FAMILY HEALTH CENTERS
OF SAN DIEGO

PCMH Connections for Multiply Diagnosed San Diegans Living with HIV

Family Health Centers of San Diego (FHCSD)

Creating a collaborative care navigator model that serves individuals in San Diego who are experiencing homelessness and living with HIV, and who face substance use or mental health challenges

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PCMH CONNECTIONS FOR MULTIPLY DIAGNOSED SAN DIEGANS LIVING WITH HIV AT A GLANCE

Family Health Centers of San Diego (FHCSD)

Geographic description: San Diego, CA, the 8th largest city in the country with a population of 1 1/3 million people

Main challenges: San Diego has the third highest HIV infection rate in CA, an increasing rate of homelessness made worse by lack of affordable housing and inadequate emergency shelters

Focus population: People in San Diego County who are homeless, living with HIV, and with mental health and/or substance use disorders

Description of the model: FHCSD addressed HIV care and behavioral health needs and partnered with People Assisting the Homeless (PATH) to address housing needs. A care navigator model in which a FHCSD Case Manager collaborates closely with a PATH Care Navigator to support clients and connect them to needed services.

Medical home model staff: A SPNS Case Manager and a PATH care navigator coordinate efforts to link unstably housed clients to needed services. A full-time program coordinator, a part-time marriage and family therapist and Psychiatrist support the program. A portion of the program director, associate director and program manager oversee the day-to-day operations. The Institute for Public Health at San Diego State University serves as program evaluators.

Clients served: 254

Impact: Services provided to 254 participants; Strengthened partnerships with housing providers, landlords and property managers; collaboration among navigators and case managers result in fewer gaps in care for clients; staff have gained experience and strong skills in working with the focus population

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 iving 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 are unstably housed, 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 multisite evaluation study of the models. For more information about the initiative, visit http://cahpp.org/project/medheart/

Family Health Centers of San Diego was one of the nine demonstration sites funded under this initiative. This manual describes their experience implementing and evaluating the PCMH Connections for Multiply Diagnosed San Diegans Living with HIV program.

*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-projects-national-significance-spns-program

INTRODUCTION

Challenges Faced in San Diego County

In FY 08/09, San Diego County's estimated unmet need among people living with HIV/AIDS (PLWHA) was 40%: more than 7,200 PLWHA were aware of their HIV-positive status but not engaged in primary care. Of these, 58% live in San Diego County's Central Region, the primary service area for Family Health Center of San Diego's clients served by the Ryan White Part C Early Intervention Services (EIS) program. The unmet need is even higher among specific groups—more than half of HIV-positive women (69%), African Americans (61%) and Native Americans (72%) were not engaged in primary care.[1]

At the same time, homelessness was on the rise in San Diego County. According to a 2011 survey, the number of unsheltered individuals experiencing homelessness increased by 19% since 2008, from 8,575 to 9,020. Only 38% of individuals experiencing homelessness in the county received services at an area health clinic, with 31% turning to area emergency rooms or hospitals for care, at great cost to local taxpayers, and more than 31% receiving no health services at all. Accessing health care was more difficult for this population because of a shortage of affordable housing and supportive services—the 16 emergency shelters and 5 inclement winter shelters had capacity for only 18% of the city's population experiencing homelessness, leaving more than 4,000 men and women without emergency shelter.

As the regional lead for HRSA's health care for the homeless program, FHCSD served more than 22,000 individuals experiencing homelessness in 2011. One fifth of FHCSD's clients who were experiencing homelessness were best served in a language other than English. FHCSD's clients who were experiencing homelessness suffered greater incidence than the general patient population of hepatitis C, type 2 diabetes and hypertension, substance use, and mental health conditions. Among FHCSD's Ryan White-supported clients living with HIV, more than 50% were experiencing homelessness.

[1]2010 HIV/AIDS Needs Assessment Survey of People Living with HIV/AIDS. Retrieved from http://sandiegohealth.org/disease/std_hiv/sdhiv_hsplanning/2010_needs_assessment.pdf

About PCMH Connections for Multiply Diagnosed San Diegans Living with HIV

Family Health Centers of San Diego (FHCSD) – one of the first federally qualified health centers (FQHC) in the United States to be recognized as a Primary Care Medical Home (PCMH), and People Assisting The Homeless (PATH) – one of the most innovative organizations serving the needs of people experiencing homelessness on the West Coast – partnered to create an integrated coordination model to improve the health and housing stability of San Diegans who are experiencing homelessness and living with HIV and co-occurring mental health and/or substance use disorders. In this model, care navigators work one on one with clients to establish a relationship and connect them with a Primary Care Medical Home (PCMH), which, depending on client needs, may include HIV primary care, behavioral and substance use treatment or permanent housing services.

The PCMH Connections project takes place at **Connections Housing**, located in downtown San Diego. Connections is a partnership between FHCSD and People Assisting The Homeless (PATH), which has created an integrated service and residential community whose primary goal is to help individuals living on neighborhood streets to rebuild their lives and secure permanent housing. Virtually every resource an individual needs to break the cycle of homelessness is available on-site at this facility, including 73 permanent supportive housing units (+2 manager units), 16 special-needs single-room occupancy units, 134 interim housing beds, a one-stop social service center (with 16 service partners) and an FHCSD Primary Care Medical Home on the first floor.

PCMH Connections builds on an earlier collaboration between FHCSD and PATH: Connections Housing, an integrated service and residential community in San Diego County whose primary goal is to help individuals living on neighborhood streets rebuild their lives and secure permanent housing. Connections Housing replicated PATH's innovative PATH Mall of social services designed to connect people with social services and permanent housing which has produced nationally recognized results in Los Angeles. Dubbed "San Diego's PATH-2-PCMH," Connections Housing in San Diego has transitional housing, permanent supportive housing, a PATH Depot "one-stop-shopping resource" for social services, and an FHCSD clinic co-located under one roof. Connections Housing opened November 1, 2012 and has served as a demonstration project that is replicable elsewhere in San Diego County.

PCMH Connections for Multiply Diagnosed San Diegans Living with HIV provides an ideal environment for demonstrating an intervention for Dually Diagnosed HIV-Positive Homeless Clients (DDHHC) that includes coordinated case management between PATH serving as the clients' housing advocate, and FHCSD serving as their medical home for primary care, HIV medicine, and behavioral health/substance use care.

Participants in PCMH Connections for Multiply Diagnosed San Diegans Living with HIV will transition through Connections Housing, connecting them with a PCMH, up to three months of transitional housing at Connections, substance use and mental health treatment, job counseling, and permanent housing placement upon "graduation."

The local evaluation was conducted by the Institute for Public Health (IPH) at San Diego State University (SDSU), which has served as an evaluator for many of FHCSD's HIV services programs. Results of the evaluation and program data were shared with the federal Evaluation and Technical Assistance Center (ETAC) for the SPNS initiative.

About Family Health Centers of San Diego and People Assisting the Homeless

Several factors made the San Diego partnership between Family Health Centers of San Diego (FHCSD) and People Assisting the Homeless (PATH) an ideal test site for piloting an integrated coordination model for improving the health and housing stability of dual-diagnosed HIV-positive homeless clients (DDHHC). FHCSD is one of the first Federally Qualified Health Centers (FQHC) in the U.S. to be designated as a Joint Commission-recognized Primary Care Medical Home (PCMH); its system comprises one of the largest FCHQs in the country, based on the number of clients served annually. FHCSD is the regional lead for HRSA's Health Care for the Homeless Program (HCHP) and the largest provider of coordinated HIV counseling, testing, and treatment in the eighth-largest city in the country (with the third-highest HIV infection rate in California).

FHCSD provides behavioral health services through multiple contracts from the County of San Diego, including an ICARE contract, through which FHCSD primary care providers offer integrated behavioral health services in a primary care setting to medication-stabilized, seriously mentally ill individuals, and a Biopsychosocial Rehabilitation (BPSR) Wellness Recovery Center contract in the county's Central Health and Human Services Agency (HHSA) Region. FHCSD provides substance use care to clients living with HIV through its dedicated HIV Coordinated Services Center. The Solution for Recovery outpatient non-residential program provides outpatient support groups, individual counseling, one-on-one support, education sessions, and intervention casework to individuals living with HIV. Treatment services includes a comprehensive assessment, treatment planning, goal setting, on-on-one-counseling, relapse prevention, and groups focusing on addition, health, wellness, and life skills.

