# Building a Medical Home for Multiply Diagnosed People Experiencing Homelessness and Living with HIV/AIDS

**Multnomah County HIV Health Services Center, Portland, Oregon**

Using patient navigators to connect individuals who are multiply diagnosed, experiencing homelessness, and living with HIV with a medical home in Portland, Oregon

# ACKNOWLEDGMENTS

This manual was written, organized and reviewed by the following individuals:

## Main authors

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# BUILDING A MEDICAL HOME FOR MULTIPLY DIAGNOSED PEOPLE EXPERIENCING HOMELESSNESS AND LIVING WITH HIV/AIDS AT A GLANCE

**Multnomah County Health Department, Portland, OR**

**Area served:** Portland, OR metropolitan area

**Focus population:** People living with HIV who are experiencing homelessness/unstable housing and diagnosed with mental health or substance use disorders.

**Main challenges:** Engagement and retention in HIV specialty and primary care; lack of affordable housing; insufficient, appropriate mental health and substance use treatment resources; inadequate primary care medical home model; barriers such as unresolved legal issues, interpersonal violence, frequent interactions with criminal justice system, transportation, lack of legal identification, and food insecurity.

**Description of the model:** Integrating patient navigators and housing support into a comprehensive HIV medical home model to better engage and retain clients experiencing homelessness in order to improve medical outcomes such as HIV viral suppression.

**Partners and linkages:** Multnomah County's primary partnership was with Cascade AIDS Project. Additionally, Multnomah County collaborated with a variety of housing, mental health, substance use, legal, and social service agencies.

**Medical home model staff:** The intervention staff included 3 network/patient navigators (3.0 FTE) and 1 housing case manager (1.0 FTE). Evaluation staff included the principal investigator (0.1 FTE), project manager for local and multisite study evaluation (0.9 FTE), and 2 evaluators to support project manager (0.2 FTE). This intervention was integrated into an existing Ryan White funded medical home model clinic. Existing staff included HIV/primary care providers, nurses, medical assistants, medical case managers, mental health providers, clinical pharmacist, pharmacy technician, front desk staff, eligibility specialists, referral clerks, and administrative staff.

**Clients served:** 148

**Impact:** Of the first cohort of 27 clients who started in 2013, only two (7%) patients had a suppressed HIV viral load at the time they were assigned a patient navigator. In March 2017, 70% of the 25 remaining clients are virally suppressed—two patients died and were virally suppressed at the time of death. Members of the first cohort were all street homeless or couch surfing when they started working with navigators—now 72% of the remaining 25 clients are stably housed. Although some patients have sustained viral suppression while continuing to experience homelessness, the navigators found that patients with stable housing were more easily able to adhere to treatment and achieve viral suppression. The clients with unsuppressed viral loads have continued to struggle with addiction and/or untreated mental health and are in and out of jail (which we see in EPIC). The clients with a suppressed viral load also battle some of these same challenges but generally are living less chaotic lives and are deeply connected to their medical care teams. If these more engaged clients experience relapse or a period of untreated mental illness, they know they are not alone in getting back on track.

# ABOUT THE SPNS INITIATIVE

## Building a Medical Home for Multiply Diagnosed HIV-Positive Homeless Populations, 2012-2017

People who are experiencing homelessness are disproportionately affected by HIV, and those who are also living with HIV are more likely to delay entering care, have poorer access to HIV care, and are less likely to adhere to antiretroviral therapy. In 2012, the Health Resources & Services Administration (HRSA), HIV/AIDS Bureau through its Special Projects of National Significance (SPNS) Program* funded a national initiative with the goal of building a medical home for a vastly underserved population: those who are experiencing homelessness or unstable housing, living with HIV, and who face challenges of mental health or substance use disorders. Nine clinic and community-based organizations and one multisite coordinating center were funded to implement and evaluate 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; 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 all created a role of care coordinator/network navigator who worked with clients to access a networked system of services among HIV, housing, and behavioral health care providers. To measure achievement of project goals, the nine programs conducted a longitudinal multisite evaluation study of the models.

Multnomah County HIV Health Services Center was one of the nine demonstration sites funded under this initiative. This manual describes their experience implementing and evaluating the Building a Medical Home for Multiply Diagnosed Homeless People Living with HIV/AIDS project.

For more information about the initiative, visit http://cahpp.org/project/medheart/

*The Special Projects of National Significance (SPNS) Program is 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. Through demonstration projects such as the initiative that gave rise to the Building a Medical Home for Multiply-Diagnosed People Experiencing Homelessness and Living with HIV/AIDS project, 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

# INTRODUCTION

## About Building a Medical Home for Multiply Diagnosed People Experiencing Homelessness and Living with HIV/AIDS

In 2012, when this project was funded, the local system of care had several critical gaps and barriers to successfully identifying, engaging, and retaining multiply diagnosed people who are experiencing homelessness and living with HIV/AIDS (PLWHA) in medical care. Enhancing the HIV Health Services Center (HHSC) medical home with network navigators provided new resources that improve the continuum of care at the client, provider, and structural levels. The first gap the project and network navigators addressed was a gap in knowledge among service providers and the homeless community. The second gap addressed was the urgent need for system navigation services. In addition to addressing these gaps, the project has reduced several system barriers within the continuum of care, including insufficient capacity for mental health and substance use treatment and affordable housing; complicated intake processes; the inability to access or share client information; and poor discharge planning from treatment centers, jails, and prisons.

### The Setting

The Multnomah County HIV Health Services Center is located in downtown Portland, Oregon. Portland is located in the Willamette Valley region of the Pacific Northwest, at the confluence of the Willamette and Columbia Rivers. Portland's estimated population of 632,309 in 2015 makes it the 26th most populous city in the United States.[1] It's known for its parks, bridges and bicycle paths, as well as for its eco-friendliness and its microbreweries and coffeehouses. In 2015, the U.S. census reported the city as 76.1% White, 7.1% Asian, 6.3% Black or African American, 1.0% Native American, 0.5% Pacific Islander, 4.7% belonging to two or more racial groups  and 5.0% from other races. Almost 10% were Hispanic or Latino.  HIV/AIDS prevalence in Portland in 2015 is shown in the table on the next page.

[1]Oregon and Washington electronic HIV/AIDS Reporting System (eHARS)

## 2015 HIV/AIDS Prevalence in Portland, Oregon

| HIV/AIDS Prevalence as of 12/31/2015 in the Portland Metro Area | | | |
|---|---|---|---|
| Category | Subcategory | Persons Living with HIV/AIDS | General Population[2] |
| Race | Hispanic | 12.7% | 11.7% |
| | American Indian/Alaska Native | 1% | 0. 7% |
| | Asian/Pacific Islander | 2.5% | 7.0% |
| | Black/African American | 8.3% | 2.8% |
| | White | 73.1% | 74.3% |
| | Multiracial | 2.4% | 3.4% |
| Sex | Male | 91.4% | 49.4% |
| | Female | 8.6% | 50.6% |
| Age | 0-12 years | 0.2% | 16% |
| | 13-24 years | 1.8% | 14.6% |
| | 25-44 years | 33.9% | 29.6% |
| | 45-64 years | 56.4% | 26.2% |
| | 65 years | 7.7% | 13.6% |
| Percent of FPL* | Below 138% FPL | 51.2% | 20.6% |
| | 138%-399% FPL | 45.1% | 41.4% |
| | 400% FPL and above | 3.8% | 38.0% |
| Educational Attainment | Less than high school | 10.7% | 8.0% |
| | High school diploma or GED | 23.5% | 23.1% |
| | Some college | 42.1% | 27.3% |
| | Bachelor's degree or higher | 23.7% | 33.0% |

*FPL = Federal Poverty Level

## Homelessness in Portland

Homelessness has been a significant and growing problem in the Portland area. The region was among the worst hit by the recession, with record unemployment rates and per capita incomes that trail the national average. Despite declining incomes, the cost of housing in the region has continually increased, making it more difficult for low-income residents to afford market rate rents. Any crisis, from a medical emergency to job loss, can put a household with this level of rent burden at risk of homelessness. The high housing costs also make it extremely difficult for households already experiencing homelessness to transition off the streets. The housing vacancy rate has hovered between 2-4% over the past year. See the figure above.



