CommWell Health

NC REACH

NC-Rurally Engaging and Assisting Clients who are HIV positive and Homeless (NC-REACH)

CommWell Health, Dunn, NC

A client-centered medical home for people in rural North Carolina who are living with HIV, experiencing homelessness or unstable housing, and have substance use and/or mental health diagnoses

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NC-REACH AT A GLANCE

CommWell Health, Dunn, NC

Geographic description: Rural Area: nearly 22 percent of North Carolina's general population lives in rural counties of North Carolina, making up 80% of the state counties. The geographic area that CommWell Health serves is designated as a medically underserved professional shortage area.

Main challenges: North Carolina is among the 15 states in the U.S. with the highest number of new HIV diagnoses. Nearly 37,000 people are living with HIV/AIDS in the entire state, with 13.4 new cases per 100,000 people reported in 2015. There is a high homeless population among people living with HIV, about half of whom also have co-occurring mental health or substance use disorders. Organization and communication can be challenging for key partners—the Ryan White program identified a need to improve coordination among organizations to reduce treatment delay and discontinuity.

Focus populations: Adults 18 years or older who are living with HIV with co-occurring mental health and/or substance use disorder(s); experiencing homelessness or unstable housing, or fleeing from domestic violence and who receive or will receive HIV medical care at CommWell Health Clinic.

Description of intervention: Comprehensive care coordination to help clients navigate a system of services including integrated mental illness and substance use treatment and stable housing acquisition.

Medical home model staff: Linked collaboratively to existing Ryan White HIV care team (Positive Life). Team includes a network navigator(s), continuum of care coordinator, behavioral health manager, HIV physician, and case managers.

Results: Improved understanding of the needs of rural "hidden" homelessness, implementation of community outreach, a community housing coalition, behavioral health integration, and formation of new community partnerships.

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 the 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/patient 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 multi-site evaluation study of the models. For more information about the initiative, visit http://cahpp.org/project/medheart/

CommWell Health was one of the nine demonstration sites funded under this initiative. This manual describes their experience implementing and evaluating the NC-REACH project.

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

INTRODUCTION

This manual describes the program and policies implemented by CommWell Health (CWH) to address the needs of people living with HIV/AIDS (PLWHA) who are experiencing homelessness in a rural health care setting. It provides information about staffing, participant recruitment, and service delivery for clients, and training and supervision for staff.

Challenges Faced in North Carolina

Though the overall rates of HIV in the United States (U.S.) have declined over the past 10 years, the health landscape of the Deep South (Arkansas, Alabama, Florida, Georgia, Louisiana, Mississippi, South Carolina, Tennessee, Texas, and North Carolina) has changed dramatically in recent decades. From 2008 to 2013, more HIV/AIDS diagnoses occurred in the Deep South than in any other region in the U.S. accounting for 40 percent and 43 percent of new HIV and AIDS diagnoses in the U.S., respectively. People living in the Deep South make up 34% of PLWHA, and North Carolina is one of the 15 states in the U.S. with the highest number of new HIV diagnoses (Southern AIDS Coalition, 2012).

Nearly 37,000 people are living with HIV/AIDS in North Carolina with 13.4 new cases per 100,000 people reported in 2015. Nearly 22 percent of the state's general population lives in rural counties of North Carolina, which accounts for 80% of the state (AIDSVu). There are high rates of homelessness among people living with HIV in North Carolina, and about half have co-occurring mental health or substance use disorders (Substance Abuse and Mental Health Services Administration, 2013).

The nine counties that comprise the CommWell Health (CWH) service area demonstrate high rates of PLWHA and large numbers of new HIV/AIDS diagnoses from 2012-2014 as reported by the North Carolina Department of Health and Human Services (NCDHHS) (North Carolina HIV/STD Surveillance Unit, 2015). The counties are part of a designated Medically Underserved Professional shortage area and have disproportionate rates of unemployment and high rates of people living in poverty compared to other areas in North Carolina. Shortages of medical professionals, lack of transportation systems, scarcity of affordable

The "hidden homeless" among us

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

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

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

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

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

Introducing the network navigators into the health care team was a crucial first step in bridging this divide. The navigators are the voice of the client, advocating for them in meetings with the comprehensive care team. Navigators address clients' needs in ways that other staff members cannot. "They have the flexibility in their schedule to go out in the community, to go with our clients to apply for food stamps or a social security card—whatever the client needs and whatever will help them be successful in finding and maintaining housing," said Lisa McKeithan. "Having the network navigators enhances the ability of the clinic to provide housing options to clients. Everyone at CommWell Health believes that housing has greatly improved the health status of our client population."

housing, and greater stigma in rural areas compared to non-rural areas make HIV treatment difficult (HRSA Data Warehouse, n.d.; Rural Policy Research Institute, 2006). CommWell Health found that clients struggling with substance use, mental illness, and the "hidden homeless" (see the sidebar on pg. 7) were difficult to retain in the Positive Life program. However, the existing HIV case managers, who had large client caseloads of approximately 100 clients, had limited time to devote to the intensive follow-up needed to care for PLWHA with housing, mental health and substance abuse challenges. The Ryan White HIV/AIDS Program (RWHAP) also identified a need to improve coordination among organizations to reduce HIV treatment delay and discontinuity. For these reasons, the team tailored the SPNS project to fit the needs of this special population in rural North Carolina.

About CommWell Health

CommWell Health (CWH, http://www.commwellhealth.org) is a Joint Commission, dually accredited, ambulatory, and behavioral client centered medical home located in Dunn, North Carolina. This community health center has 16 locations serving a geographic area consisting of the following counties in rural Southeast North Carolina: Johnston, Harnett, Sampson, Pender, Bladen, Brunswick, Robeson, Duplin, and Cumberland.

CWH HIV/AIDS treatment services have expanded immensely since 1977, when CWH began providing services. Since being an HIV/STD prevention and care branch and HIV counseling and testing site, the organization has created a comprehensive HIV/AIDS care program that delivers health care and support services. Beginning with Positive Life in 1997, CWH created an HIV-care program that was awarded Ryan White Program Part B funding and six quality-performance awards from the State of North Carolina AIDS Care Program for exceeding state-established HIV-client care benchmarks, relative to HIV/AIDS Bureau clinical performance measures. When first instituted, the Positive Life program constituted CWH's initial client-centered medical home model. The program offers comprehensive oral health screenings and dental services, primary medical care, and behavioral health services to HIV-positive clients. Positive Life also includes rapid HIV testing services, HIV-client counseling, and referrals to case managers that specialized in HIV prevention for those who are deemed to be at high risk for contracting HIV/AIDS. (Learn more at http://www.commwellhealth.org/services/special-healthcare-services/positive-life.)

About NC-Rurally Engaging and Assisting Clients who are HIV-positive and Homeless (NC-REACH)

In 2012, CommWell Health introduced NC-REACH, a new component to the Positive Life medical home model. The goal of the program was to engage and retain the most vulnerable PLWHA in their service area in care and provide them with comprehensive social services. NC-REACH was one of the first Ryan White HIV/AIDS Program (RWHAP) SPNS initiatives to be implemented in a rural setting. As the only rural site among nine sites participating in this initiative, NC-REACH offered additional services to meet the three primary goals for the National HIV/AIDS Strategy goals: reducing HIV incidence, increasing access to care/optimizing health outcomes, and reducing HIV-related health disparities. This Ryan White HIV/AIDS Program Part F addition was a research grant to support models with the following goals: to promote

timely entry for care for people living with HIV; improve client engagement and retention in medical and behavioral health services; and to focus on services for clients that experienced unstable housing or homelessness.

