THE HIV, HOUSING, & EMPLOYMENT PROJECT

No Wrong Door for High-Acuity Care:

A Federally-Qualified Health Center and AIDS Services Organization take the next steps by integrating employment services and intentionally coordinating care.

FENWAY HEALTH

Contents

Executive Summary

Fenway Health, AIDS Action Committee (FH's public health division), and MassHire Downtown Boston created a partnership to provide coordinated access to HIV healthcare, housing, and employment services. The intervention sought to improve HIV health outcomes for low-income, uninsured, and underinsured people living with HIV (PLWH) in racial and ethnic minority communities. Prior to this project, significant components and systems for HIV medical care, housing, and employment (outside the HIV context) already existed; however, we found that these systems operated in silos and individuals facing multiple barriers had challenges navigating them. Prior to the SPNS project, there was little evidence of active collaboration beyond initial referrals between systems of HIV medical care (primarily medical case management) and housing programs. Employment services existed in a completely separate sphere, without even referral relationships. We developed this partnership to institute both systems-level and provider-level collaboration between these robust systems. Our major innovation was a "no wrong door" approach for initial referrals as well as ongoing follow up during the course of the project.

Background & Intervention Context

The Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV primary medical care, essential support services, and medications for low-income people with HIV who are uninsured and underserved. The Program funds grants to states, cities/counties, and local community-based organizations to provide care and treatment services to people living with HIV to improve health outcomes and reduce HIV transmission among hard-to-reach populations.

The intervention outlined in this manual was part of the "Improving HIV Health Outcomes through the Coordination of Supportive Employment and Housing Services" Initiative (otherwise known as the "HIV, Housing & Employment Project"). This HRSA Special Projects of National Significance (SPNS) Initiative was funded by the U.S. Department of Health and Human Services (HHS) Minority HIV/AIDS Fund, and the intervention was conducted and evaluated within a RWHAP-funded site.

The Housing and Employment project intervention was implemented by Fenway Health, a RWHAP Part A sub-recipient and Part C recipient based in Boston, MA.

Introduction

The purpose of the implementation manual

The intervention manual provides a detailed description of the design and implementation of each site's intervention for the HRSA/SPNS Initiative "Improving HIV Health Outcomes through the Coordination of Supportive Employment and Housing Services." As stated in Funding Opportunity Number: HRSA-17-114, each demonstration site is required to document their intervention methodology, implementation, outcomes and lessons learned for the purposes of replication. The Evaluation and Technical Assistance Provider (Boston University) will review and develop a companion guide highlighting the similarities and differences of the intervention programs for dissemination to the wider Ryan White community, Department of Housing and Urban Development (HUD) programs, Department of Labor (DOL) programs, and other key stakeholders.

Audience

The audience for this manual is: service providers, county, city and state agencies who are interested in improving access and quality of care and services for people living with HIV/AIDS who are homeless or unstably housed and unemployed/underemployed.

Overview of the SPNS initiative

Fenway Health developed an intentional partnership with employment services at MassHire Downtown Boston that provides clients with case coordination among medical care, housing and employment service providers. To expand this model of integrated services to the region, Fenway works with other Ryan White providers to strengthen system-level service coordination where clients are routinely screened for housing and employment needs, and referred to available services.

The initiative, entitled Improving HIV Health Outcomes through the Coordination of Supportive Employment and Housing Services, supports the design, implementation, and evaluation of innovative interventions that coordinate HIV care and treatment, housing and employment services to improve HIV health outcomes for low-income, uninsured, and underinsured people living with HIV (PLWH) in racial and ethnic minority communities.

The specific target population is clients who are or intend to receive care at Fenway, who are homeless or unstably housed, and who are un- or underemployed. This project serves clients with incomes below 400% of federal poverty level, with a special focus on members of racial and ethnic minority communities. Racial and ethnic disparities are apparent at each stage in the Massachusetts-specific HIV Care Continuum compiled by the Massachusetts Department of Public Health. In Massachusetts, Black and Hispanic/Latinx people living with HIV are less likely to be engaged in medical care, to remain in care, and to be virally suppressed. Only by understanding and addressing how racial and ethnic disparities are rooted in social determinants such as poverty, discrimination, and lack of stable housing and employment, will the state succeed in achieving higher rates of retention in care and viral suppression.

Fenway Health provides HIV care and treatment, including access to Medical Case Management. AIDS Action Committee, the public health division of Fenway Health, provides comprehensive housing services, including housing search and rental assistance. Fenway partnered with MassHire Downtown Boston, a division of Jewish Vocational Services (JVS), Greater Boston's largest workforce development provider, to provide employment services.

Clients worked with case managers to engage and remain in care and treatment, and were referred for housing services and employment assistance. All providers involved with a particular client coordinated services; the Project Coordinator facilitated this coordination with liaisons in the Medical Case Management program, employment services agency, and each of the Housing programs.

Through this project, Fenway Health/AAC and MassHire developed integrated systems of referrals, case coordination and resource sharing. Beyond the three years of this grant, these programs and services will have integrated systems to best serve our clients.

Intervention Methodology

Organizational context

Fenway Health/AIDS Action Committee

Fenway Community Health Center, Inc. (Fenway Health) is a federally qualified health center (FQHC) and longtime recipient of Ryan White CARE Act funding under Parts A and C to provide case management and early intervention services to those living with HIV. Fenway Health is the largest non-hospital provider of HIV/AIDS medical and behavioral health services in Massachusetts, treating more than twice as many persons living with HIV as all of Boston's other community health centers combined. In 2013, in strategic response to health care reform and evolution of the HIV/AIDS epidemic, Fenway Health began a merger process with AIDS Action Committee of Massachusetts, Inc. (AAC), which was until then operating independently as Massachusetts' largest community-based AIDS Service Organization. AAC brought to the partnership extensive experience with and infrastructure for providing housing services. A new MA HIV State Plan (2017-2021) was released in 2016, which delineated a significant shift in funding priorities and funding categories from the past 20 years. Particularly relevant to this project was the shift of case management funding from a community-based service to a clinic-based service focusing on high acuity clients. The new procurement and award to Fenway reflected this shift, practically eliminating the largest service category for AAC, Community-based Case Management.

Now constituting the public health programs division of Fenway Health, AAC provides community-based services to those living with or at risk for HIV, regardless of where they receive primary medical care. We largely organize services in two areas of focus, Prevention Services, including Sexual Health Program and Drug User Health Program, and Social Determinants of Health (SDOH) Services, including Housing, Legal, a Homeless Youth program, and Case Management programs. The Housing Department was a key part of this intervention; we describe its structure in the Intervention section below.

Fenway Health also brings a particular strength in managing and leveraging data. Fenway's Informatics Team is embedded within The Fenway Institute, Fenway Health's integrated research arm. This team maintains the electronic medical record in the form of Centricity Practice Solution (CPS). The Informatics team also provides real-time, filterable reports from CPS in Tableau Server. A subset of the Informatics Team also maintains AAC's database, an instance of Efforts to Outcomes (ETO). ETO also contains a built-in reporting and visualization platform called ETO Results. Lastly, the Informatics Team also maintains an instance of REDCap; one of the many projects we maintain in REDCap is one for managing referrals for the SPNS project.

MassHire Downtown Boston

MassHire Downtown Boston is a division of Jewish Vocational Service (JVS), whose mission is "to empower individuals from diverse communities to find employment and build careers, and to partner with employers to hire, develop and retain productive workforces." The MassHire career center is imbedded in JVS, a major workforce development provider in Massachusetts; clients are able to access a wide range of services and activities, free of charge, as well as obtain valuable information, resources, and potential acceptance to a variety of skills training programs, English classes, and adult education services. Fenway Health and MassHire created an intentional, contracted partnership through this project, with significant buy-in from both leadership and front-line staff.