Figure 1 HOMELESS SLEEPING OUTSIDE IN MULTNOMAH COUNTY, OREGON
SOURCE: POINT-IN-TIME COUNT OF HOMELESSNESS

The Point-in-Time homeless count is conducted every two years in January, on a date set by the U.S. Office of Housing and Urban Development. In warmer weather, the number of homeless sleeping outside generally increases.
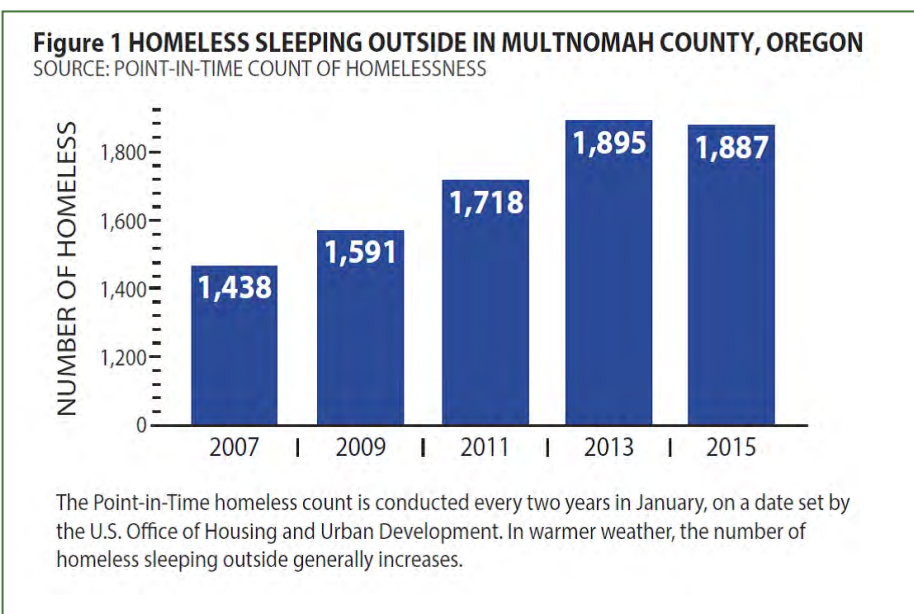
[2]U.S. Census Bureau 2015 Population Estimates

## About Multnomah County HIV Health Services Center and Cascade AIDS Project

### Multnomah County Health Department

The Multnomah County Health Department (MCHD) has been operating Section 330 Health Centers for uninsured/underinsured and low-income county residents since 1977. Twenty-six medical and dental sites provide access to culturally competent, comprehensive primary health care. MCHD provides more than 284,000 medical, dental, and field visits to approximately 67,000 county residents annually. All services are available without regard to ability to pay. MCHD clinics provide primary care within a Patient Centered Medical Home (PCMH) model that emphasizes nursing case management, open access, prevention and wellness, patient self-management and integrated behavioral health. MCHD also provides health care to persons incarcerated in the county's corrections system.

### Patient Demographics

Approximately, 86% of HHSC clients are male, 13% female and 1% transgender. HHSC has an aging patient population with 51% of clients over the age of 50. The primary HIV transmission categories are men who have sex with men (MSM, 74%) and Intravenous drug users (IDU, 18%). Approximately, 28% of clients are persons of color—16% limited English speakers. About 20% of clients have been incarcerated at least once in the past 2 years (high recidivism).

HHSC patients have high rates of substance use (29%) and mental illness (56%). The population is overwhelmingly low income (71% ≤ 138 FPL) and 1 in 5 patients are experiencing homelessness or unstable housing. HHSC patients have high rates of comorbidities such as diabetes, hypertension, and mental illness.

### HIV Health Services Center (HHSC)

The Health Department has a strong history of planning and implementing programs related to the provision of services to persons living with HIV/AIDS (PLWHA) and has provided medical care to PLWHA since the onset of the HIV epidemic. To respond to the growing number of clients living with HIV and the demand for specialized care from expert providers, MCHD was first awarded Ryan White Part C Early Intervention funds in 1990. These funds established the HIV Health Services Center (HIV Clinic), which has been in operation since that time. The HIV Clinic now serves over 1450 patients per year in the Portland metro area as well as rural parts of the state where persons living with HIV are unable to get care in their communities. (See the sidebar on this page.) This clinic is the largest single provider of HIV-specific care in the state (serving almost 1 out of 4 PLWHA in Oregon) and also is an AIDS Education and Training Center funded partner. It is recognized locally and nationally as a center of excellence.

HHSC is committed to ensuring its medical care is accessible to marginalized and hard-to-reach populations through a well-established patient-centered medical home model. HHSC's primary focus is on serving PLWHA who are uninsured, underinsured, and low income, and as a result, many (slightly under one-fifth) of these clients are also experiencing homelessness or unstable housing. Clients who are experiencing homelessness with dual diagnosis of mental illness and substance use are a client group the HHSC has identified as needing navigation assistance due to being extreme vulnerable, hard-to-reach, or marginalized by traditional systems of care. Other groups receiving navigation services include: recently incarcerated persons, as this population is more likely to experience mental illness and substance use and can be difficult to engage in care; immigrants and refugees, as these populations struggle with access to care due to language barriers, cultural differences, low health literacy levels, and a fear of being outed as HIV-positive within their small communities; women, as female clients are more likely to be racial/ethnic minorities, more likely to be living at or below

100 of the federal poverty level, and more likely to have higher acuity levels than male clients; youth 13-24, as these individuals are less likely to seek care and are more likely to be uninsured than older clients; and people age 50 and older, as this population tends to have more comorbidities than younger patients and is experiencing a higher rate of new diagnoses than it did in the past.

### Cascade AIDS Project (Community Partner)

Founded in 1983, Cascade AIDS Project (CAP) is the oldest and largest community-based provider of HIV services, housing, education and advocacy in Oregon and Southwest Washington.  In 2013, $1,177,808 went directly to 804 individual households for rent, utilities, and emergency assistance.  A total of 2,292 people received some type of support services, including housing, employment counseling, referrals, and continuing education.  Additionally, 115 people received employment counseling and assistance through Working Choices.  CAP specializes in housing and navigation services.  CAP's navigation services provide one-on-one individualized support to PLWHA.  Specifically, they help individuals to connect with medical care; adhere to HIV medications; connect to mental health and substance use treatment services; help secure stable housing; develop life skills; build and sustain positive relationships; and work toward self-sufficiency.  CAP's supportive housing program provides short-term rental assistance (up to 6 months); long-term rental assistance; application fees and deposits; eviction prevention; landlord advocacy; tenant education; and furniture/household items delivery and referral.

## The Theoretical Model

The Multnomah County Building a Medical Home for Multiply Diagnosed Homeless PLWH/A intervention is firmly grounded within the theories of the Medical Home Model and Community Health Worker Models. It is supplemented with additional components of work based on the theories of Housing First, Trauma Informed

Care, and the need to create sustainable, community-wide change through system and policy work. The intervention also uses innovative strategies based in specific best practice models such as Critical Time Intervention and the Continuous Relationship Model. These frameworks were integrated into our navigation intervention in order to:

- Improve timely entry, engagement and retention in HIV care and supportive services
- Build and maintain sustainable linkages to mental health, substance use treatment, housing, and HIV primary care
- Increase access to and receipt of stable housing
- Integration of HIV primary medical care with behavioral health services

### Medical Home Model

Patient-Centered Medical Homes (PCMH) can reduce costs while also improving the quality and efficiency of health care.  The PCMH or Medical Home Model uses an innovative approach to delivering preventive and primary care.  This model is designed around patient needs and aims to improve access to care, increase care coordination and enhance overall quality, while also reducing costs.  It relies on a multidisciplinary team of providers and attention to the "whole-person" approach. The idea is that the integration of all aspects of health care improves physical health, behavioral health, access to community-based social services and management of chronic conditions.

The characteristics of this model include:

- Multi-disciplinary teams
- Engage our clients in all aspects of their medical care
- Remove barriers to care
- Improve clinical outcomes
- Improve the client experience of care
- Decrease or sustain the cost of care
- Increase staff satisfaction and involvement

## Community Health Worker Model

The Community Health Worker Model utilizes frontline public health workers to serve specific communities. These workers develop trusting relationships with community members which enables them to serve as advocates and liaisons between health care and social services and to facilitate access to services thereby improving the quality and cultural competence of service delivery. Community health workers (CHWs) build individual and community capacity by increasing knowledge and self-sufficiency through a range of activities including outreach; community education; and advocacy. Our project used the term network navigator in place of the label CHW. As the project progressed, we started using the term patient navigator interchangeably with network navigator. This model helps complex clients engage in care by:

• Taking control of their health care decisions
• Forming a bond with their medical team and clinic
• Accessing needed services
• Learning how to navigate community programs and paperwork
• Interacting effectively with their medical teams and community partners

# INTEGRATING NAVIGATORS INTO THE MEDICAL HOME MODEL

## Challenges Faced in the Multnomah County Area

In 2012, things were coming to a head at the Multnomah County HIV Health Services Center (HIV Clinic) in Portland, Oregon.  In the prior six years, the number of patients served by the clinic had almost doubled from 593 to 1124, while the number of staff stayed almost the same—increasing from 21 FTE to 22 FTE.  The patient caseload not only grew but also shifted from an established group of fairly well educated, white MSM to one characterized by  higher proportions of people experiencing homelessness, severe mental illness and substance use disorder.  This shift resulted in an overworked team of providers, nurses, case managers, front desk staff and supervisors and a more volatile wait-ing room.  The medical director and other key staff were concerned that the clinic no longer had the bandwidth to get the sickest, most complex patients to start and adhere to HIV medications.

