

The nine sites all conducted outreach to the community to identify clients. CommWell Health staff regularly participated in community events such as county fairs, festivals, and church events where they handed out information and talked with attendees about programs and services. (See CommWell Health's manual at http://cahpp.org/CWH-NC-REACH.pdf pg. 30 for examples of community events their NC-REACH staff participated in.)

San Francisco Department of Public Health relied on its partner Homeless Outreach Team (SF HOT) to identify clients. SF HOT is a public/private partnership involving the non-profit Public Health Foundation (PHF), the San Francisco Department of Public Health, and the San Francisco Human Services Agency (HSA). Since HHOME's inception, the SF HOT team is now under the Department of Homelessness and Supportive Housing and serves as part of the HHOME team. SF HOT staff reaches out to individuals who are homeless and engages clients in emergency shelters, food programs, and even the public library. SF HOT has access to stabilization units that can move people off the streets into basic housing in less than 24 hours. By partnering with this team, HHOME has had unparalleled access to the city's most disconnected individuals and to temporary and permanent housing for these clients.

The HHOME program also sought a peer navigator who grew up in the local neighborhood, the Tenderloin,

one of San Francisco's most impoverished and disadvantaged communities. An effective peer navigator in the HHOME program had to be someone who is not only familiar with and respectful of the local businesses, residents, and community leaders, but also understands how to effectively navigate a community plagued by high street-based substance use and sales.

Participate in community councils and boards

Many SPNS staff members, including clinicians, supervisors, and navigators attended regular meetings where housing and health partners came together to discuss program updates and resources, and used the opportunities to identify clients. For example, the peer navigator at Pasadena Public Health Department participated in meetings of the Access to Care Committee meeting of housing providers in the county and was the go-to person for referrals for people living with HIV who needed housing and health care. In New Haven, Yale and Liberty Community Services staff participated in Ryan White Planning Council meetings, the New Haven Mayor's Task Force on AIDS, the Greater New Haven Opening Doors Steering Committee, and meetings with Connecticut Department of Correction staff and probation and parole officers to ensure that persons experiencing homelessness and those at risk for homelessness due to incarceration could be referred to mHEALTH for medical, housing and behavioral health support as needed.

Create new partnerships with community agencies outside the Ryan White community

External referrals might also come from partner agencies, local hospitals and medical facilities, agencies that provide services to homeless people, or other community-based organizations.

The justice system is also a potential partner in identifying clients. The Yale partnership with the Connecticut **Department of Correction** led to referrals of potential clients who are newly released from prison. The Houston **Police Department's** Homeless Outreach Team (HOT) frequently referred new cases to the Project Hi-5 team.

Nothing about us without us

It is important in working with community partners to make sure that you have a memorandum of understanding (MOU) in place to share information about clients to protect client confidentiality. It may be necessary to update information and obtain signed releases from clients to let them know that if they don't hear from you within a specified time, you may reach out to agencies with the client's permission to help the client obtain needed services. Take the time to explain to clients why you wish to talk with agencies and specifically the types of information that will and will not be shared. This can help the client build trust in the service system. For example, the City of Dallas Shelter Plus program, through a formal MOU, agreed to provide 25 vouchers for Health, Hope and Recovery clients in exchange for care coordination and medical services provided by Prism Health North Texas.

Using Internal Communication and Data Systems to Identify and Re-engage People Living with HIV Who Are Experiencing Homelessness

There are several strategies to identify people living with HIV who are experiencing homelessness within your agencies.

- **Connect with the Ryan White Case management system**: At Prism Health North Texas, Ryan White case managers were the point of entry for RW case management services for all people living with HIV in Dallas County. The intake coordinators briefly screened people who may need housing services and then referred potential clients to the Health, Hope and Recovery program director and the care coordinators for services. Referrals would also come via the behavioral health case manager who worked in the clinic with the HIV medical providers who may have clients who report housing challenges.

- **Screening during clinic**: At CommWell Health, the program director attended the HIV clinics and screened potential clients for housing instability. One issue that CommWell Health came across was that a provider might not be aware that a client is homeless or unstably housed based on interactions with the client. It required some education on the nature of homelessness in rural North Carolina to make providers aware of the problem so that they could make the referral to NC-REACH. (See the sidebar on page 34.)

- **Informal referrals from health care providers during team huddles**: Some teams checked in with HIV care providers routinely, such as during morning team huddles prior to clinic, about patients they have

Brochures used in outreach efforts in North Carolina and Dallas, TX.

not seen in a while. It can also be helpful to have navigators involved in the team meetings so they can work with the provider to share information and locate the client.

• **Establish weekly communication with providers about patients who were no shows**: Health care providers and navigators communicated via weekly team meetings or regular communication via email or the EMR. In this way, they updated each other about clients who missed their appointments or may not have picked up their medications. This could alert the team to go out and find the person and re-engage him or her in care.

• **Develop and review the "out of care" list**: Some of the sites used electronic health records to identify potential clients. At Harris Health, staff review out-of-care patient lists from Thomas Street Health Clinic to identify clients experiencing homelessness who may have an upcoming appointment. The individual's record is flagged so that when they show up at clinic, staff can meet with them. Similarly at Family Health Center of San Diego, staff monitor the electronic health record system to identify clients who have been out of care for six months or more. Staff attempt to reach the client by phone or in person to determine and address barriers that are preventing the client from accessing care. These lists were run on a monthly or quarterly basis as people were re-engaged in care or after several attempts to locate the person with no luck they may be removed from the list and noted in their record that staff were unable to reach.

