### Sample policies and procedures

Health Hope and Recovery staff follows procedures and protocols relevant for all staff providing similar services. However specific procedures were developed to support the unique needs of the priority population.

#### Procedure: Program Outline and Protocol

**Purpose:** To provide a program outline and guidance for referrals, assignment, contact, waiting lists, and termination and closure.

1. **Eligibility**

Clients must be homeless or at risk of homelessness as defined below:

1. People who are living in a place not meant for human habitation, in emergency shelter, in transitional housing, or are exiting an institution where they temporarily resided.
2. People who are losing their primary nighttime residence, which may include a motel or hotel or a doubled up situation, within 30 days and lack resources or support networks to remain in housing.
3. Families with children who are unstably housed and likely to continue in that state.
4. People who are fleeing or attempting to flee domestic violence, have no other residence, and lack the resources or support networks to obtain other permanent housing.

**In ADDITION to meeting homeless eligibility, clients must have active mental health and/or substance abuse disorders that impact success in medical care.**

1. Client must be HIV+
2. Clients must be receiving or enrolling in HIV medical care at PHNTX clinic.
3. **Referral**
4. Clients who are screened eligible at intake will be staffed with program director.
5. Current PHNTX clients identified as eligible through their medical providers, case managers or other PHNTX service providers are referred to Program Director HHR.
6. Outside agencies may refer clients however if the client is not currently with PHNTX they will need to first go through intake and plan to enroll in medical services at a PHNTX clinic. A care coordinator will be assigned to follow this client through the intake process as needed.
7. **Assignment**
8. The Program Director HHR will assign new client screenings to care coordinators based on care coordinator's caseload, special skill sets, and prior relationship with client.
9. During screenings, care coordinators will assess client’s level of acuity.
10. Care coordinators will present client screening information to program director to review client assessment as well as to assign client to care coordinator.
11. If possible, the client will be assigned to care coordinator that completed initial screening to reflect the trauma formed care model.
12. However, the program director will make every effort to ensure that care coordinators will have no more than (5) level 4 clients on their caseload at a time.
13. **Contact**
14. All clients will be contacted by their care coordinator within 48 hours.
15. Minimum contact is determined by acuity level.
16. It should be noted that all care coordinators must attempt to meet “minimum” guidelines, however many clients will require more frequent contact.
17. Plans of contact must be determined at initial appointment and clearly documented by care coordinator. Client will be provided with written reminders and/or telephone reminders if client has a telephone.
18. Missed meetings, appointments and failed contact attempts must be clearly and accurately documented. All missed appointments require follow up and documentation by the care coordinator. Reasons for missed appointments will be immediately addressed.
19. **Maintenance Mode**
20. After 16-18 months of intensive care coordination clients will be offered an option of transitioning into maintenance mode.
21. If during a reassessment a client screens as acuity level one they will be offered to transition into maintenance mode.
22. Upon reaching acuity level one; clients will be transferred to the HHR case manager to ensure a “warm transfer” into case management.
23. **On Hold**
24. If a client is missing for 90+ days s/he will be placed “on hold.”
25. During the 90 days the care coordinator must be making consistent attempts to contact and re-engage the client. All attempts must be accurately documented.
26. If a client goes to jail or another closed institution and is expected to stay longer than 90 days s/he will be placed “on hold.”
27. If a client wishes to reinstate services while “on hold” s/he will be directed to the program director for reassessment of acuity and reassignment. The program director will assign the client to the previous care coordinator unless that care coordinator does not have capacity, in which case s/he will be assigned to another care coordinator.
28. In the event of a waiting list clients who wish to reinstate services will be placed on the waiting list and assigned according to acuity.
29. Clients who are “on hold” are not included in outcome assessment.
30. If a client is not participating in the treatment plan the care coordinator will staff with the program director who may decide that the client will be placed “on hold.” The client will have the opportunity to return at any time in the event that s/he completes requirements outlined by care coordinator.
31. Clients “on hold” are not eligible to receive services until they meet with program director and are reassigned to a care coordinator.
32. **Waiting List**
33. In the event that care coordinators reach capacity the program director will place new or reinstated clients on a waiting list.
34. As openings come available clients will be assigned based on acuity, preference given to highest acuity levels.
35. **Termination and Closure**
36. Clients may decide to terminate services at any time.
37. After a period of stability the care coordinator and client will collaboratively make a transition plan based on the assessment. Transition options are: maintenance mode, general case management, and referral case management.
38. Services may be suspended or terminated for disruptive behavior according to PHNTX Disruptive Behavior policy.
39. In the event of client death appropriate parties will be notified and Procedure for Closure of Client File of Deceased will be followed.

*This publication is part of a series of manuals that describe models of care that are included in the HRSA SPNS Initiative* Building a Medical Home for HIV Homeless Populations*. Learn more at* <http://cahpp.org/project/medheart/models-of-care>