The situation was exacerbated by limited housing and community resources for the high-acuity clients.  The highest-need clients experienced difficulty accessing needed social services.  Lamar, a 32 year- old African American male, was one of these clients (see sidebar on the following page). It was not uncommon for HIV case managers to refer clients to community-based organizations for mental health, substance use, and housing services only to find that these clients did not make it through the intake process due to problems such as "bad" behavior: not showing up or showing up late for appointments, incarceration, arriving for an appointment while under the influence, not providing required eligibility documentation, and not following up on required paperwork.  Or even worse, for staff to get the dreaded call that one of the patients is BANNED from an agency. Additionally, services provided by social service agencies (including housing and shelter, mental health, substance use treatment, respite care, transporta-tion, food, etc.) were not focused on persons living with HIV or structured in such a way for easy collaboration with a primary care medical home.

## Lamar's Profile

The HIV Clinic was seeing an increase in the number of highly complex patients. Lamar's profile was common:

- New to Portland
- Untreated AIDS, syphilis, bipolar disorder, schizophrenia
- Chronic homelessness
- Estranged from family
- History of poly-substance use
- Long history of methamphetamine use
- Untreated mental illness
- No income, uninsured
- Low CD4 count
- High viral load
- Outstanding arrest warrants
- Engagement in care limited to crisis situations

"We have always had clients who were experiencing home-lessness prior to this. They would come in when they were in crisis for a couple of weeks and then we'd see them in 10 or 14 months. But it's the first time we had navigators and actually had a strategy. We learned that the process is not linear. You can't have too many rules. You have to walk the talk around flexibility.

- MCHD staff

The tri-morbid (homeless, mentally ill and addicted) clients were only marginally engaged in medical care resulting in personal and public health problems. These clients had greater numbers of comorbidities, engaged in high-risk behaviors, and were not on HIV anti-retrovi-rals. They had numerous medical issues resulting in high ambulance and emergency room utilization. High HIV viral loads and engaging in high-risk behaviors such as unsafe sex and sharing needles contributed to increased incidence of new HIV cases. This group of clients would typically connect with the clinic following a hospital stay or incarceration. They would show up like a tornado. For a couple of weeks, case managers would try to address a myriad of challenges, including getting them connected with community resources. Invariably, before anything could be wrapped up, these clients would dramatically drop off the radar for several months or longer—until the next big drama unfolded. With caseloads of over 250 clients, medical case managers had no time to chase clients down in the community.

At this point, the clinic manager and the management team were very concerned about their ability to serve clients who were experiencing homelessness and were severely mentally ill. The number of client altercations and outbursts in the waiting room were becoming more frequent, as were calls to 911. Partnering agencies were not picking up the phone when called for help. For the first time, staff began talking about their safety and the safety of clients.

In spring 2012, the HIV clinic got a call from one of Portland's largest homeless programs, Central City Concern (CCC), to say they were thinking about apply-ing for housing grant dollars directed to persons living with HIV. After a brief conversation, the parties agreed to convene essential partners to explore the funding opportunity. Health Department and clinic leadership, Cascade AIDS Project housing and support services managers, the Housing Opportunities for Persons with AIDS (HOPWA) grantee, and CCC came together for a preliminary meeting.

This grouping of agencies and programs was a first. On the surface, the meeting was convivial and all agreed that persons experiencing homelessness and living with HIV

had special needs and challenges not experienced by the general homeless community. The planning members were quite open about identifying each agency's respective "special interests" and desired outcomes. Members were assigned to collect specific community data to guide the decision whether to proceed. There was an underlying concern about who would be best to apply for the money and how the money would be spent and split up. The HIV Clinic was not interested in the "same old same old"—and, as previously mentioned, the clinic was at a fork in the road related to serving clients experiencing homelessness.

Many client needs and gaps in services were identified. The planning partners got clarity about each other's strengths and weaknesses. The group started researching best practices and then ran out of steam—and did not meet the grant deadline. The work was chronicled and set aside for another day. The interested parties all promised "to stay in touch and to better coordinate existing services," and everyone parted ways. Then a serendipitous thing happened: the Health Resources and Services Administration, HIV/AIDS Bureau, Special Projects of National Significance (SPNS) Program released a funding opportunity announcement (FOA), Building a Medical Home for Multiply Diagnosed HIV Positive Homeless Populations. The phone started ringing as, to a person, everyone on the planning group had seen the request for proposal at the same time. The HIV Clinic was very excited about this five-year funding opportu-

nity, as it could enhance its recently accredited Patient Centered Medical Home model. The HIV Clinic management saw the potential to be in the driver's seat to try something different with community partners.

## How the Project Came Together

The planning group was reconvened. The county would serve as the lead agency and submit the grant application. Cascade AIDS Project (CAP) was selected as the clinic's primary partner who would receive a sub-award of funds to enhance the existing medical home model by adding patient navigators to the team. The navigators would be CAP employees who were already linked to community-based housing, mental health, substance use and other services. The navigators would be fully integrated into the HIV clinic's existing medical home teams to work with clients who were homeless or at-risk of homelessness and had mental health and/or substance use disorders.

The proposed project included the following components:

1) network navigation;
2) client outreach and identification;
3) client enrollment into the research study;
4) intensive care coordination;
5) quality HIV primary care;
6) retention in care;
7) access to stable/permanent housing;
8) building sustainable partnerships; and
9) project administration and quality improvement.

The proposed best practices included the Medical Home Model, Harm Reduction, Housing First, Community Health Workers, and Critical Time Intervention. The model also addressed the need to create sustainable, community-wide change through system and policy work. The overarching deliverable was to improve the engagement and retention in HIV primary care and support services for multiply diagnosed persons experiencing homelessness and unstable housing and living with HIV. The clinic's Client Advisory Board was instrumental in guiding the project implementation and ongoing quality improvement.

### The Vision

Patient navigators and medical case managers will coordinate client care seamlessly. Clients will be linked to mental health and substance use services quickly and will be connected to CAP housing programs with the goal of achieving stable housing. Navigators will guide clients through the process of engaging with all needed services and aid in the exchange of timely and relevant information among service providers. The medical case managers are the provider teams' primary liaisons with the navigators.

### Training of Navigators

Basic community health worker training was augmented:
- Suicide prevention procedures
- Home visit safety
- HIV 101
- Nursing triage
- Quality improvement
- HIPPA and confidentiality
- Community resources
- Email and texting procedures
- Community resources
- Offsite behavioral resources
- Electronic medical record (EPIC) documentation

## Once the Project Was Funded

A small team was formed to oversee project implementation and troubleshoot interagency communication and coordination. The oversight team revisited the proposal, focusing on the staffing, deliverables and the Year 1 Work Plan (See pg. 21 for an example of the work plan). Incredibly, the proposed work plan appeared solid and required very few modifications. The team met weekly for several months and then dropped back to meeting monthly. The project design clearly delineated the division of labor—CAP would hire the navigators and oversee the integration of housing services into the HIV Clinic.  The clinic would provide the medical team staff, grant management and evaluation services.

## Recruiting and Training Navigators

The navigator job description and minimum qualifications were designed by the project oversight committee. (See the SPNS Job Descriptions in the *Resources* section.) The job description was clear about the work to be done and required qualifications were those commonly found in entry-level social work.  Recruitment started in October 2012.  An interview committee was convened—three navigators were hired, oriented, and assigned a caseload by February 2013.

None of the navigators had previously worked in a medical setting. They received extensive training both at the HIV Clinic and the Cascade AIDS Project (see sidebar on the left), and later received additional training on mental health first aid, suicide prevention, and motivational interviewing.  The navigators also attended a 96-hour county community health worker workshop in order to become certified Medicaid providers which will allow them to bill for services in the future. (See the sidebar below.) In additional to a clinic orientation, the navigators received training on CAP's housing and support programs and CAP's employee policies, including data sharing. The navigators participate in continuing education.