Target population and description of need

Demographics and health disparities

The project's specific target population was case management recipients with incomes below 400% of federal poverty level who were homeless, unstably housed, or at risk of homelessness who also had employment needs; this necessarily created a special focus on members of racial and ethnic minority communities. Fenway Health now provides integrated HIV case management services those who receive primary medical care at Fenway Health's three clinical sites in Boston.

Across Massachusetts and in greater Boston specifically, racial and ethnic minorities experience disparately high incidence of HIV infection and disparately poor HIV-related health outcomes. Of people living with HIV (PLWH) in Massachusetts, 30% are Black (non-Hispanic) and 25% are Hispanic/Latino, compared with 42% who are white. According to the Massachusetts Department of Public Health (MDPH), as of 2015 there were 14,439 men living with HIV/AIDS in the state, 23% of whom were Black (non-Hispanic) and 24% of whom were Hispanic/Latino. Of 5,833 women living with HIV/AIDS, 46% were Black (non-Hispanic) and 27% were Hispanic/Latina. In Massachusetts, Black and Hispanic/Latina women are diagnosed at rates 33 and 12 times that of white (non-Hispanic) women. In the Greater Boston area specifically, Black and Latinx people are even more disproportionately affected: 50% of men living with HIV are Black or Hispanic/Latino and 86% of women living with HIV are Black or Hispanic/Latina. Among those with late diagnosis of HIV (as evidenced by receiving an AIDS diagnosis within two months of initial HIV diagnosis), 35% are Black, compared to 22% who are White.

In Fenway Health's metropolitan Boston service area, a significant number of low-income PLWH in need of health care, housing and employment services are non-US born. While only 16% of the total population of Massachusetts was born outside the United States, 26% of PLWH and 35% of those recently diagnosed with HIV are non-US born. Those who were recently diagnosed and born outside the US were primarily from sub-Saharan Africa (28%), Central and South America (28%), and the Caribbean Basin (27%), demonstrating a particular need for services among Black and Hispanic/Latinx PLWH who are non-US born. Thirty-three percent (33%) of current AAC clients were born outside the US. These individuals face barriers such as unknown, evolving, or undocumented immigration status, the need for interpretation and translation services, a shortage of services provided with cultural competency and sensitivity, and in many cases, a history of untreated trauma.

Racial and ethnic disparities are apparent at each stage in the Massachusetts-specific HIV Care Continuum compiled by the Massachusetts Department of Public Health.[1] Of all Massachusetts PLWH, 75% are engaged in care; 59% are retained in care; and 65% are virally suppressed.

Health outcomes are worse among Black PLWH: 60% are retained in care and 63% are virally suppressed. Similarly for Hispanic/Latinx PLWH, 57% are retained in care and 60% are virally suppressed. These health disparities among Black and Hispanic/Latinx PLWH contribute disproportionately to Massachusetts' failure thus far to meet its continuum of care goal of seeing 90% of PLWH linked to care, 90% retained in care, and 90% virally suppressed. Only by understanding and addressing how racial and ethnic disparities are rooted in social determinants such as poverty, discrimination, and lack of stable housing and employment, will the state succeed in achieving higher rates of retention in care and viral suppression.

Social determinants of health for PLWH

Throughout Greater Boston, substance use, and the opioid crisis in particular, presents a substantial barrier to engaging and retaining PLWH in care and treatment. This issue is also closely linked to instability in housing and employment. Among people diagnosed with HIV and substance use disorder, those experiencing homelessness had 92% more ED visits and 113% more inpatient admissions.[2] Fenway Health's Drug User Health Program serves those who are living with and at high risk for HIV and Hepatitis C infections. Of the clients served by this program, 38% are homeless or living in unstable situations; of those, 72% were HCV-positive, demonstrating a high rate of infection among those living with a substance use disorder and lack of housing. Rates of homelessness are notably higher among those living with HCV infection, at 52% compared with 38% of all clients served. This demonstrates a disparity in housing need between those living with HCV, which extends to PWLH as well, including many who are co- infected with HCV. Substance use, HCV and other infections further interfere with consistent retention in care and viral suppression, and are contributing factors in the prevalence of health disparities.

Health disparities are closely linked to poverty, homelessness and unstable housing. Stable housing has a significant and demonstrated impact on the health outcomes of PLWH in all aspects of the care continuum. Those who are homeless or unstably housed are more likely to be delayed in diagnosis and linkage to care, more likely to have interruptions in care and treatment, and less likely to achieve viral suppression.[3] The cost and scarcity of affordable housing is a common threat to stability, leading many clients to live in substandard housing or far away from their medical care. In a randomized study, those who received stable housing were twice as likely to be virally suppressed as those without stable housing.[4] According to the CDC, housing stability is a stronger predictor of health than other individual factors, and "housing itself may improve the health of PLWH."[5] Housing instability disproportionately impacts people of color, and 68% of AAC clients who are homeless or will imminently be homeless identify as people of color.

[1] Massachusetts HIV Care Continuum, released March 1, 2016. www.mass.gov/eohhs/docs/dph/aids/2016- profiles/hiv-care-continuum-factsheet.pdf. Accessed July 15, 2017.

[2] Masson CL, Sorensen JL, Phibbs CS, Okin RL. Predictors of medical service utilization among individuals with co- occurring HIV infection and substance abuse disorders. AIDS Care. 2004; 16(6):744–755.

[3] https://www.hudexchange.info/resources/documents/The-Connection-Between-Housing-and-Improved- Outcomes-Along-the-HIV-Care-Continuum.pdf

[4] Buchanan, D.R., et al. (2009).The Health Impact of Supportive Housing for HIV-Positive Homeless Patients: A Randomized Controlled Trial. Am J Public Health, 99:6

[5] Kidder, D., et al. (2007). Health status, health care use, medication use, and medication adherence in homeless and housed people living with HIV/AIDS, Am J Public Health, 97(12): 2238- 2245

The project is predicated on the belief that linking clients to resources to stabilize income and housing will improve retention in care and adherence to medication. In Massachusetts, those who make some connection to care demonstrate improved health outcomes: 89% are engaged in care, 71% are retained in care, and 77% have achieved viral suppression. New York City has been able to demonstrate the connection between housing assistance and health outcomes: of clients receiving assistance from the Housing Opportunities for People with AIDS (HOPWA) program, 95% were retained in care, compared with 62% of the total PLWH population, and 73% were virally suppressed, compared with 51% of the total PLWH population. Through the HEI-HO project Fenway Health expects to demonstrate similarly, in Greater Boston, that access to resources intended to stabilize housing lead to improved health outcomes.

Limited income and income instability are significant challenges for many patients. Helping to obtain and maintain income is critical for maintaining access to healthcare and other support services. Fenway Health assists PLWH to apply for benefits and connect to employment services programs. In the past year, 76% of AAC's clients were not working. Greater than 95% of these clients had income at or below 400% of the Federal Poverty Level, demonstrating a significant unmet need for income maximization and employment services among PLWH who are already accessing some services.