• **Develop relationships with emergency departments and respite care centers:** Several of the sites established referral processes with hospital emergency departments or respite care centers; in some cases potential clients were identified and referred through shared medical record systems.   For example, Harris Health System set up a coordinated system to receive referrals from internal departments and services as well as affiliated emergency rooms and other local hospitals. (See the Establish internal and external referral processes section on pg. 18.) San Francisco's HHOME project also recruited clients through relationships with local hospitals and emergency departments (See HHOME from referral to discharge on the next page.)

HHOME from referral to discharge

HHOME: from **referral** to **discharge**

| REFERRED | OUTREACH | (RE)ENGAGED | ACTIVE | DISCHARGED* |

| NOT ACCEPTED | IN ASSESSMENT | | ENROLLED IN STUDY | NOT YET ENROLLED |

REFERRED BY OUTSIDE PROGRAM/ ORGANIZATION

MEETS ELIGIBILITY CRITERIA (ACUITY: 2 or 3) AS DETERMINED BY REFERRING ENTITY

NOT YET ACCEPTED BY HHOME TEAM : CLIENT UNDER REVIEW

MEETS ELIGIBILITY REQUIREMENTS

ACCEPTED BY HHOME TEAM

TEAM MEMBERS BEGIN OUTREACH:
- STREETS
- HOSPITAL
- SHELTER
- OTHER SITE

CONTACT NOT YET MADE

CONTACT MADE

PRIMARY CARE: RECEIVED

and/or

SUPPORTIVE SERVICES: RECEIVED

DETERMINED BY STAFF TO BE READY FOR ENROLLMENT IN STUDY

ENROLLED IN STUDY OR FIRST INTERVIEW SCHEDULED

RECEIVING MOBILE MEDICAL CARE

ATTENDS APPOINTMENTS

CONSISTENT CONTACT MADE

PRIMARY CARE: WEEKLY

SUPPORTIVE SERVICES: ONGOING

ENROLLED IN STUDY

COMPLETING FOLLOW-UP INTERVIEWS

RECEIVING PRIMARY CARE AT A FIXED SITE WITH A FIXED PCP

CONSIDERABLY MORE SELF-RELIANT

ACUITY: 1 or 2

IDEALLY, UNDETECTABLE VL

* AT ANY POINT, A CLIENT MAY BE CONSIDERED "DISCHARGED," DUE TO CIRCUMSTANCES OUTSIDE OF HHOME'S TREATMENT PLAN (i.e. DECEASED | LOST TO FOLLOW UP)

The HHOME team worked with partners throughout San Francisco to clarify the process of engaging individuals in care. They developed and shared the above diagram with local service providers, and the words "Referred-Outreach-Engaged-Active-Discharged" became standard terms in the local service community to describe a client's status.

Just because a potential client was referred or identified didn't mean he or she was willing to engage with the medical home model team, however. A client may express ambivalence about receiving services. In this situation, the HHOME team continued to attempt to build a positive rapport with the individual. The client was placed on the team's outreach list which the peer navigator used to prioritize clients for engagement. If the client could not be found, an alert was placed in the individual's electronic medical record to notify the HHOME team if the client appeared in a city hospital or emergency room. The peer navigator continued to search for clients on the outreach list by calling local jails and emergency rooms on a weekly basis.

For example, it took a year and a half before Scott Carlisle engaged with a member of the San Francisco HHOME team, who visited him in the hospital. At a 2017 meeting at HRSA headquarters in Rockville, MD to present results of this initiative, Scott shared with staff from HRSA, Housing and Urban Development (HUD), and Substance Abuse and Mental Health Services Administration (SAMHSA) what "Referred-Outreach-Engaged-Active-Discharged" meant for him. "I could finally close both eyes, I didn't have to sleep with a pistol," he said. "If it wasn't for…the entire team, I wouldn't be here." (Read more of Scott's experiences, together with those of two clients from San Diego and Portland at http://cahpp.org/stories-behind-the-numbers)

The "hidden homeless" among us

Homelessness in rural areas takes on different forms than urban homelessness—one does not see people under bridges or grouped in tents. However, it remains a barrier to health care for many rural clients. The NC-REACH project opened health care providers' eyes to the difficult circumstances facing many of their rural clients.

Data collected in 2015 indicated that only 3% of CommWell Health patients receiving HIV services are unstably housed or in temporary housing. However, this is far from reality. In the community in which CommWell Health operates, a client telling his provider that he is staying at his mother's house is unlikely to raise any alarms—multigenerational households are common. However, this may be emblematic of a more unstable situation than is apparent at the surface.

"Our clients don't see themselves as homeless or unstably housed," explained Lisa McKeithan, SPNS principal investigator and program director. "They have a stable place to stay—it just might not be the same place every night. If they told a provider they stayed with a parent last night and three months earlier they had said they were staying with someone else, that may not raise a red flag. It's only when you build rapport with the patient and start to ask more questions about how long the person has stayed there and how their housing affects the way they take medications that a more complete, complex picture emerges."