### 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 did not use patient navigators.  When MCHD staff developed the clinical model to better serve homeless patients, 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 obvious 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. MCHD navigators fall into the Community Health Worker and Patient Health Navigator categories. The major efforts that we took to sustain navigation services are outlined on pg. 31.

As a result of these efforts, navigators are now a permanent part of the multidisciplinary team at Multnomah County Health Department.

> "The overarching shift was to become more of a trauma-informed organization. We reminded people we are not here to be comfortable, we are here to serve people. We did a lot of individual coaching and sticking to the model.
>
> – MCHD staff

Over the course of the project, navigators received a variety of additional training based on their individual needs. They also participated in agency-wide training offered by both the HIV Clinic and Cascade AIDS Project. (See the SPNS Training Document in the *Resources* section.)

The team later found the original navigator job description missed the mark—it did not fully reflect the heart of the work in terms of 1) the complex medical and psycho-social needs of clients, 2) the intensity and unpredictability of the work, 3) the high level of independent decision-making with minimal supervision, 4) the lack of easily accessed resources, and 5) vagaries of integrating field work into a clinic setting.

Two years later, only one of the original navigators was still around—Maurice Evans. Evans had the least amount of formal education, had overcome many of the same barriers as the clients, was very familiar with local legal, housing and social service systems, and was fearless in the face of adversity. He demonstrated a willingness to learn, had common sense and was able to think on his feet, was not afraid to make mistakes, had a great sense of humor, got along well with others, was open to supervision and had developed good boundaries along the way. Evans went from an intimidated member of the medical team to a valued colleague. Future recruitment

and hiring focused on the type of strengths that Evans brought to the job. Reference checks were also more thorough. Evans was joined by Jamie Christianson in early 2014. She and Evans have now worked side by side for three years and are bringing the demonstration project to a close. They transitioned from being CAP employees to being Multnomah County employees in October 2016. This change was made to more easily integrate them into the ongoing clinic budget, thus sustaining their positions beyond the research project period.

## Adaptation of the Medical Setting

In planning to integrate patient navigation into the HIV Clinic's patient-centered medical home model, the HIV Clinic had focused on orientation and training for the navigator as described above. It turned out that the navigators were not the only ones who needed

### Debriefing Navigators and the Need for IPV Training

Field-based work with the homeless is stressful. The clinic lost a highly effective and compassionate navigator. She had worked at the clinic for about a year. During this time, one of her clients had struggled with domestic violence. One day the client walked in, badly beaten—his jaw was broken—he had soiled his pants—it was horrible. He asked the front desk to get his navigator. She went to meet with him in a triage room off the lobby. Within a short time, she was joined by the team nurse. The navigator was highly distressed and upset by this traumatic situation. We were not clear how to best support this navigator. When all was said and done, she did not want to continue working as a patient navigator, and transferred into a different position. This event led to formalizing situation debriefs in the clinic and to providing Intimate Partner Violence training to the whole staff. (See the Debrief guidelines and form in the *Resources* section.)

> "Introducing the new intervention and a new class of employees like 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? What is your role in helping the navigators be successful? What is your role in helping these clients engage in care? What is your role in transitioning the clients from the navigator to standard of care?
>
> - MCHD staff

training and orientation. The medical staff was skeptical about how these navigator "newbies" could possibly help to improve clinical outcomes for the most complex, difficult clients when other more experienced staff had failed. The project oversight committee circled back and provided additional information to the clinic staff about the new navigation services. Additionally, they worked with everyone, including the navigators, to create new protocols and workflows to address concerns related to logistics and communication. As the navigators started gaining traction with their clients, outcome data and client success stories (however small the success!) were shared with clinic and CAP staff, community partners and MCHD leaders. In instances such as this, the role of an internal champion is key in promoting clinic buy-in and continued support.

Other challenges to the traditional medical home model occurred. 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. This created a couple of issues. The clinic's approach to triage was not adequate to handle the increase in walk-in traffic. Ultimately, the nursing staff and medical case management team developed a new workflow for walk-in patients. The first part of the decision tree was for the front desk to ask if the clients needed to be seen for a medical appointment, case management, or both. Based on the answer, a clear decision tree as to what happened next supported the clinic's goal of all walk-in being triaged in a timely manner. The increase in triage support resulted in building 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. The increased traffic in the clinic lobby also resulted in rearranging the space and adding a big table for homeless client to use for reorganizing their belongings and filling out paperwork. Access to charging stations for phones and laptops was made available.

In addition, the clinic's Client Advisory Board (CAB) requested the development of drop-in programs to provide newly engaged-in-care clients experiencing homelessness with social support. The CAB developed a weekly program called "Here for You." Every Thursday afternoon, CAB members set up coffee and snacks and visit with clients. The CAB also recommended that the clinic offer drop-in art classes—art therapy is now offered two afternoons per week. Many navigation clients have or still struggle with methamphetamine use. One of the navigators put together a book group to discuss this topic. The book group was well attended; clients requested that the book group be continued on other topics.

"
*When you are serving people and their barrier to care is homelessness and not coming to clinic, it's a whole different approach. When you have a team that's more field-based, you have to make sure that they have really good cell phones, that they can look resources up, that they can access medical records in the field, there has to be a clear line of authority so that if somebody has a crisis, they have to be able to reach somebody in the clinic.*

*- MCHD staff*

## Focus on Supervision and Support

Moving into the second year of the project, additional adaptations to the medical home model needed to be made. The initial plan for supervision of the navigators was very traditional, designed for staff who worked onsite, with predetermined times to meet with supervisors. Once the navigators started working in the field, supervisors at both CAP and the clinic got together with the navigators to hear what they thought would be most helpful. The supervision ratcheted up. For field safety, the navigators carried a charged cell phone. 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. (See the sidebar Debriefing Navigators on pg. 15 and the Debrief guidelines and form in the *Resources* section.)

Several guiding principles evolved for supervisors to address staff stressed with field-based work. First, whenever a client's behavior or a situation is out-of-control, navigators take a step back and consult with a supervisor or co-worker—they don't have to handle it alone. Second, supervisors create space for navigators to be creative in problem solving with clients—even in dicey situations. Third, navigators debrief difficult situations in the way that best suits the navigator—the options vary from informal discussions to the formal debrief.

# RECRUITING CLIENTS INTO THE PROGRAM

## Referrals, Eligibility, and Enrollment

Medical teams can refer clients for two types of navigation assistance: short-term, one-time only and/or intensive, longer-term navigation. Prior to referring a client for navigation services, a medical team member must 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. Clients must be interested in working with a navigator to be eligible. The following chart describes the general eligibility criteria:

| NAVIGATION PROGRAM* | ELIGIBILITY | DURATION |
|---|---|---|
| **INTENSIVE LONG-TERM ASSISTANCE** | • Homeless or at risk of homelessness<br>• History of mental health and/or drug & alcohol use<br>• Unsuppressed HIV viral load<br>• Poor engagement in care, out of care, or newly diagnosed<br>• Needs assistance to connect with medical care/ critical services | Determined on an individual basis —usually 9 – 12 months |
| **ONE-TIME SHORT-TERM ASSISTANCE** | • Needs assistance attending a specialty appointment<br>• Needs other specific short term service (clear beginning/ end) | 1-2 meetings with navigator |

The step-by-step referral process is as follows:

- Medical team members identify eligible clients who might benefit from working with a navigator.
- The medical case manager talks to client to ascertain interest and willingness to work with a navigator.
- Medical case manager sends email referring client to the navigator team. The email includes the name of the client, MRN, brief description of the client's current situation, and client goals. The email specifies if this is a referral for short-term or intensive navigation services.
- The navigator team lead and navigators review the referral to determine which navigator is available to take on a new client. Client assignments occur not only based on availability of navigator, but also urgency of the referral which is determined on an individual basis via case consult/discussion.
- All referrals are added by the team lead to the client navigation tracking document.
- If navigators are unable to take a new client at the time of the referral, this information is communicated to case manager via email and/or in person. The client stays on a waitlist until a navigation slot opens up. When a navigator is available to take on a new client they speak directly with the medical case manager to determine if the client is still in need of assistance. If the client is still in need of assistance, the medical case manager will assist the navigator to connect with the client.
- The medical case manager facilitates an initial meeting that includes themselves, the client, and the navigator. The purpose of the meeting is for the client and navigator to get acquainted, to review the client's goals, and to identify next steps. Staff work with clients to identify a series of small goals that can be achieved in a short period of time. Small "wins" help the client and navigator bond and more importantly set the stage for success and change with the client. This meeting is documented in the EHR.
- Once the navigator has met with the client, the client is considered "enrolled" and the navigator enters the "enrollment date" into the client navigation track-

> **We took the criteria of severe mental illness, homelessness and substance use very seriously. This was a hallmark of our program.**
>
> **- MCHD staff**

ing document. At this time, the navigator also adds their name to the patient care team in Epic and to Epic Snapshot (along with the date enrolled). The navigator then works with the medical team member to obtain any additional information and coordinate services.

