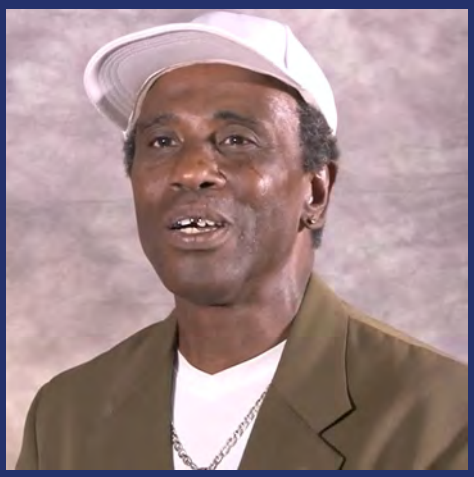

The Partnership for Access to Treatment and Housing (PATH Home)

University of Florida Center for HIV/AIDS Research, Education and Service (UF CARES)

River Region Human Services and Ability Housing of Northeast Florida

A partnership for access to HIV treatment and housing in Jacksonville, Florida

ACKNOWLEDGMENTS

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TABLE OF CONTENTS

PATH HOME AT A GLANCE

University of Florida Center for HIV/AIDS Research, Education and Service (UF CARES) and River Region Human Services and Ability Housing of Northeast Florida

Geographic description: Jacksonville, FL – The number of people experiencing homelessness has increased dramatically in Jacksonville and is concentrated in and around downtown Jacksonville which has the highest rates of unemployment, poverty and HIV/AIDS incidence. In 2012, there were 5393 people living with HIV disease in the Duval County of Residence. During this same time there were 2533 people considered homeless, living in shelters on the street (Homeless count taken within a 24-hour period) in Duval County.

Main challenges: People living with HIV who are experiencing homelessness present complex demands on the HIV care continuum. Stigma in accessing services, lack of knowledge of available services, mental health and substance use comorbidities all interfere with HIV primary care treatment adherence. Cycling among substance use treatment facilities, the street, jail, and varied medical care at different points contribute to individuals being out of care.

Focus population: People experiencing homelessness or unstable housing and living with HIV/AIDS, located in Jacksonville, Florida.

Description of intervention: Through a close collaborative relationship with River Region, UF CARES staff provided HIV primary care twice a month at a clinic held at River Region. River Region provided housing, substance use treatment services, and mental health care to residents of Jacksonville including those living with HIV. The model used peer navigators to serve as an extension of case management services, providing intensive case management and linking clients to the services at both River Region and the clinical care provided by UF CARES.

Medical home model staff:
UF CARES: 1 peer navigator, 1 medical case manager, 1 program coordinator, 1 program evaluator
River Region: 1 peer navigator, 1 comprehensive case manager, 1 program coordinator

Clients served: 167

Impact New partnerships: We have strengthened our partnerships with River Region Human Services and Gateway Community Services, both are area substance use treatment facilities. As a direct result of this project, we have established another satellite medical clinic at Gateway Community Services very similar to the PATH Clinic. We are also using the results of this project as a basis to seek funding for intensive case management services in our area. We have also developed relationships with several local housing agencies. During the course of this project we enrolled 103 clients in a multisite evaluation and served 167 overall.

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.

UF CARES was one of the nine demonstration sites funded under this initiative. This manual describes their experience implementing and evaluating the Partnership for Access to Treatment and Housing (PATH Home) program.

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 Hi-5 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

Challenges Faced in Jacksonville, FL

At the time the Partnership for Access to Treatment and Housing (PATH Home) was launched, Jacksonville, Florida's homeless population had been rising dramatically. According to a 2010 Report on the Homeless Populations in Duval, Clay, Nassau, and Baker Counties prepared for the Emergency Services and Homeless Coalition of Jacksonville, Jacksonville had more than 4,000 individuals who were homeless, an almost 20% increase over the 2008 point-in-time count. *(See the Appendix for details of the report's findings.)*

As a Ryan White Medical Case Management agency providing services to HIV-positive individuals, UF CARES found that a majority of patients entering services through the hospital emergency department were experiencing homelessness or unstable housing. Through our experiences working with persons who are experiencing homelessness or unstable housing and living with HIV, we learned that issues that interfere with identifying, engaging and retaining these patients in medical care include: stigma in accessing services, lack of knowledge of systems available, mental health disorders, and substance use. Unaddressed mental health needs in particular impact adherence, and substance use interferes with all aspects of an individual's self-care.

The cycling among substance use treatment, the street, jail, and medical care access at different points, including the emergency department, as well as a lack of transportation are challenges in keeping patients in care and supporting treatment adherence. Clients of UF CARES and River Region Human Services (RRHS) who are experiencing homelessness or unstably housed and living with HIVare highly mobile, and about one third of the phone numbers provided as contact information do not work due to lack of minutes on the phone, lost or stolen phones, or clients changing numbers frequently. Those that are unstably housed or experiencing homelessness are difficult to locate unless there is good linkage to services and active engagement with case management and medical care. There is also some degree of treatment fatigue with our population: those who know their status often have fallen out of care. Treatment fatigue also arises out of difficulties accessing care, maintaining appointment schedules and medication regimens and challenges accessing Ryan White services due to misplacement or loss of required documentation.

About the Partnership for Access to Treatment and Housing (PATH Home)

The focus population for this demonstration project is people who are experiencing homelessness or unstable housing and living with HIV/AIDS, located in Jacksonville, Florida. The demographics for this population: 60-70% African American, 50-60% male, and 50% homeless and 50% unstably housed, based on the current demographics of the area of focus, i.e., the downtown core.

To address the needs of this population, UF CARES and River Region Health Services joined forces to launch the Partnership for Access to Treatment and Housing (PATH Home) model. This project primarily addressed structural and behavioral barriers, targeting linkage-to- and retention-in-care challenges impacting individuals experiencing homelessness and living with HIV. The approach we employed follows the "*Identify-Meet-Treat-Retain to Care*" model where individuals who are on the outskirts of the Ryan White System, and oftentimes on the outskirts of society, have access to a focused, structured, yet flexible model of care. Housing is an important component of this project because it can make such a difference for those living with HIV/AIDS; River Region Human Services staff have found that once patients are stably housed, their engagement in medical care can be as high as 90%. By improving the housing status of individuals experiencing homelessness and living with HIV and addressing co-occurring mental health and substance use disorders, the program aims to impact:

1. The health of the individual (through increased engagement in substance use treatment, mental health, and medical care)
2. The health of the community (through decreased transmission)
3. The cost of care (by identifying health conditions earlier in the process and reducing the need for urgent and emergent care.)