The NC-REACH model incorporated three innovative components to the standard of care: introduction of network navigators, introduction of a continuum of care coordinator, and partnerships with community agencies and housing providers.

To address the gaps in services for the "hidden homeless" clients of the Positive Life Program, NC-REACH incorporated new staff members—network navigators and a continuum-of-care coordinator—to provide intensive short-term services and to ensure that clients were well connected to clinic services and received follow-up on both their medical and behavioral health care. The network navigators work with the HIV medical care team to provide transportation and social support services to people who are homeless or unstably housed and living with HIV. They served as clients' main point of contact, connecting them with behavioral health, substance use, and housing services as needed, and supporting clients as they defined and worked towards their goals for well-being and self-care.

The continuum of care coordinator (CCC) worked closely with the network navigators to provide intensive services focused on clients' education and self-management of their HIV care within the context of each client's individual life circumstances. As a registered nurse specializing in infectious disease, the CCC coordinated with the infectious disease specialist physician and worked with clients and navigators to develop an appropriate treatment program and make referrals to specialty care as needed.

The ability of network navigators and the continuum of care coordinator to address clients' social, behavioral, and housing needs was enhanced through development of partnerships with community agencies and housing providers. These partnerships allowed for collaboration and shared information about housing options and other resources, expanding the range of services available to clients.

SETTING UP THE MEDICAL HOME MODEL

Laying the Groundwork in a Rural Environment

Although homelessness is often perceived as an urban problem, individuals and families do experience homelessness in rural America. However, there is limited infrastructure to support them, and limited research to quantify their needs. One of the biggest challenges for housing in our local community is transportation; long distances must be travelled to reach services that are few and far between, and options are limited. In our community, there is no public transportation. Rural areas can be isolating due to their expansiveness. People who are experiencing homelessness often feel cut off from the services that are available in their area; the migrant farm workers we serve here also feel isolated linguistically and culturally. Lastly, few homeless-specific providers are available in most rural areas. Mainstream services can be difficult to access, spread over large areas, and often not structured to accommodate people experiencing homelessness or unstable housing. Often, there are duplication of services, despite a shortage of housing providers and lack of permanent affordable housing. Often, the system is fragmented. Individuals experiencing homelessness in rural areas have a need for solutions to overcome barriers to care, such as assistance with gas cards, car repairs, or the cost of emergency shelters.

Identifying Internal and External Stakeholders

We worked with a number of internal and external stakeholders at the system, community, and clinic level to create a network of medical care, behavioral health services, and stable housing options for PLWHA in this rural setting. We considered the barriers in our rural community: limited resources for permanent and transitional housing, costs for emergency shelters, lack of transportation, limitations in access to services because of background checks and drug screens, and shortage of mental health and substance use treatment options, to name a few. We then approached local agencies to find common ground in addressing some of these challenges. We built formal and informal partnerships by attending meetings, building rapport, and educating stakeholders about “hidden homelessness” and its effects on a

person's health and quality of life. Community agencies and stakeholders included internal departments within CommWell Health, local mental health organizations, social services departments and services, substance use disorder inpatient treatment programs, housing providers, school system representatives, homeless shelter managers, employment assistance program, private landlords and other community programs (i.e., United Way, Salvation Army, Alliance Behavioral Healthcare, and the local branch of the Veteran Affairs administration) that would help our clients obtain and maintain stable housing.

Thus, we coordinated intensive service provision spanning departments at CommWell Health and local service providers. The team met with several local community and housing agencies to enlist their services to expand the housing resources and supportive services available to clients in the program. These early efforts to reach out to other agencies in the community led to an ongoing collaborative that meets regularly to address challenges and share resource and program information that benefits our clients. (See pg. 29.)

Internal stakeholders included CommWell Health staff that provided support services to clients as well as CommWell Health management teams. To obtain buy-in from senior leadership, program staff met with management and other departments at CommWell Health to provide updates about the program and receive suggestions. Furthermore, the staff educated the community health center staff on rural homelessness, housing instability, "hidden homelessness," and the process of referrals for eligibility in the SPNS program through pamphlets, presentations, and community outreach events.

Defining Expected Outcomes and Process Flow

To anticipate the effects that incorporating housing and behavioral health services with HIV services might have for our clients, we defined the below expected outcomes:

Reducing stigma in the community

The team handed out brochures describing HIV-related services at local events to raise awareness about the availability of CommWell Health services.

The stigma around HIV and homelessness often prevents clients and potential clients from seeking services. Through the NC-REACH project, CommWell Health has reached out to the community to create awareness about homelessness and HIV.

"In rural America, community is very important, and we are known for our festivals and fairs," said Lisa McKeithan, SPNS project manager. "The best way to decrease stigma is for us to get out in the community and inform and educate. Network navigators and other staff attend different events - sometimes we go to churches, a few weeks ago we went to a migrant farm festival. We hand out flyers about NC-REACH project, about HIV, and just generally talk with people. It's a low-pressure way to invite the community to get involved in our mission of reducing stigma."

Primary

- Improved health status: Viral load suppression—meaning viral load below limits of quantification—at last test during the measurement year
- Engagement and retention in care: At least two medical visits during the measurement year with at least 60 days in between each visit
- Linkage to stable housing: Permanent housing with supports or other stable housing

Secondary

- Client self-sufficiency: Combination of stable earnings and/or economic benefit programs sufficient to meet basic living expenses
- Client stability: HIV/AIDS, psychiatric and physical illness/symptoms stable through regular treatment and appropriate self-management

- Sobriety: Substance use no longer interferes with daily functioning
- Social support: Adequate network of social support to provide buffers for crises and losses
- Safety: Low vulnerability to abuse or exploitation
- Improved client engagement in their own care

The program management team developed a flow chart (see pg. 22) illustrating the many facets and stages of the program from recruitment of clients to transition from the program. The team also created the forms and tools needed to support the program at each stage. These tools are listed in the Resources section of this manual, and we include more details about individual tools in the Service Delivery Model section below.