Most clients enrolled in the NC-REACH program do not have a lease or mortgage in their name. They may be couch surfing (staying with a friend or family member but moving frequently) or living in unsafe living conditions. Many have mental health or substance use disorders and struggle with treatment compliance, negatively impacting their relationships with family and friends, and thereby eliminating safe housing options. Unstable housing greatly impedes a client's ability to take HIV medication regularly.

Additionally, the triple stigma of HIV, mental illness, and substance use may cause clients to hide medications and avoid taking them in front of family members. A lack of daily routine and structure makes it difficult to arrange for client transportation and appointment reminders, ultimately resulting in missed appointments.

Introducing the network navigators into the health care team was a crucial first step in bridging this divide. The navigators are the voice of the client, advocating for them in meetings with the comprehensive care team. Navigators address clients' needs in ways that other staff members cannot.

"They have the flexibility in their schedule to go out in the community, to go with our clients to apply for food stamps or a social security card—whatever the client needs and whatever will help them be successful in finding and maintaining housing," said Lisa McKeithan. "Having the network navigators enhances the ability of the clinic to provide housing options to clients. Everyone at CommWell Health believes that housing has greatly improved the health status of our client population."

Care coordinator and client,
Prism Health North Texas

BUILDING THE MEDICAL HOME: TYPE OF SERVICE MODELS FOR PEOPLE LIVING WITH HIV WHO ARE EXPERIENCING HOMELESSNESS

While each model is unique to the organization and community in which it functions, all the SPNS demonstration sites had common elements once clients were found and enrolled in the SPNS program. These included:

- The navigator as the bridge to the care team and services
- Team approach to creating client-integrated care plan with HIV and housing providers
- Providing accessible, comprehensive HIV care services
- Building a coordinated system of care to address health and housing needs via team meetings and sharing data systems
- Integrating behavioral health and HIV primary care
- Use of tangible reinforcements and access to cell phones for client engagement in services
- Emergency housing support
- Support to maintain housing
- Transition to standard of care: Navigator and the HIV medical case manager

The diagram on the next page presents an overview of the components contained in all of the models.

The Navigator as the Bridge to the Care Team and Services

Whether the position was called peer navigator, patient navigator, continuum of care coordinator, or housing coordinator, each medical home model included at least one staff member whose role was to provide a central point of contact and serve as "the bridge" between the client and the larger system of care. (See the table on page 23 for a description of navigator positions and qualifications.) Some of the critical activities and key tasks of the navigators in the medical home model include:

- Client tracking and outreach for those who are out of care
- Identifying needs and barriers and developing the care plan

Components of the medical home models

Client enrollment	Patient navigator	Intensive Care Coordination	Assessment for health and housing stability	Transition to Standard of Care
•Needs assessment through acuity tool •Program director/ supervisor assigns client based on navigator's case load, compatibility	•Generally 25-30 clients per navigator •Housed in HIV clinic, housing partner, sometimes both •Works with client and providers to develop goals	Navigator builds relationship with client, works with team to links to : •Medical care •HIV care •Behavioral health •Substance use treatment •Housing services •Other social services	•Program duration generally about 12 -18 months in program •Defined goals for graduation •Periodic assessments of client progress	•Assignment to general Case Manager •Introduction to new CM prior to warm handoff •Follow up with client following transmission

Repeat until client is ready for transition

- Provide treatment support including obtaining and storing medications and direct observation therapy
- Educating clients about antiretroviral treatment (ART) and managing side effects
- Supporting client retention in medical care
- Providing emotional support and encouragement
- Addressing stigma (both external and internal)
- Coordinating services and educating about the service systems
- Connecting clients to behavioral health services
- Maintaining regular communication with providers
- Supporting patient self-management
- Identifying, linking and maintaining housing

In some cases, the navigators have dual roles addressing clients' HIV and housing needs, while in other sites, such as at Family Health Centers of San Diego, one coordinator focused on HIV care and another dedicated to housing needs worked together intensively on behalf of the client. Navigators may be housed in clinics, in housing agencies, or, as in the case of UF CARES, in a substance use facility. Because of the clients' general high acuity and the intensity of services needed to address their needs, caseloads among patient navigators were generally about 25 – 30 clients.

Navigator vs. case manager

Why should I introduce a navigator into the team if our agency already has HIV and/or housing case managers?

A navigator is not a person to replace a case manager but to support case managers' work with clients. Most navigators (also called care coordinators, peers, community health workers) work closely with case managers, who often have caseload sizes of 50 clients or larger and may be busy with clients with a varied acuity level of need. In this initiative, because of the complex and multiple needs of the clients who are experiencing homelessness and have substance use and mental health disorders, a navigator can devote more intense time working one-on-one with clients. They can accompany a client to services, track down necessary paperwork for referrals, do regular check-ins on the street or at a client's current residence (whether it be a hospital, shelter, hotel, or permanent home) and offer emotional support. In some instances, the navigator may appear to be duplicating tasks of the case manager; it takes careful communication and coordination between staff to understand how each can play a supportive role. A navigator often will have more time to spend in the street and community if the person is not tied to a clinic. In this program, the navigator is there from the beginning to support the client and the HIV care.

In a meeting in early 2017, navigators talked about the things they keep in mind as they work with clients. This led to the "Navigator manifesto" included in the sidebar on page 28.