PATH Home engaged a peer outreach and care management model focusing on people who are experiencing homelessness/unstably housed, living with HIV, and multiply diagnosed with mental health and/or substance use disorders. The community access site for HIV/AIDS primary medical care was co-located at River Region, a mental health and substance use treatment facility, in addition to the main UF CARES location. The combination of these two innovative strategies opened doors to wrap-around medical services of the medical home.

About UF CARES and River Region

UF CARES and River Region Human Services have formed a strong and unique alliance, building on years of supporting and sustaining joint efforts to provide services to people living with HIV, including the previous JailLINC SPNS project (2000 – 2005 https://careacttarget.org/sites/default/files/file-upload/resources/openingdoors.pdf) which linked incarcerated people living with HIV with medical care and case management services upon release from prison.

UF CARES

The **University of Florida Center for HIV/AIDS Research, Education and Service** (UF CARES http://www.hscj.ufl.edu/pediatrics/ufcares/about.aspx) is part of the University of Florida system. Because of its mission and the services it provides, it operates in many ways as a community-based organization. Since 1988, UF CARES has been a leader and innovator in providing HIV care and has received numerous awards and recognitions, particularly for its groundbreaking work in decreasing perinatal transmission. UF CARES has a long history of consumer involvement, with a 20+ member consumer advisory board made up of patients and clients of the center who participate in evaluation and outreach activities. It also employs staff who have been impacted by HIV/AIDS in various positions.

UF CARES has a variety of comprehensive services available, including access to clinical trials, mental health and substance use screenings and linkage to treatment, prevention health education/risk reduction, gynecologic services, family planning counseling, HIV counseling

and testing, prenatal care coordination, early intervention services, legal services, and psychological services. Additionally, in 2008 UF CARES put into place an open-access model for clinic services, where clients are able to walk in for labs without appointments Monday – Friday, and Fridays are open for clients to walk in for medical visits without appointments. In 2012 UF CARES received Level 3 Patient-Centered Medical Home recognition from the National Committee for Quality Assurance (NCQA).

River Region Human Services, Inc.

The mission of **River Region Human Services, Inc.** (RRHS, http://www.rrhs.org/about-river-region-human-services/) is to improve the quality of life for individuals and families of Northeast Florida affected by substance use, mental illness, homelessness, or HIV and other communicable illnesses through outreach, prevention, treatment, and housing services. As a community leader in responding to the HIV/AIDS crisis, in 1986, RRHS cofounded the AIDS Crisis Network. Working with city, state, and federal officials and funding sources, and deploying an outreach team that included members who are representative of the target population, RRHS staff pioneered the development of a national model for HIV outreach, education, and risk reduction.

The services that River Region Human Services provides include mental health treatment, substance use treatment, and housing services using a Housing First[1] model. RRHS has been recognized for decades as a pioneer in developing and implementing national model programs in HIV outreach, prevention, and intervention services, as well as innovative, effective, evidence-based HUD and HOPWA-funded permanent supportive housing, case management, substance use and mental health assessment and treatment. It operates the first, oldest, and largest HOPWA program and the largest supportive housing program for people living with HIV in Northeast Florida. RRHS has successfully partnered with the Jacksonville Housing Authority for the HUD-funded Shelter Plus Care program, which provides stable, affordable housing, case management, and linkage to comprehensive supportive services to 29 formerly homeless persons with severe persistent mental illness. Its Supportive Housing Opportunities (SHO) program provides stable, affordable scattered-site housing, case management, and linkage to comprehensive supportive services for 22 families with severe and persistent mental illness. Next to its residential treatment facility is Andy's Place, where RRHS provides affordable, stable housing to formerly homeless individuals.

Next to River Region Human Services' residential treatment facility is Andy's Place, where RRHS provides affordable, stable housing to individuals who were formerly homeless.

[1]Housing First is a homeless assistance approach that prioritizes providing permanent housing to people experiencing homelessness, thus ending their homelessness and serving as a platform from which they can pursue personal goals and improve their quality of life. National Alliance to End Homelessness. April 2016. Fact sheet: Housing first, retrieved from http://www.endhomelessness.org/page/-/files/2016-04-26%20Housing%20First%20Fact%20Sheet.pdf

SETTING UP THE MEDICAL HOME MODEL

Strategies for Informing/ Partnerning with Stakeholders

In anticipation of the PATH HOME program, UF CARES identified and reached out to all internal and external stakeholders. (*See the table on pg. 10-11 for a list of stakeholders.*) We conducted a community needs assessment of agencies that focus on clients who are living with HIV and experiencing homelessness. These included shelter programs, transitional housing support providers, City of Jacksonville HOPWA and HUD officials, and two of the major substance use providers for people living with HIV/AIDS. Nine agencies were represented at the planning meeting. Key issues identified through the agency needs assessment were:

- Increased mortality of PLWHAs served by one of the homeless shelter programs (3 in the last several months)
- Need for access to care and continued linkage for women, children, and adolescents facing HIV/AIDS
- Post-incarceration linkage needs
- Challenges serving adolescents experiencing homelessness and living with HIV and concerns about DCF involvement
- Overwhelmed case managers at shelters
- Increasing number of clients who lack permanent housing
- Decreases in funding for transitional housing, shelters, and needed support systems
- Limits to how long clients can be helped by housing programs
- No day shelter programs
- Needs for photo identification to access services

Memoranda of Understanding (MOU) were signed between:

- UF CARES to provide HIV care, medical case management, psychological care, and nutrition therapy
- River Region Human Services to provide primary care, substance use treatment, housing case management, and psychological services, and
- Ability Housing to provide housing services for the PATH Home program.

Other key partners included two substance use treatment agencies-- Gateway Community Services and Substance Abuse, Community Rehabilitation Center Substance Abuse --and the Women's Center.

We also obtained letters of support from multiple stakeholders in the provision of housing and other services, to better coordinate the delivery of services and better ensure sustainability moving forward. Each of the following programs and agencies with whom we collaborate addresses different aspects and comorbidities associated with homelessness:

- Jacksonville Sheriff's Office
- Emergency Services and Homeless Coalition
- City of Jacksonville HOPWA Administrator
- Duval County Department of Public Health
- Gateway Community Services
- IM Sulzbacher Center for the Homeless
- Ryan White Part A Office
- City of Jacksonville Housing and Urban Development
- North Florida AIDS Network

As a result of coordinating efforts with stakeholders, we developed a services referral guide that frontline staff could consult when referring clients to needed services. This services referral guide is included in the *Resources* section. Every third Thursday, during the monthly area case manager's meeting, any new resources are discussed and the referral guide is updated.