Growing income inequality—the gap between the wealthiest and the poorest citizens—now has Boston ranked as the #1 most unequal city in the nation.[6] Poverty is a persistent problem, at 21.4% in Boston compared to 11.9% in Massachusetts as a whole (US Census Bureau). This region is particularly burdened by housing costs. Greater Boston is the third most expensive rental market in the nation, with the median monthly rent for a one-bedroom apartment being over $2200. With the Fair Market Rent in this region set at $1372 there is a significant gap between what is considered reasonable and affordable, and what the market will support. This demonstrates the needs of PLWH to access both housing assistance, permanent and affordable housing search, and employment services to increase income. The rental market in the Boston area leaves many PLWH, and all low-income PLWH, priced out. This results in such households living in temporary and unsustainable situations, experiencing homelessness or renting substandard apartments that compromise their health. When the rent burden is high, other needs go unmet, including things such as transportation to medical appointments, pharmacies and job interviews; cell phone service and computer access; utility bills; and clothing. The stress and anxiety associated with homelessness, lack of stable housing, and lack of suitable income are harmful to health and adversely affect retention in care and treatment.

Employment is fundamental to a sense of dignity and self-reliance. Yet access to employment is one of the most significant barriers that prevent the full integration of people with disabilities and the long-term unemployed, including many PLWH. This disparity in opportunity is discouraging for individuals seeking to join the workforce and contribute to their community. It is also a waste of talent at a time when Massachusetts' overall unemployment rates are at historic lows and more employers have shown their willingness to give people across the spectrum of disabilities a fair chance to compete for jobs. The challenge facing people with disabilities who seek to engage in meaningful work is daunting. An individual with no disability is about four

[6] Brookings Institute, 2016.

[7] Massachusetts Executive Office of Labor and Workforce Development. Report and Recommendations to Improve Employment Outcomes Among Populations Facing Chronically High Rates of Unemployment. January 2016. http://www.mass.gov/lwd/docs/executive-office/eo-561-task-force-report508.pdf

times more likely to be employed (65% labor force participation). In March 2015, Massachusetts Governor Charlie Baker, through Executive Order 561, created a Task Force to recommend solutions to help end persistent economic disparities for certain populations.[7] A recommended Best Practice by the Task Force is for the state One Stop Career Center system to leverage the work of and collaborate with community-based organizations – and vice versa.

Services landscape

Greater Boston has many medical providers available to meet the needs of HIV-positive individuals below 400% of the FPL, though a handful of providers including Fenway Health care for a disproportionate number. Greater Boston has many FQHCs that accept patients without insurance and offer sliding scale discounts based on income, the largest of which (besides Fenway Health) are East Boston Neighborhood Health Center, South Cove Community Health Center, Harbor Health Services, DOTHouse Health, Codman Square Community Health Center, Whittier Street Health Center, and Dimock Community Health Center. A number of FQHC look-alikes, such as South End Community Health Center and Market Square Family Health Services, also exist in this area. Further, numerous acute-care facilities in greater Boston provide outpatient HIV/AIDS medical services with financial assistance for low-income patients, including: Massachusetts General Hospital, Boston Medical Center, Beth Israel Deaconess Medical Center, Boston Children's Hospital, Brigham and Women's Hospital, and the VA Boston Healthcare System. Seven health centers in Greater Boston are recipients of Ryan White Part C funding, including, Boston Healthcare for the Homeless, Brockton Neighborhood Health Center, Cambridge Health Alliance, Dimock Community Health Center, East Boston Neighborhood Health Center, Harbor Health Services and Fenway Health.

Greater Boston has numerous housing programs for low-income PLWH, including set aside units through Boston Housing Authority, designated programs through the Boston and Cambridge Continua of Care, Justice Resource Institute's housing programs, Victory Programs' permanent and transitional housing programs, Nazareth Residence, New Beginnings, Proyecto Opciones, Pine Street Inn, Seton Manor, Sheila Daniels House, SMOC (Southern Middlesex Opportunity Council) Supportive Housing Program, and SRO Special Needs Housing Collaborative through Commonwealth Land Trust. These programs pair designated rental subsidies for PLWH with supportive services including case management and stabilization, additional housing search assistance, referrals and navigation to medical care, benefits, and other resources. Local project sponsors receiving HOPWA funding include AAC, Boston Public Health Commission, Father Bill's and Main Spring, Justice Resource Institute, Commonwealth Land Trust, Metropolitan Boston Housing Partnership, Institute for Health and Recovery, Lowell House, Lowell Housing Authority, SMOC, Victory Programs, and Lynn Housing Authority and Neighborhood Development. Fenway Health, through AAC, is one of the state's largest providers of HOPWA- funded housing services. AAC's Housing Services programs provide services from four offices, reaching clients throughout Greater Boston with permanent supportive housing programs, housing search and advocacy assistance, and rental and utility assistance. AAC's Housing Services programs have formal and referral relationships with most of the HOPWA project sponsors mentioned above, facilitating coordination of care and resources.

There are few programs within the specified geographic region which offer employment support and services specifically for HIV-positive individuals. Victory Programs operates the Boston Living Center, a community center which offers employment counseling and support to HIV-positive people in the Boston area as well as the opportunity for these individuals to engage in volunteer positions and internships before committing to the demands of full-time employment. A number of other employment programs operated across the state may also provide services to HIV-positive individuals; however, they largely remain focused on income eligibility rather than health status, leaving case managers unaware of the distinctive needs of their HIV-positive clients. Programs included in category are the Massachusetts One-Stop Career Centers, nine of which are located in the Greater Boston area. These centers provide clients with career counseling, job search assistance, skills development, access to resources, and specialized services depending on the career center, with most services provided free-of-charge. Other employment programs offering such services either free-of-charge or at a low cost include: South Shore Career Services, Project Place, Goodwill, Justice Resource Institute, Operation A.B.L.E., Asian American Civic Association, Fenway Community Development Corporation, Community Learning Center, Lawrence CommunityWorks Inc., Action for Boston Community Development, and Quincy Community Action Programs. Further, a number of programs offer specialized skill training (e.g. food service industry skills, housekeeping skills) with a subsequent transition to an internship or job, including Community Servings' Teaching Kitchen Program, Haley House Bakery Café Transitional Employment Program, Pine Street Inn, Boston Education Skills and Training (BEST) Corp., Action Inc, and YMCA Training Inc. While Fenway Health Case Managers make referrals to most of these agencies at one time or another, they have little to no firsthand familiarity with their staff and services, which limits their ability to make a strong and supported referral. Also, since existing HIV Case Management protocols include only limited assessment of employment-related needs, it is likely that Case Managers are missing the opportunity to hear from clients about employment-related goals and needs.

Currently there are no comprehensive housing and employment programs offered specifically for low-income individuals living with HIV in Greater Boston. This project addressed this gap and improve the continuum of care for HIV-positive people in the Boston area by developing a coordinated program of housing, employment and medical case management, and by establishing a close working relationship with a strong employment services partner, MassHire Downtown Boston.

The Intervention

Although MA has had a robust and comprehensive HIV prevention and care system for a long time[8], health disparities in access, engagement and retention in care persist for those individuals who experience a multiplicity of structural barriers[9], compounded often by comorbidities such as mental health and substance use, in addition to HIV. Similarly, housing and employment services and providers exist in the area and have served individuals with HIV over the years. System-level coordination and collaboration is necessary to insure high acuity clients can navigate successfully to achieve positive outcomes. With this project, we identified that within our own organization, similar structural barriers and programmatic silos existed when attempting to coordinate services for SPNS clients who were Fenway patients. This was not surprising, given that we were attempting to integrate services that had existed in a Federally-Qualified Health Center with services that had existed in an AIDS Services Organization, each with its own distinct organizational culture.

In this manual, we will describe how we approached better integration with non-Fenway Health patients as well as the integration process that began across departments and disciplines within Fenway Health for its own patients. Internally, this project provided the opportunity for staff working in different departments, and physical locations, to develop a vision for the sustainability of the work that began with this project: to create an internal, seamless system of referral and linkage to services, including clinical care, medical case management, housing and employment services for patients of Fenway Health who are HIV positive or at risk for HIV infection.