- The navigator documents all client interactions and outcomes of service (if applicable) in Epic.
- The navigator, client, and medical case manager have monthly follow up meeting to track progress on meeting goals and problem solve barriers. These are charted in EPIC. The navigator and medical case manager are in frequent contact.
- In most cases the one-time, short-term requests are addressed in real time.

Medical case managers and SPNS navigators meet on a monthly basis to discuss referrals, staff clients, and develop and streamline processes. Navigators attend morning huddles with medical teams to identify potential referrals and discuss client engagement and care. Navigators attend monthly Client Advisory Board meetings; HIV Network meetings; CAP Housing meetings; and the clinic's quality team meetings. Additionally, they spend time at the HIV Day Center for the purposes of collaboration, access, and referral. See the Navigation Eligibility and Referral Process documents in the *Resources* section.

# SERVICE DELIVERY MODEL

## Intervention Staffing in the Final Project Year

**SPNS Principal Investigator and Clinic Manager, Multnomah County:** Provides general oversight of the SPNS project integration into the clinic structure and activities. Manages sub-contract with Cascade AIDS Project (CAP) and provides input and final approval to evaluation plans and grant reports. This position entails directing activities rather than implementing them. Ms. Davich brings with her a wealth of experience managing and evaluating grant-funded projects serving PLWH/A, homeless individuals, and other marginalized populations. (0.1 FTE)

**Director of Housing & Support Services, CAP:** This is a contracted position. Responsible for oversight of the SPNS housing case manager and network navigators. Works closely with Multnomah County Health Department staff to ensure that housing services and support are accessible and prioritized for SPNS clients. This position oversees contract with Multnomah, including approving the final contract draft. Angie has over ten years of experience delivering, coordinating, supervising and evaluating social services in affordable housing. Additionally, she has 6 years of experience managing compliance with long-term, federal funding contracts. (0.05 FTE)

**SPNS Project and Data Manager, Multnomah County:** The project manager is responsible for leading local evaluation activities, including working with Med-HEART, HRSA and other SPNS grantees to participate in the development and implementation of

> " Senior leaders were asked to make themselves totally available to navigators and to help problem solve. That is what made it successful.
>
> - MCHD staff

# Annual Work Plan

Below is a summary of the project's annual work plan

**GOAL 1:** To expand and support a comprehensive, coordinated, culturally competent continuum of care that is able to identify and care for individuals who are experiencing homelessness/unstable housing, living with HIV and with comorbid mental health and substance use disorders.

*Objective 1.1* Maintain the fiscal and programmatic infrastructure for managing the new SPNS grant award.

Objective 1.2 Link SPNS project to local organizations serving HIV+, homeless, substance-using and/or mentally ill populations

**GOAL 2:** individuals who are experiencing homelessness/unstable housing, living with HIV and with co-occurring substance use or mental health diagnoses and engage them in care.

*Objective 2.1* Conduct community outreach, education, support, and advocacy to locate individuals who are experiencing homelessness/unstable housing, living with HIV and with multiple diagnoses who are not in care.

**GOAL 3:** To improve medical outcomes for PLWHA with comorbid mental health and substance use disorders who are experiencing or at-risk for homelessness by providing them a medical home with comprehensive primary care and links to support services.

*Objective 3.1* Provide primary medical care to enrolled clients.

*Objective 3.2* To provide initial and ongoing adherence education to all clients receiving antiretroviral therapy.

*Objective 3.3* Provide initial and ongoing assessment of high-risk behaviors and provide education.

*Objective 3.4* Provide initial substance use assessment, planning and treatment, and make referrals to appropriate community partners.

*Objective 3.5* Provide initial mental health assessment and referral to new clients.

*Objective 3.6* Provide immediate access to short-term housing and assistance in acquiring permanent housing.

*Objective 3.7* Utilize the Critical Time Intervention (CTI) Model (a three-phase model) to strengthen the individual's long-term ties to services, family and informal support networks.

*Goal 4:* To assess the efficacy of the model through an evaluation plan.

*Objective 4.1* Implement established research methodologies, including data collection, outcome reporting, process and cost data collection

*Goal 5:* To implement a long-term sustainability plan for the SPNS project model.

*Objective 5.1* To explore housing resources and opportunities to more adequately address the need for permanent housing options for PLWHA in the transitional grant area (TGA).

*Objective 5.2* To develop a plan for funding network navigators beyond the project period.

the multi-site evaluation tools and activities; preparation, collection and analysis of local program service data; coordination of program implementation; oversight of the Cascade AIDS Project contract; coordination of various SPNS meetings; preparation of program reports, budgets and renewal applications; coordination between CAP and HHSC staff; liaison between the program and community partners; application of SPNS best practices; support and supervision to the intervention and evaluation staff; and dissemination of results. Additionally, she conducts participant interviews; medical record abstractions; IRB activities; data cleaning; and participant tracking. Ms.  has worked in both service delivery and administrative capacities for HHSC for over eleven years. (0.9 FTE)

**SPNS Network Navigators; CAP and Multnomah County:** The three network navigators carry out the majority of the program's intervention.  As navigation services are being moved in-house as opposed to the previous model when CAP staff were sited at the clinic. Navigators (community health workers) possess a variety of knowledge, skills, and abilities including past experience working with PLWHA, people who experience homelessness, and those with mental health and substance use histories.  These positions carry a small caseload (10-15 clients per navigator) as they provide intensive services required to engage these complex clients. (3.0 FTE)

**SPNS Housing Case Manager, CAP:** Housing emerged as the most pressing need for SPNS clients. In response to this need, a SPNS housing case manager position was created.  The SPNS housing case manager specializes in housing clients with significant barriers to housing placement and retention.  Similar to the navigators, the SPNS housing case manager possesses a variety of knowledge, skills, and abilities including past experience working with PLWHA, people who experience homelessness, and those with mental health and substance use histories. This position carries a small caseload (20-25 clients), as this position provides intensive housing services to house complex clients.  (1.0 FTE)

**Evaluators (Interviewers), Multnomah County:** These two positions were created to provide assistance and back-up to the project/data manager with client inter-

views as part of the evaluation. The project and data manager is the primary evaluator and these positions provide coverage when the data manager is unavailable. Marshall. Beatty has been working for several years as an eligibility specialist with members of the focus population, which has given him significant experience interviewing clients and gathering various kinds of information. Toni Kempner is the nursing supervisor for the clinic and has many years of experience in research development and evaluation as well as providing direct patient care to PLWHA. (0.2 FTE)

## Community Partners (Internal and External Stakeholders)

HHSC and CAP maintain relationships with a wide range of community social service agencies as well as over 50+ housing groups to address homeless service needs.  The HIV Clinic is not the "expert" in areas such as housing, substance use treatment and specialty mental health.  As we prepared to roll out the navigation intervention, we identified community resources that would help fill in the service gaps in our expanded medical home model.  We met with staff from various agencies to cull out the groups most likely to have the capacity to serve individuals who are experiencing homelessness/unstable housing, living with HIV and with multiple diagnoses. Our goal was to partner with a variety of organizations to meet the diverse needs of our clients. The following table lists both the key homeless-specific and non-homeless-specific organizations that are willing to help with our target population. Service providers that specifically serve HIV-positive individuals are noted as such.

Navigators work with numerous landlords and attend various meetings to ensure client needs are taken into account.  We have navigator representation on the Integrated Planning Group (statewide planning body); the Office of Equity and Inclusion monthly meeting; the HIV Network; and the Home for Everyone meetings to name a few. (See the Description of Community Partners in the *Resources* section.)