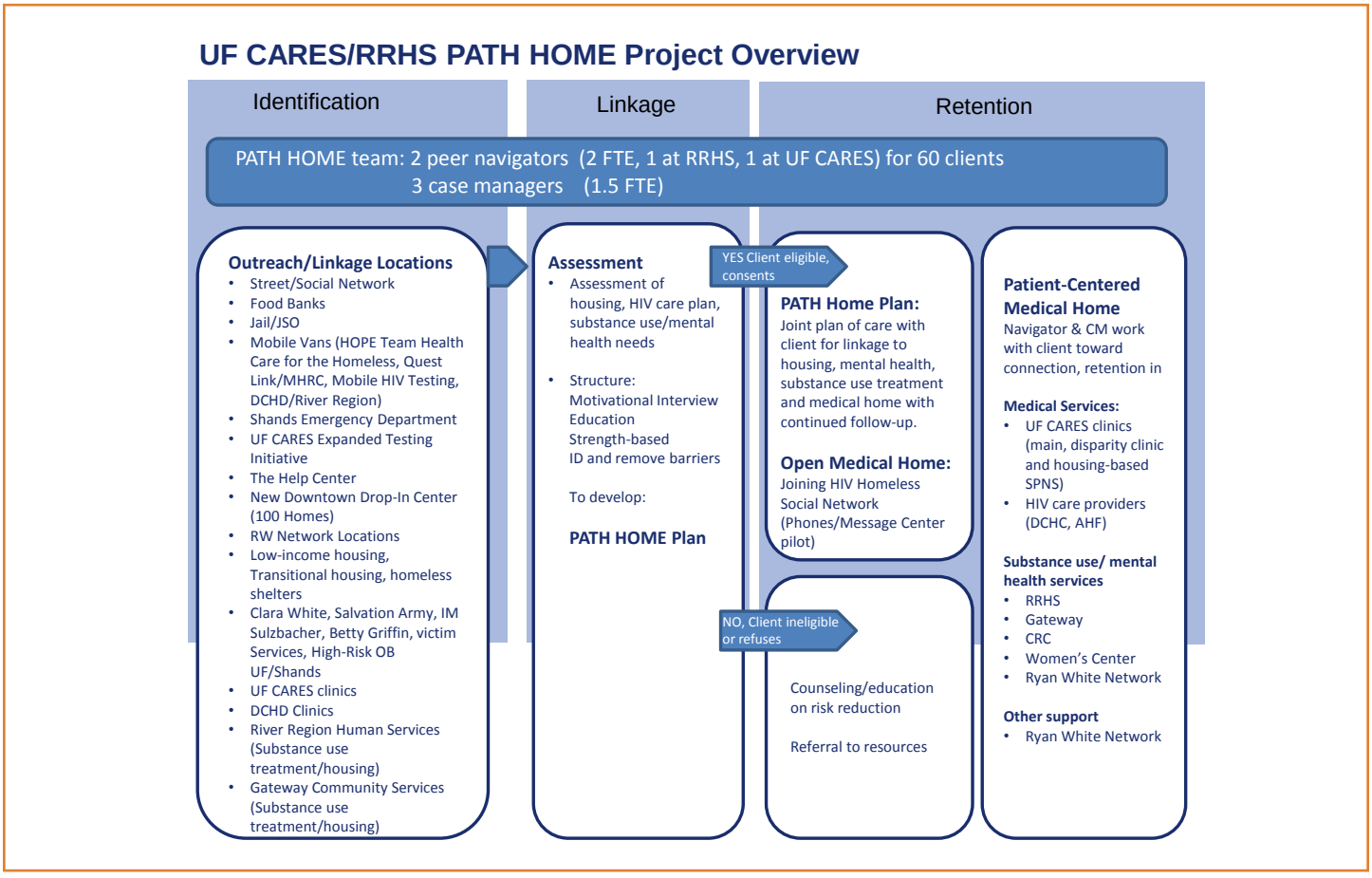
Internal and External Stakeholders

The PATH project receives client referrals from these stakeholders and refers clients to these agencies for services as needed. In the list below, we have denoted those who were at our SPNS Community Needs Focus Group (C), those with whom UF CARES has a MOU (M), and those with whom we have reciprocal referral relationships (R).

Shelters *Some also have transitional housing Quest into housing is available	Downtown Shelters: City Rescue Mission C, R, M Trinity Rescue Mission (Men, Women, Families) R Salvation Army R IM Sulzbacher Center for the Homeless (Men, Women and Families) C, M, Clara White Mission R Hubbard House R Betty Griffin House (Domestic Violence Shelter) R Youth Crisis Center R Mission House R Various Church Programs scattered out of the downtown core Emergency Rooms for Families NFIN
Transitional Housing/ HUD For the purpose of River Region Human Services, transitional housing refers to 3 months to 1 year. This may vary with other partnering agencies.	Ability Housing SPNS M, River Region Human Services C, M, R, Community Connections, Gateway Community Services, (HUD and Non HUD) C,M,R, Clara White Mission (HUD), R ESHC, Liberty Housing for Women, R Volunteers of America Children's Home Society, R
HOPWA (Formula Grantee: City of Jacksonville) Competitive Grantees: IM Sulzbacher, River Region	NFAN, C,M, IM Sulzbacher, C,M River Region Human Services, C,M,R Catholic Charities, C,R Gateway Community Services, CMR
Permanent Housing	River Region Human Services, 100 Homes ESHC, Ability Housing, JHA, Gateway Community Services, noted above and Others (R)
Health Care Services for HIV+ Homeless	Ryan White Network C UF CARES C, Boulevard Comprehensive Care (DCHD)M, AHF, M

General Health Care Services for Available Homeless	IM Sulzbacher (HCH) M, C, R VA Medical Center R Mission House Clinic Volunteers in Health Care We Care Clinics Shands Disparity Clinics- must have residency of 60 days. R Shands Emergency Department R
Mental Health Services for HIV+ Clients Psychiatric evaluations, treatment plans, individual and group counseling and day treatment	Psychiatrist/Psychologist UF CARES (not Part A funded, but Part D) River Region Human Services PATH Lutheran Social Services, M, R Community Rehabilitation Center M, R Women's Center of Jacksonville C,M,R IM Sulzbacher Mobile Unit C,R Mental Health Resource Center Mobile Unit R Shands Jacksonville- Inpatient Crisis Stabilization Units
Substance Abuse Services for HIV+ Psychological evaluation, treatment plan development, detoxification, individual and group counseling, residential treatment	River Region Human Services PATH Gateway Community Services M, C, R Community Rehabilitation Center M,C,R

The project overview diagram below indicates where many of our stakeholders may play a role in supporting clients through the PATH project:



Clients for the PATH Home project were identified through community partners, PATH Home staff, case managers, peer navigators, clients, self-referrals and lost-to-care reports. Once linked to care, clients initially met with the medical and comprehensive case managers to develop the individualized care plan (ICP). The ICP directed the course of care for the client during the time in the PATH Home program. Each week the PATH Home team met to review clients to be served; the ICP for each client provided direction, with oversight by the case managers, to the peer navigators regarding supportive needs for the client. Once the client arrived for the PATH Home medical clinic visit, they met with all disciplines available during the visit and exited after the joint case managers' meeting to review and update the ICP.