FHCSD provides services in multiple locations including the Downtown Family Health Center (DTFHC), which serves many of the city's downtown homeless residents and FHCSD's new Elm Street Family Health Center (ESFHC), which is strategically co-located on the ground floor of the San Diego Rescue Mission to connect San Diegans experiencing homelessness with a medical home. A certified substance use counselor is available at FHCSD's Downtown Family Health Center at Connections, in the building space with PATH.

To address housing needs, FHCSD leveraged its relationship with the San Diego Housing Authority, which as a Move To Work (MTW) housing agency possesses flexibility in its use of Section 8 vouchers, as well as HUD funds. FHCSD also built on the innovative Connections Housing model to connect people with social services and permanent housing.

SETTING UP THE MEDICAL HOME MODEL

Laying the Groundwork

In addition to creating a memorandum of understanding with PATH, FHCSD staff met with several local housing agencies including Affirmed Housing Group, PATH Ventures, Alpha Project, and Solari Enterprises Inc. , as well as project management companies that partnered with PATH to enlist their services to expand the housing resources available to clients in the PCMH Connections Program. Program management staff from FHCSD and PATH worked together to define existing staff roles in relation to the new program and wrote job descriptions for positions where new staff would be hired (*See the sidebar description of collaboration between FHCSD and PATH staff on the next page*). They outlined the program from recruitment of clients to transition from the program and created the forms and tools needed to support the program. Several of these tools are listed in the *Resources* section including a referral and screening form, the acuity tool used to assess the client's level of need, a form for case managers and clients to use when determining goals for client care, a protocol to guide case managers during off site visits, and a tool to support the transition from the program to ongoing care once a client achieves specific milestones.

> "Our medical case management staff was already working with individuals who are living with HIV who oftentimes need housing support, so we made sure they were fully on board and aware of the initiative.
>
> - FHCSD staff

How the FHCSD Case Manager and PATH Care Navigator Collaborate

One area that required advance planning was determining how the case manager and care navigator would work together to serve clients in the PCMH Connection model. The case manager receives referrals, schedules clients for intake, and explains how PATH interim housing works. A screening appointment is scheduled with the PATH outreach program manager.

Once the client is screened, he or she is placed on a waiting list. Once the client is placed at PATH, the FHCSD case manager and PATH care navigator work together with the client and the medical case manager to assist the client with establishing a housing plan, medical care, and behavioral health services. In addition, PATH and FHCSD staff collaborate to assist the client with any challenges that occur. The goal is to stabilize the client to build life skills.

To obtain buy-in from their larger organizations, staff met with management and other departments at FHCSD and PATH to introduce the new program and address any questions or concerns. The presentation used to introduce the program is included in the *Resources* section.

In addition FHCSD and PATH staff fostered partnerships with community members and organizations by providing quarterly and bi-annual in-services or presentations focused on increasing referrals and resources for downtown clients experiencing homelessness to the following entities:

- Ryan White Network
- Housing Agencies and Coalitions
- Shelters
- Substance Use Treatment Centers
- Behavior Health Providers
- Crisis Center
- Emergency Departments

Personnel Roles and Responsibilities

A SPNS case manager and a PATH care navigator coordinated efforts to link clients who are unstably housed to needed services. A principle investigator, associate director, program coordinator, full-time case manager, evaluation manager, part-time marriage and family therapist, and psychiatrist supported the program. The associate director and program manager oversaw the day-to-day operations. The Institute for Public Health at San Diego State University served as program evaluators.

The sidebar on the next page lists the positions that contributed to the PCMH Connections program. Program management staff from FHCSD and PATH worked together to define existing staff roles in relation to the new program. These position descriptions are included in the *Resources* section.

Staff Recruitment, Hiring, and Orientation

The Family Health Center of San Diego (FHCSD) program manager participated in the hiring selection process with supervisors from both PATH and IPH to identify the care navigator and evaluator intern. The newly hired care navigator and evaluator intern met with program staff from various programs within FHCSD including Medical Case Management, Needle Exchange, Gay Men's Health, and the charge nurse from the HIV clinic. The initial FHCSD SPNS case manager was recruited internally and is familiar with the system of care. In the fourth year of the project, this case manager left the position and we hired a case manager based on the criteria outlined in the case manager job description included in the *Resources* section.

Additionally PATH's care navigator shadowed the Ryan White medical case managers to understand the intake and follow-up process with clients. The Ryan White medical case management staff received an overview of the SPNS Initiative to appropriately refer clients from their caseloads to the SPNS program. Descriptions of administrative, evaluation, and intervention staff roles are included in the *Resources* section.

Staff Positions within the PCMH Connections for Multiply Diagnosed San Diegans Living with HIV Program

The PCMH model is to connect dually diagnosed clients who are experiencing homelessness and living with HIV with a Primary Care Medical Home (PCMH), which includes HIV primary care, behavioral and substance use treatment to address needs of the clients as well as permanent housing. Participants will transition through Connections Housing, connecting them with a PCMH, three months of transitional housing at PATH, substance use and mental health treatment, job counseling, and permanent housing placement upon "graduation." Below is a list of positions of staff involved in the program.

Family Health Centers of San Diego
Principle Investigator
Associate Director
Program Manager
Program Coordinator
Evaluation Manager
Case Manager
PATH
Director of Programs
Care Navigator III / Residential Services Supervisor
Care Navigator
Institute for Public Health San Diego State University
Evaluator
Intern Data Specialist
Consultant
Psychologist

Training

Because many clients who are facing homelessness have experienced trauma, one area of skill development identified as crucial for working with this population was trauma-informed care. A consultant was added to the Trauma Informed Care (TIC) training team, who provided one-on-one individual assessment of clinical case management skills, existing trainings, and technical assistance to enhance clinical skills around trauma informed care and excellence. This initial assessment informed the consultant's customized feedback, which was provided to enhance the skills of case managers in working with traumatized clients. Additionally, the consultant conducted the following trainings that benefitted the team at FHCSD and PATH: the Stages of Change (Transtheoretical) Model, Mental Illness and its Treatment, Addiction and Its Treatment, and Cultural Competency. Staff completed about 12 hours of training.

FHCSD initially had an internal licensed mental health clinician who worked with the Ryan White Medical Case Management and the FHCSD/PATH SPNS teams to review cases, discuss TIC implementation and provide group-level support. Our current clinician has provided both individual and group-level support. The trauma-informed care component has been embraced by direct service staff and supervisors, and has provided a strong foundation for FHCSD's work with clients who have a history of trauma.

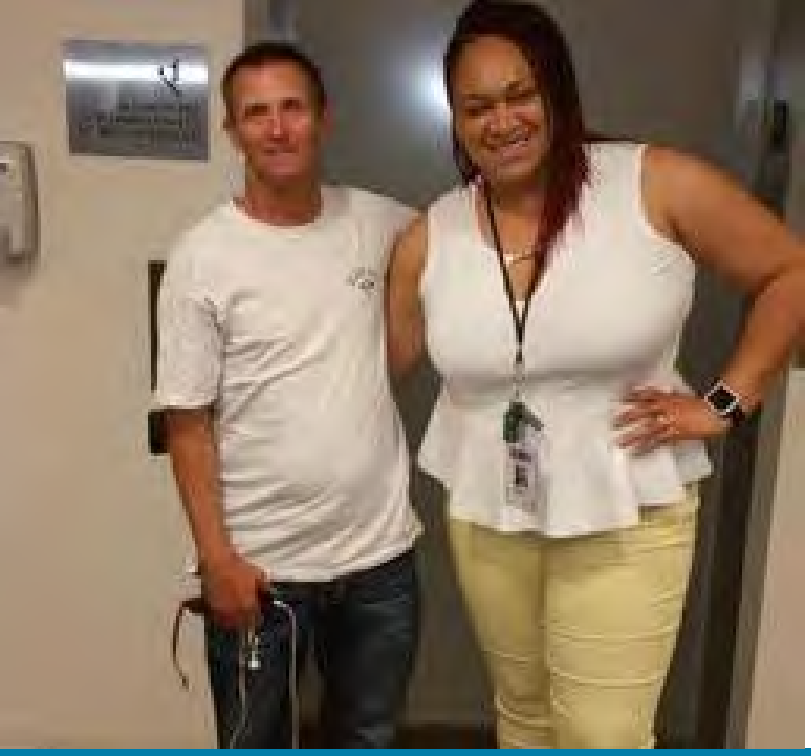
The Coldspring Center for Social & Health Innovation was selected to provide department training because this organization is able to offer both leadership and direct staff training. The chief innovation officer at the Coldspring Center (www.coldspringcenter.org) facilitated a four-day training on Trauma Informed Excellence with FHCSD and PATH direct service staff and supervisors. The goal of the training was to provide a basic understanding of how trauma affects the lives of individuals seeking service as well as how leadership impacts trauma

> The trauma-informed care component has been embraced by direct service staff and supervisors, and has provided a strong foundation for FHCSD's work with clients who have a history of trauma.
>
> - FHCSD staff

through service delivery and supervision. FHCSD established three leadership and organizational goals for TIC: wellness, recognition, and trust, which are the focus for implementation of TIC implemented with staff and clients receiving care.