Team Approach to Creating a Client-integrated Care Plan with HIV and Housing Providers

The nine demonstration sites all developed an integrated care plan which outlines not only the medical treatment plan for HIV but also the plan for obtaining behavioral health services such as mental health counseling or medication-assisted therapy for substance use or residential treatment, if warranted, and the plan for getting to stable housing or other basic needs such as food, clothing and employment. As mentioned in Section I on setting up the program, assessing a client's acuity and developing the care plan by the navigator with input from the team is the first step. For example, at SFDPH the physician, social worker, nurse, housing case manager, and peer navigator met weekly to review and update the progress of the care plan for each HHOME client. Plans for who would follow up with the client on specific issues were discussed and documented. Also at these meetings, the team reviewed available labs and medications and discussed how to promote adherence to treatment, leading to viral suppression. A description of the process used to manage specific client-level data that each staff person tracked and updated is available in the Panel Process document (http://cahpp.org/wp-content/uploads/2017/05/SF-Panel-Process.docx) on the Resources webpage at http://cahpp.org/project/medheart/resources

The San Francisco team also used a universal care plan across partner agencies which included client goals and strengths, and assessments and care plan in areas that included medical treatment for HIV, mental health, substance use, social supports, housing needs, social supports, and basic needs. (See the template at http://cahpp.org/wp-content/uploads/2017/10/SF-Client-Universal-Care-Plan.docx) Integrated care plans allow for all providers involved in the care of the client to understand the client's goals and review progress simultaneously about housing, health care, and other support services as needed.

For sites where medical team members were not available, navigators still met regularly at least weekly with medical and housing case managers to review progress and communicate via email or phone with medical providers and then update the care plan in the shared electronic health record.

At some sites, the navigators attended medical visits with the client, thus including the medical plan in the care plan and apprising the medical provider of support services.

Providing Accessible, Comprehensive HIV Care Services

The service delivery model selected across the nine models varied, yet all were able to provide accessible, comprehensive HIV care services. Outlined below, you will find a list of models, all of which were used by at least one site in the initiative. Based on your agency's population, you can determine which method of delivering services would work best for you.

On-site comprehensive HIV care services

Seven sites offered onsite comprehensive HIV care services, including HIV medical care and treatment, laboratory testing, case management, nutrition, and adherence support. Five organizations have patient-centered medical home certification from a national accrediting agency for their HIV medical care services. Most sites have open access to medical care for clients during regular business hours with available walk-in slots for clients without a scheduled appointment. Five sites have additional evening or early morning hours during the week to see clients, and three sites offer weekend hours.

Mobile HIV care

Three organizations used mobile outreach teams to deliver HIV care in community settings to clients who were experiencing homelessness or unstable housing. The teams conducted their work either on foot or in a mobile medical clinic to provide primary care services at

specific sites, including shelters, day treatment programs, single room occupancy (SROs) units, parks and/or places in the community where people experiencing homelessness gather. These teams also worked with individuals experiencing homelessness to link them to more comprehensive HIV services at affiliated community health centers.

Establishing satellite clinics

Three sites expanded access to HIV services by establishing satellite clinics within shelters or training staff at an existing shelter clinic to provide HIV care and treatment. One site provides directly administered antiretroviral therapy (DAART), an evidence-based practice, from a mobile medical clinic to further ensure adherence to HIV treatment. The aim is to reduce barriers, including transportation, which may affect a person's HIV health care utilization. Clients are also able to access HIV care from their existing providers with whom they feel comfortable and whom they trust with addressing their medical needs.

Building a Coordinated System of Care to Address Health and Housing Needs via Team Meetings and Sharing Data Systems with External and Internal Partners

As mentioned previously, the navigator often served in the role of the "bridge" between the client and the various providers who offered the necessary care and services required by people living with HIV who are experiencing homelessness. One of the critical tasks of navigators is educating and coaching the client about the services available and how to access and obtain necessary services. This requires time-intensive tasks such as visiting various housing agency offices or meetings with landlords to complete paperwork, going to a behavioral health specialist who may be outside the HIV clinic, or going to an employment agency to look for work. These visits take time, and case managers with large caseloads may be too busy to attend intensively to clients' other social needs that impact medical care.

The Value of Building Housing Relationships

Prism Health North Texas's Health, Hope and Recovery team placed a client in a housing complex and built a relationship with Sue*, the property manager. Sue interacted with the team as various issues came up and learned about how the team worked. In the process, she became very supportive of the program. She came to understand the barriers facing clients and appreciated working with care coordinators and case managers before, during, and throughout the housing process. Her experiences with clients were positive for the most part, and she housed several additional program clients in her complex, including Tom.*

Unfortunately, Tom ended up making choices that compromised his housing, and eventually Sue decided that he needed to be evicted. However as a result of working closely with the care coordinator, she realized that an actual eviction would ruin Tom's chances for finding future housing. As a result of her positive working relationship with staff and her belief in Health, Hope and Recovery's value to the community, she was willing to be of assistance.

Sue agreed that provided he left voluntarily, she would not file an eviction notice or any derogatory reports against Tom. This allowed him to find another housing situation instead of becoming homeless again. This case highlights the importance of building effective relationships with property managers and/or owners so that they become vested in ensuring that clients have positive outcomes as program staff work to ensure that clients are responsible tenants.

* Names have been changed.

The navigator can also serve as a bridge of communication between health care providers and the housing agency on behalf of people living with HIV. Where clinic staff may not be able to go out to the community regularly, the navigator can share updates and information about non-medical services with the health care staff.