Consumer Involvement

Consumers are actively involved in planning, implementing, and evaluating services delivered at UF CARES. Our Consumer Advisory Board (CAB) is an integral participant in our efforts to understand our target population; consider all cultural perspectives including race, ethnicity, language, age, gender, education, literacy, and socioeconomic status; and consider how these factors affect health beliefs, values, and practices. The CAB provided insight on services needed to serve our targeted population in developing The PATH Home Model. Once underway, clients for the PATH Home project joined the CAB to continue providing feedback on services received.

Key objectives identified for the PATH Home project

1. Utilize peer navigators to identify and link 100 or more individuals experiencing homelessness and living with HIV to housing through a comprehensive joint plan (PATH Home) each year.
2. Use empirically demonstrated behavioral models to implement plan of care
3. Link individuals experiencing homelessness and living with HIV into mental health/ substance use treatment
4. Engage individuals experiencing homelessness and living with HIV in a medical home (housing and clinic based at River Region Human Services), utilize peer navigators and medical case management models to continue engagement in care.
5. Implement the '*open doors model'* to the medical home through innovative social network connections (Phones and Voicemail)
6. Demonstrate the impact to the community (measuring reduced hospitalizations, cost measures, increased adherence) to garner ongoing support for these focused efforts.
7. Through this project of intense work with this population, we planned to serve 100 individuals experiencing homelessness and living with HIV with comorbidities (mental health and/or substance use disorders) over the five-year demonstration project.

Envisioning the Program

After receiving input from stakeholders, we created a model of how the different components of the project would contribute to success (*see the diagram on pg. 14*). We also developed key objectives for the PATH Home project, identified in the sidebar to the right.

Staff Recruitment

As outlined in the diagram on page 14, UF CARES and River Region Human Services defined the following positions, for a total of 7 staff for the PATH program:

- 2 peer navigators, one at UF CARES and one at River Region Human Services
- 2 program coordinators, one at UF CARES and one at River Region Human Services
- 1 medical case manager at UF CARES
- 1 comprehensive case manager at River Region Human Services
- 1 program evaluator at UF CARES

This provided for a total of 7 staff for the PATH Home project.

> We've had peers for years, so case managers are used to working with them. We just changed the dynamics of what peers were doing and added additional responsibilities.
>
> - UF CARES staff

The two organizations worked closely to solidify a strong and cohesive team dedicated to assessing and addressing the multiple needs of clients. In particular we examined the key frontline positions to determine how these roles would interact within the existing organizational structures of both organizations. All positions were newly filled for this specific project. Each agency interviewed and hired through their normal hiring process. Once hired, staff went through joint trainings to ensure a cohesive team and a uniform understanding of roles and responsibilities. A description of the peer/network navigator and case manager roles is included in the *Resources* section.

Training and Supervision

All staff received training in key areas of practice including peer navigation, motivational interviewing, trauma-informed care, HIV 101, cultural diversity, de-escalation techniques, self-care, CITI and HSP. Case managers successfully completed certified medical case manager training sponsored by the Jacksonville FL Ryan White Transitional Grant Area (TGA). Additionally, as an AIDS Education and Training Center member covering northeast Florida and the sponsor of the HIV/AIDS Conference of Northeast Florida, UF CARES has access to ongoing training opportunities for staff to learn and to present.

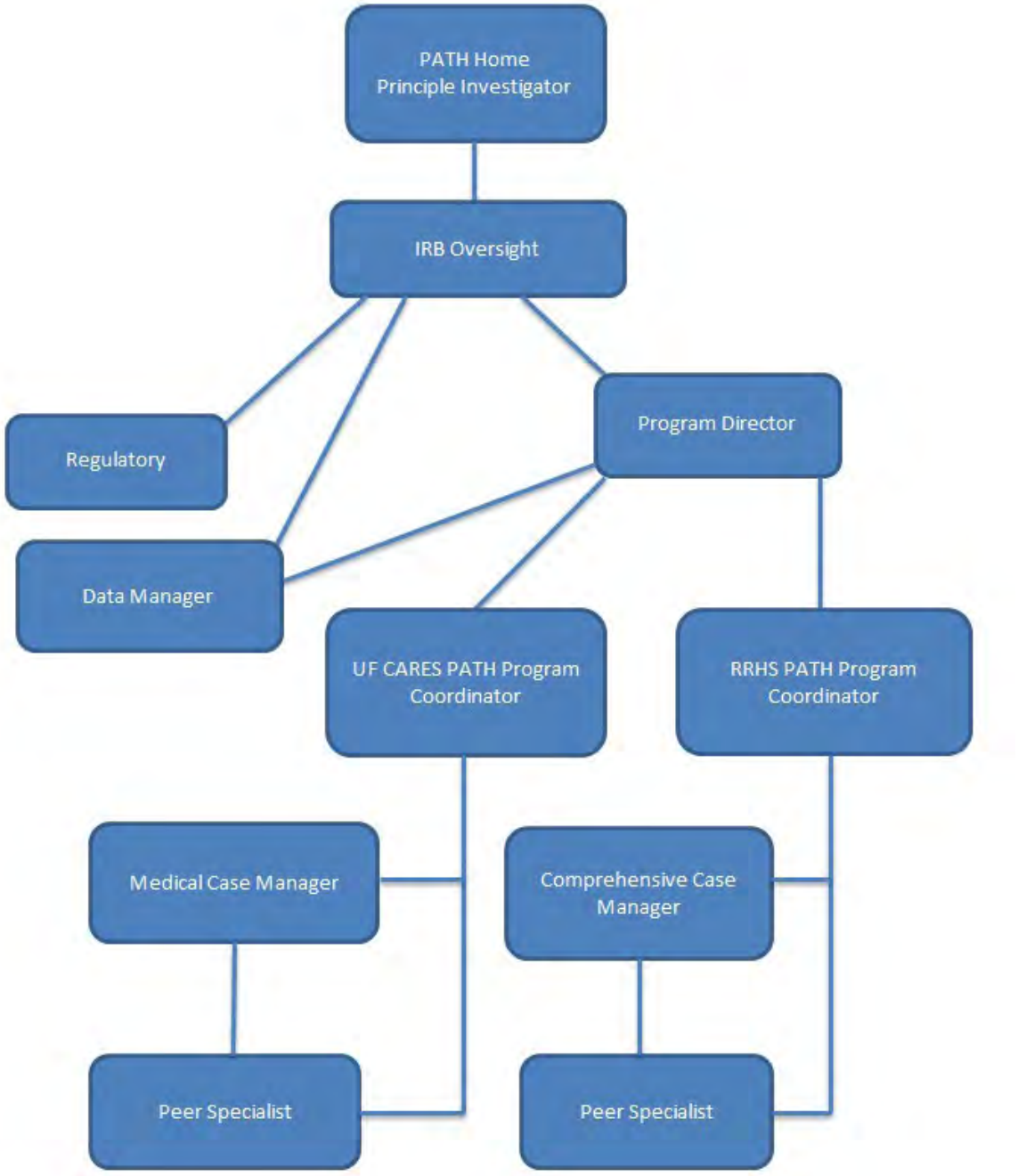
Peers and case managers were supervised by the program coordinators within their respective organizations. Program coordinators provided administrative and clinical supervision during biweekly combined team meetings, and as needed on client-specific challenges.