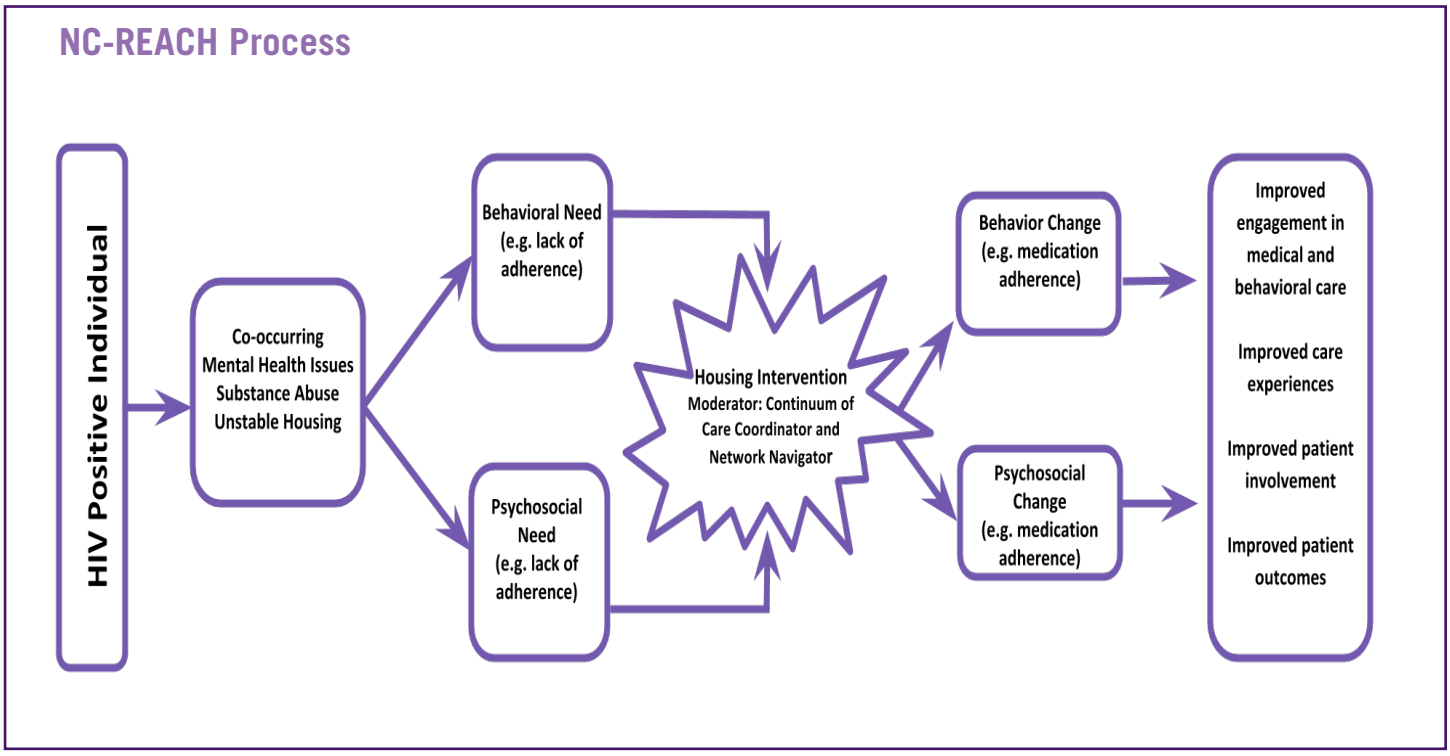
The figure below shows the conceptual model for the client-centered medical home through the NC-REACH project.

NC-REACH Recruitment and Hiring

The NC-REACH medical home model calls for the care team to develop, implement, and evaluate a culturally competent, coordinated, integrated, interdisciplinary and community-based medical model. The NC-REACH team aimed to improve timely entry, engagement and retention, and supportive services in HIV care to 80 medically underserved individuals in rural Southeast North Carolina who were living with HIV, have a substance use or mental health disorders, and who were experiencing homelessness or unstable housing.

For the network navigator (NN) position, we sought an experienced and compassionate HIV case manager to provide direct support and guidance to participants. For the continuum of care coordinator position (CCC), we sought an experienced and compassionate registered nurse specializing in infectious disease. This position would provide case management services to the HIV/AIDS population as they requested such services. The CCC would perform client and program-related record keeping functions and stay abreast and informed of all aspects of the AIDS epidemic. The NN must also assist persons with the acquisition of public assistance, Medicaid/Medicare, ACA, food stamps, Social Security, housing and other benefit programs.

Other essential qualities and responsibilities for both of these positions included:



- Personal knowledge of HIV/AIDS medical and medication updates
- Completion of HIPAA annual certification
- Research experience to assist with client enrollment
- Provision of consultation, guidance, direction, resource identification, problem resolution, seeking input

Roles and Responsibilities within the NC-REACH Model

CommWell Health communicated with all staff members who worked with the network navigators and continuum-of-care coordinator to make sure that existing team members understood the goals of the NC-REACH project and that roles and responsibilities were well defined. This ensured smooth integration of these new positions into the cultural and organizational fabric of CommWell Health. Below is a table describing all team members' roles within the model. This information was shared and discussed with staff.

Network Navigators

As a new position in the client-centered medical home model for PLWHA, the network navigators served as the clients' main point of contact. The network navigators attended weekly meetings with clients' HIV care team and updated the providers on the social factors that may influence treatment. Unlike other members of the care team, network navigators were mobile and tasked with following and finding clients in the community. They located clients and accompanied them to potential housing options as well as appointments at other supportive services, and ensured that clients were retained medical care.

The network navigators assisted the clients with tasks including:

- Helping the clients find safe and affordable housing
- Providing the clients with transportation to and from medical and specialty appointments

The NC-REACH team in 2017 included two network navigators, a continuum-of-care coordinator, infectious disease specialist, principal investigator/project manager, project director, and clinical research study coordinator.

Position	Responsibilities
Principal investigator/project manager (PI/PM)	• Manages the day-to-day implementation of the project • Provides overall personnel management and budget management • Coordinates all the different aspects of the project • Ensures project documentation and maintenance of files, upholding the highest level of security and confidentiality • Supervises the activities conducted by the NC-REACH staff members • Coordinates all local and regional project meetings and dissemination and outreach activities • Manages the process to ensure integrity, correctness, appropriateness and accuracy of all data collected locally
Infectious disease/ HIV specialist	• Provides the clinical expertise for the management of the HIV patient in coordination with the primary care provider and the rest of the health care team • Provides consultation to medical staff • Works closely with PI/PM to ensure implementation of medical aspects of project
Behavioral health specialist	• Ensures the integrity and comprehensiveness of mental health and substance use services provided to program participants • Facilitates coordination of behavioral services between behavioral health staff and the rest of the CommWell Health Mental Health team
Clinical research study coordinator (bilingual)	• Conducts client interviews • Participates in recruitment and enrollment activities • Ensures that all patient care and evaluation activities are completed in adherence to the study protocol • Supports the work of the PI/PM and lead evaluator in collecting and submitting data • Conducts interviews with study participants at baseline and monthly follow-ups • Administers and keeps track of patient incentives • Participates with the PI/PM and lead evaluator in the preparation of reports • Conducts and or coordinates quality assurance activities • Maintains project documentation and files ensuring the highest level of safety and confidentiality
Continuum-of-care coordinator	• Works in tandem with the Infectious disease/HIV specialist to ensure the necessary referrals are initiated and appointments are scheduled • Conducts and updates the program participant's culturally competent care plan • Coordinates the involvement of program participants in chronic disease self-management activities • Supports patient education and self-management of their HIV condition and connection to additional behavioral health services • Gives the patient access to necessary information and assets, as well as involves the patient in the program's decision-making process
Network navigator (2)	• Assists in housing initiative coordination and implementation • Works closely with PI/PM to assure study fidelity • Facilitates access to services for clients • Assists in developing housing and care coordination resources • Accompanies clients to appointments to ensure engagement and retention in care • Provides support and immediately acts in response to providers' instructions regarding care and referrals • Works closely with the medical home team network of providers and supportive services to facilitate timely care and compliance with appointments • Provides supportive services that involve linking and coordinating components of the continuum of care to ensure that the client's HIV and behavioral healthcare needs are appropriately met • Manages program participant's housing needs • Keeps tracks of all patients' appointments and referrals