Beyond forming formal relationships with housing partners mentioned earlier, program staff used a variety of strategies to work with landlords. For example, navigators would develop a personal relationship with property managers, who then were more likely to notify staff when a unit is available or when there is a tenancy issue with a client. (See the sidebar on the previous page.) Landlord appreciation events and communications were also used to strengthen these relationships. See the housing toolkit *Finding Home: Tips and tools for guiding people living with HIV toward stable housing* at http://cahpp.org/project/medheart/housing-toolkit for ideas and resources to help organizations increase access to stable housing for their clients. In addition to the in-person contact, coordinated systems are also built by sharing data. In almost all of the sites in this initiative, navigators had access to HIV case management data through the Ryan White system (Casewatch, CareWare), a housing management information system for housing providers, and the electronic health record. Access to these systems provides the team with information in real time about the services and providers the client is accessing, allows for updates to other providers about services provided by the navigator, and helps the navigator understand where the client is with their care and treatment plan goals.

Integrating Behavioral Health and HIV Primary Care

A key component of each model in achieving housing stability and viral suppression was addressing substance use and mental health disorders. Related to coordinating a system of care, the sites also implemented models that improved the integration of behavior health care with HIV primary medical care so clients had improved access to services. Models of integration differed depending on the organization setting and infrastructure. Below are several examples.

Co-location of services

A majority of sites offered on-site mental health and substance use counseling in addition to HIV care and treatment. Most sites also had a prescribing provider in the HIV clinic a few days a week (psychiatrist or psychiatric nurse practitioner). This co-location reduced barriers to attending appointments, allowed medical and behavioral health providers to share information to consult easily with each other about a patient's treatment plan or medications prescribed, and to track the patient's health status. For example, at CommWell Health, the SPNS initiative allowed people living with HIV to have better access to appointments in the behavioral health department. The role of behavioral health case managers at this clinic, as well as at Prism Health North Texas and Family Health Centers of San Diego, ensured that the medical plan, social service plan and behavioral health care plan were more closely tracked and followed. If a client failed to attend a mental health visit, the behavior health case manager could contact the navigator to follow up with the client and find out reasons or reschedule the appointment. UF CARES' PATH program also took the innovative approach of establishing an HIV primary medical clinic at the substance use treatment facility. This allowed for single point of entry for the priority population to access necessary primary care, mental health substance use treatment, mental health services, nutrition, and case management at a central location in Jacksonville, FL.

Mobile teams with behavioral health providers in the field

At San Francisco and Yale, the mobile team included medical providers and behavioral health providers who could offer evaluation and prescribe medications for mental health and substance use disorders when they encountered the patient.

Training medical providers in management of substance use disorders

Many medical providers were trained in the medical management of substance use disorders, and this also

reduced barriers to treatment. Five SPNS sites had HIV primary medical providers who could provide treatments such as Suboxone for opioid dependence or Vivitriol for opioid and alcohol dependence. Having this expertise available readily allowed individuals to receive the attention they needed without the extra step of going to another provider or waiting a long time for treatment.

Use of Tangible Reinforcements and Access to Cell Phones for Client Engagement in Services

To support people living with HIV who experience homelessness, several programs also provided tangible reinforcements such as food, clothing, and hygiene kits to clients. Sites leveraged other Ryan White funding and local resources to ensure clients had access to food vouchers or pantries. At Yale/LCS, in the winters and during holiday season, "goody bags" with gloves, hats, and socks were provided. At SFDPH, staff provided clients with an HHOME bracelet that included the program number for clients to wear and could call if they needed emergency assistance. (See the photo on this page.) Many sites also assisted clients with access to prepaid cell phones to facilitate communication with staff about appointments. These phones were made available through the federal "Lifeline" Cell Phone program (http://www.lifelinesupport.org/ls/)

Emergency Housing Support

Three sites (Prism Health North Texas, Harris Health, and SFDPH) also instituted support for emergency housing services, especially for clients who were shelter resistant. In these programs, temporary housing was provided to the client, usually at a hotel or motel, for a brief period until the client could obtain a more stable situation and/or enter permanent housing. At Prism Health North Texas, clients were able to access the emergency housing program for up to six weeks while more permanent housing could be finalized, either through a housing voucher or with a private landlord.

At San Francisco Department of Public Health, program staff offered bracelets imprinted with the HHOME phone number to clients so that they have contact information readily available if they need to reach anyone on the team—a literal symbol that someone has their back. Staff also gave gifts of nail polish, a small luxury that makes a person feel pampered

Support to Maintain Housing

Once a client was able to obtain safe, affordable housing, a navigator continued to check in at least monthly for up to 3 months. This period and contact was important; for some people living with HIV who had experienced homelessness for a long period time, now having the responsibility and stress of paying rent and bills and keeping a job could result in depression and isolation that would lead to skipping medications or relapsing to substance use. Having the support service helped to establish whether the client was ready to live independently. The navigators remained available for longer periods of time if the client needed to resume supports. Navigators across all sites noted that clients often needed additional support after being initially housed; clients felt particularly vulnerable as they adjusted to multiple changes in their living situation, daily schedules, and new environments and people. See the toolkit *Finding Home: Tips and tools for guiding people living with HIV toward stable housing* (http://cahpp.org/project/medheart/housing-toolkit) for a section devoted to tips and tools that can be used to support clients as they

make the transition to stable housing.