Biweekly combined team meetings provided an opportunity for the entire intervention team including case managers, peers, mental health counselors and program coordinators to discuss all aspects of client care services.

Reviewing Policies and Procedures

In thinking through the various components of the PATH Home project, we set up processes, procedures, and in some cases forms and tracking sheets, to ensure the smooth delivery of services to clients. Several of these processes and tools are included in the *Resources* section—processes related to recruitment and referral of clients, providing services during half-day clinics, providing housing services, and helping clients transition out of the project when they are ready. We needed to be somewhat flexible in our approach to processes--occasionally there might be a change in policy that has an unintended impact on the project and requires a change in the way we provide services, as we learned when the University of Florida changed a policy that we relied on. (*See sidebar pg. 15.*)

The UF CARES and River Region Human Services positions were organized to work together to serve PATH Home clients.



Funding

The efforts of the PATH project were strengthened by the support of the following agencies: Ryan White Part A/B Network, existing Part C funds for clinic services, private funds for clinical services (BCBS of Florida Foundation- Impact Funds), Shands Disparity clinic funds, and possibly Health Care for the Homeless expansion funds through partnerships that exist within those programs. For those clients who are uninsured for medical care, our eligibility specialists and peer navigation specialists work to enroll clients in eligible Veterans Administration, Medicaid/Medicare, Shands Card, and Ryan White (payee of last resort) and other programs to help cover the cost of medical care for those identified in the program.

Shift in transportation policy means major adjustments for PATH program

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

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

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

Strong partnership put to the test during rapid turnover

River Region Human Services and UF CARES have a long, productive history of working together to serve the needs of people living with HIV in their community, including a recent SPNS project linking individuals living with HIV who are released from prison with services. At the start of the PATH Home project, the two organizations created a memorandum of understanding and worked together to put in place a coordinated process to serve a population with complex needs.

Everything worked smoothly until a new management team at River Region replaced those who had worked to set up the program. "No one in upper management or on the intervention staff who is there now was there when we first started," explained Alma Biba, PATH Home clinical quality assurance coordinator at UF CARES. "The turnover in upper management caused shifts in the mission and the goals of our intervention. We had to educate new staff all over again, and in the beginning we had to pick up some of the pieces. For the people we are serving, you don't have time to think and wait, sometimes you have to act. Our UF CARES staff became champions for the program, teaching the new people at RRHS and developing new relationships every time someone new came on board."

Alma credits strong education, relationship building, and especially the staff's dedication as key to the continued progress of the PATH Home program. "Those changes could have handicapped our intervention if not for the staff, who were stable and committed. Instead, we became stronger as an organization. Our staff pulled together and overcame difficulties. Hiring the right staff is a key component to this program."

RECRUITING CLIENTS INTO PATH HOME

Eligibility Criteria

Adults (18+) are eligible for the PATH Home program if they have these characteristics:

- HIV-positive status - newly diagnosed, lost to care, non-compliant in treatment
- Homeless, unstably housed, or fleeing domestic violence
- Mental health and/or substance use disorders

Clients were referred using a referral form both from within UF CARES and other community partners

Referrals to the Program

Referrals were received from both internal and external sources, both Ryan White and non-Ryan White providers; internal UF CARES staff or any of the stakeholders (*listed on pp. 10-11*) may refer a potential client to our program. Clients were referred from state prison and the local jail system, and all of the Jacksonville medical and case management providers. Potential clients might also be identified by medical case managers who reviewed a monthly report of individuals who had been out of care for six months or longer.

Because UF CARES is located in UF Health Jacksonville and specializes in indigent care, many referrals came through the hospital/emergency room and inpatient services. In this case, an inpatient UF CARES medical case manager made contact with each Ryan White client coming through the hospital, either through the emergency room or inpatient services. If the client was in need of services, the Inpatient medical case manager made a referral to the PATH Home team. We received several newly diagnosed and lost-to-care clients through this model.

Referrals were screened for appropriateness and followed up by the medical case manager, who was the gatekeeper for the project. All services (medical, peer navigation, and all supportive services) were coordinated through this entry point; it was the medical case manager who linked to PATH Home services and other needed resources. The medical case manager completed all Ryan White forms, determined eligibility, and obtained client consents. He or she ensured initial labs were completed and scheduled a PATH Home clinic appointment for the client. The medical case manager completed a needs assessment and made appropriate referrals to River Region Human Services for housing, mental health, or substance use services; linked the client to the peer navigator to assist with needed services and education; and developed the client chart, began documentation in CAREWare, and notified the referral source that the client has been enrolled in the PATH Home program. If a client did not meet PATH Home eligibility requirements, the medical case manager linked that client to appropriate resources.

The *Resources* section includes several tools related to the referral process, including process descriptions, a referral form, and a monthly referral tracking sheet. If a client was determined to be ineligible or chose not to participate in the program, a form and log sheet were used to track that information as well.

SERVICE DELIVERY MODEL

An Overview of Services Provided

Services were delivered in the medical home model of care. Twice a month, clients had the opportunity to attend a half-day clinic based at River Region Human Services' mental health/substance use treatment facility. Clients were offered transportation to and from the clinic, if needed, and lunch was provided. During the clinic, clients' primary and specialty care needs were addressed. Clients also met with the medical and comprehensive case manager to develop a joint plan of care. Due to the complexity of the clients' needs, caseloads were kept relatively small and based on an average of the overall acuity level of the case load. For the PATH Home project, at any one time, the active caseload was about 60 clients. For this reason, a team approach was developed to meet the needs of the caseload without over-stretching any individual. Nutritional, mental health, and substance use assessments, interventions, and linkages to care were also completed during the medical home visit. Clients had access to all resources daily, but the two half-day clinics allowed clients to receive all services during the medical visit.