Supervision

At FHCSD and PATH, staff were trained and supervised by their program manager and program coordinator. Staff engaged in clinical supervision with an internal FHCSD mental health clinician who met with SPNS and medical case management teams for one hour monthly for clinical supervision. The clinician reviewed cases, discussed self-care with staff, provided trauma-informed care knowledge, skills and principles; and offered regular group supervision with the case management teams at FHCSD and PATH. Both FHCSD and PATH staff had weekly supervision and monthly department meetings, combined and individually at the respective sites.



RECRUITING CLIENTS INTO THE PROGRAM

Program Eligibility

The PCMH Connections for Multiply Diagnosed San Diegans Living with HIV program focused on clients who met the following criteria:

- 18 years or older
- HIV Positive
- Homeless or unstably housed, defined as:
  - o Literally homeless: an individual who lacks a fixed, regular and adequate nighttime residence;
  - o Unstably housed: an individual who has not had a lease, ownership interest, or occupancy agreement in permanent and stable housing with appropriate utilities (e.g., running water, electricity) in the last 60 days; **OR** has experienced persistent housing instability as measured by two moves or more during the preceding 6 days; **AND** can be expected to continue in such status for an extended period of time.
  - o Fleeing, or attempting to flee, domestic violence: an individual who has no other residence and lacks the resources or support networks to obtain other permanent housing.
- Multiply Diagnosed: An HIV-positive individual who has been screened and determined to need treatment services for one or more of the following co-occurring illnesses:
  - o Mental illness: within client's lifetime, any illness that significantly interferes with 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.
  - o Substance use: within client's lifetime prior to program intake, any use of illicit drugs or the misuse 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, their eligibility status at most recent incarceration date (i.e., 12 months prior to entering prison or jail) is used.

Paths to the PCMH Connections Program

Potential clients may enter the program through several paths, as outlined below.

Referrals (Internal and external)
Clients were identified and recruited through a number of proactive outreach and in-reach activities. FHCSD and PATH conducted street outreach as well as community-based in-services presentations that describe the program and its enrollment system. In addition, referral forms (*see the* Resources *section for this form*) were distributed to community-based organizations, to elicit new enrollments. Referrals were received from PATH, from FHCSD's HIV Services Department and from current enrollees. The sidebar on this page provides a breakdown of internal and external referrals from August 2012 – February 2017:

Internal and External Referrals

Internal referrals from departments within FHCSD	
Medical Case Management (MCM)	142
Minority AIDS Initiative (MAI)	61
Total	**203**
External referrals from community-based organizations	
Being Alive San Diego	1
Christie's Place	8
North County Health Services	2
Neighborhood Health Association	21
Owen Clinic	5
San Yisdro Health Center	10
University of California San Diego Medical Center	2
Veteran Administration	1
Vista Community Health Center	1
Total	**51**
Grand Total	**254**

Newly Diagnosed Clients and New Clients
For new patients that were encountered through Ryan White medical case management or FHCSD's Hillcrest Family Health Center (HFHC), an initial intake was provided by the SPNS case manager. The initial intake was conducted to determine which services and referrals were needed. During this encounter the Ryan White case manager referred to the SPNS case manager if the client met the eligibility criteria and was interested in program participation. If eligible, the SPNS case manager provided the contact information to the SDSU/IPH evaluation intern.

Newly diagnosed patients within HIV Services or those new to HFHC may be directly referred by Counseling Testing and Referral (CTR) staff to the program coordinator, if the client meets eligibility criteria and is interested in program participation.

Referrals from Partner Agencies
Referrals for this program that came through partner agencies were directed to the SPNS Case Manager for a screening. The referral process should include a completed referral form (*included in the* Resources *section*). Referring agencies include:

- Ryan White Network
- Housing Agencies and Coalitions
- Shelters
- Substance Use Treatment Centers
- Behavioral Health Providers
- Crisis Centers
- Emergency Departments

Existing Out-of-Care Clients
At FHCSD, the SPNS case manager and program coordinator received monthly data reports from our electronic health record (**EHR**) system of clients who have been out of care for 6 months or more.
Clients identified from this report were contacted by the SPNS case manager and program coordinator, by phone and through outreach with the goal of scheduling a medical appointment or a follow-up case management appointment. Three phone and in-person contact attempts were made to re-establish patients in care.

Using the Electronic Medical Record to engage clients in care

FHCSD's SPNS case manager and PATH's care navigator ensured that all clients were established and engaged in their Primary Care Medical Home. One way of doing this is through the use of the electronic medical record.

Staff tracked the patient medical visits in EHR, ARIES, and Service Point. Additional support came from FHCSD Ryan White Medical Case Managers to ensure clients were engaged in quality HIV primary care with FHCSD Downtown and Hillcrest Clinic, and other local Community Health Clinics in San Diego. FHCSD and PATH encouraged all program clients to attend all scheduled HIV primary care medical appointments. Retention in care was tracked by completed and revised Individual Care Plans (ICPs), Electronic Health Records, (EHR), and documentation in the ARIES and HMIS Service Point databases. In addition, mental health and/or substance use treatment was offered on-site weekly at PATH, which assisted with regular attendance and engagement.

A list of all clients who have missed their medical appointment was generated weekly, and used to follow-up with those clients to identify and address barriers, and to reschedule their appointment. Staff also ran reports of missed appointments and clients who have not been seen in at least 3-6 months. FHCSD conducted a quality activity for our no show rate. The PATH Care Naviagtor followed up with all HIV primary patients the next day after their missed appointment through a phone call and worked one-on-one with those clients to address those barriers that were keeping patients from attending their appointments, and assisted in rescheduling their appointment. Additionally, we conducted a deep dive in our electronic health records to identify patients who were deceased, moved out of state, and no longer receiving services from FHCSD.

Ryan White medical case managers and outreach staff referred the returning out-of-care clients to the SPNS case manager to assess service needs or to a physician for a medical appointment and inform the project coordinator of any appointments that have been scheduled. The Ryan White medical case manager maintained a list of potential participants brought in through outreach who attended appointments.

During the initial visit, if the client had been out of care for 6 or more months, the RW medical case manager referred the individual to the SPNS case manager/project coordinator if they met the eligibility criteria listed above.

Screening Procedures

Clients who were referred to the SPNS case manager met with that staff member during the initial care visit or when reconnected to care. Whenever possible, the screening was completed within one week of the initial encounter with clinical staff. (*See the screening tool in the* Resources *section.*) The initial visit and screening process may be scheduled to take place in the clinic or in the field with the client. During the visit with the case manager, the client was informed about the program and assessed for medical, mental health, and substance use, housing, domestic violence, income, low literacy and immigration status. The SPNS case manager completed the eligibility criteria form for the participant. If the client agreed to participate in the program services, the client reviewed and signed a program consent form. Whenever possible, these procedures were completed during the client's initial visit with the SPNS case manager.