NC-REACH Network Navigators

- Connecting the clients with behavioral health and substance use treatment services
- Assisting the clients with obtaining services to meet basic needs
- Helping the clients obtain employment
- Serving as advocates and providing psycho-social support for clients
- Working closely with partner agencies and the current HIV health care team

Program management staff, including the PI/PM, NN, and CCC, were hired to facilitate community engagement and bridge the gap between the NC-REACH team and all external stakeholders. The NN were pivotal in conducting focused community outreach in terms of:

- Engagement & recruitment
- Connecting to community housing and other support services
- Monitoring resource development
- Participating in the multidisciplinary clinical team
- Building partnerships in community
- Providing SPNS clients with transportation

Each client is assigned a comprehensive care team that provides the client with an array of medical and behavioral health services. The network navigators ensure these clients are cared for outside the context of the clinic, and assist the client in establishing an adequate, safe and balanced home-life. The network navigators and continuum-of-care coordinator support client education and self-management of their HIV condition and connection to additional behavioral health services. The network navigators and continuum of care coordinator give the client access to necessary information and assets; this education and additional resources empower the client to make better-informed health care decisions for him or herself.

> "These patients are all extraordinary people, having overcome so much in their life—whether it is stigma, addiction, mental illness, or homelessness. Many of them just seek equality and acceptance, and I feel that is what we strive to give them: a home, a family. They come into my office, give me a hug and sit and chat about everything that happened since the last time we chatted. It is truly a rewarding experience to see their growth from the beginning through reaching their goals.
>
> -Network navigator at CommWell Health

Through our client's eyes—What the network navigators do

This is how Tammie describes the staff at CommWell Health. Diagnosed with HIV in 2010 and grieving the 2014 loss of her husband, Tammie [spelled with two Ms in the video] was struggling to stay healthy and keep things going for herself and her family. When her HIV provider left the state, Tammie was referred to the SPNS program at CommWell Health, 35 miles away. She relied on CommWell Health's transportation services to get to her appointment.

"I met Krystal [her network navigator] in my first interview with CommWell Health," Tammie recalls. "I don't care what the problem was, I could call her; she'd fix it."

Krystal worked with Tammie not only on health issues, but to help her find housing, driving her to meet with landlords. It took time and patience, but eventually Tammie found a place to live for herself, her family, and the family pet.

Tammie notes that in rural North Carolina, living with the stigma around HIV is a challenge. "I tried dealing with it by myself at first. They didn't tell me a lot about it, they just told me I had it, that I need some medicine for it. Not knowing was scary."

Having graduated from the SPNS program at CommWell Health, Tammie feels much better informed and able to manage her HIV. The new living quarters contribute to her well-being. "I've been here a little over two months, and I love it," she notes. "I have a place for life."

> "Everything rolled up into one: friends, you're my family, you're my number 1 supporter, you're information. Anything I need, I can get from you all. I don't have to go outside CommWell Health. And that means a lot."

Hear more of Tammie's story by watching her video at https://youtu.be/ocjdNji9x8A.
(All SPNS demonstration site client story videos can be viewed on the client story page: http://cahpp.org/project/medheart/videos)

Continuum-of-Care Coordinator

Clients were assigned a continuum-of-care coordinator who made appropriate specialty-care referrals. As a registered nurse specializing in infectious disease, the CCC provided the client with HIV/AIDS education, helped the client adhere to medication regimens, and worked with clients and the team to develop an appropriate treatment program. Both the continuum-of-care coordinator and the network navigators were tasked with connecting clients struggling with mental health and substance use disorders to needed treatment. Part of CWH's client-centered medical home model was to offer on-site substance use treatment and counseling services. Previously, many referred clients failed to make appointments or show up once scheduled. The continuum of care coordinator and the network navigators supported the client by working with behavioral health specialists to gain access to appointments, conducting follow-up reminders, and checking in with the client about transportation plans to ensure clients were able to attend appointments and receive necessary treatment.

Trainings and Supervision

Every member of the comprehensive care team received training in numerous areas relevant to HIV care and the lives of clients. All members attended annual HIV clinical update workshops that provided specific information related to HIV history, origination, transmission modes, disease progression, testing types/options, prevention, universal precautions, laws, and statistics. These workshops provided staff with a greater understanding of HIV/AIDS, testing protocols, domestic violence, and client-centered risk reduction counseling skills.

Additionally, staff members were trained in:

- Trauma-informed care
- Cultural sensitivity
- Health and housing
- Human subject training
- Critical time intervention
- Types of stigma
- Social determinants of health
- Client-centered behavior change
- Opioid overdose prevention
- Harm reduction
- HIV counseling, testing and referral training
- Applied suicide intervention skills
- CPR

RECRUITING CLIENTS INTO THE PROGRAM

Eligibility and Enrollment

To participate in the SPNS study, an individual met the following four eligibility criteria (see SPNS eligibility screening form):

1) 18 years or older
2) HIV-positive
3) Homeless or unstably housed, defined as:

- Literally homeless: an individual who lacks a fixed, regular, and adequate nighttime residence
    - An individual who has been sleeping in emergency shelters or other facilities for homeless persons or in places not meant for human habitation (e.g., abandoned shacks, shooting galleries, cars, parks, sidewalks, abandoned buildings, or somewhere in the fields) will be considered homeless. This will also include clients who ordinarily lived in such places but were in a hospital or other institution on a short-term basis (30 consecutive days or less).
- Unstably housed individuals who:
    - Have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to a homeless assistance application;
    - Have experienced persistent housing instability as measured by two moves or more during the preceding 60 days; and
    - Can be expected to continue in such status for an extended period of time.
    - Individuals who have frequently relocated or who moved between temporary housing situations, so that housing is deemed neither appropriate nor stable.
- Fleeing domestic violence: Any individual who:
    - Is fleeing, or is attempting to flee, domestic violence;
    - Has no other residence; and
    - Lacks the resources or support networks to obtain other permanent housing.

4) Multiply diagnosed: An individual living with HIV who has been screened and determined to need treatment services for one or more of the following co-occurring illnesses:

- Mental illness: within client's lifetime, any illness that significantly interferes with the performance of major life activities such as learning, working and communicating, including, but not limited to anxiety disorders such as post-traumatic stress disorder, and mood disorders such as major depression, bipolar disorder, and dysthymia.
- Substance use: within 12 months prior to project intake, any use of illicit drugs or the abuse of alcohol, prescription or over-the-counter drugs for purposes other than those for which they are indicated or in a manner or in quantities other than directed.
    - For recently released prisoners or jail detainees: use criteria of what their eligibility status was at most recent incarceration date (i.e., 12 months prior to entering prison or jail).

Outreach, Screening, and Referral Procedures

Recruitment of individuals to participate in NC-REACH was a joint effort shared by the PI/PM, network navigators, and continuum of care coordinator. We aimed to recruit and enroll at least 80 participants over the course of the project.