Housing needs were handled through a referral from UF Cares to River Region Human Services, where the client met with the comprehensive case manager to determine what programs the client might be eligible for and begin the process of gathering all necessary documents and completing the steps to prepare for the housing search. The housing search included the coordinated housing entry process through the Quest Program (http://www.mhrcflorida.com/programs-for-homeless-individuals.html). Clients met with a Quest intake specialist who assessed their housing needs and eligibility using the VI-SPDAT (Vulnerability Index-Service Prioritization Decision Assistance Tool). Quest staff maintain a community-wide waiting list and refer individuals as openings become available. Access to several food and clothing banks is available to clients, and hygiene items are provided as needed through both network and non-network providers. These referrals and resources could be provided by any member of the team followed by documentation in the client's CareWARE record.

Peer navigation was instrumental throughout the process of delivering services. Peers are employed to provide linkage to care, network navigation, mental support, and encouragement. Peers are an extension of the case manager and follow the direction of the case manager that the peer is aligned with. Whereas peer navigators may meet with clients more frequently, case managers meet with clients based on acuity to assess progress on the plan of care, perform home visits, make linkages to needed services, and review health outcomes.

The *Resources* section has several tools to support the delivery of services, including a description of the clinic flow, the process of working with clients on housing, procedures to link clients with behavioral health services, a patient flow sheet to track the services an individual client receives, a plan of care form to document the goals agreed to by the client and frontline staff, a housing/mental health/substance use services referral form, and a housing readiness checklist to make sure the client is prepared to begin the housing search.

The Team Approach to Service Delivery

The PATH Home model is a team effort. After clients complete the consent and initial review, they were introduced to the PATH staff, and the team started working to link them to care and community services. Comprehensive individualized treatment plans which provide direction for each client were developed by the UF CARES medical case manager (MCM) and River Region Human Services comprehensive care manager (CCM) in collaboration with the client. This treatment plan was instrumental to the coordination of care as it encompassed both medical and social issues to be addressed. Peer navigators used the treatment plan as a guide to assist clients with meeting social and clinical goals. Staff in both agencies often went beyond the scope of work to assist clients in achieving individual goals, either related to re-entry to care, retention, housing, or social inclusion.

UF CARES/River Region Human Services PATH Home Workflow

The program coordinators from each organization worked together to ensure the team was functional, coordinate trainings, and perform consents and interviews. The medical case manager and comprehensive case managers worked together to ensure all patient needs were addressed and coordinate care. They also provide day-to-day direction to peer navigators. Similarly, the peers worked together on day-to-day interactions with clients, location of clients, coordination of transportation, and access to community services.

The chart on page 19 illustrates the workflow as the client engages with the PATH Home model.

> "Good strong communications have to take place and things have to be outlined clearly to make this close working relationship succeed.
>
> - UF CARES staff

Communication among PATH Home Staff

Such intense coordination of services required the team to stay in frequent contact with each other; the PATH team had several meetings to facilitate communication. In addition to email and phone communications, the intervention team participated in team huddles as needed. The intervention team—UF CARES MCM, peer navigator, RRHS peer and case manager and medical staff—also attended biweekly intervention team meetings to discuss medical and social issues of clients and determine the course of action for the next week. The multidisciplinary care team reviewed each individual treatment plan prior to the clinic visit in a weekly team staffing meeting. This team included physicians, research, medical case management, PATH Home team, medical team, nutritionist, and psychologist. The individualized treatment plan was stored as a hard copy in the client's chart. It was updated as the client's status/needs change, at minimum every 6 months.

The UF CARES staff, including providers, case managers, nutritionists, program coordinators, medical assistants, and peer navigators, had access to the client's electronic medical record. The River Region Human Services staff had access to the Homeless Management Information System, HMIS. Information was shared and discussed from both systems during the multidisciplinary team staff and team meetings to provide a holistic view of each client and to provide insight on progress towards completion of goals outlined on the individualized treatment plan.

Communication within the Community

To make sure our partners stayed abreast of the developments in PATH Home while monitoring the changing landscape of services within our community, the PATH team hosted a monthly meeting with all partners involved with the PATH Home project. In this meeting, program objectives (*enumerated on page 12*) were reviewed and compared to actual outcomes. Discussions were also held regarding structural issues and changes.

PATH Home team members participated in various meetings and on planning boards in the Jacksonville Ryan White Transitional Grant Area (TGA). We used these meetings to discuss progress being made in the PATH Home project. The Jacksonville TGA has a strong network of community providers. Our relationship was strengthened through participation in regularly scheduled structured network meetings. The Jacksonville partnership hosted several area provider meetings during which the PATH Home team provided updates on the project. We also participated in the CHAT (Community Housing Assessment Team) meetings, a monthly meeting where all the community housing partners meet to discuss resources and clients in need of services. The City of Jacksonville RW partnership hosts several meetings where all stockholders/interested parties/providers are invited to discuss services being offered and to receive provider updates monthly. Members of the PATH Home team, primarily the program coordinator and the medical case manager, attended these meetings.

Transitioning to Standard of Care

Clients were considered ready for transition to the standard of care once they met certain markers indicated on the individualized plan of care, including medical, psychological and social goals that were outlined for the individual client. (*See the sidebar on the right for details.*) Once markers were achieved, a client was presented during multidisciplinary staff meeting for transition. If all disciplines agreed, the client was reintroduced into the standard of care. Examples of client markers include acuity, housing stability, medical compliance, participation in substance use treatment, and involvement in support group meetings.

Standard of care includes a reduction in case management and peer navigator interventions. The PATH Home case manager met with the client to discuss transition. The client was provided with a list of all pertinent contacts for medical and social services. Following this meeting, the client was monitored to gauge continued success in care and was provided support as needed.

Because we know that clients progress and regress in each of the areas mentioned, clients received continued support at a lowered intensity after transitioning. Upon initiating the transition process, we also ensured clients were linked to a primary Ryan White case manager. The primary Ryan White case manager is available to assist clients with accessing medical care, HOPWA assistance, community resources and to work with the medical provider to ensure medical compliance.

A description of the transition process, transition form, and transition letter and contact information are included in the *Resources* section.

Determining markers for transition

Below is an example of what markers might indicate that a client is ready for transition out of the PATH program.

The client is a 61-year-old black male. He entered into the PATH Home program after 29 years of incarceration. The client suffered from years of substance use, bipolar/manic depressive disorder, schizophrenia, and homelessness. He had no family support. The client's individualized plan of care addressed medical compliance, mental health, homelessness, and client reentry into community population. Below are the markers that must be reached in each of these areas before the client transitions out of the PATH program to standard of care.

Clients Markers

Medical: Consistency in treatment as evidence by completion of medical appointment and viral suppression

Mental Health: Compliance with counseling sessions

Housing status: Client consistently maintaining stable residence and paying bills appropriately Social: Client involvement in support groups and local planning committees, church involvement, successfully housed and married.

Social: Client involvement in support groups and local planning committees, church involvement, successfully housed and married.