Goal

To build upon the SPNS model and lessons learned in order to provide a comprehensive set of clinical and non-clinical services to patients of Fenway who are HIV positive or at risk for HIV infection.

[8] As of 2015, 86% of those engaged in care in Massachusetts and 89% of those retained in care were virally suppressed. See "Massachusetts Integrated HIV/AIDS Prevention And Care Plan, HIV/AIDS Services In The Commonwealth: 2017-2021," Massachusetts Department Of Public Health (MDPH);Bureau Of Infectious Disease And Laboratory Sciences (BIDLS);Office Of HIV/AIDS (OHA), p 33. https://www.mass.gov/files/documents/2016/12/vz/mass-hiv-aids-plan.pdf

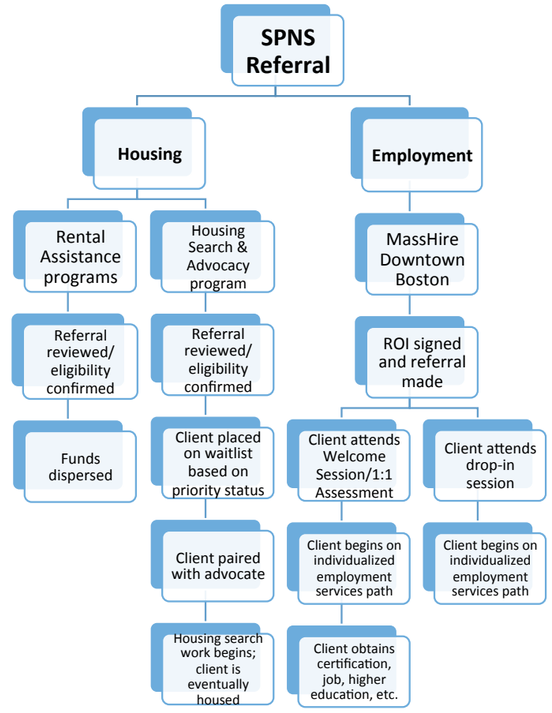
[9] This particularly applies to racial and ethnic health disparities. The HIV/AIDS prevalence rate for Black (non-Hispanic) people in MA is 11 times greater and for Hispanic/Latinx people 8 time greater than the white population. Ibid, pp. 19-20.

Key Components of the Intervention

Referral flow (at right)

HIV Care

Clients served in this program primarily received HIV care and medical case management at Fenway Health, but others received their care at external clinics throughout Greater Boston. At Fenway Health, medical case managers (MCMs) help with communication and navigation of Fenway Health services. They link patients to community resources, refer to other agencies, and help patients apply for benefits programs when applicable/eligible. MCMs work as part of two organizational structures: a) team-based case managers support specific medical provider panels for lower-acuity patients, and b) high-acuity case managers have smaller caseloads of exclusively high-acuity patients. High-acuity case managers[10] have an explicit mandate to overcome access barriers, including traveling to meet and navigate patients in the community. Through this project, high-acuity case managers accompanied patients to housing appointments and employment drop-in hours. Of participants in the project receiving HIV medical care at Fenway Health, approximately one-third of participants were referred by high-acuity case managers and approximately two-thirds were referred by a team-based case manager or project liaison.



Housing

AIDS Action Committee provided the housing services involved in this intervention, through three different housing programs.

Housing Search and Advocacy Program: works intensively with clients of all backgrounds to navigate the complex system of applying for and obtaining affordable housing in Massachusetts. The staff works with, and are part of, integrated teams of case managers, medical providers, attorneys and health navigators to provide housing search as a specialized service; staff have expertise and extensive ongoing training in all aspects of affordable housing in Massachusetts. HS&A serves clients across the Greater Boston region. HS&A work receives funding from the Massachusetts Department of Public Health Office of HIV/AIDS (MDPH OHA, through Ryan White Part B pass-through funds); Boston Department of Neighborhood Development (DND, through HOPWA funds); and Boston Public Health Commission (BPHC, through RW Part A).

[10] High-acuity medical case management positions are funded by the Boston Public Health Commission through Ryan White Part A.ce rate for Black (non-Hispanic) people in MA is 11 times greater and for Hispanic/Latinx people 8 time greater than the white population. Ibid, pp. 19-20.

Rental Assistance Programs: deliver short-term emergency assistance to the households of HIV-positive people who face eviction or unaffordable housing, need assistance with move in costs (security deposit, first or last month's rent), and high utility bills or shutoff. While Rental Assistance Programs assist individuals in emergency situations, they are designed to create long-term, sustainable and improved living situations. RAP receives applications from agencies across Massachusetts. RAP receives funding from MDPH OHA (state funding); DND and the City of Lowell (HOPWA); BPHC (RW Part A);

Supportive Housing Programs: offer an array of supportive housing programs, providing subsidies and supportive services to families and individuals living with HIV who are exiting homelessness. Programs include project-based rental assistance and tenant-based rental assistance, intensive case management services, and housing stabilization support. Supportive housing programs receive funding from MDPH OHA (state funding); and DND and the Cities of Cambridge and Lowell (HOPWA).

Employment

MassHire Downtown Boston provided the employment services component of the program. All clients that utilized these services underwent an extensive intake and assessment by a dedicated career navigator who helped map out an individualized job search plan. Services included access to daily free workshops; networking groups; job search strategy groups; information and referral to skills training programs; citizenship and green card advice and assistance; advice and assistance for ex-offenders and criminal background check advice; English classes, adult education, and other educational programs.

At first, we attempted to connect clients to one-on-one employment services through MassHire's existing mechanism of having them attend a Welcome Session. MassHire regularly holds these sessions at their offices. As we discuss in our Results and Lessons Learned sections, we discovered that this created a barrier for many clients. In response, we developed a new service delivery model of holding employment drop-in hours for participants at an existing AAC location that clients (and staff) were more familiar with.

Services coordination

Coordination was a key piece of this intervention and was the responsibility of the project coordinator. The coordinator worked closely with clients' MCMs, housing advocates, and employment services navigator to connect clients to services. The coordinator received and processed all referrals to the SPNS program, developed systems of coordination and communication, made all employment services referrals to MassHire, conducted numerous outreach presentations, and engaged in consistent follow-ups with providers regarding client needs and updates.

Systems integration: As explained in the organizational context section, we recognized that each service component was not integrated with each other. HIV medical care and medical case management, housing services, and employment services operated in silos. This intervention benefited from having a full-time coordinator role who could focus on increased coordination and communication among program areas, beginning a process among all parties about how to create long term, sustainable, systems integration. While we initially thought that adding employment services to the range of services available through Fenway Health and AAC would strengthen our ability to address structural barriers for our hardest to engage patients, we soon realized that we had significant work to do internally regarding service integration.

We focused on three key areas for integration: Programmatic integration, protocols and procedures, and infrastructure support.

Programmatic integration

We learned that teams across different divisions of the organization largely did not know each other, and did not regularly reach out across programs to coordinate care with shared clients or patients. We realized that certain staff had built relationships across divisions; however, these staff had often either moved from one division to another, or had roles spanned divisions, or had workspaces across different physical office locations. Not surprising, these individuals were often stronger collaborators across divisions as a result.

We found that working on real, individual-level client issues was the most effective in building working relationships among front-line staff; this was gratifying but not surprising given front-line staff's strong focus on the best immediate outcomes for their clients.

Given this knowledge, we created an ongoing meeting structure that brought together management and staff of all programmatic areas involved in the project on a bi-monthly basis. In addition, managers and supervisors from housing or case management teams participate in each other's regularly scheduled team meetings, as needed, to provide project updates, share successes and challenges and get staff input on strategy. By bringing together direct managers and supervisors across housing programs and medical case management on a rotating basis allowed stakeholders to bring lists of shared clients for troubleshooting as well.