SERVICE DELIVERY MODEL

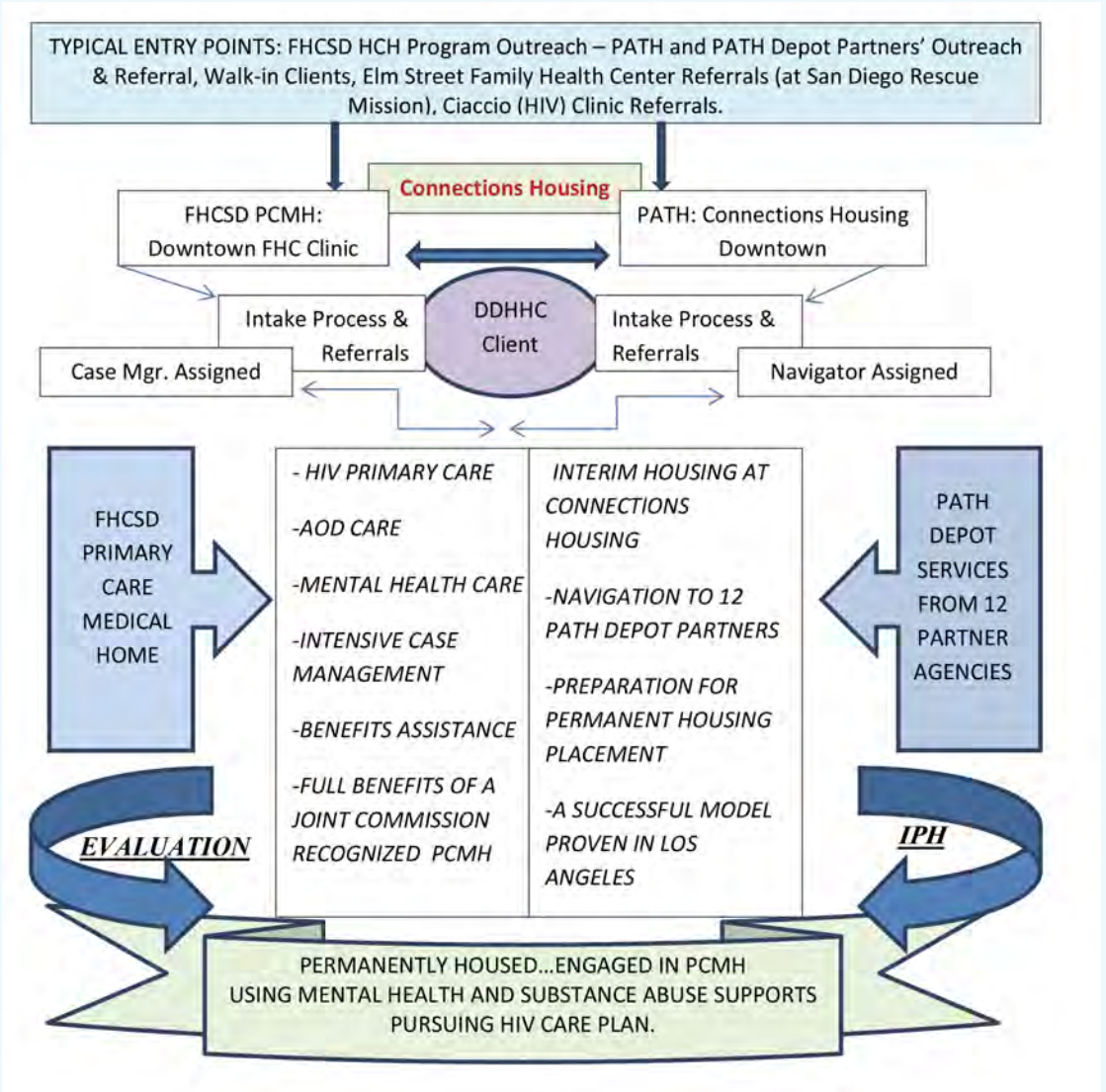
Overview of Services

The graphic on the next page provides an overview of how services are provided to clients in the PCMH Connections for Multiply Diagnosed San Diegans Living with HIV program. Key to the intervention are the roles of FHCSD's SPNS case manager and PATH's care navigator, who work closely together to make sure a client's care needs are met. The SPNS case manager meets individually with a referred client to work toward mutually identified goals for the client's care and well-being (*see the* Resources *section for a sample.*) According to need, the SPNS case manager may link the client with services within the FHCSD primary care medical home network, including everything listed on the left side of the graphic including HIV primary care, mental health or substance use counseling, and benefits assistance.

The SPNS case manager introduces the client to the PATH care navigator at Connections Housing Downtown San Diego. The care navigator provides the client with support to transition from street to housing, using the full resources of the PATH Depot, including everything listed on the right side of the graphic including interim housing, preparation for permanent housing, and support in searching for housing as well as services that address vocational, social, emotional, spiritual, and safety needs.

All newly enrolled participants are screened for mental health and substance use disorders using the program acuity tool (included in the *Resources* section) and several other tools listed in the sidebar. The acuity tool is used to screen client needs and barriers for services. Based on the outcome of the acuity tool, individuals in need of a higher level of substance use outpatient services are referred to FHCSD's outpatient Alcohol and Other Drug services. The PATH care navigator meets with clients monthly, or as needed to ensure their medical, mental health and/or substance use reduction needs are met. Clients that present with severe mental illness or substance use disorders, including those who are participating in the PCMH Connections program, are discussed during monthly case conferences. Strategies to assist these individuals in overcoming barriers and improving appointment attendance are developed at that time. Lastly, any need for referral to more intensive services is discussed. The SPNS case manager and PATH care navigator caseload consists of between 16 to 20 clients.

PCMH Connections for Multiple Diagnosed HIV+ San Diegans: Care Integration and Coordination Overview



Coordinating Efforts on Behalf of the Client

At any given time, a client may be receiving intensive case management services from the Ryan White case manager (whose primary goal is to assist clients that have fallen out of care to reengage them with a PCMH), the SPNS case manager, and the PATH care navigator. To make this work, FHCSD and PATH share case management information intensively between the "medical" and "housing" side of the program. PATH and FHCSD staff members are co-located at least one day per week at each other's primary facilities. The FHCSD SPNS case manager and the PATH care navigator monitor clients' individual care plan to ensure they attend all scheduled primary medical appointments. Additionally, FHCSD staff received the "daily missed" appointments list. The following day, the SPNS case manager connects with the clients to identify any barriers that impede their medical appointment.

To facilitate sharing at the system level, FHCSD worked with the County of San Diego to secure ARIES HIV database access for PATH. Hillcrest Family Health Center (HFHC) also shares the client's medical problems list from the electronic medical record with the housing case manager. (Clients were provided with HIPAA information and data sharing agreements upon

> At any given time, a client may be receiving intensive case management services from the Ryan White case manager, the SPNS case manager, and the PATH care navigator. To make this work, FHCSD and PATH share case management information intensively between the "medical" and "housing" side of the program. PATH and FHCSD staff members are co-located at least one day per week at each other's primary facilities.
>
> - FHCSD staff

entry to the program, and all program forms were subject to an annual review by the project's IRB.[2] The SPNS case manager and care navigator verify that all appropriate client consent forms are in place and together they review ARIES and HMIS records (including client goal plans) to ensure alignment of core services, which may include transportation, housing resources, financial support/income, etc. The care navigator and FHCSD SPNS case manager meet together with clients, who are only housed at PATH, to follow up on their care plan in wraparound client support meetings that are held weekly. In addition, the SPNS case manager regularly meets with clients who are not housed at PATH, for example, Josue House or Townspeople, organizations that provide emergency, permanent and supportive housing for people living with HIV. These meetings promote housing stability by working with residents, property management, and other staff on issues that could impact housing.

FHCSD Ryan White medical case managers work closely with residents who have fallen out or are at risk of falling out of care to re-engage them and to provide referrals. For clients dually enrolled in Ryan White and SPNS case management, FHCSD's SPNS case manager communicates with the Ryan White medical case managers every two weeks, on average. Some examples of shared contacts include updating contact information and sharing new contact information, managing the individual care plan (ICP), and discussing emergency housing options covered under Ryan White. The medical case managers work with Ryan White-related goals as listed in their ICP and meet with each client a minimum of once a month, or as needed. The FHCSD SPNS case manager completes an in-person, or telephone-based contact every two weeks with their caseload. At the conclusion of service, when the client has transitioned to permanent housing, the FHCSD SPNS case manager refers to the Ryan White medical case manager for continued support. (See the *Transitioning to Standard Care* section below for details on this process.)

There is not a joint care plan, however PATH and FHCSD utilize ARIES where client case notes are documented. For example, FHCSD Ryan White case management staff referred a client to SPNS case manager for housing services. The SPNS case manager worked with PATH's navigator to ensure the client was linked to housing and attended medical and behavioral health appointments. After joining the SPNS program, the client was able to receive various services that he had no knowledge he was eligible to receive. In addition, the client was able to secure permanent supportive housing as a result of the SPNS program.