A large part of our outreach in all settings--with local agencies, within CommWell Health, and within the Positive Life program --included educating service providers about how homelessness and unstable housing looks different in rural North Carolina from more urban settings. (See the sidebar about hidden homelessness on pg. 7.) We shared with them the kinds of questions our staff asked clients to obtain a more detailed understanding of the stability of a client's housing situation. Questions such as:

- Describe to me where you are staying.
- How long have you been staying there?
- Where did you stay before?
- Where did you stay last night?
- What about two weeks ago, where were you staying then?

(If a person lives on his or her own)

- Is your electricity on?
- Where does your water come from?

Through gentle probing and follow-up questions, providers were able to identify potential "red-flag" answers that might indicate that a person was in an unsafe or unstable living situation, regardless of whether the individual reported himself or herself as "homeless."

Formal recruitment strategies and referral processes include the following:

Community Outreach

The project manager and network navigators recruited individuals through outreach efforts to local community-based organizations and service providers such as shelters, hospitals, other health clinics, and substance use treatment facilities.

Staff also frequently attended various community activities and handed out brochures about the NC-REACH program or more generally about HIV. This helped with recruitment as well as awareness more broadly. (See the sidebar on pg. 30.)

If a network navigator out in the community identified a potential participant, she completed the SPNS Eligibility Form (included in the Resources section), and if possible, transported the client to CommWell to meet with the study coordinator that same day.

In-reach within CommWell Health

All providers within the CommWell system including behavioral health, medical, or dental, providers were aware of NC-REACH eligibility criteria. If a provider encountered a client who met the criteria, the client was referred to the PI/PM, network navigators, and continuum of care coordinator who screened clients for eligibility. This same procedure applied for individuals who were newly diagnosed as HIV-positive, and for new

clients presenting to CommWell for the first time—for example, someone recently relocated to the area from another state.

In-reach within Positive Life

The majority of clients in the NC-REACH program were referred from within the Positive Life program. In-reach identified clients who came into the Positive Life program for care and whose housing status may have changed since their last appointment. The PI/PM, network navigators, and continuum of care coordinator screened all clients who came in for an appointment with their HIV providers for eligibility. This same procedure applied to the individuals who were newly diagnosed as HIV-positive, and to the new clients presenting to CommWell Health for the first time.

Active Re-engagement

The staff were on the lookout for the clients in the Positive Life program who had fallen out of care who might meet eligibility criteria. Each month, the data manager pulled a report from Care Ware and the CommWell client database to identify HIV-positive individuals who have been out of care for 6 or more months. The PI/PM reviewed the list of out-of-care clients and referred potential clients to the network navigators. The network navigators located and screened clients for eligibility. They reported back to the NC-REACH team the status of the contact attempts, and the team decided how to proceed. If the navigator was successful in re-engaging an individual who was lost to care and may qualify for NC-REACH, that individual was referred to the clinical research study coordinator. Navigators used the out-of-care outreach log sheet in the Resources section to track contact attempts.

Referrals (Internal and External) to NC-REACH

If an external service provider deemed a person eligible for NC-REACH, he or she completed a Commwell Health SPNS patient referral form (included in the Resources section) and forwarded it to the PI/PM, network navigator, and/or continuum of care coordinator.

A provider from a department within CommWell Health might also make a referral through the patient referral form. Any CommWell Health staff could also make an internal referral to the project manager, network navigator, and/or continuum of care coordinator via the Electronic Health Record.

Once a potential client was referred to NC-REACH, program staff reviewed the eligibility criteria with the individual using the SPNS eligibility form. If NC-REACH staff determined that the client did not meet NC-REACH eligibility criteria, he or she was referred to Ryan White services and became part of the Positive Life program.

If the client met eligibility criteria, the PI/PM, network navigator, and/or continuum of care coordinator referred the client to the clinical research study coordinator for participation in the SPNS study. If a client did not want to be in the study, he or she could still receive NC-REACH services. However, all of the clients consented to be in the study.

SERVICE DELIVERY MODEL

NC-REACH Activities

The NC-REACH model represented an expansion of the medical, behavioral, and supportive services that individuals living with HIV received as standard of care at CommWell Health in the context of Ryan White-funded services. This expansion of services included the provision of network navigation, intensive care coordination, and housing assistance delivered to the client in an integrated manner among medical, behavioral health and supportive services. The specific strategies contained in this expansion aimed to improve timely entry, engagement, and retention in quality HIV primary care and supportive services for individuals living with HIV, experiencing homelessness or unstable housing and with co-occurring mental illness and/or substance abuse disorders. For this population of focus, the integration of medical care, behavioral health services, and housing assistance was critical to the achievement of enhanced client health and care outcomes.

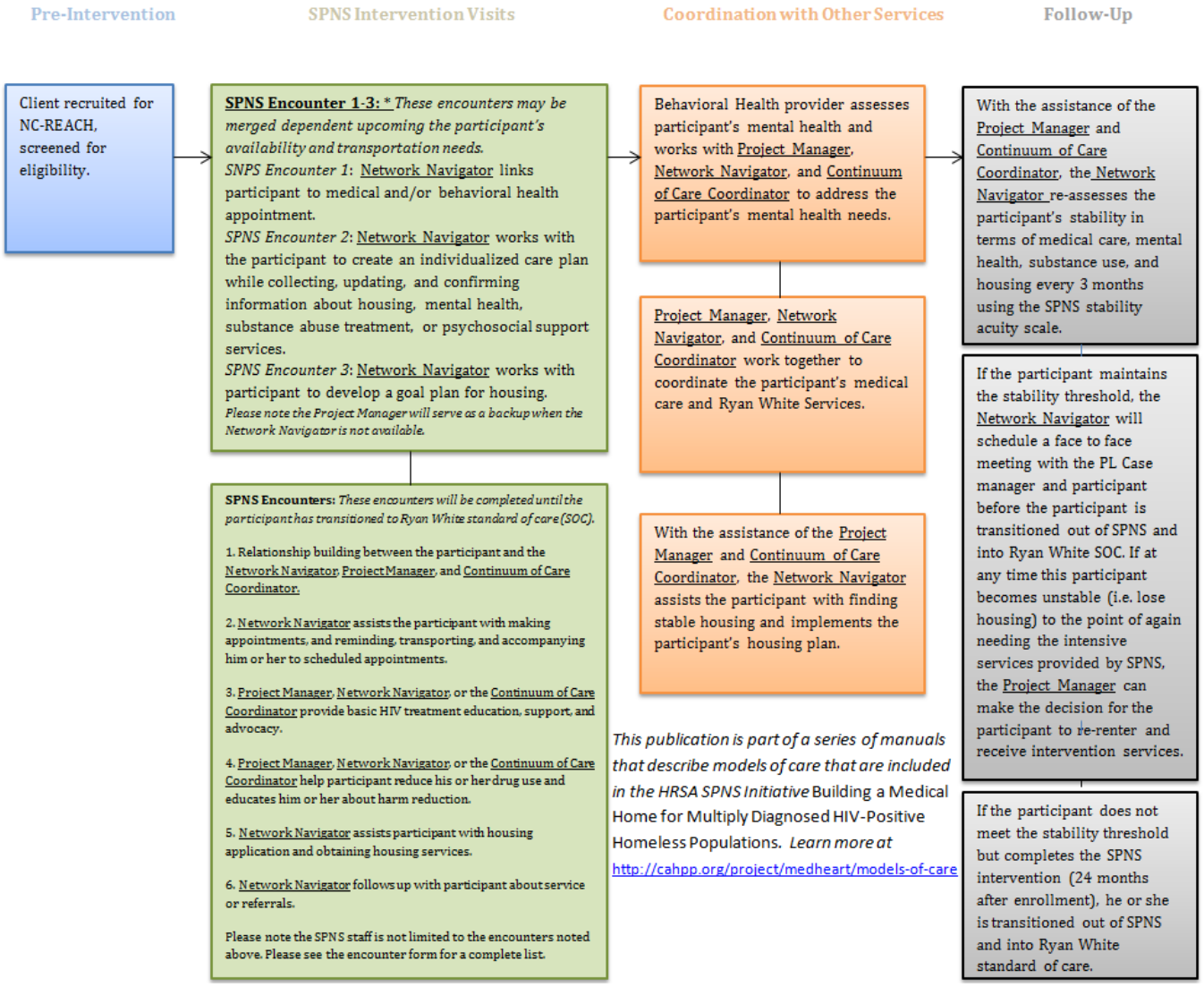
Below is an overview of the activities that took place within the NC-REACH program.