In addition to this more systematized approach, as part of the intervention we also started communicating between housing and medical case management programs on an ad-hoc basis. We did this when a client or patient had a specific concern that spanned content areas or when a difficult-to-locate client had an upcoming appointment with one leg of the intervention. We found that working on real, individual-level client issues was the most effective in building working relationships among front-line staff; this was gratifying but not surprising given front-line staff's strong focus on the best immediate outcomes for their clients.

Lastly, we have identified that we will need more integrated on-boarding practices for new staff, including some initial cross-training and shadowing opportunities. Beyond the training phase, solutions such as partial or complete co-location have already started to improve collaboration and increase client/patient access to various aspects of care. For example, a Public Health Social Worker now works part-time from the same location as our housing team, and as a result has been able to provide participants in this project with quicker access to immediate, short-term counseling.

Protocols and procedures

Through the process of program level integration, we identified a number of work flow and process steps for optimal client care coordination that need to be institutionally supported by developing new, or revising and updating existing protocols and procedures. To drive this process, we engaged a Fenway staff who is responsible for QI efforts within the organization. Some of these protocols are nearly complete, while others are just being developed. Below are examples of protocols that we are developing.

Housing referrals and housing search work

- Determine what happens when a referral comes in incomplete and/or incorrect
- Communicate clear definitions of living situations per HUD guidelines (especially literal homelessness)
- Standardization of caseloads based on a) client acuity and b) level of client engagement
- Define and systematize dismissal conditions

Employment referrals

- Determine what accompaniment to off-site or drop-in employment services looks like

Infrastructure Support

Data collection and reporting: For this project, we used a combination of pre-existing systems, with some customized forms for the project:

Referrals and study participant tracking: REDCap

The Fenway Health data and informatics team maintains an instance of REDCap[11], primarily for The Fenway Institute, Fenway Health's research division. For this project, we developed a REDCap project for referrals, eligibility pre-screening, and participant tracking. The first form in the project was an electronic referral survey (attached) which we shared with potential referrers. The form allowed us to collect sufficient information to pre-screen participants for eligibility. In some cases, referrers filled out a paper version of the form, which we then entered into the database separately. We used additional, internal-only forms to record information such as enrollment status.

Electronic Medical Record: CPS

The data and informatics team maintains the Electronic Medical Record that Fenway Health uses, Centricity Practice Solution (CPS) version 12. Like all EMRs, CPS allows for the documentation of biomarkers and health services a patient receives; we also have customized forms for medical case management, such as Ryan White intake or discharge, acuity assessments, and outreach.

[11] Research and Evaluation Data Capture (REDCap) is a web-based, open-source database platform which allows for easy instrument and survey creation. https://www.project-redcap.org/software/

As part of this project, we learned that we needed to make it clearer and more readily available to other teams when a high-acuity case manager was assigned to a patient (otherwise team-based case management assignments would mean that knowing a patient's medical provider would be sufficient to identify the MCM). For other teams who needed to follow up with a case manager, it was cumbersome to identify the correct staff person. As a result, we developed a case manager assignment form for this purpose.

Medical case management staff make extensive use of flagging in CPS to send messages, linked to specific patient charts, to other team members and medical providers.

We store CPS data in a SQL server database maintained by our IT team; this is helpful in accessing the data from analysis and visualization platforms, as we describe below.

Community-based work: ETO

A portion of the data and informatics team maintains AAC's primary database, Efforts to Outcomes (ETO)[12]. ETO is a relational database, meaning that different teams and projects can share information relatively simply, such as client demographics and necessary client documents, according to customizable user-level security and permissions. The data and informatics team develops new forms as needed for new or existing projects.

For this project, we developed an innovative approach to tracking case coordination and navigation. We based some of the specific data entry elements on requirements from the Evaluation and Technical Assistance Provider at Boston University. However, we expanded upon these elements to track three critical concepts in the same form (attached): activities, short-term outcomes, and barriers. Tracking short-term outcomes in the same form allowed us to report on these outcomes regularly, with less reliance on periodic status assessments.

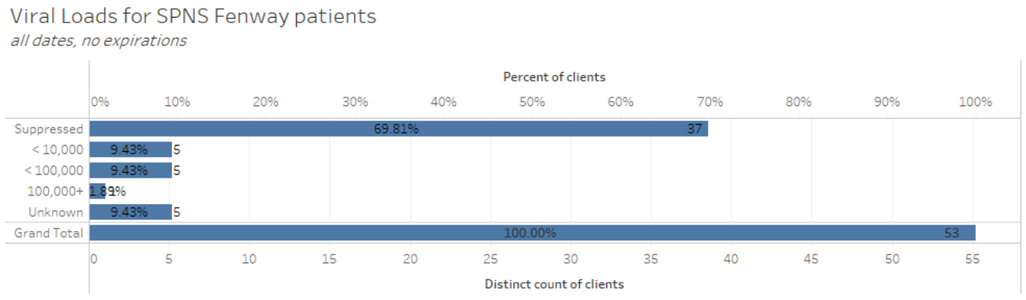
ETO also includes a built-in data reporting and visualization platform called ETO Results, built on SAP BusinessObjects WebIntelligence. We use this platform to build real-time reporting dashboards that program staff and managers can run at any time, not just evaluators. We structure these reports to be useful for quick information that programs need for operations, as well as for reviewing outcomes and data quality.

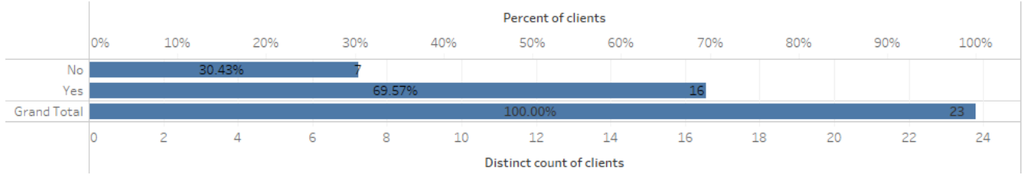
For this project, we built general summary reports in ETO Results, as well as client-level and aggregate services and outcomes dashboards. We include a visualization of an aggregate employment outcomes cascade in our results section. For a sample client-level employment outcomes dashboard over time, please see the appendix.

Visualization: Tableau

The data and informatics team uses Tableau (among other tools) for real-time data analysis, visualization, and dissemination. Tableau, similar to other visualization platforms, is helpful in that we can connect it directly to real-time data sources through queries, including CPS and REDCap data. We can also join multiple data sources together where we have shared identifiers. This allowed us to display HIV health outcomes data for patients receiving their medical care at Fenway Health, restricted to just participants of this project.

[12] Efforts to Outcomes (ETO) is a web-based, nonprofit Customer Relationship Management (CRM) database, developed by Social Solutions Global. https://www.socialsolutions.com/software/eto/





We disseminate Tableau data in several ways. For ongoing projects, we publish a copy of the Tableau workbook to an internal Tableau server. Program leadership then logs in to access these workbooks directly. For projects with active evaluation activities, data and evaluation staff share exports from these dashboards during check-in meetings.

Data integration

The data and informatics team and several project teams began discussing data integrations, both as a natural result of merging organizations and as a part of this project. We see enormous potential benefit for teams having access to both aggregate and individual-level status updates for their patients and clients. For teams that use database platforms for communication could see even more benefit. We will discuss this further in our lessons learned section below.

Staffing

Principal Investigator (PI): Oversees team in meeting outcomes and strategizing systems-level change; engages organization leadership

Project Manager: Uses content knowledge to design effective interventions; convenes meetings and collaborations.