Communication among Program Staff

On a day-to-day basis, FHCSD and PATH staff communicate when they are out-stationed at each other's organizations. For example, FHCSD program staff

[2]Office for Human Research Protections (OHRP) at San Diego State University (Federal wide Assurance #00003782).

spend one day weekly located on the PATH premises where they support case management and strategize with the PATH team on complex client cases. They also communicate via email and telephone. To ensure ongoing communication, FHCSD's program manager and program coordinator meet with staff for weekly case conferencing (case review) and monthly case manager meetings to review client progress and administrative functions related to protocol or client procedures (i.e., form completion, facilitating supportive referrals). Both FHCSD and PATH conduct monthly staff meetings at their organizations. This is an opportunity for staff to

Screening for Mental Health and Substance Use Needs

Below is a list of tools that are used to screen for mental health and substance use needs:

Brief Symptom Inventory (BSI): assess clients for psychological problems and it provides an overview of the client's symptoms and their intensity at a specific point in time.

Generalized Anxiety Disorder 7-item (GAD-7) scale: assess severity of generalized anxiety in our clients over the last 2 weeks

Patient Health Questionnaire-9 (PHQ-9): screen, diagnose, monitor and measure the severity of depression in our clients over the last 2 weeks.

The Drug Use Questionnaire (DAST-10): a self-administered screening instrument used to assess the clients' substance use dependency. Its purpose is to provide information on the client substance use for evaluation by the alcohol and other drug counselor. The DAST-10 asks 10 questions that concern potential involvement with drugs during the past 12 months.

An acuity tool that was developed to determine the level of need and kinds of services required by clients in the PCMH Connections program is included in the *Resources* section.

Mental Health and Substance Use Scores

The PHQ-score is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of 'not at all', several days, more than half the days, and nearly every day, respectively, and adding together the scores for the nine questions. The lower scores represent anxiety or depression. The higher the anxiety or depression the score is greater. The maximum score of the PHQ-9-7 is 27, lower scores are better. The scoring guide is as follows: 1-4 minimal depression, 5-9 mild depression, 10-14 moderate depression, 15-19 moderately severe depression and 20-27 severe depression.

The GAD-7 score is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of 'not at all', 'several days', 'more than half the days', and 'nearly every day', respectively, and adding together the scores for the seven questions.

The maximum score of the GAD-7 is 21, lower scores are better. The scoring guide is as follows: 0-4 normal anxiety, 5-9 mild anxiety, 10-14 moderate anxiety and 15-21 severe anxiety.

The BSI score is calculated by assigning scores of 0, 1, 2, 3, and 4, to the response categories of 'not at all', 'a little bit', 'somewhat', 'quite a bit', and 'extremely' respectively, and adding together the scores for the fifty-three questions.

The maximum score of the BSI is 212, lower scores are better. The BSI instrument screens for possible psychological issues or disorders.

The scoring does not drive the level of intensity of services for SPNS Case Management or PATH Care Navigator. anxiety or depression the score is greater.

provide updates on the program. In addition, FHCSD and PATH communicate regularly between Medical and Behavioral health via email, phone, face-to-face and intervention. FHCSD and PATH establishes a Release of Information for external medical and behavioral health organizations. Communication is also conducted during FHCSD weekly huddles with the Ryan White and SPNS case manager for any clients that are experiencing challenges with retention in care, substance use, and mental health.

Communication within the Community

At the community level, FHCSD and PATH have established memoranda of understanding with various local organizations in San Diego. FHCSD and PATH staff attend monthly community meetings such as the People of Color Case Manager meeting to promote and recruit participants for the program.

Staff from both organizations are members of various committees, including the Faith Based Action Coalition, San Diego HIV Planning Council, Joint City/County HIV Housing Committee for People Living with HIV/AIDS, and Women and Children Care Partnership. These committees are a forum where staff can provide program updates and network with other service providers. Staff attend the meetings monthly and actively participate in special HIV/AIDS awareness events.

Transitioning to Standard Care

When clients enroll in the PCMH Connections program, FHCSD 's case closure and client disenrollment (i.e., discharge) policy is explained to them. Case closure occurs when the client has adequately met set ICP goals and the client agrees to end case management services. Alternatively, the client may initiate the closure. According to the policy, client cases may be closed when their medical care has stabilized, and when all of the following criteria are met: (a) client is enrolled in HIV medical care; (b) following his/her medical plan since the previous assessment; (c) keeping medical appointments; and (d) the client is taking medications as prescribed. RW Case Managers work with clients to create their transition plan. The *Resources* section includes a disenrollment criteria form to make sure the client understands why he or she is transitioning from the program. The SPNS case manager, care navigator, and Ryan White case manager are involved in the transition. After the client has saved money or established resources to transition into permanent housing, staff from PATH and FHCSD collaborate to ensure the client has achieved all the goals on their care plan, which includes viral suppression and adherence to ongoing medical care and behavioral health appointments. The SPNS case manager checks in with PATH staff weekly for updates on client progress and support with any challenges.

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>
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> d) the client is taking medications as prescribed.
>
> - FHCSD staff

Using the transition tool included in the *Resources* section, FHCSD's SPNS case manager and PATH's care navigator ensure all clients in the PCMH Connections program have established and will continue to engage in care with a FHCSD medical provider. Staff track the client's medical visits in EHR, ARIES, and Service Point. Additional support comes from FHCSD Ryan White medical case managers to ensure clients are engaged in quality HIV primary care with FHCSD Downtown and HFHC, and other local Community Health Clinics in San Diego. FHCSD and PATH encourage clients to attend all scheduled HIV primary care medical appointments. Retention in care is tracked by completed and revised Individual Care Plans (ICPs), Electronic Health Records (EHR), and documentation in the ARIES and HMIS Service Point databases. In addition, mental health and/or substance use treatment is offered on-site weekly at PATH. The average length of time in the SPNS program is 3-6 months, depending on the client ability to secure permanent or long-term housing. The client works with the SPNS case manager and PATH care navigator with support and guidance to ensure the client is retained in care and is virally suppressed.

Clients are able to re-engage in the program if they relapse. Using the Housing First model and utilizing harm reduction, the client is given options for detox, outpatient treatment, SMART Recovery and/or other mental health/therapeutic services. The individual will be placed on a behavior contract outlining the client's care and responsibilities. This contract is signed by the client and the program counselor. The client will receive a treatment care plan to assist in the development of a sobriety plan. If the contract is breeched, participation in the program may be terminated. The client case will be case conferenced by administrative staff and the decision will be made on a case-by-case basis.

Mentoring and support groups help clients develop skills, manage program transition

Clients who are transitioning out of the PCMH Connections program have opportunities to participate in programs that help them hone skills while providing support to others.

Graduates from PATH Connection Housing program participate in the UpLift-San Diego program, which allows an opportunity for graduates to continue to receive support and also provide companionship to chronically homeless individuals residing at PATH. The UpLift Companionship Program works on a six-month cycle. Each volunteer graduate (companion) is matched to a recently housed and formerly homeless client for a full cycle. Companions meet regularly with the current resident to engage in simple social interactions, such as getting coffee, going on walks, or chatting over a meal to provide social support and to build hope for the potentiality of change. Currently 21 clients have graduated from PATH and participate in the UpLift-San Diego program.

The PATH Care Navigator facilitates the "Beaten Path" support group for residents and graduates. Participants develop coping skills, financial literacy, medical adherence management, mental and substance use awareness, and other behavioral modification skills. The support group is a forum in which clients can receive assistance navigating services offered throughout The Depot and FHCSD primary care clinics.

I have never seen my own birth certificate

Rick (not his real name) is a 47-year-old Native American male living with HIV. He was raised in a dysfunctional family and was homeless for 25 years. While living on the streets he was alone, starving and scared. He struggled with substance use and mental illness and lived in denial about being HIV positive, as well as living with Hepatitis C since 2008. He experienced severe paranoia and delusions of persecution, believing individuals from prison were following him around town. Due to his homeless situation, Rick was often beaten and mugged, and experienced episodes of rape.

Rick had the courage to come to Family Health Centers of San Diego to access medical case management and establish medical care. When he was enrolled in PCMH Connections, his CD4 count was 20 and he had an extremely high viral load. During a case management session, Rick mentioned that he did not care about himself enough and he was waiting to die on the streets.