## Table 2. Existing Medical, Mental Health, Substance Use Treatment & Ancillary Services

| Service Provider | Services & Approximate Number of Clients Served Annually |
| --- | --- |
| *Service Organizations Geared toward Homeless or with Homeless Programming* | |
| **Cascade AIDS Project (HIV-specific)** | **Medical:** MAI case management services. **Ancillary:** case management, housing services |
| **Cascadia Behavioral Healthcare** | **Mental Health:** counseling and crisis intervention. **Substance Use:** addictions treatment. **Ancillary:** housing for people suffering from poverty, mental illness, and/or substance use challenges |
| **Central City Concern** | **Medical:** Old Town Clinic, a 330(h) grantee. **Substance Use:** multiple addiction and chemical dependency treatment centers. **Ancillary:** housing services |
| **Luke-Dorf** | **Medical:** medical coordination, medication monitoring. **Mental Health:** psychiatric treatment, cognitive and creative therapy. **Substance Use:** alcohol and drug addiction treatment. **Ancillary:** Housing placement and support through multiple assisted housing facilities, employment assistance, case management, skills training, homeless outreach |
| **Outside In** | **Medical:** primary care through a 330(h) grant. **Mental Health:** psychiatry and counseling. Substance Use: syringe exchange program. **Ancillary:** housing, education, employment, and nutrition assistance. |
| **Wallace Medical Concern** | **Medical:** urgent medical care for uninsured/underinsured patients, operates a mobile medical van in partnership with MCHD |
| *Non-Homeless-Specific Service Organizations* | |
| **Clark County Health Dept (HIV-specific)** | **Medical:** dental care. **Mental Health:** therapy/counseling. **Ancillary:** health insurance assistance, case management, housing services. |
| **DePaul Treatment Centers** | **Substance Use:** alcohol and drug addiction treatment and detox, residential and outpatient services. **Mental Health:** individual and family counseling for substance users. |
| **Ecumenical Ministries of Oregon HIV Day Center (HIV-specific)** | **Ancillary:** psychosocial support services, food/home delivered meals |
| **LifeWorks Northwest** | **Mental Health:** counseling for a wide range of mental health challenges of varying severity. **Substance Use:** individual and group counseling to support recovery from alcohol and drug addiction. |
| **Our House of Portland (HIV- specific)** | **Medical:** Supportive Housing with 24 Hour Skilled Nursing |
| **Project Quest** | **Mental Health:** group and individual mental health counseling, stress management. **Substance Use Treatment:** outpatient alcohol and drug treatment. **Ancillary:** peer mentoring, pain management groups. |

# Navigator's Role in Engaging Clients Who are Experiencing Homelessness into Care

Because of the acute lack of affordable housing in Portland, navigators literally met clients where they were—at shelters, meal kitchens, homeless camps, and storefronts. Navigators started building relationships by helping their clients with the basics—emergency shelter, food, acute medical problems and clothing. Twenty-five dollar incentive cards were used judiciously for getting clients to attend appointments and as a support during transitional periods such as getting housed or moving from jail to a shelter. Most clients have basic cell phones with unlimited or ample texting. Purchasing minutes for clients phones was used as an incentive to encourage clients to follow up on next steps. The navigators would establish a routine for meeting with clients both in the clinic and in the community. The clinic provided bus tickets and monthly passes (a much desired incentive!) so clients could get to the HIV clinic as well as other

medical and social services using public transportation. The navigators worked with clients experiencing homelessness/unstable housing and their medical team to develop individualized plans for starting anti-retroviral therapy (ART) and adhering to their medication regime. The plans included options such as:

• Weekly medication bubble packs dispensed at clinic or by the pharmacy
• Daily observed therapy (clients coming to clinic daily to take meds and given weekend meds on Fridays) Securing food resources (food coupons, food stamps, arrangements with dining halls, etc.) so that meds could be taken with meals
• Frequent check-ins by the navigator and medical team which included regularly scheduled CD4/VL tests to track adherence and/or resistance.

As the clients became more involved in their medical care, navigators worked with the medical team on referrals to mental health and/or substance use treatment. As with medical care, the navigators worked with clients, referring them to appropriate behavioral health services. The sidebar on the next page illustrates a profile of Joe, a 42-year-old white male client, and the range of services he received.

CAP had the primary responsibility for working with navigators to overcome barriers to housing. This usually included a laundry list that ranged from cleaning up criminal records (outstanding warrants), to securing legal IDs, to resolving child protective services issues, to paying off past rental debt. They got clients on housing wait lists, found furniture and prepared the client to be a good tenant through "Ready to Rent" classes. Navigators also helped a few clients to look for work or go back to school.

Clients were considered engaged in care when they showed up for medical appointments, actively worked with their medical case managers, and had a suppressed HIV viral load. Once the client's core navigation goals were met, the medical case manager took over to provide ongoing psycho-social support. A final navigation "graduation" meeting was usually held between the client, the navigator and the medical case manager. Clients received a certificate of completion and a $10 coffee card. The certificates proved to be very meaningful, as most

> "It took some time, but when the providers started saying 'OMG, these patients are taking their meds, they are showing up!' then they started seeing navigators as a resource and clambering for more.
>
> – MCHD staff

clients had never received a certificate before. And, if/when things fell apart for the client, the navigator/client relationship was renewed. See the graduation template in the *Resources* section.

## Core Medical Services Provided

Within HHSC, each client is assigned a medical case manager who is responsible for working with the medical team to coordinate care and facilitating regular interactions with all members of the medical team. Each medical case manager reviews charts for patients scheduled that day and compiles notes in preparation for the daily huddle with their clinical team. In addition to huddles, the clinical teams meet twice a month to engage in thoughtful case consultation and care planning for complex patients. All new patients at HHSC complete a comprehensive assessment with their medical case manager and team nurse that includes a detailed psychosocial and medical assessment. These assessments result in an individualized service plan that may include referrals to other core and support services, problem solving, or brief crisis intervention if needed. Medical case managers reassess client needs every six months. Team-based services at the HIV Clinic include:

• Primary care and HIV specialty care
• Medical case management
• Patient navigation services
• Home-based nursing visits

## Client Story: The Path Is Not Linear

**March, 2013:**
A long-time patient of the Multnomah County HIV Clinic, who we will call "Joe", is street homeless and severely mentally ill. Joe has schizoaffective disorder which includes a lot of paranoia, delusions, and hallucinations. Joe was sleeping on the streets  He was actively abusing alcohol and occasionally meth. He was assigned a patient navigator in March, 2013. He would not interact with his navigator on a regular basis, but did take his HIV meds. By the end of the summer, he was inactivated from navigation services. **His HIV viral load (VL) was undetectable.**

**June, 2015:**
Joe recently re-engaged with us after being out of care of many months. **His HIV viral load was extremely high (VL = 129,379 copies).** He arrived in clinic one day reporting that he hadn't taken off his shoes or socks for months. Joe was covered in scabies and lice, was extremely paranoid, and refused to let anyone help him.  He smelled as if his skin was rotting, and the medical team was extremely concerned that he may have gangrene or possibly lose his legs. The clinic and medical team worked compassionately and patiently with Joe to try to convince him to accept medical care. Joe was transported to the hospital where it took them 6 hours to remove his shoes and socks that had adhered to his skin. Over the next couple of weeks, we were able to treat Joe for lice, teach him how to change the dressing on his leg wounds, and get him to take antibiotics. Since Joe returned to care, he has been in daily, some days spending hours with his case manager and patient navigator.  Joe agreed to take mental health medication. Because our clinic operates as a client-centered medical home, Joe has been able to access health care and wrap-around support services when he needed them most. The team has been flexible to meet his needs and priorities on his timeline and coordinated to get him connected to mental health counseling, alcohol and drug support, housing, clothing, and food services. Joe was accepted into supportive mental health housing and will be moving in June. Joe is still not taking his HIV meds consistently.  **His viral load remains very high.**

**November 2015 Update:** In late June 2015, Joe received housing through a supported mental health program, Luke-Dorf. His mental health care was transferred from the clinic to this community program which, like our clinic, is located in downtown Portland. Joe was paranoid about his new "partner" in his medical and mental health care. He refused to take his psych and HIV meds and to engage with Luke-Dorf programs and staff. His physical health is declining and despite having a bedroom and access to food, he is back to spending significant time on the streets. His medical team is working with Luke-Dorf to re-engage him in care.