Assessment and Development

When a client was newly enrolled in NC-REACH, a network navigator was assigned to that client according to the county in which the client resided. Each network navigator covered different counties and had expertise in the resources available within that county. For example, one navigator covered Cumberland County (the largest county by population density), and the other covered Sampson, Johnston, Hoke, and Harnett Counties, which have fewer clients but larger geographic area.

The network navigators met with the clients to learn about the clients' life and holistic health circumstances. Working one-on-one to build a relationship of trust, the network navigators determined what the client's needs were over time (even when the client wasn't aware what those needs were). Using a process informed by evidenced-based practices, the network navigator and the client worked together to create an individualized client service plan based on goals they establish as priorities for the client. The network navigators, in collaboration with the client, were essential to developing the individualized client service plan.

NC-REACH System Flow Chart



The purpose of completing an individualized client service plan was to ensure our clients were meeting the goals that they set for themselves. This form was completed every 4 to 6 months. Some of the needs addressed included financial assistance, health services, behavioral health, and housing assistance. Each need clearly indicated what the client would do and what the network navigator would do within a specific time frame. See the Resources section for an example of the individualized SPNS client service plan.

Additionally, during the SPNS Intervention visits and coordination with other services, the tools that the network navigator might use in this process included:

- Individualized SPNS Client Service Plan form—used to clarify with the client what the client's goals are and steps to take to work toward them
- Stability Acuity tool—used every three months to determine the level of need in various areas, to assess progress at regular intervals

The NC-REACH program served clients in nine counties in southeast North Carolina characterized by high rates of PLWHA, unemployment, and poverty and a shortage of medical professionals, public transportation, and affordable housing options.

- SPNS Contact Form—used to provide best contact information to locate client
- Progress Notes—used throughout the study when the network navigator would meet or have updates regarding the client's progress
- Intervention Encounter Form—used daily to document specific services provide for each client and the time spent
- SPNS Behavioral Health log—used to monitor the client's mental health compliance by keeping track of dates and attendances of behavioral health appointments
- Out-of-Care Outreach Log Sheet—used to document attempted contacts (home visits, telephone, shelter or institutional visit, emails, text message, and other) with the client who are out of care and/or lost to follow up

All of these tools are available in the Resources section on pg. 32.

Sue's transformation

Sue was diagnosed in 2010 and was a new patient to the clinic when she enrolled in the NC-REACH program. When the network navigator arrived to pick her up for her initial behavioral health assessment, Sue was very shy and would not say much. When she was at the clinic, she would go straight to her appointment and back to the van. Over time with the network navigator, she began to open up little by little. Sue is now at a place where she calls the network navigator just to check in and see how we are doing. When she is at the clinic, she stops by everyone's office to say hello.

> We don't have taxis, we don't have the metro, we don't have subway-it's our network navigators who are providing the transportation. Sometimes they would go 60 to 90 miles to pick up our patients to bring them into care.
>
> - Lisa McKeithan
> NC-REACH Project Manager

Transportation

Transportation was an essential part of the network navigation position. Being in a rural area, there is no public transportation and the population of people we serve may not be able to afford a car. Our clients usually live outside of the city limits, are on a fixed income, and cannot afford to pay someone to pick them up. They may not have a drivers' license or their license may have been suspended.

Providing this service to our patients allowed time to build a rapport with the patients. The network navigators could discuss many things in confidence; things that may be difficult for the client to discuss with a provider or case manager. See the sidebar to the right for more about the role of transportation in building relationships with clients.

To document the transportation services, the network navigator completed a client services form, included in the Resources section. The form indicated the transportation needed to service location, summary of transportation services, and included the client's signature and staff initials. The client's signature was required to indicate his or her permission to be transported.

The Role of Transportation in Building Relationships with Clients

The NC-REACH project serves clients in a large geographic area consisting of nine counties in rural southeast North Carolina. These counties have thousands of miles of secondary roads that may not provide direct access from one location to another. Thus, clients sometimes must travel long distances, including large swaths of swampland, forests and federal military properties to see a medical provider. "Because our clients lack access to public transportation, us being there for them is crucial to their health and well-being. It's also a great time for us get to know our clients better," said Michaella Kosia, one of the network navigators.

The network navigator position requires a lot of driving. A clean driving record is one of the requirements of the job. CommWell Health provides a car for use by the network navigator, who may spend 90 minutes driving a client to a medical appointment. Network navigators coordinate appointments carefully, often scheduling appointments to more than one provider for a single trip and using their knowledge of client schedules and preferences to determine the dates and times that are most convenient for the client. Result: lower no-show rates among these clients than before the NC-REACH project was introduced.

Another benefit of having the network navigators provide transportation is the opportunity to just sit and talk with the client. "Driving my clients is a great opportunity to get to know them better," said network navigator Shalonda Pellam "Clients can be their authentic self when there are no outside distractions, and they will tell you a lot about what's going on with them."

Integration of Mental Health, Substance Use, and Housing Services within the NC-REACH Model

Mental Health and Substance Use Services

As mentioned previously, CommWell has a Behavioral Health Department and Residential Treatment services for substance use. Harvest House is CHW's 10-bed residential substance use rehabilitation program that provides a full scope of services for up to three months for men seeking recovery from addiction. However, one of the challenges was poor coordination between the Behavioral Health Department and Positive Life Program. One of the key tasks of NC-REACH was to establish a more coordinated system of care. A Behavioral Health case manager was assigned to Positive Life and NC Reach and attended clinic huddles so clients could be prioritized for care and services. In addition the continuum of care coordinator followed up and documented closely clients from Positive Life who were referred to Behavioral Health.

The network navigators used the Behavioral Health/ Substance Use Appointment Attendance Log (included in the Resources section) to ensure that clients attended their appointments with the behavioral health care providers. In addition, the network navigators and continuum of care coordinator were key to ensuring that people coming out of residential treatment programs were back in medical care. The network navigator and continuum of care coordinator helped the client obtain behavioral health services either inside or outside CommWell Health, depending on client convenience and preference, and followed up to make sure clients obtained necessary care. The network navigator also worked with the behavioral health case manager to find housing for people if needed.