Project Coordinator: Coordinates referrals; conducts outreach; introduces clients to services; and conducts ongoing coordination of services.

Career Navigator at MassHire: Serves a coordination role for all eligible clients; receives all referrals; and provides ongoing case coordination with both Fenway and specialized services within MassHire.

Medical Case Management Liaison: A member of the MCM team at Fenway Health that serves as the point person for referrals, project information, and ongoing coordination for enrolled clients.

Housing Program Managers and Coordinators: Triage and manage housing caseloads based on eligibility and markers of need

Housing Search Advocates: Provide direct housing search and advocacy to clients

Data and evaluation staff: Design new data collection instruments; develop outcomes tracking and reporting; disseminate findings; support improvement capacity-building

Quality improvement analyst: Guides team through articulating processes, identifying systemic barriers, and selecting effective and efficient projects for improvement. (See attached organization chart)

Implementation activities

Recruitment

Referrals for this project came from a number of sources. Housing programs at AIDS Action (the Housing Search & Advocacy, Rental Assistance, and Supportive Housing programs) constituted one of these sources. Housing advocates, coordinators, and managers working in each of these programs identified clients that fit the eligibility criteria for SPNS and completed an online referral. Across the programs, staff made concentrated initial efforts for referrals for a few-month period. After this, supervisors responsible for receiving and assigning cases assessed cases at that time for eligibility. Housing staff received trainings and presentations regarding the project, including eligibility requirements, and were a vital source for referrals.

Referrals also came from medical case managers at Fenway Health. The Fenway MCMs work with a number of high acuity clients and clients that are not well engaged in their HIV care. MCMs also received training and presentations regarding the SPNS project, including eligibility criteria and the referral process. This allowed MCMs to identify eligible clients in a clinical setting and refer them through the online portal.

Another referral source was **external clinical providers**. The Project Coordinator presented information regarding the SPNS project, including eligibility criteria and the referral process, to a number of outside clinical sites in the Greater Boston area. These included a one-time presentation to the Ryan White Planning Council as a whole, and a specific presentation to the Needs Assessment sub-committee, outreach to other clinical partners such as Boston Health Care for the Homeless Program, other Community Health Centers, as well as participating at a NEAETC educational event. These outreach efforts yielded referrals from medical case management teams and social work teams at these sites. We discuss lessons learned in working with external clinical providers for this project below.

To systematize this experience across all referral sources, we used our REDCap referral platform for regular quality improvement. To prepare for each team meeting, data and evaluation staff ran data on referring entities and individuals as well as statuses of those referrals. Supervisors used this data when reviewing caseloads with their staff for potential referrals.

In reviewing the successes of our referrals, we found that an important takeaway was reinforced: for high-acuity clients, relationships with a provider are key. To ease the burden for internal referring partners, we allowed programs to make internal referrals even if they were not able to reach the client directly[13]; project staff would then reach out to the client to explain the project and gauge their interest. However, we found that this was a double-edged sword; clients that did not have the project explained to them by someone with a pre-existing relationship engaged much less often.

Referral coordination

The project coordinator facilitated the completion of referrals to appropriate programs. As part of the SPNS referral (using the previously described REDCap survey) the referring MCM noted which housing program they have referred or are intending to refer the client to within AAC. The project coordinator followed up with MCMs about completing these housing referrals. For the internal Fenway MCMs, the coordinator provided the medical case management liaison with an updated spreadsheet regarding clients' housing referral status on a bi-weekly basis. This allowed the MCM liaison to follow up with their team and stay updated about where clients stand in terms of their housing referral. The project coordinator attends a monthly meeting with the Fenway MCM team to provide and receive updates regarding housing referrals. Additionally, the project coordinator and housing search coordinator met monthly to follow up about SPNS/Housing Search referrals and were in consistent communication regarding these clients.

The project coordinator also facilitated referrals for MassHire's employment services using a standardized referral form (see the appendix). The referral included basic, necessary identifying information including client name, DOB, and contact information, case manager's contact information, and any notes regarding current employment situation. The project coordinator sent these referrals to our MassHire liaison via secure email. The liaison then reached out to the client directly to schedule an initial Welcome Session at MassHire and 1:1 career coaching session. The Welcome Sessions were offered daily and provided a general overview of services, trainings, workshops, and other employment related resources that clients can utilize at MassHire.

[13] This was particularly true for our Rental Assistance Programs, which normally work with case managers rather than having direct client contact. We believed this would ease the burden of asking the external referring case manager to explain the project to the client and make the referral.

Ongoing coordination of services

In addition to coordinating initial referrals to the SPNS project and to MassHire, the project coordinator continued to work closely with clients' medical case managers, housing advocates, and the employment services navigator. The coordinator maintained frequent communication with providers, with the goal of addressing client needs, updates, or concerns. Clients in this project were out of care or at risk of falling out of care in at least one area; to address this we focused our coordination on facilitating the connection or re-connection of clients to services in each of the intervention components – HIV care, housing, and employment services. Each of the programs use their own unique patterns of intake and follow-up; we therefore tailored coordination efforts for each of them:

Housing:

- Meeting with the coordinator of Housing Search and Advocacy monthly to review clients' housing status, status on the program's waitlist, and relaying any necessary follow-ups to the medical case management team

Employment:

- Communication with the employment services navigator on a weekly basis to remain updated about client activities and progress; after we started co-located drop-in employment services this sometimes took place in person

HIV medical care, for patients receiving medical care at Fenway:

- Individual client communication via EMR flagging
- Sharing monthly reports on individual and aggregate levels

HIV medical care, for patients receiving medical care at other health centers and hospitals:

- We faced greater difficulty due to lower project buy-in (discussed in greater detail in lessons learned section)
- Attempts to coordinate via secure email or phone calls on an individual client level

We also used daily secure emailing with all service providers as needed. The project coordinator ensured that providers were aware of client updates and necessary follow-ups. Providers in each of the domains used this coordination to help support their clients as they worked towards attaining stability in their HIV care, housing, and employment situations.

Training

We conducted in person and online trainings to cover both content knowledge and organizations or systems. We conducted trainings for MassHire staff on AAC housing services and set up visits for housing staff and medical case managers to MassHire to learn about employment services. In the process, staff became more familiar with how patients or clients would navigate through the other programs and physical locations, which allowed them to advise their clients better.

In addition, staff from all programs completed training provided by the Department of Housing and Urban Development (HUD) and Department of Labor (DOL) called Getting to Work (GTW). GTW oriented staff to employment concepts in the HIV context specifically. This included considerations such as the interaction of benefits and employment; HIV health and employment; and HIV disclosure in the workplace.

Theoretical and evidence-informed frameworks

The SPNS initiative built on established expertise of Fenway Health as a long-time provider of Ryan White funded HIV care, and AAC as a long-time provider of HOPWA-funded housing services, with both care and housing services designed to meet the needs of low-income PLWH. We use specific tools to target these programs to match client's needs. As part of mandates by funders, several program components use acuity-based caseloads. As previously mentioned, the medical case management team includes several high-acuity case managers. These staff use an HIV care acuity tool to assess patients; the team adapted this tool from one developed by MDPH OHA (see appendix). Secondly, our Housing Search & Advocacy team receives some funding specifically for clients with acute housing needs. The team developed a tool to assess this acuity across nine housing domains, also inspired by the MDPH OHA acuity tool (see appendix).

Finally, our Rental Assistance Programs require a sustainability plan as part of applications for homelessness prevention funds or rental start-up funds (see the appendix). Since the program only distributes short-term funds, staff must assess whether it is feasible for the client to sustain their situation (whether a current situation that is being stabilized or a new situation they are moving into) beyond the end of this assistance. (Staff do this in a client-centered way, rather than as a means of denying applications.)