Documenting the Work

Patient medical documentation is housed in the EPIC health care software system. The staff from UF CARES have access to this system; information from this system was used to develop and measure progress on medical goals established on the individualized treatment plan.

Case management and peer navigation notes are housed in the Ryan White CAREWare electronic health and social support services information system. This was the main source of documentation for the PATH Program. All staff involved in patient care have access to this system. CAREWare assists in the coordination of care and reduces duplication of effort.

Access to the Homeless Management Information System (HMIS) through River Region Human Services was extended for housing services. The staff from RRHS have access to HMIS. Access to HMIS allowed the PATH Home staff to assess the client's attempt to access housing and follow through with housing referrals.

In their own words

To truly understand the impact of the PATH Home program, just ask the clients:

"I wasn't easy but you all took the patience and time and you all dealt with me, and I thank God for that," said Dennis, a 58-year-old client of the PATH Home program who is living with HIV and diagnosed with Hepatitis C. "After doing 14 years incarcerated, it took me a little time to get familiar with the system, but I finally got familiar with it, and I've been involved with it for 3 ½ years."

"I have been housed for the last 3 ½ years. I ended up losing one … the PATH program picked me right back up and got me involved to focus on what I was doing. So now I'm back in my own place again and hopefully that's where I'll be."

In their own words (cont.)

To truly understand the impact of the PATH Home program, just ask the clients:

Eric was introduced to the PATH when he was released after 29 years in prison. "I was brought to Jacksonville where I knew absolutely no one. I was like a child. I was afraid to cross the street. I didn't know anything about traffic lights. The people at PATH took me by the hand and they taught me all the basic fundamentals that I needed to survive. There were a couple of times that I failed, and they were there to pick me up, dust me off and say 'Let's do it again.'"

"PATH got me situated with first: an identification card, second: medicine, third: medical care. They set me up with counseling, clothes…they provided basically everything."

Michael, a client of PATH Home who is living with HIV and has a history of substance use, was homeless when he entered the PATH Home program.

"I was going from hotel to hotel, from shelter to shelter, when I got introduced to Autumn Redding [peer navigator at UF CARES PATH Home program]," Michael recalls." I got into the PATH program, and when I got out of rehab at Gateway Community Services, I continued with that program. They helped me with housing, with substance abuse, HIV treatment."

"I'm adherent to all my medical appointments, and if I'm not, Autumn Redding is right there saying 'OK, boy, let's go, I know you can do this. Remember the three D's, which I still do to this day: Desire, Determination, Discipline. I sit there and still follow that to this day because if I wasn't, I'd be back on the streets doing what I used to do and slamming drugs but because of Autumn and the UF CARES team, I'm not doing that any more."

To hear these clients tell their stories, watch the video at https://youtu.be/6Zee-82_Bvs

EVALUATION AND QUALITY IMPROVEMENT

Quality Improvement Efforts at UF CARES

Quality Improvement (QI) is a large component of UF CARES's ability to successfully ensure the quality of all medical care services we strive to provide in our clinics. Additionally we are bound by the commitment to monitor and track client data to measure performance opportunities and performance successes and to adhere to the reporting requirements of the Administrative Agency, HRSA and all of our other grantees. Therefore, we have committed a full-time data management support staff and a full-time clinical quality improvement coordinator to ensure the quality of the services we provide and oversee the quality of client-level data reported to CAREWare on a real-time basis. With over 1200 clients served in 2014, the task of ensuring the quality of care in our clinic has necessitated the development of a system of checks and balances to ensure timely services for all of our clients.

UF CARES' Continuous Quality Improvement (CQI) team provides monitoring and oversight of all services provided by the UF CARES programs. Representatives from all departments and programs are required to sit in the CQI monthly meetings and discuss the updates of the respective program or area. Quarterly reports are also run from CAREWare to monitor specific performance measures and identify patients who have missing services. Each year, the clinical quality coordinator, in collaboration with the CQI team, monitors three or more clinical HIV/AIDS Bureau (HAB) indicators, by setting goals for clinical quality improvements. Improvement on these HAB measures are also reported yearly to the Transitional Grant Area (TGA) Part A city quality manager. The quality improvement model adopted by UF CARES constitutes not only the cornerstone of the individual organization's quality efforts but strives to coordinate quality improvement efforts with other sister organizations in similar efforts.

Specifically, for the PATH Home project, we implemented our biweekly team meetings to discuss progress with clients and specific barriers that arose. Goals developed on the individualized care plan were addressed for each client during this meeting. The multidisciplinary PATH Home staff, prior to each PATH Home clinic visit, provided an opportunity for group discussion of

> "For the PATH Home project, we implemented biweekly team meetings to discuss progress with clients and specific barriers that arose.
>
> - UF CARES staff

the client's case among all disciplines involved in care during the next medical visit. The PATH Home checklist and PATH flow sheets (available in the *Resources* section) were also used as guides to ensure that clients were receiving the services needed. All changes in the clients' medical care or progress/regress towards social goals were documented in CAREWare and Epic.

Screening and Evaluation Tools used in the PATH Program

The PATH Home model made great use of some of the screening and evaluation tools that are otherwise used for the Ryan White Outcome Reporting (RSR). The following instruments proved of great support to our PATH Home staff, especially to the case managers involved directly with providing care and support to our homeless population:

- **SAMISS screening:** Substance Abuse and Mental Illness Screener (SAMISS) evaluates the Mental Health (MH) and Substance Abuse (SA) of the patient population and is administered yearly. PATH Home case managers administer these screenings. This screening assesses if the client has any immediate needs for treatment. Once the data was collected, a note in the CAREWare data management system notes the availability of the data. Additionally, a scanned copy of the screener is made available in our institutional Electronic Health Records (EHR), Epic, to all in-house mental health providers.

- **Needs assessment:** The needs assessment is administered as part of the HAB measures, every six months. As in the case of SAMISS, case managers administer it in a face-to-face meeting with the client. The needs assessment allows the case manager to identify needs and services that should be addressed on the individualized plan of care. Data is kept confidentially in individual clients' RW charts and a note is made in CAREWare noting the availability of the data.

- **Individual Treatment Plan / Plan of Care:** The individual treatment plan is administered as part of the HAB measures, every six months. As in the case of SAMISS, case managers administer the individualized care plan in a face-to-face meeting with the client. It is a roadmap to be followed throughout the course of client care. The individualized plan of care is a living document that is updated as needed in accordance with client progress or regression. Data is kept confidentially in individual clients' RW charts and a note is made in CAREWare noting the availability of the data.

- **Acuity tool:** The acuity tool is administered as part of the HAB measures, every six months. As in the case of SAMISS, case managers administer the acuity tool, upon concluding a meeting with the client. The acuity tool provides insight to the case manager on the client's ability to navigate the Ryan White network and provides a picture of possible barriers that may need to be overcome. Data is kept confidentially in individual clients' RW charts and a note is made in CAREWare noting the availability of the data.