As a result of this improved internal coordination between Behavioral Health and Positive Life all 80 clients enrolled in the NC-REACH program attended at least one behavioral health appointment for assessment. The majority of those receiving behavioral health services were compliant with their treatment. For more about the behavioral health component, see Mental Health & Substance Use Questions & Answers in the Resources section.

Housing Services

During the initial encounters with a client, network navigators completed a housing assessment with the client. If the client needed immediate access to housing, NC-REACH staff had agreements with the Salvation Army, a local faith-based emergency shelter, and a domestic violence shelter to streamline clients into emergency shelter. At the same time, the network navigators worked with clients to find long-term housing. The network navigator consulted with the behavioral health provider and the client to determine the client's readiness for housing and the housing budget range. Over time, the network navigators built partnerships with local housing authorities, private landlords, and private housing managers to help NC-REACH clients find housing. They sought housing in local housing authorities in the counties within CHW's service area, subsidized housing, and trailers rented from private landlords. During community days when the navigators outreached within the community, they conferred with their contacts within various housing sources to stay abreast of housing options that might be available for their clients. For more about the housing process, see Housing Questions & Answers for Service Providers in the Resources section.

Communication within Staff

When coordinating many different services to address client needs, communication is essential. Processes were put in place to make sure all staff members were up to date on the life circumstances of each client in the NC-REACH program. For short updates, the team used secured emails, assigning tasks to staff members within the Electronic Health Record, and cell phone communication (i.e., phone calls and texts) using only the client's initial. In addition, several mechanisms for face-to-face communications were put in place.

Team Meetings

The core NC-REACH team met every other week to discuss SPNS implementation. At these meetings, time was dedicated to discuss enrollment and retention numbers, upcoming client appointments, and client progress. Mandatory larger team meetings were held periodically where all staff learned about program updates and developments.

Daily huddles

Multiple huddles occurred each day with different combinations of team members. The SPNS team, the Positive Life team, and the behavioral health team all participated in these regular meetings:

- Patient centered medical home huddles focused on the discussion of unmet needs, social supports, all medical appointments, behavioral health concerns, medical compliance, and medication adherence for the clients who are scheduled to attend appointments that week
- Treatment plan team meetings focused on the discussion of out-of-care clients and creation of a plan to get them back into care
- One-on-one meetings with behavioral health providers to discuss clients' needs and housing status
- Huddles with medical case managers to discuss clients' care plans
- Transportation huddles to discuss transportation services for the week

During this time, staff had an opportunity to voice concerns and take time to "value" people who were going above and beyond their duties and to appreciate the individual strengths of team members. The huddle served as a time for team members to discuss how to exemplify the values of collaborative leadership teamwork and continuous improvement in their work.

Documentation

Electronic Health Record

CommWell Health uses Citrix, an electronic health record (EHR), to document patients' health records. Network navigators, behavioral health counselors, providers, case managers, and other staff members contribute to the EHR to build a comprehensive record of the patient's holistic health and life circumstances.

CommWell Health also reports CareWare, a statewide database. If a client chooses to share data across state providers, CommWell Health providers view the Ryan White services that the patient accessed at other agencies.

Progress Notes

The team members entered case notes after each encounter with a client. (See the progress notes form in the Resources section.)

Encounter Forms

The Encounter forms document the specific services that the network navigator provides for the client (See the intervention encounter form in the Resources section.)

Plan for Transitioning a Client from SPNS to Positive Life Standard of Care

Every 3 months, the project manager, network navigator, and continuum of care coordinator met to discuss which SPNS clients might be appropriate to transition from SPNS to Ryan White standard of care. They used the acuity scale (available in the Resources section) as a basis for their decision. If a client was determined stable to transition to standard of care, the NN made a note in the SPNS client's file, and the client would be transferred to the care of a Positive Life case manager. In all cases, the client, the network navigator, and the assigned case manager met prior to the transfer. The network navigators conducted a "warm hand off" with the client to the medical case manager. Prior to this handoff, the network navigators met with the Positive Life case manager to come to a consensus about the client's care plan and discuss the next steps of their medical and non-medical needs.

After 18 months of services, 53 clients transitioned from NC-REACH to standard of care. If at any point a client who transitioned from SPNS intensive services to standard of care became unstable and needed the intensive services provided by NC-REACH, the project manager readmitted the client to the NC-REACH program. See the transition to standard of care form in the Resources section.

PROGRAM IMPACTS

Clients Served

Often, clients participating in NC-REACH were Positive Life clients with the most complicated cases in terms of housing situation, mental health and substance use history, and medical problems. The NC-REACH program was tailored to meet the needs of each client at the client's own pace, generally within 12-18 months. Ultimately, SPNS aimed to provide intensive services to these clients with the end goal of stabilizing their situation until they were appropriately transitioned into the regular Positive Life/Ryan White standard of care. At this point, the client was expected to show positive experiences in medical care, leading to improved trust and attitudes towards the medical system and providers.

NC-REACH served 80 clients over the course of the project. After 12 months of services, 83% were retained in care and 75% of these clients were virally suppressed. The percentage of clients who were stably housed increased, and clients' unmet needs in the areas of housing, transportation, and employment all decreased.

The Community Housing Coalition

One of the goals of the NC-REACH program was to improve housing options for clients in their community. To this end, CommWell Health initiated a series of quarterly meetings with service providers in the area, as described on page 29. The Community Housing Coalition was very informative and vastly increased collaboration among service providers within the community, including housing agencies, landlords, United Way, faith-based organizations, the local branch of the U.S. Division of Veteran Affairs, the Red Cross, and the Salvation Army. It proved to be an excellent vehicle to update partners on developments at CommWell Health and to hear from them about anything that might impact NC-REACH. There are about 40 members in the coalition to date, and over the course of the NC-REACH program, we convened 16 coalition meetings, with meeting size ranging from 20 – 45 people.

Successes in Care Integration

For the clients in the NC-REACH program, HIV care alone was not enough—we were concerned about their housing and behavioral health needs as well. By integrating HIV care, behavioral health and substance use treatment, and housing services in a coordinated intervention, we met the needs of our most vulnerable clients seamlessly in all of these areas. One side benefit to this closer collaboration has been an improved relationship with the Behavioral Health department, a department that now understands the unmet needs of our clients. In terms of housing, the network of relationships with community agencies that we built continues to benefit clients CWH's Positive Life program and beyond. It is not unusual for a case manager from CWH's Women, Infants, and Children program, for example, to call and ask about county-specific resources for a client whose housing is in jeopardy.

Increased Community Education

As can be seen from on page 29, NC-REACH staff members, including network navigators and the continuum of care coordinator, were active in reaching out to the community at community meetings and events. In addition, NC REACH staff members are diligent members of local coalitions in different counties and subscribe to several community housing listservs. Wherever we came in contact with our constituencies—whether within CommWell Health, at community events, or at the community housing coalition mentioned above, for example--we explained what hidden homelessness and housing instability looked like in rural North Carolina. We held impromptu workshops about HIV treatment, prevention, discrimination, stigma, and homelessness, and how these factors intertwined to affect a person's compliance with medical care. These efforts led to an increased awareness and understanding of what homelessness looks like in the community, HIV prevention and treatment, and how the community can support individuals living with HIV.