**October 2016 Update:**
Joe is re-engaged in care and is being followed for mental health by the CORE team at Central City Concern. There is a high level of community between CCC and the HIV Clinic. Joe has periodic relapses with Meth and alcohol.  Navigators and medical case managers continue to provide support as needed to keep him engaged in care. **VL = 40 copies**

**March 2017 Update:**
Joe is still virally suppressed, housed, and engaged in both medical and mental health care.
**VL = Undetectable**

- Onsite, integrated behavioral health services
- Hepatitis C and anal dysplasia screening and treatment
- Referrals to nutrition and dental services
- Health education
- Crisis intervention
- HIV prevention and risk reduction support
- Onsite clinical pharmacist support
- Drug assistance program
- Adherence counseling

As part of the SPNS project, the medical case manager was responsible for directing the client-focused activities of the navigators in conjunction with the client's care plan and worked with the navigators to anticipate triggers and identified client needs to ensure coordination with the medical home and external services such as housing and substance use treatment. The navigators, clients and medical case manager usually met once a month at minimum to coordinate care and check in about client goals, successes and challenges. Frequent meetings with the medical case manager helped to assure that all involved have a clear understanding of the care plan and follow up action items. In addition to the navigation and intensive community-based support services provided by the navigators, clients enrolled in the program received intensive care coordination between the navigator, members of their medical home team, and additional service providers that participate in their care.

## Organizational Meetings

Navigators and other project staff participate in a number of meetings in order to promote navigation services, streamline processes and referrals, implement new activities, and improve efficiency and quality of care. Medical case managers and navigators meet on a monthly basis to discuss referrals; staff SPNS clients, and develop and streamline processes. Navigators attend morning huddles with HHSC medical teams to identify potential referrals and discuss client care. Navigators attend monthly HHSC Client Advisory Board Meetings, HIV Network Meetings, CAP Housing Meetings, and HHSC All Staff and BBC (Building Better Care, HHSC's quality program) meetings. Project administration staff also held monthly SPNS oversight meetings.

## Transition to Standard of Care

Careful consideration is taken in transitioning (graduating clients) to ensure that they remain engaged in care and stably housed. The navigators, medical case managers, CAP housing staff and/or peer mentors (when applicable) meet with participants who are ready to transition to standard of care. Navigators work with participants to complete a graduation/ongoing goal plan so that clients know what to expect as they move forward. As far as tools go, we use a SPNS graduation certificate and a SPNS graduation goal plan that is set up as a smart phrase in Epic. A copy of the goal plan is given to the client along with the graduation certificate. It is also scanned and sent to members of the care team. The graduation goal plan includes the name and contact information for all members of the client care team; expectations for checking in with medical case manager, housing case manager, and peer mentor; expectations for meeting with medical provider; plan for medication refills; and a list of ongoing services that the care team can provide. Navigators may also continue to check in with clients once they have graduated to ensure that their transition is going smoothly. We have had no changes to our transition protocol. Occasionally, clients who have graduated from or dropped out of SPNS may return to the program to work with the navigator. (Please see the Graduation Template and SPNS EMR Smart Phrases in the *Resources* section.)

## Documentation and Tracking

The navigators and the SPNS housing case manager are required to chart in HHSC's electronic medical record (Epic). HHSC and CAP completed a memorandum of understanding (MOU) to specifically address documentation. (See the Charting MOU in the *Resources* section.) Additionally, the navigators have developed a number of smart phrases that they use in Epic in order to standardize documentation and provide clear and consistent information. (See the SPNS EMR Smart Phrases in the *Resources* section.) In addition to documenting intervention activities in Epic, the navigators and project manager record outcomes and referral information into a client tracking Google document. This allows the project manager to better track program referrals, and outcomes and assists with reporting requirements. This document is also shared with other clinic staff so they can monitor client referral status and outcomes.

# EVALUATION AND QUALITY IMPROVEMENT

## Quality Infrastructure

HHSC's infrastructure development efforts have addressed the following aspects of quality improvement:

• Linking the HIV quality management program with the organization's overall quality management program;
• Staff education efforts;
• Unique or comprehensive methods of communicating with staff about quality improvement activities across the local HIV continuum of care;  and
• Engaging clients in quality improvement.

Clinic staff are engaged in reviewing quality data and implementing quality improvement processes.  All staff members are assigned to one of four Building Better Care (BBC) provider teams. These teams meet twice a month to review team-level data, identify areas for improvement, and develop/implement improvement plans.

For the HHSC, implementation of robust quality improvement has involved:

• Providing staff with training on teamwork, communication, and conflict resolution
• Creating time in the provider schedules for team meetings
• Integrating behavioral health and front office staff into the medical teams
• Running new monthly data reports that highlight key performance measures
• Orienting staff to *The Model for Improvement* (rapid improvement cycle processes) as a means to test solutions to team-identified problems
• Adopting an active coaching style of supervision as well as changing the behaviors of leaders to model process improvement tenets.

## Leadership

The clinic manager and medical director provide oversight and serve as a link between the HIV clinic and the integrated clinic services Senior Leadership team. The grants manager co-facilitates the Quality Management Team with the clinical pharmacist. Both sit on the Clinic Management Team. It is critical to the success of these types of initiatives to have program leadership visibly supportive of the effort in order to champion the intervention and promote buy-in and support from other staff.

## Clinical and Operational Quality Improvement

The HHSC quality management program builds on The Model for Improvement which is promoted by the Institute for Healthcare Improvement. Our quality program is called Building Better Care (BBC). The guiding principles include:

- Team members are co-located
- Frequent communication among all team members
- The team is proactive in meeting the needs of their patients
- Behavioral health is incorporated into primary care visits
- Every team member is engaged in the process, doing what they are uniquely qualified to do
- "Not my job" is not part of the vocabulary.

The BBC model requires that teams take responsibility to review their team outcomes monthly and develop a plan for measures not meeting their target or that show less robust results than previous months. In the course of doing their work, teams identify processes that are inefficient, redundant, create rework, or simply do not accomplish the purpose for which they are intended. The care teams utilize the Plan-Do-Study-Act (PDSA) cycle to test and implement changes in real work settings.[3] The PDSA cycle guides the test of a change to determine if the change is an improvement.

The Clinic Management Team is responsible for ensuring there is a quality improvement system and a process for monitoring, evaluating and improving the access, quality, appropriateness of services, and that care is delivered in concordance with the PHS Guidelines. The current management team includes the medical director, the clinic manager, the nursing supervisor, clinical pharmacist, lead case manager, grants manager, a medical provider, and the operations supervisor.

Our Quality Management Team meets monthly to guide and review the quality improvement efforts of the clinic. The team membership includes a diverse representation of both role groups and provider teams. Membership rotates every twelve months so that all clinic staff has an opportunity to participate over time. The Quality Management Team: 1) identifies opportunities to improve clinic operations, clinical outcomes, and track team-based/clinic improvements; 2) regularly reviews data (clinical measures, patient satisfaction etc.) and identifies priorities for improvement; 3) plans, implements, and monitors spread for site-based and program-wide improvement initiatives; 4) monitors individual team progress; 5) problem-solves issues/challenges. Clinic Management Team members (one or two persons) participate in the Quality Team meetings.

## Consumer Involvement

**Consumers' involvement in decisions regarding their personal health care:** Clients are expected to be full partners in their health care. During intake, staff introduce the concept of client responsibility and encourage the client to become actively involved in care decisions. Clients are encouraged to be honest with providers, communicate what is and isn't working for them, and ask for what they want/need from the care team. Time is also spent discussing client rights and responsibilities, clinic expectations, and the grievance/complaint procedure. Staff work with the clients to develop tools for keeping track of important medical information (e.g., appointment times, questions for the provider, medication schedules). Clients have access to their electronic

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[3]The Plan-Do-Study-Act (PDSA) cycle was originally developed by Walter A. Shewhart as the Plan-Do-Check-Act (PDCA) cycle. W. Edwards Deming modified Shewhart's cycle to PDSA, replacing "Check" with "Study."

medical record via My Chart. Using My Chart, clients can review lab results and visit information. They can also email their provider and schedule appointments.

**Role of consumers in the Quality Management program:** Clients are involved in quality improvement through the HHSC Client Advisory Board (CAB), focus groups, and satisfaction surveys. The Client Advisory Board (CAB) is made up of 9 consumers who work to: promote community outreach, engage clients in advocating for their own needs, give clients a voice in clinic decisions and policies, and provide education to clients and the community. The HHSC management team seeks input from the CAB whenever any major changes are being contemplated, and when forces outside the HHSC's control are causing client difficulties. Examples of CAB activities include:

- Improvements made to the waiting area and patient restrooms to make them more welcoming to clients.

- A bulletin board to post educational material and provide a forum for the clinic staff to post educational materials for patients.
- A plan to have a peer support program, (Here for You) provided by CAB members to connect and welcome patients and connect them to community resources.
- Input to a project to re-engage out-of-care patients.
- Creation of a subcommittee to develop client arts and crafts venues. This effort was successful in involving clients who had not been previously engaged in clinic or support activities.
- Provision of input and approved clinic design for the new building where the clinic will be moving.