Rick rapidly established a rapport with his SPNS case manager and began to trust the services by attending medical appointments, therapy, case management appointments, legal services, housing, community support groups, and prevention services. He met weekly with the PATH Care Navigator to review progress toward the housing care plan goals. He enjoyed meeting with his therapist regularly and working with the prevention team at FHCSD. He was overwhelmed with tasks, but finally obtained his birth certificate, which allowed him to obtain his California identification card. Rick became emotional and proud of himself because it took him 25 years to finally accomplish a goal. "I have never seen my own birth certificate or California identification card," he told his case manager.

While working with his SPNS case manager, Rick was on several affordable housing lists and continued to struggle with his mental health. There were many times he felt he just wanted to quit and run away because he felt his life was too good to be true. His viral load is suppressed and his hepatitis C Serological Viral Response (SVR) is undetectable cleared/cured.

Rick experienced obstacles but remained patient, and now he finally received his first set of keys for his apartment at PATH. He has remained sober and is working on obtaining his SSI. This is an example of how a strong and consistent support system, a hot meal, and a "place called home" can change an individual's perspective on life. The partnership with FHCSD and PATH, support from other community organizations, and funding from HRSA has helped Rick establish a primary medical home and permanent supportive housing.

> **"A strong and consistent support system, a hot meal, and a "place called home" can change an individual's perspective on life.**

Clients that moved into the Special Needs Units and Interim beds completed an intake with the PATH Care Navigator. Each client works with the Care Navigator and Case Manager to develop their Individual Care Plan (ICP). Staff met with clients at least weekly to ensure they were meeting their ICP goals and to monitor their progress for medical appointment adherence, permanent housing, outpatient substance use, mental health treatment, and job readiness. To support these goals, clients were able to access out-patient substance use and mental health counseling. Additionally the FHCSD SPNS case manager attended weekly Interim Program Team Meeting to offer comprehensive support and services for the residents and staff within the program. In addition, she attended the FHCSD monthly medical case manager meetings. During the meeting, the medical case managers are able to receive updates related to SPNS intervention and evaluation. FHCSD and PATH staff participated in ongoing case conferences to discuss strategies for working with clients that have complex issues, especially those associated with mental health and substance use.

I can start looking for a place and bring my 3-year-old son home

DJ is a client in the PCMH Program. When he arrived he was diagnosed with renal failure, kidney issues, severe psychosis, and he was non-adherent to his HIV medication. Working with the SPNS Case Managers, he was able to link to medical care and mental health services. Working with the PATH Care Manager, he succeeded in obtaining housing. Having housing and a medical home created a stable environment so DJ could attend medical appointments, participate in a regimen to improve his liver condition, and become compliant with his HIV medication. Below is an excerpt from a thank you letter from DJ:

"Before coming to PATH Connections, I was homeless on the streets for 3 years. PATH and [housing partner] Solari afforded me with the opportunity to come a long way. As I have been here since April, I moved from interim housing to SRO rooms, which have been a great help while I've been going through my treatment for Hep C, of which I am now cured. This program also has brought me great success as I just received my HUD voucher, so now I can start looking for a place and bring my 3-year-old son home. I don't know what I would have done without this place. I would like to give thanks to [case managers] Nick [and] Amelia, and of course property manager Makda. These are all very skilled and caring people."

"DJ did whatever it took to remain housed, and with that type of self-motivation and determination, he eventually transitioned to our Short-Term Transitional housing, where together we began the journey to attain permanent housing," his care manager explained. "He has shown us that no matter what, if you want change in your life, you have to be willing to travel the many stages that you will come across. He has helped me see supportive services in a different way. His diligence inspired me to become more creative in the way I help my clients."

One year later, DJ remains stably housed. He stays in contact with the PATH Care Navigator and FHCSD case manager and reports being adherent to his medications, with undetectable viral loads for both HIV and Hep C. DJ is in the process of moving from a one-bedroom into a brand new two-bedroom apartment with his son, who will be entering kindergarten this year. DJ continues to trust the process, utilize the tools provided while at PATH, and stay connected with his case manager. DJ's participation in the SPNS programs and wraparound services are a testament to success that isn't that scary after all.

"Before coming to PATH connections, I was homeless on the streets for 3 years... I moved from interim housing to SRO rooms, which have been a great help while I've been going through my treatment for Hep C, of which I am now cured... I just received my HUD voucher, so now I can start looking for a place and bring my 3-year-old son home.

Educating Alice

Alice (not her real name) is a 58-year old, HIV-positive African American female who struggled with addiction that led her to homelessness. She was living in the streets for well over a year, often getting into trouble and engaging in illegal activities.

Alice was on parole, and court mandated to complete an outpatient alcohol and other drug program. As a result, she was referred to the PCMH Connections program and introduced to medical case management for ongoing supportive services.

To address substance use issues, Alice entered an outpatient program called Solutions for Recovery where she learned how to cope with life and how to control the things that triggered problem behavior. She was later referred to PATH for a housing screening. While staying there she attended the typing class, AA big book study, bible study, and credit repair classes that they offered on the premises. The PATH care navigator taught Alice how to budget and save money.

Alice and her husband now have their own place thanks to PATH, Family Health Centers of San Diego Solutions for Recovery and Minority AIDS Initiative program. Alice tells her story in a video here: https://youtu.be/jZSpdW28Q5A

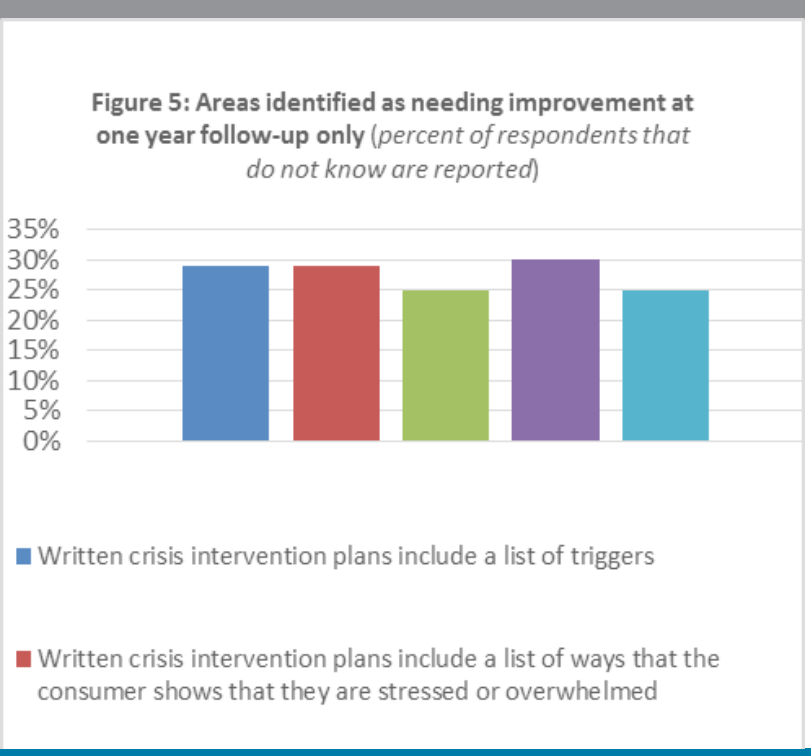


Figure 5: Areas identified as needing improvement at one year follow-up only (*percent of respondents that do not know are reported*)