PROGRAM IMPACTS AND CHALLENGES

The most significant impact of PATH Home has been a uniting of all of our health care team members and community partners to engage them in the process of ensuring we are providing the highest quality of care to our clients and families with respect to addressing medical and social needs. Overall, implementing PATH Home has improved our effectiveness, efficiency, and timeliness in providing quality care and taking actions to improve care when needed. UF CARES has also established another clinic, similar to the PATH Home clinic, with Gateway Community Services, a residential treatment facility providing substance use and mental health services.

> "The most significant impact of PATH Home has been a uniting of all of our health care team members and community partners to ensure we are providing the highest quality of care to our clients.
>
> - UF CARES staff

The major challenge faced was the collaboration of resources between agencies. As the example in the sidebar on pg. 15 indicates, major changes in administration and staff in one agency directly affect the progress of the entire program. One can rarely foresee changes of this magnitude, but must in some way prepare for the unexpected. Some recommendations to prepare for this challenge may be:

- Cross-training of staff from all agencies involved. This can assist in reducing any negative impact on service delivery.
- Partnering with multiple agencies that may provide some duplication of services.
- Ensuring that all new staff are thoroughly briefed on concepts of programs
- Maintaining regular communication on all levels of staff and management

RESOURCES

The following resources from the PATH Home 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

Setting up the Program

- Services referral guide: a categorized list of local services with contact phone numbers, used to refer clients to needed services

Description of Staff Roles within the PATH Program

- Peer navigator
- Network navigator
- Medical case manager
- Comprehensive case manager
- All PATH staff role descriptions

Participant Recruitment

- Referral and linkage process: outlines eligibility requirements, recruitment strategies and processes, an overview of client service processes, and transition out of the PATH program
- PATH referral form: Form used by network agencies to refer clients to the PATH program
- PATH referral process: outlines the process once a referral has been made to the PATH program
- Client denial of services form: used when a client is offered services and chooses not to participate in the program
- Ineligible/declined patient log sheet: used to track clients who are ineligible for or declined PATH services
- Monthly referral tracking sheet: used to track referrals to the PATH program

Service Delivery

- PATH outpatient process: describes the steps taken once a client is enrolled in the PATH program
- PATH clinic flow: a step-by-step description to ensure a smooth flow of clients through all services during clinic hours which take place twice monthly for half a day
- PATH patient flowsheet: a tool to tracks the services received by individual clients as they move through the PATH program
- PATH plan of care: tool used to document goals agreed to by the client and frontline staff and the steps needed to work toward these goals.
- Referral form for housing, mental health, and/or substance use: Form used by UF CARES to refer clients to housing, mental health, and/or substance use services at River Region Human Services

Housing Services

- PATH housing referral process: outlines the process of working with the client on housing when UF CARES makes a housing referral to River Region Human Services.
- Housing readiness checklist: PATH Home staff use this checklist to make sure a client has all documents needed in advance of the housing search.

Transitioning to Standard of Care

- Transition from PATH process
- Transition form: a checklist used by UF CARES and River Region Human Services frontline staff to make sure the client has received all services needed to be eligible for transition
- Transition letter and contact information: a client receives this letter with all contact information when transitioning from the program

APPENDIX

Emergency Services and Homeless Coalition of Jacksonville Needs Assessment Findings

https://www.unf.edu/uploadedFiles/aa/coas/cci/projects/2010%20Homeless%20Report.pdf

The number of people experiencing homelessness in Jacksonville, Florida has risen dramatically in the last several years. This has been seen firsthand by those agencies serving people experiencing homelessness in Jacksonville, and has been demonstrated by local needs assessments focused on individuals experiencing homelessness. Since 2000, the Emergency Services and Homeless Coalition of Jacksonville Inc. (ESCHC) has held an annual assessment of homeless using a Point in Time Count (PTC), and also completing a review of agency data. According to the 2010 *Report on the Homeless Populations in Duval, Clay, Nassau, and Baker Counties* prepared for ESCHC by the University of North Florida, Duval County, Jacksonville had 4,105 homeless individuals, a 19.9 % increase since the 2008 PTC when there were 2,821 homeless. Of those, 55% were African American, compared with 29.9% of Jacksonville/Duval's percentage of African Americans in the population. 71% of the homeless in the PTC report were males; and 75% were between the ages of 26-55.

- Unemployment rates in the Jacksonville metropolitan area ranked at about 12 percent, in 2010. People experiencing homelessness are more likely to be unemployed, with survey data demonstrating 85% mostly unemployed. Temporary employment was the primary work of Jacksonville's homeless: 9.3% were working temporary or seasonal jobs, and only 2% had full time employment. We do see a large number of people coming to Duval county in the winter who seek employment in the temporary labor market for construction (November – April) due to the warmer climate.

- Of those surveyed in the Homeless Count Project, 59% had been homeless for the first time in the last 3 years. 26.3% had been homeless two or three times, and 13.8% had been homeless four or more times. In the survey of 372 individuals, 51% said they had been homeless one year or more. People experiencing homelessness are not as transient as some may guess with stereotypes that we often have about "the homeless," with over 76% being in the county at least one year, only 13% said they had been here less than 3 months. Reasons for homelessness in our region as found in the survey were: Employment/Financial 50.4%, Housing Issues 24.6%, Medical/Disability Problems 17.9%, and Family Problems, 6.9%.

- One fourth of the homeless survey respondents had served in the military, similar to previous years. 15% had been in foster care at some point in their lives. And a full 20% had been a survivor or victim of domestic violence.

- Of those participating, 32% claimed to have a physical disability, and 21.9 % claimed to have a mental health issue, 15% noted having a substance abuse issue, and 1% noted HIV/AIDS (lower than previous years of 3%). It was noted that the questions changed on the survey relating to HIV in the 2010 count, and that may have resulted in lower responses to the question.

- The **top needs identified by the homeless survey** participants included in ranked order: (1) Housing/Shelter 85%, (2) Job 60.5%, (3) Medical 46% (4) Food 39.1%, (5) Money 20.5% (6) Clothes, 10.2 % and (7) Other. Other needs brought out by the survey had to do with the population's ability to wash clothes, food stamp office downtown, and the need for 24-hour shelter programs.

- While Jacksonville's unsheltered population experiencing homelessness is spread out in various areas, including the beaches and suburban areas, transitional housing and emergency shelters as well as sheltered and unsheltered people experiencing homelessness are concentrated primarily in and around downtown in Jacksonville's urban core zip codes (32202, 32204, 32205, 32206, 32207, 32208, 32209, 32210, 32211 and 32254) which have the highest rates of unemployment, poverty and HIV/AIDS incidence.

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