The CAB gives input to all quality initiatives. For example, the CAB provided input to the "open access" initiatives, implementation of MyChart, the women's wellness project and the revised intake process. Clients also help pinpoint areas needing improvement and suggest interventions to be piloted.

# PROGRAM IMPACTS, SUSTAINABILITY AND LESSONS LEARNED

## Program Impacts

The SPNS project ended on August 31, 2017. In the first year of the project, while IRB approvals were being secured, we put together a pre-study cohort of 27 clients who started receiving navigation services in 2013. Of this cohort, only two (7%) clients had a suppressed HIV viral load at the time they were assigned a patient navigator. Flash forward to March 2017. Now 70% of the 25 remaining clients are virally suppressed—two clients died and were virally suppressed at the time of death. These clients were all street homeless or couch surfing when they started working with navigators—now 72% of the remaining 25 clients are stably housed. Although some clients have sustained viral suppression while continuing to experience homelessness, the navigators found that clients with stable housing were more easily able to suppress their viral load. The clients with unsuppressed viral load have continued to struggle with addiction and/or untreated mental health and are in and out of jail (which we see in Epic). The clients with a suppressed viral load also battle some of these same things but generally are living less chaotic lives and are deeply connected to their

medical care teams. If these more engaged clients experience relapse or a period of untreated mental illness, they know they are not alone in getting back on track.

Another 99 clients were enrolled into the research study between September 1, 2013 and March 31, 2016. Of the original 99 study participants, 26 are not currently clinic clients for the reasons summarized below. Our clients who have a background of homelessness are highly mobile. We anticipate that in the next year, many of these clients will rejoin the clinic.

| Reason No Longer a HIV Clinic Patient | Number |
|---|---|
| Moved out of the service area | 14 |
| Lost to care | 5 |
| Discharged | 2 |
| Deceased | 2 |
| Transferred Care Locally | 2 |
| Incarcerated | 1 |
| **Total** | **26** |

As of May 1, 2017, 23 of the remaining 73 study participants are still receiving navigation services. The 50 study cohort members who have graduated from SPNS have demonstrated positive outcomes similar to the pre-study group:

- 66% are virally suppressed compared to 22% at study enrollment; and
- 80% are stably housed compared to 0% at study enrollment.

The 23 study participants who are still receiving services have also made progress:

- 48% are virally suppressed compared to 13% at study enrollment; and
- 61% are stably housed compared to 0% at study enrollment.

Also of note, 30 SPNS clients had a positive Hep C antibody. Of these, two patients have been cured to date. The remaining clients are being assessed for readiness to treat.

## Sustainability

Prior to participating in this national demonstration project, the HIV Clinic at Multnomah County did not use patient navigators. When MCHD staff developed the clinical model to better serve homeless patients, 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 average cost per participant is $4,600. This is based on 1.0 FTE network navigator serving an average of 25 clients per year. The client mix would include new clients who might need intensive support as well as established clients who might need less intensive support. The cost includes 1.0 FTE network navigator salary and benefits. Major efforts to sustain navigation services that were initiated with SPNS funding have included the following:

- Becoming acquainted with the state's rules and regulations for community health workers, personal health navigators and peer wellness specialists and the potential to bill for navigation services.

- Taking advantage of existing newsletters, webinars and meetings that provide regular updates about both Medicaid and community health worker programs.
- Forming relationships with the state and local coordinating care organization to stay abreast of opportunities for Medicaid support (contracted or billable services) for navigation services.
- Finding out the training and certification requirements for navigators to become Medicaid certified. In Oregon, certification requires 96 hours of training in the classroom which usually takes about 2 months. Once the training is completed, participants receive a Medicaid provider certificate that is good for three years. Twenty hours of continuing education is required for renewal every 3 years.
- Arranging for our navigators to complete required training in order to become a Certified Medicaid Traditional Health Worker.
- Identifying how navigators needed to document their work in the patient's electronic health record.
- Realigning other client support resources to build on the navigation model. For example, staff refocused Ryan White Part D funds to include navigators as part of the staffing plan.
- Training navigators to document and chart in the electronic health record.
- Developing management reports to track the navigators' efforts and associated patient outcomes using a combination of data reports and chart reviews.
- Implementing a more robust clinical supervision of navigators to address burnout and safety.
- Making a decision about whether to continue with contracted navigators or County-employed navigators. MCHD staff decided that it would be easier to integrate the SPNS navigators into the ongoing clinic budget if they were employees of the county during the last year of the project. We can more easily sustain them through various that funding streams: third party billing, Bureau of Primary Health Care and Ryan White grants, and one-time-only CCO monies. Direct hires save on administrative costs associated with contracted services.

As a result of these efforts, navigators are now a permanent part of the multidisciplinary team at Multnomah County Health Department.

As work with SPNS study participants subsides, the navigators have expanded their horizons to serve additional high risk, complex client groups such as African refugee women. These women have unique barriers such as battling HIV stigma in very small ethnic communities and finding interpreters for rare dialects. Not only are these women coping with HIV, they are doing so in a new country and a strange medical system. The patient navigators are developing new skills, cultural competence, and community resources to meet the challenge of helping these newcomers engage in care.

## Lessons Learned

- Keep your eye on engagement in care and viral suppression—the housing will follow. For the chronically homeless client, learning to engage in care and adhere to medication regimes teaches valuable skills that are transferrable to things like getting and keeping housing.
- Supervisory and management staff need to be flexible and nimble enough to respond in real time to patient/navigator issues. We learned that the navigation process is not linear. You can't have too many rules. You have to walk the talk around flexibility.
- Navigators who come to the job with more "life" experience seem to be more resilient and need less support and supervision. Be prepared to provide more direct supervision and debriefing time to younger navigators. (See the sample Situation Debrief Guidelines in the *Resources* section.)
- Start small. Implement this new intervention with a small number of clients and grow the caseload slowly.
- Establish clear expectations around client/navigator boundaries particularly around texting and phoning clients as well as afterhours work. Monitor what is going on and address problems in real time.
- Develop strong partnerships with agencies that add value to the process. Create detailed Memoranda of Understanding so that the partnerships are not based solely on staff-level relationships.

- Collect and address feedback from your medical team about the successes and shortcoming of the new navigation intervention. Everyone's input can help to strengthen navigation services and clinical outcomes of clients receiving navigation services.
- Approach the work with a trauma-informed care (TIC) lens. Decide what TIC means in the context of your organization and provide ALL staff with training. Also, there is a great deal of abuse and intimate partner violence (IPV) in homeless populations. Be prepared not only to train your navigators and staff about IPV but develop protocols for navigators and other staff to handle IPV in the field and clinic.
- There are a lot of "three steps forward, one step back" working with this population. Celebrate any success, no matter how small.
- Remember to coach your navigators on charting in the medical record. Audit their chart notes on a regular basis.
- As the project was ending its fourth year, we hired a housing navigator who intensively worked with navigation clients specifically on housing barriers. This position was integrated into the medical team and attends daily huddle. Integrating the housing position into the medical team has made a significant difference on our ability to get and retain clients with a multitude of housing barriers into stable housing situations.
- Be prepared to have your homeless clients dropping in to clinic on a frequent basis.
- If you are relying on one-time only funds to start your program, start figuring out how to sustain the program on day one. Integrate navigation into your regular budget by increasing billable hours or leveraging other funds on an ongoing basis.

# RESOURCES

The following resources from the Building a Medical Home for Multiply Diagnosed Homeless People Living with HIV/AIDS model can be found on the Center for Advancing Health Policy and Practice website. All resources from the initiative Building a Medical Home for Multiply Diagnosed HIV-Positive Homeless Populations can be found on the web at http://cahpp.org/project/medheart/resources

SPNS job descriptions (.docx)

SPNS training document (.docx):  used to track training for navigator and housing case manager staff

Description of Community Partners (.doc): a list and brief description of community partners and the services they provide

Navigation Eligibility (.docx): Description of criteria for eligibility in navigation programs provided at the clinic

Referral Process (.docx): Description of process for referring clients to navigation services

Graduation Template (.pdf): Certificate a client receives when reaching the milestone of graduating from the SPNS program

SPNS EMR Smart Phrases (.docx): Standardized phrases to use when entering various kinds of encounters into the Epic system

Charting MOU (.pdf): Memorandum of Understanding guiding the conditions under which CAP network navigators and managers may document in the MCHD Epic electronic health record for shared clients

Debrief Guidelines and Form (.doc): provides guidance for HIV clinic staff when participating in a debrief of a crisis or traumatic event impacting staff and clients