EVALUATION AND QUALITY CONTROL

Evaluating Staff Skills Related to Trauma-Informed Care

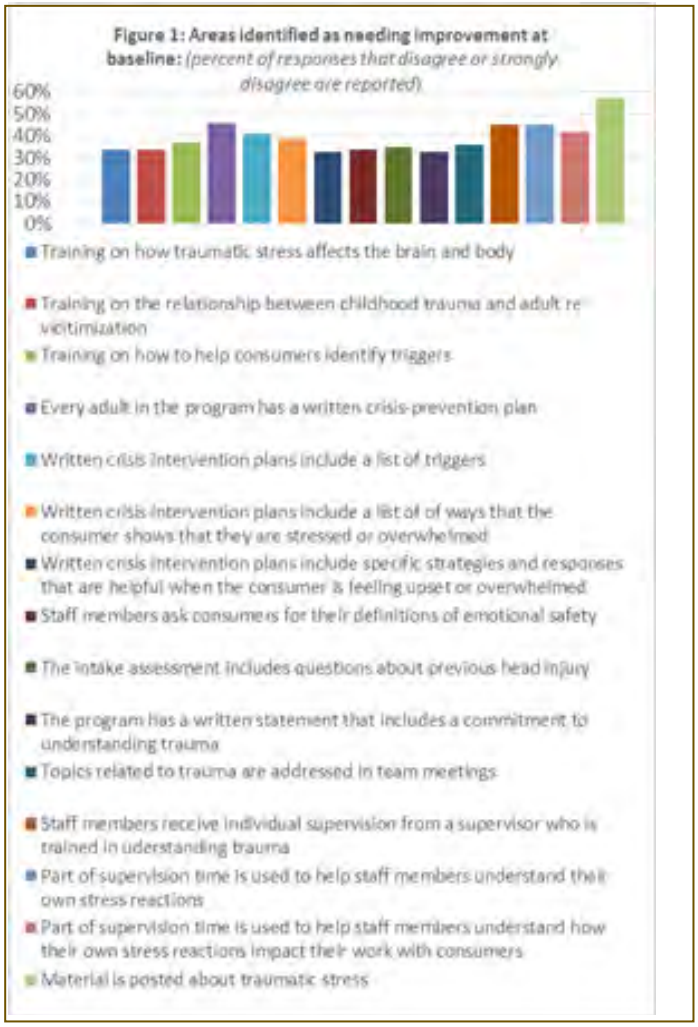
Trauma-informed care is a skillset that staff identified as key when working with people who are homeless and with mental health and substance use challenges. For this reason, the PCMH Connections team at FHCSD participated in a department-wide initiative to assess and build skills in this area. San Diego State University Institute for Public Health administered a Trauma Informed Care staff survey for a local evaluation to assess the readiness of staff within FHCSD HIV service department to work with clients that have experienced trauma. The results of these efforts are described below.

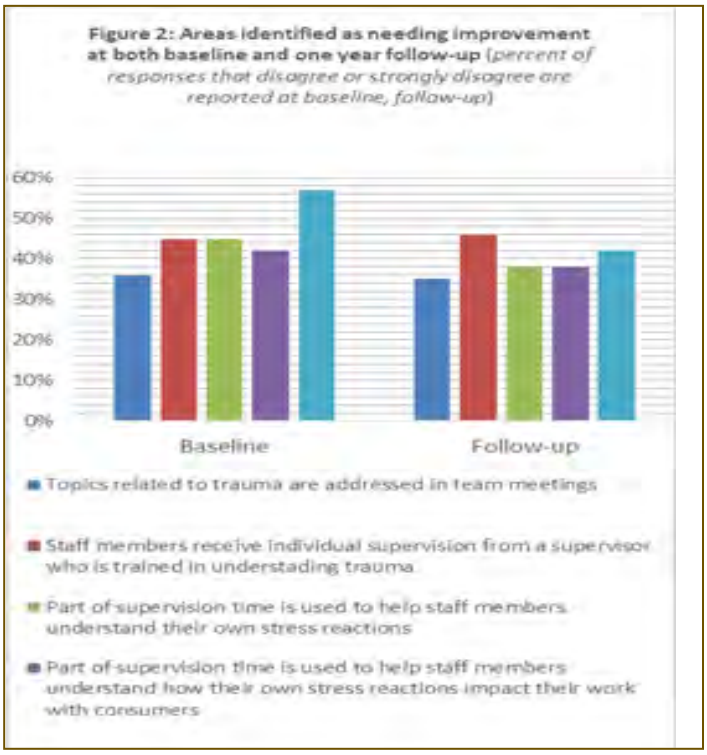
Data Collection Activities for the Local Evaluation

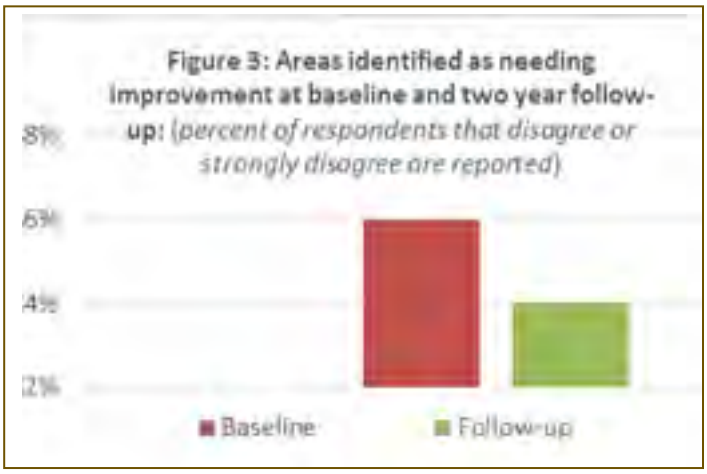
FHCSD continues to assess its readiness to provide Trauma Informed Care via a survey adapted from *The Agency Self- Assessment for Trauma Informed Care* by Orchard Place/Child Guidance Center's Trauma Informed Care Project. In 2014, surveys assessing staff knowledge of trauma-informed care were administered to staff in the HIV department, including PCMH Connections frontline staff, followed by intensive training on trauma-informed care. Additional training was provided to address needs uncovered by the survey results, and follow-up surveys have been administered after one year and two years. For the two-year follow-up, surveys were distributed at an HIV services departmental meeting in January 2016. Fifty-five follow-up surveys were completed and returned. Of those, fifteen were completed by staff hired after the Trauma-Informed Care training in February 2014.

Areas for Improving Department's Ability to Provide Trauma-Informed Care

The local evaluation shows that improvements have been made on the department's ability to provide trauma informed care. Areas that need improvement are indicated by items where more than 33% of participants reported that they either *strongly disagree* or *disagree* that the item was adequately provided. As indicated in Figure 1 below, at baseline, areas identified as needing improvement included training on multiple topics related to traumatic stress, crisis intervention planning, using supervision and team meetings to address trauma-related