Transitioning to Care: Navigator and the HIV Medical Case Manager

One of the original premises in building the medical home was that a person living with HIV who was experiencing homelessness could work intensively with the navigator and HIV care team to be connected to stable, safe housing and behavioral health care that would result in viral suppression. Interventions were designed to provide intensive services from a navigator until the client was stable. Once stable, the client would work with their case manager to maintain their care. Across the sites, for people with multiple comorbidities, the average length of time in the program was 19 months. Each site established a system to assess acuity and reductions in unmet need for services and determine whether the person had achieved his or her goals in the care plan. This assessment was conducted typically every 3 months of services. The process for transitioning a client from intensive work with a navigator to support focused on maintenance with an HIV case manager was based on several criteria. Some of the common elements across sites included:

- Meeting as a team and with the client to determine if the care plan goals are met and there is agreement that the client no longer needs follow up with a navigator (All sites)
- Client is enrolled in HIV medical care, coming to appointments consistently, taking medication as prescribed by evidence of viral suppression (FHCSD, Pasadena, Harris Health)
- Client is consistently attending behavioral health care appointments (Pasadena, CommWell Health)
- Client achieved a lower acuity level that is maintained (CommWell, PHNTX, SFDPH)
- Client is making payments on rent for 3 consecutive months (Yale/LCS)
- Client understands and is able to navigate through systems (i.e., benefits, medical care, etc.) independently and/or knows how to seek assistance (Pasadena)
- Client is able to follow up on referrals independently (Pasadena)
- Client is able to demonstrate basic life skills, such as grocery shopping, budgeting, and bill payment, to ensure continued success (Pasadena)

The model of what clients were transitioned to varied across sites. For many clients, an introduction was made back to the case manager. At CommWell Health this meeting was a "warm hand-off" bringing together the navigator, HIV case manager, and client to draft a care plan that focused on maintenance for medical care and housing. At Prism Health North Texas, because of the intensity of behavioral health needs in some clients, a client might reduce his or her time with the care coordinator but be followed by a case manager (II) with behavioral health training rather than the traditional HIV non-medical case manager.

Evaluators from Harris Health

MONITORING AND EVALUATING THE PROGRAM

Establish a System to Track Client Progress

As part of the regular team meetings and case conferences, sites used reports and updates from data and evaluation managers to help track client progress. These "dashboard reports" helped the care team to monitor client enrollment, services utilization, and outcomes. Information included:

- Clients referred and the referral sources (clinics, hospitals, jails/prisons, other community agencies)
- Client demographics
- Housing and program services provided (cell phones, food, clothing and other basic needs)
- Referrals to substance use treatment and mental health services and completion of referrals
- Transportation services provided
- Housing services—types of housing assistance provided (emergency housing, vouchers, housing searches and meetings with landlords)
- Clients discharged from the program, moved out of area, or for other reasons no longer receiving services
- For people enrolled in the outcome evaluation, study retention rates

Links to sample dashboards and several tracking and quality improvement tools are included on the Resources webpage.

Develop New Strategies or Build upon Existing Systems to Assess the Quality of Service Delivery for People Living with HIV Who Are Experiencing Homelessness

In addition to tracking reports to describe and document the progress and number of clients and services provided, sites also implemented systems to ensure that staff were delivering similar quality services. At Prism Health North Texas, the team used a Plan-Do-Study-Act methodology for assessing the staff skills related to use of motivational interviewing (MI) techniques, cognitive behavioral therapy, strengths-based case management and other techniques in providing services to clients. As part of this process, supervisors used MI rating forms and observed staff on a quarterly basis during client encounters to ensure application of MI techniques.

Peer reviews were also conducted on a quarterly basis in which the care coordinators reviewed each other's case notes to critique and provide supportive feedback on care and services delivery. More information can be found in PHNTX's implementation manual at http://cahpp.org/HHR-Prism-Health.pdf

Recognizing the importance of building staff skills to provide trauma-informed care, Family Health Centers of San Diego (FHCSD) developed an HIV department-wide initiative to assess staff skills, implement enhanced training, and examine areas for improvement. The agency recognized that in order to successfully link and retain clients in care, especially those who are experiencing homelessness, addressing trauma is critical. Surveys assessing staff knowledge and skills related to trauma were conducted, followed by intensive training for all staff. Post-training surveys identified areas for improvement, such as adjustments to supervision time dedicated to addressing trauma and protocols and procedures for supervisors to help with stress reactions from staff and clients. This effort is described in FHCSD's implementation manual at http://cahpp.org/PCMH-Connections-FHCSD.pdf

Ensure All Staff Have Access to Electronic Health Records and Housing Management Information Systems

To ensure that people living with HIV and experiencing homelessness are using services and receiving quality care, having access to data record systems including electronic health records and housing information systems is critical. At Multnomah County, navigators and housing case managers had access to EPIC and could write their case notes and update the care team on non-medical services that are provided to clients. The navigators developed a series of "SMART Phrases" they used to standardize documentation (a link to Multnomah's EMR smart phrases is available on the Resources webpage at http://cahpp.org/wp-content/uploads/2017/04/Multnomah-SPNS-EMR-Smart-Phrases.docx). Access to the Ryan White Case Management System and Housing Information Management System in their local area was also critical so navigators and case managers could coordinate services and reduce duplication of efforts.