In terms of employment, MassHire offered skill building, job training and employment readiness and search services. MassHire enhanced the client experience for this project's high-acuity client population by providing one-on-one coaching to navigate through their many employment services offerings. MassHire developed a tool called Career Rx® (see attached), which provides guidance to clients to help them prioritize which services will help them become job-ready, in order to develop a focused job-search strategy. At an initial triage meeting with a client, Career Navigators assess work readiness using a strengths-based approach and identify which of three service pathways – Job Search, Training or Education – best meets the immediate needs of each client. Based on this, the Career Navigator develops a customized "prescription" with next steps. Eligible clients in need of skill-building as a next step attend a workshop to learn about opportunities; and may pursue training through federally funded training vouchers issued by the career center.

Consumer input

In shaping the implementation and grounding it in evidence, we sought and incorporated input from consumers in several ways. First, we held a focus group with potential participants prior to program launch. As employment services was the newest service area for Fenway Health and AAC, we primarily structured our focus group to learn the best way to deliver those services. Our primary takeaways from the focus group was that consumers emphasized that employment services should be individually-tailored and high-quality, including offering extensive training; the location of services was less important. We were gratified by this learning, as these were areas of particular strength for MassHire. As we discuss below, this finding was not in keeping with our experience through the implementation.

Secondly, we presented our intervention to and sought input from our local Ryan White Planning Council. We received more input on the housing aspect of our intervention than on employment. This input centered on identifying new housing resources to provide to clients.

Local evaluation plan

Theoretical model

For this Special Project of National Significance, our approach to Monitoring, Evaluation, and Learning (MEL) draws upon the Developmental Evaluation approach outlined by Michael Quinn Patton.[14] We find this approach especially appropriate for SPNS due to the need for rapid learning and innovation. This project is supported by both theory and prior research (and will contribute to further research) on the effect of employment on health[15] and social determinants of health more broadly[16]; we furthermore have developed an intended logic model (see below). Nevertheless, we find ourselves continuously discovering new barriers, new facilitators, and new incremental outcomes, as well as innovating new intervention strategies appropriate to those discoveries.

Logic model (see attached)

Our logic model presents factors operating at both the participant level and system level. As described elsewhere, we begin with the inputs of the Massachusetts and Greater Boston contexts:

- widespread availability of medical care and health insurance coverage for People Living With HIV/AIDS;
- important subsets of high-acuity patients who are not virally suppressed;
- a largely unaffordable local housing market as well as organizational experience in providing housing services; and
- employment services entities with limited experience serving PLWH.

On the systems level, we begin with the following inputs:

- inadequate coordination of employment services planning; and
- limited knowledge of employment-related concerns and issues for PLWH.

We identify desired long-term outcomes in which participants' housing stability and careers serve as platforms for increased engagement in care and participants' viral suppression levels improve.

[14] Quinn Patton, Michael (2010). "Michael Quinn Patton on Developmental Evaluation." American Evaluation Association AEA365: A Tip-A-Day By and For Evaluators. https://aea365.org/blog/michael-quinn-patton-on-developmental-evaluation-applying-complexity-concepts-to-enhance-innovation-and-use/

[15] U.S. Department of Housing and Urban Development, "Getting to Work: A Training Curriculum for HIV/AIDS Service Providers and Housing Providers", available at https://www.hudexchange.info/trainings/dol-hud-getting-to-work-curriculum-for-hiv-aids-providers/

[16] U.S. Centers for Disease Control and Prevention, "CDC Research on SDOH", Social Determinants of Health: Know What Affects Health, available at https://www.cdc.gov/socialdeterminants/research/index.htm

Impact evaluation

The intended impact of our project, similar to any integrated project intended to reduce the burden of HIV, is improved community-wide viral suppression; this also follows a Treatment as Prevention model to reduce new HIV infections.[17] With many concurrent projects and funders operating in the local context, we do not expect to link the success or failure of this impact to our project.

Results: outputs and outcomes

We present our results on two levels:

- *Systems:* new partnerships, processes, and innovations
- *Individuals:* how much we worked with our clients (outputs) and the changes in their lives (outcomes)

Systems-level

Process outputs

- SPNS team meetings
- Number of staff cross-trained
  - MCM and Housing
  - MassHire

Outcomes

Housing and MCM team integration

- Program leadership know each other and their work
- Team members know each other and their work
- New work flows that support coordinated care supported by new, revised, improved protocols and procedures
- Service coordination: staff coordinate locating clients and traveling between locations
- Working on data integrations: Training managers in using and understanding each others' data systems to view notes and find clients, as well as to view aggregate-level data

The intended impact of our project, similar to any integrated project intended to reduce the burden of HIV, is improved community-wide viral suppression; this also follows a Treatment as Prevention model to reduce new HIV infections.[1]

[17] Nearly 70 percent of new HIV infections are transmitted by those who know their HIV status but are not virally suppressed. Fauci, A., et al (2019). "Ending the HIV Epidemic: A Plan for the United States." Journal of the American Medical Association. DOI:10.11001/jama.2019.1343. Available at https://jamanetwork.com/journals/jama/fullarticle/2724455

Employment services integration

- Staff know MassHire services
- MassHire Referral process developed for SPNS or non-SPNS-eligible clients
- Employment spectrum beyond MassHire: in development

Data sharing

We developed dashboard reports for AAC housing clients receiving medical care at Fenway, including waitlist status, housing advocate assignment, housing placements, and engagement in services. This will support keeping MCMs informed across service areas.

We are currently developing a CPS form for documenting housing referral consistently, to allow follow-up and process improvement. Those with housing need should have housing referrals.

Inspired by this project, we began strategizing how to create shared identifiers between CPS and ETO, so that we could pull in data from both databases to a platform such as Tableau. This will allow us to not only represent unique aggregate counts of patients, but also link individual-level outcomes across domains of care.

Individual-level

Participant characteristics

The demographics of participants in this project largely reflected Ryan White populations. Participants were mostly cis-men and mostly people of color. While a fifth (19%) of participants were newly diagnosed, almost three quarters (77%) were previously-diagnosed individuals who were not well-engaged in care. Almost three quarters (77%) were unstably housed or at risk of homelessness. Lastly, the majority (65%) were not employed at the time of referral.

Gender Identity	n	%
Male	69	75%
Female	13	14%
Trans Female	6	7%
Trans Male	0	0%
Non-binary or gender-diverse	1	1%
Unknown	3	3%
Unique Total	92	100%

Race/ethnicity	n	%
Asian/Asian American	3	75%
Black or African American	34	37%
Hispanic/Latinx	25	27%
Multi-racial	2	2%
White	23	25%
Unknown	5	5%
Unique Total	92	100%

Current age	n	%
18–29	16	17%
30–39	31	34%
40–49	12	13%
50–59	27	29%
60–69	6	7%
70+	0	0%
Unique Total	92	100%

HIV Transmission mode	n	%
MSM	37	40%
IDU	5	5%
MSM/IDU	1	1%
Hetero	15	16%
Blood Products	2	2%
Perinatal	1	1%
Other	2	2%
Unknown	29	32%
Unique Total	92	100%

HIV care status at referral[18]	n	%
Recently diagnosed	18	19%
Not virally suppressed	26	28%
Exiting incarceration	4	4%
Gaps in care	36	39%
Missed appointments	9	10%
Unique Total	93	100%

[18] This is an exclusive count; referrers were able to select multiple HIV care challenges for participants. We present counts within the first applicable category in this table.

