With the assistance of the Project Manager and Continuum of Care Coordinator, the Network Navigator re-assesses the participant’s stability in terms of medical care, mental health, substance use, and housing every 3 months using the SPNS stability acuity scale.

**SPNS Encounter 1-3:** \* *These encounters may be merged dependent upcoming the participant’s availability and transportation needs. SNPS Encounter 1*: Network Navigator links participant to medical and/or behavioral health appointment. *SPNS Encounter 2*: Network Navigator works with the participant to create an individualized care plan while collecting, updating, and confirming information about housing, mental health, substance abuse treatment, or psychosocial support services. *SPNS Encounter 3*: Network Navigator works with participant to develop a goal plan for housing. *Please note the Project Manager will serve as a backup when the Network Navigator is not available.*

Behavioral Health provider assesses participant’s mental health and works with Project Manager, Network Navigator, and Continuum of Care Coordinator to address the participant’s mental health needs.

Client recruited for NC-REACH, screened for eligibility.

Project Manager, Network Navigator, and Continuum of Care Coordinator work together to coordinate the participant’s medical care and Ryan White Services.

If the participant maintains the stability threshold, the Network Navigator will schedule a face to face meeting with the PL Case manager and participant before the participant is transitioned out of SPNS and into Ryan White SOC. If at any time this participant becomes unstable (i.e. lose housing) to the point of again needing the intensive services provided by SPNS, the Project Manager can make the decision for the participant to re-renter and receive intervention services.

**SPNS Encounters:** *These encounters will be completed until the participant has transitioned to Ryan White standard of care (SOC).*

1. Relationship building between the participant and the Network Navigator, Project Manager, and Continuum of Care Coordinator.

2. Network Navigator assists the participant with making appointments, and reminding, transporting, and accompanying him or her to scheduled appointments.

3. Project Manager, Network Navigator, or the Continuum of Care Coordinator provide basic HIV treatment education, support, and advocacy.

4. Project Manager, Network Navigator, or the Continuum of Care Coordinator help participant reduce his or her drug use and educates him or her about harm reduction.

5. Network Navigator assists participant with housing application and obtaining housing services.

6. Network Navigator follows up with participant about service or referrals.

Please note the SPNS staff is not limited to the encounters noted above. Please see the encounter form for a complete list.

With the assistance of the Project Manager and Continuum of Care Coordinator, the Network Navigator assists the participant with finding stable housing and implements the participant’s housing plan.

If the participant does not meet the stability threshold but completes the SPNS intervention (24 months after enrollment), he or she is transitioned out of SPNS and into Ryan White standard of care.

*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 Multiply Diagnosed HIV-Positive   
 Homeless Populations*.  Learn more at*   
 <http://cahpp.org/project/medheart/models-of-care>