Reconciliation with Family Members

One unexpected and very encouraging result of the NC-REACH program was that clients reported improved relationships with family members. As clients became compliant with not only their HIV treatment, but also their behavioral health care, their mental status improved and they became more stable. They began to foster relationships and build bridges with parents, children, and significant others. In some cases, clients reported conversing regularly with family members they had not spoken to in years. Rebuilding these relationships led to an improved quality of life and in some cases stable housing with a formerly estranged relative.

National Rural Health Association Awards

Mainly as a result of the successes outlined above, the National Rural Health Association named NC-REACH the Outstanding Rural Health Program for 2017. Additionally CommWell Health received the Outstanding Rural Health Organization award, and Lisa McKeithan, NC-REACH's project manager, received the Outstanding Educator Award. To learn more about NC-REACH straight from the mouths of Lisa McKeithan, network navigators Shalonda Pellam and Michaella Kosia, and other staff members, watch the video at https://youtu.be/McjJLKDEsZs.

NC-REACH Model Leads to New Coalition of Service Providers

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

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

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

Objectives:

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

As part of the larger SPNS initiative, NC-REACH staff drew on the coalition-building experience of their colleagues at UF Cares in Jacksonville, FL to gain information about their model of partnership building. Draft LOIs were developed to generate discussion on how agencies will work together and how referrals between agencies would be made. Over time, these LOIs were finalized and agreements were put in place.

By September 2014, quarterly meetings were established and organizations began increasing the number of referrals to each other's services. Participant expanded beyond housing providers to include private landlords, people from faith-based communities, local detox centers, and representatives from agencies such as Veteran Affairs, the Red Cross, and United Way. There are now about 40 coalition member organizations. By the end of the NC-REACH program, 16 coalition meetings had been convened, with meeting sizes ranges from 20 to 45 people. The benefits have extended far beyond housing options for clients. Organizations have a better understanding of many aspects of our clients' challenges. As they learn more about each others' services, they have begun to

> "We invite anybody that can help our clients. When a hurricane came through in mid-2016, we brought in agencies to talk about sustainable solutions to help our clients who are dealing with the aftermath. The coalition has been very informative and has vastly increased collaboration within the community. We are exploring ways to continue the coalition beyond the end of the SPNS initiative.
>
> -Lisa McKeithan,
> SPNS principal investigator

NC-REACH Team Participation in Community Outreach Events

Reaching out to the community was an important strategy to educate the community on HIV, stigma, and hidden homelessness in rural North Carolina. Outreach events that the NC- REACH team members participated in are listed below:

April 17 2015 – Annual Booster Conference for Clients at William Baptist Church in Spring Lake

Annual Conference hosted by the William Baptist Church in Spring Lake, where hundreds of participants (HIV clients and caregivers) get together to learn and share information in regards of the HIV infection. CWH/PLP provided transportation and participated in the creation of the quilt for the area.

August 8 2015 – Latino Community Connect "Cumberland County Hispanic Festival"

The Latino Community Connect hosted the Cumberland County Latino/Hispanic Festival to provide the community with family fun, music and the opportunity for the local agencies to explain their available services for the community.

October 16 2015 – "One Homeless Night"

Event hosted by the Sampson County United Funds, gear to raise awareness of the necessity of more services for the homeless or unstable housed. In attendance were different organizations including churches and girls and boys club. People who had formerly experienced homelessness, including one SPNS participant, presented personal testimonies. The community was invited to spend the night at the park as homeless, sleeping in the cars, boxes, or sleeping bag.

March 7,8,9 2016—Sampson County HIV/AIDS Task Force: National Week of Prayer

The Sampson Co. HIV/AIDS Task Force hosted the National Week of Prayer at Olivet Institutional Church in Clinton, NC. The event took place over the course of three nights and the service included a 10-minute educational component and a personal testimony.

May 24 2016—Salvation Army Luncheon

The network navigators attended a charity event hosted by the Salvation Army in Fayetteville, NC. This event recognized sponsors of this agency and valuable volunteers in the Fayetteville area.

June 2016 & 2017—Annual Father's Day Cookout with Sanford Housing Authority

The SPNS team attended the Sanford Housing Authority's Annual Father's Day Cookout. This event was open to the public and included different activities for families in the area. Local agencies including CommWell Health were there to help with the event as well as provide information about their services.

June 24 2017—National HIV/AIDS Testing Day at CWH

The SPNS department, Positive Life, and Eastpointe hosted a testing day event at CommWell Health. They offered on site rapid testing, snacks, and information regarding services at CWH & Eastpointe.

October 4 2016—CWH Food Drive

The SPNS Department, along with other departments in the agency, volunteered at the Migrant Farmworker food drive. We provided 100 families with food donations and information about CWH and its services

March Annually—Sampson County HIV/AIDS Task Force: National Week of Prayer

The Sampson Co. HIV/AIDS Task Force hosted the National Week of Prayer at Olivet Institutional Church in Clinton, NC. The event took place three nights, the service included a 10-minute educational component and a personal testimony.

February 2017—Safety Net Advocacy Day at State Legislature in Raleigh, NC

April 28, 2017— 3rd Annual Tri County Shining Star Conference

The CommWell Health SPNS team presented at the 3rd Annual Tri County Shining Star Conference in Dunn, NC. The SPNS team gave an informational presentation about the quality health care and dental services provided at the CommWell Health locations and the importance of preventive screenings. Many people in the audience were interested in making appointments at CommWell for their healthcare needs. In addition, the agencies, clients, and staff were empowered, motivated, and given resourceful information on how to improve their quality of life by representatives from various local community agencies.

RESOURCES

The following resources from the NC-REACH 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

CommWell Health Website:
http://www.commwellhealth.org

Setting up the Medical Home Model

NC-REACH flow chart: maps the client's experience through the NC-REACH program from pre-intervention through transition.

Finding and Engaging People

SPNS eligibility screening form: Staff used this form to determine program eligibility for individuals referred to the SPNS program

Out of care outreach log sheet: Network navigators used this to track contact attempts for individuals who have been identified as being out of care and the results of those contacts

Stability acuity scale: this assessment tool was used to assess level of client needs in areas including mental health, substance use, housing, level of self-sufficiency, social support, domestic violence, and health status.

SPNS contact form: Network navigators filled out this form with client to obtain permission and determine best method to stay in contact with the client

Patient referral to NC-REACH form: Other agencies and departments used this form to refer potential clients to the NC-REACH program

Service Delivery

NC-REACH individualized client service plan: This form was completed every 4-6 months to identify, track, and update how well the client's needs are being addressed

Intervention encounter form: Network navigators used this form daily to document specific services provided for each client and the time spent

RESOURCES

CommWell Health progress notes: This form was used to document a client's progress toward goals in the service plan. It became part of the client's record and serves as a reference for updates about the client, family, job, life, etc.

Client transportation services form: The network navigators used this form during transportation to document the type of service the client is receiving and obtain the client's signature (as permission to travel)

Behavioral health and substance use appointment log: The network navigators used this log to track substance use and behavioral health service appointments attended/missed by individual client

Mental health and substance use Q & A for service providers: This document answers commonly asked questions and describes the goals of the behavioral health services integrated into NC-REACH.

Housing Q&A for service providers: This document answers commonly asked questions and describes the goals of the housing component integrated into NC-REACH.

NC-REACH transition to standard of care form: This form was completed to document a client's transition to standard of care.

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