Involve Consumers in Quality Management and Decision Making

Consumer involvement was a key component to engaging people living with HIV and experiencing homelessness in care and treatment and helping build a quality program. At Multnomah County Health Department, the HIV Health Services Center Client Advisory Board (CAB) members are involved in designing satisfaction surveys and focus group studies and providing a voice in clinic decisions. CAB activities led to the following enhancements to Multnomah's project:

- Improvements to the waiting area and patient restrooms to be more welcoming
- Creation of a subcommittee to develop client arts and crafts venues which helped to involve clients who had not previously been engaged in care
- Provision of input and approved clinic design for the new clinic building

The MCHD CAB also provided input to the development of "My Chart," a component of the electronic health record that gives clients access to their laboratory results and visit information. Staff worked with clients to help them gain access and keep track of medical information via this system.

Navigator and client, Multnomah County Health Department

IMPACT

Results

By June 2017, approximately 1,338 clients were served by the nine sites. A longitudinal evaluation study was undertaken from September 2013 to February 2017. Some of the results are described below.

As indicated in the chart to the right, among a cohort of clients who were out of care or newly diagnosed (within 12 months) at baseline (n=334), 84% were linked to care within 90 days, 74% were retained in care (had 2 medical appointments at least 90 days apart in 12 months) and 71% reached viral suppression. For all clients enrolled in the multisite study who had primary care visits post 12 months (n=745) 71% reached viral suppression and 74% were retained in care.

In addition to clinical outcomes, housing stability improved for participants. Those who were unstably housed (literally homeless, living in shelters, the streets or places not meant for human habitation) were reduced from 84% to 36%, stably housed participants (in permanent or supportive housing units) was at 34%, and those in a temporary place (with friends or family, a treatment center) increased from 15% to 30% at post 12 months.

Sustaining and Replicating the Model

With these promising findings, several of the demonstration sites have been working toward sustaining and replicating the model and specifically the role of the navigators as part of the care team into their Ryan White programs. At MCHD, navigators and a housing case manager are part of the care team, and the formal partnership between the MCHD and the housing provider, Cascade AIDS Program, continues to flourish. Furthermore, navigators have undergone intensive

HIV Care Continuum (N = 334)
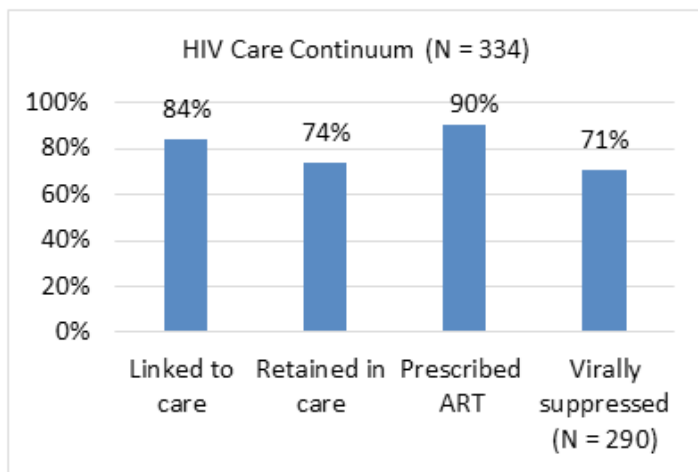
training to become certified community health workers and thus become a billable health service as part of the Medicaid system. (See the sidebar on the right.)

Across all the programs, clinic staff have become more culturally aware and competent to serve people who are experiencing homelessness. In addition, the initiative has created a heightened understanding across all providers of how to provide trauma-informed care that can help to support retention in care.

To reach clients who are experiencing homelessness, the nine models had to develop community partnerships and memoranda of understanding with partners who may be outside the traditional Ryan White services system. For example, in Houston and Pasadena, staff developed strong partnerships with the police departments to help find and locate clients when necessary. Many of these working relationships are continuing beyond the end of the initiative. Some sites are also building on their experiences with the initiative to launch new programs. For example, Pasadena Public Health Department is working with the city's public library system to station two peer navigators at the library where they can engage people who are experiencing homelessness and connect them with services. At Harris Health, as a result of the promising results of the Hi-5 project, the Ryan White Planning Council's allocation process has decided to provide four case management positions dedicated to serving people experiencing homelessness.

On June 27, 2017, the grant recipients of the initiative *Building a Medical Home for Multiply Diagnosed HIV-Positive Homeless Populations* convened a day-long meeting to present results at the Health Resources and Services Administration (HRSA) headquarters in Rockville, MD. Staff from the U.S. Department of Housing and Urban Development (HUD), HRSA, and Substance Abuse and Mental Health Services Administration (SAMHSA) were in attendance to learn about the strategies that collectively led to more than 1,300 people nationwide being served over the five-year initiative. A description of this meeting is available on the web at http://cahpp.org/HRSA-meeting-2017-06-27

Sustaining patient navigators beyond the grant period at Multnomah County Health Department

Prior to participating in this national demonstration project, the HIV clinic at Multnomah County Health Department (MCHD) did not use patient navigators. When MCHD staff developed the model to better serve patients experiencing homelessness, they were concerned about adding an incredibly rich resource (patient navigators) to the medical teams and then not having a way to sustain the effort beyond the grant period. The solution was to figure out how to bill insurance for navigation services.