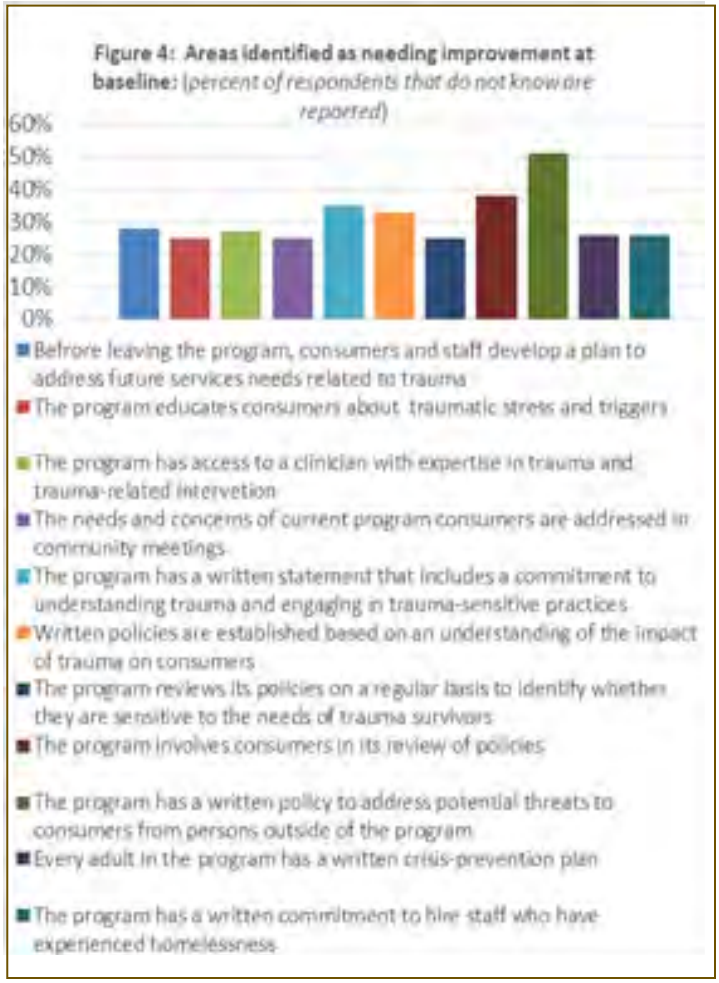


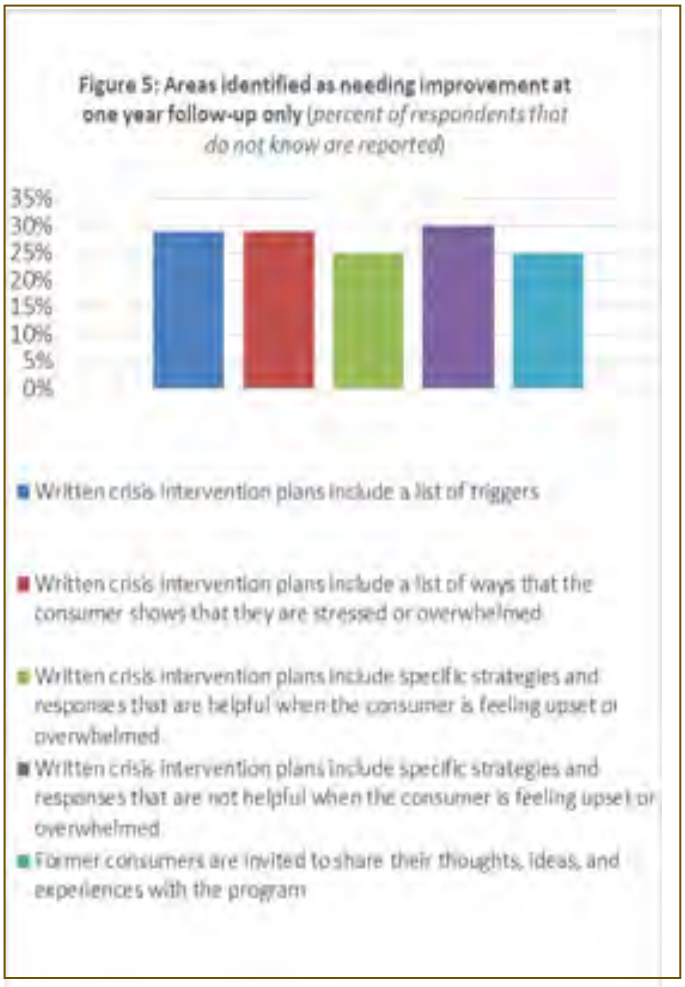
issues, and posting materials about traumatic stress. Staff participated in intensive trauma-informed care training following the baseline survey. The program manager and local evaluation staff met to review and revise crisis intervention plans. (*The updated crisis intervention plan is included in the* Resources *section.*) As indicated in Figure 2, at one-year follow-up, areas identified as needing improvement included using supervision and team meetings to address trauma-related issues and posting materials about traumatic stress. The program manager and local evaluation staff developed protocols for supervisors to address stress reactions and how they impact work with clients during supervision and team meetings. In addition, staff training was implemented on site protocols for handling suicidal or emotional distress situations. At two year follow-up, the only areas identified as needing improvement was addressing topics related to trauma in team meetings. At three year follow-up, using supervision to address trauma-related issues was identified as an area needing improvement.

Additional Training Needs

Areas where more staff training on departmental policies and procedures may be needed are indicated by items where more than 25% of participants indicated that they do not know. At baseline, eleven areas for additional training were identified (Figure 4). At one year follow-up, five areas were identified (Figure 5). And the following four areas were identified at the two year follow-up and will continue to receive focus:

1. The program has a written statement that includes a commitment to understanding trauma and engaging in trauma-sensitive practices.





2. Written policies are established based on an understanding of the impact of trauma on consumers.
3. The program has a written commitment to hire staff who have experienced homelessness.
4. The program has a written policy to address potential threats to consumers from persons outside of the program.

Areas with Trends toward Improvement between Baseline and Follow-up

To identify which items saw improvement between the baseline and follow-up surveys, responses were dichotomized into 1) *agree* or *strongly agree* and 2) *disagree* or *strongly disagree* or *do not know*. Chi-square tests were then conducted to determine statistical significance. Those with p-values less than 0.05 were considered significant and all of these items increased in the proportion that selected *agree* or *strongly agree*. Between baseline and one year follow-up, there were seventeen areas with a significant increase in the proportion of respondents who selected agree or strongly agree as a response. Based on the results from the one-year follow-up, the department revised the Crisis Intervention Plan to include a list of triggers and stressors, a list of ways that the client shows they are stressed or overwhelmed, specific strategies and responses that are helpful when the client is feeling upset or overwhelmed, and specific strategies and responses that are NOT helpful when the client is feeling upset or overwhelmed. In addition, staffs were trained on protocols for handling suicidal and emotional distress situations and supervisors worked with staff to assist them in understanding their own stress reactions and how their stress reactions impact their work with clients. As a result, the number of areas showing a significant increase in respondents selecting agree or strongly agree increased from seventeen areas in the one year follow-up to the following thirty-eight areas in the two year follow-up.

PROGRAM IMPACTS AND CHALLENGES

FHCSD has provided services to 254 participants through the PCMH Connections Program. An ongoing challenge encountered with the intervention is the lack of available affordable units for permanent housing. To overcome this challenge the PATH care navigator continues to work with non-traditional landlords and property managers to consider renting to individuals with very low income. The SPNS case manager and care navigator are working to implement self-sufficiency and life skills development as part of clients' Individual Care Plans, and monthly groups, as well. It should be noted that the San Diego Housing Commission and the City of San Diego are collaborating to meet the housing needs of homeless veterans through a multi-faceted program that includes landlord incentives (approved by the City Council on March 1, 2016). It is FHCSD's hope that this effort may help to mitigate the affordable housing shortage for individuals who are experiencing homelessness over time.

"An ongoing challenge encountered is the lack of available affordable units for permanent housing. To overcome this challenge the PATH care navigator works with non-traditional landlords and property managers to consider renting to individuals with very low income.

- FHCSD staff

Housing Breakdown for PATH Participants

At the end of the project, the housing status for PATH participants was as follows:

In Permanent Housing	83
In Temporary Housing	24
Client Deceased	15
Relocated out of state	31
Homeless	61
Couch surfing	15
Unknown (lost to follow up)	18
Incarcerated	7
Total clients enrolled in the program	**254**

To ensure there is no gap in care and services for the SPNS participants, FHCSD's SPNS Case Manager, PATH's Care Navigator, and Ryan White Medical Case Managers continue to foster their partnership in a collaborative effort to ensure all participants in the intervention are established and engaged in primary medical care with FHCSD Downtown and Hillcrest Clinic and local external primary care providers and permanent/supportive housings, and supportive services as needed. The participant will transition from the SPNS Case Manager and PATH Care Navigator and primarily work with the Ryan White Medical Case Managers.

FHCSD plans to continue to foster the relationship with PATH and other community partners to maintain sustainability beyond the 5-year project period. FHCSD and PATH will develop a sustainability plan that will include the lessons learned and successes during the 5-year program period. FHCSD and PATH will continue to pursue additional funding to replicate the model.

RESOURCES

The following resources from the PCMH Connections 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

Building a Medical Home presentation (ppt): This presentation was used to introduce the PCMH Connections program to staff within FCHSD

Job Descriptions

PCMH Connections staff role descriptions (docx): A description of each staff position in relation to the PCMH Connections program

FHCSD hired staff for the following PCMH Connections positions whose job descriptions are listed below:

- Family Health Centers of San Diego SPNS Case Manager (docx)
- People Assisting the Homeless (PATH) Care Navigator (docx)
- Institute for Public Health Senior Evaluation Specialist (docx)
- Institute for Public Health Senior Evaluation Assistant (docx)
- All PCMH Connections job descriptions (docx)

Referral and screening form (docx): Other departments within FHCSD and outside partner agencies use this form to refer potential clients to the PCMH Connections program

Acuity tool (docx): This tool was developed to determine the level of need and kinds of services required by clients in the PCMH Connections program

Medical case management eligibility screening tool and transition plan (pdf): The screening tool used to determine client eligibility for Ryan White medical case management services and to document transition plan

Case management care plan (docx): This tool assists the SPNS case manager in working with a client to identify and follow up on client goals for care and well-being.

Disenrollment criteria form (docx): This form helps the SPNS case manager communicate to the client why he or she is being transitioned out of the program

Transition tool (docx): This tool was used to determine and document a client's readiness to transition from the PCMH Connections program to the standard of care

Home visit protocol (docx): The FCHSD home visit protocol was used to provide guidance to staff meeting with clients outside of the clinic environment.

Crisis intervention plan (docx) This form was used to help staff think through and develop a plan of action to address a crisis before it occurred.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