The Oregon Health Authority (OHA) manages the State Medicaid Program (the Oregon Health Plan). OHA approves five Traditional Health Worker Medicaid provider types:

- **Community Health Worker (CHW)** – Advocates for patient and community health
- **Personal Health Navigator (PHN)** – Assists individual and groups with positive health outcomes
- **Peer Support Specialist** – Focuses on recovery from addictions/mental health conditions
- **Peer Wellness Specialist** – Focuses on recovery from addictions/mental/physical health conditions
- **Doula** – Assists with women's prenatal health care

MCHD navigators fall into the CHW and PHN categories to sustain navigation services. All patient navigators at Multnomah County Health Department underwent an 80-hour certification course approved by the OHA to be trained as community health workers; this allows MCHD to bill for the services of the SPNS navigators. As a result, navigators are now a permanent part of the multidisciplinary team at Multnomah County Health Department.

To learn more about how they did it, read Multnomah's manual at http://cahpp.org/Medical-Home-Multnomah.pdf pg. 31.

If, as a Ryan White provider, you are interested in learning about community health worker legislation in your state, see the National Academy for State Health Policy's (NASHP's) interactive State Community Health Worker Models tool at http://www.nashp.org/state-community-health-worker-models/

RESOURCES

Links to specific tools and resources mentioned in this manual can be found on the accompanying resources webpage at
http://cahpp.org/project/medheart/resources

In addition, the following materials are available as part of the initiative:

• The Med-HEART Medical Home Evaluation and Resource Team project webpage
http://cahpp.org/project/medheart/
This is the main project webpage from which you can find links to all resources, including everything mentioned below.
Additional resources will be added to this page as they become available.

• Models of Care: Building a Medical Home for Multiply Diagnosed HIV-Positive Homeless Populations
http://cahpp.org/project/medheart/models-of-care
Links to this manual and the implementation manuals of each of the nine demonstration sites can be found on this
webpage.

• Finding Home: Tips and tools for guiding people living with HIV toward stable housing
http://cahpp.org/project/medheart/housing-toolkit
This toolkit is designed to provide resources to organizations to increase access to stable and permanent housing for people
who are homeless or unstably housed, living with HIV, and who may have persistent mental illness and/or substance use
disorders.

• Medical Home SPNS demonstration sites: one-page overviews
http://cahpp.org/resources/medical-home-spns-demonstration-sites-one-page-overview/
A one-page overview of the initiative and for each individual medical home model

• Client story videos from the initiative
http://cahpp.org/project/medheart/videos
This page includes links to several videos created by the demonstration sites about their projects. It also includes a link to
a multisite overview video that contains testimonials from clients from several sites in the initiative.

• HRSA Meeting Posters for the SPNS initiative
http://cahpp.org/resources/hrsa-june-2017-meeting-posters/
Links to each SPNS demonstration site's poster presentation outlining the model that was developed as part of the
initiative. These were developed for a meeting that took place at HRSA headquarters in Rockville, MD on June 27, 2017.

• Five-year SPNS initiative results presented at HRSA meeting
http://cahpp.org/HRSA-meeting-2017-06-27
This article describes the day-long meeting that took place on June 27, 2017 to present results to staff from U.S.
Department of Housing and Urban Development (HUD), Health Resources & Services Administration (HRSA), and
Substance Abuse and Mental Health Services Administration (SAMHSA).

• The stories behind the numbers: Clients share life-changing impact of project at HRSA meeting
http://cahpp.org/stories-behind-the-numbers
This article describes the panel from the June 27 meeting in which three client-navigator teams describe the working
relationships that led to stable housing and better quality of life for the clients.

RESOURCES

• **PubMed article: Role of Patient Navigators in Building a Medical Home for Multiply Diagnosed HIV-Positive Homeless Populations**

http://cahpp.org/resources/pubmed-patient-navigators

Through interviews and focus groups, clinic and program staff from the nine organizations provided insights about the role of patient navigators in building a medical home for people living with HIV who are experiencing homelessness or unstable housing and co-diagnosed with substance use and/or mental health disorders. Results of this qualitative research are presented in this peer-reviewed article which was published in the ***Journal of Public Health Management Practice.***

Several additional articles are being prepared for publication. Links to these articles will be posted on the Med-HEART project page (http://cahpp.org/project/medheart/) once they are available.

Policy resources

Below are links to HRSA HIV/AIDS Bureau policy notices on use of Ryan White funds, policies from Housing and Urban Development, and the Housing Opportunities for Persons with AIDS (HOPWA) project.

• The following policy notices and program letters relevant to the HRSA Ryan White and Global HIV/AIDS programs can be found on the HRSA website at https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters
    o 16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds
    o Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds: Housing Services Frequently Asked Questions
    o Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds: Frequently Asked Questions
    o Program Letter from HHS and HUD re. Integrating and Using the Housing Opportunities for Persons with AIDS and Ryan White HIV/AIDS Program Data Sets August 29, 2017
    o Program letter from HRSA re. Using Ryan White HIV/AIDS Program Funds to Support Housing Services August 18, 2016
• The below resources are relevant to the Housing and Urban Development (HUD) HOPWA program
    o Housing Opportunities for Persons With AIDS (HOPWA)
    o Regulations regarding Housing Opportunities for Persons with AIDS (HOPWA)

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