Years diagnosed	n	%
< 2 years	18	20%
2–5 years	16	17%
5–10 years	17	18%
> 10 years	39	42%
Unknown	2	2%
Unique Total	92	100%

Housing situation at entry	n	%
Literally homeless	17	18%
Experiencing domestic violence	7	8%
At risk of homelessness	17	18%
Unstably housed	51	55%
Unique Total	92	100%

Monthly employment income	n	%
Not employed	60	65%
Under $500	1	1%
$1000 - 1499	13	14%
$1500 - 1999	6	7%
Missing	12	13%
Unique Total	92	100%

Case coordination

The major new addition to our services was employment navigation. The amount of outputs bears that out. The table below also demonstrates that clients also needed substantial additional coordination assistance around housing. We believe this reflects the complexity of local housing assistance systems (in terms of issues such as eligibility), the acuity of the local housing crisis, and the high-volume nature of AAC's housing work.

Areas of case coordination [19]	Number of unique clients	
Clinical/health	12	12
Educational and emotional support	2	2
Employment	957	74
Housing	498	65
Transportation and other social services	3	2
Other[20]	148	77
Unique Total	**1325**	**91**

[19] For services between July 1, 2018 and December 31, 2019.

[20] Sessions with topics of "other" often covered basic case coordination.

Employment outcomes

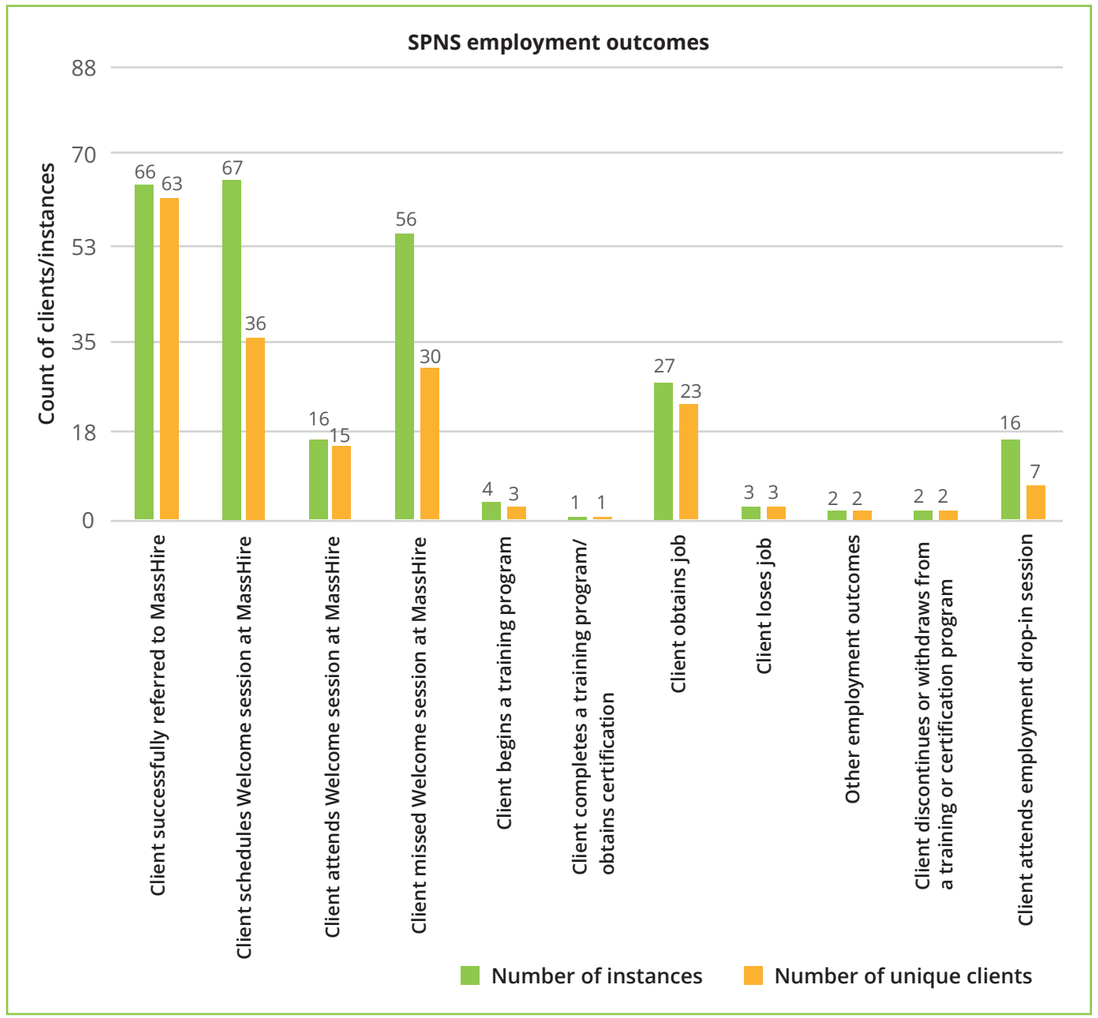
Our employment outcomes immediately highlight two major barriers around employment. First, of those who were eligible for the project, only about two thirds (68%) were sufficiently ready to work on employment for us to put through a referral to MassHire. Second, clients missed the majority of MassHire Welcome Sessions that we scheduled with them (83%). Ultimately, half as many clients made an appointment as missed one (these numbers are not exclusive of each other). As we discussed in our service delivery area, we began to address the barrier of difficulty with appointments by holding drop-in hours, which were co-located with other social support services, such as housing and legal appointments. Even though we started this relatively late in our implementation[21], we saw half as many clients at those drop-in hours compared to those who attended Welcome Sessions during the entire course of the project (some clients attended both).

Employment outcome[22]	Number of instances	Number of unique clients
Client successfully referred to MassHire	66	63
Client schedules Welcome session at MassHire	67	36
Client attends Welcome Session at MassHire	16	15
Client missed Welcome Session at MassHire	56	30
Client begins a training program	4	3
Client completes a training program/obtains certification	1	1
Client obtains job	27	23
Client loses job	3	3
Other employment outcomes	2	2
Client discontinues or withdraws from a training or certification program	2	2
Client attends employment drop-in session	16	7

Job type	n	Client attends employment drop-in session	% of all clients
Full time employment	11	27	23
Part time employment	9	3	3
Per diem work	2	2	2
Under the table work	1	2	2
Unique total	23	16	7

[21] This implementation manual includes data from only four months of drop-in sessions, compared to approximately eighteen months for the rest of the intervention.

[22] For services between July 1, 2018 and December 31, 2019



Housing outcomes

As we discussed in the housing intervention section, AIDS Action provides three main categories of housing assistance: Supportive Housing (primarily for chronically homeless people), Housing Search and Advocacy, and Rental Assistance (to stabilize an existing living situation or assist with start-up costs).

Substantial numbers of our clients received services through either the Rental Assistance Program or Housing Search and Advocacy, with some clients leveraging both services (which we encourage when applicable). Of the five supportive housing clients, three were in transitional situations and seeking more permanent ones; this work continues with the added assistance of this project. One had been at risk of losing a permanent voucher and becoming homeless. We were able to stabilize the client, assist them in moving, and maintaining the tenancy. This highlights the multiple layers of effort necessary to support clients with intersecting areas of need. Finally, one client who was unstably housed received a permanent placement (in a relatively rare program that does not require chronic homelessness).

Category of housing assistance [23]	Client count	Notes
Supportive housing clients	5	2 also assisted by housing search
Rental Assistance Programs (RAP)	21	1 also assisted by supportive housing, 7 assisted by housing search
Placed through assistance from Housing Search program	8	2 also assisted by supportive housing, 5 assisted by RAP
Housing search enrollment (separate from placements)	19	2 also assisted by RAP
Received any housing services	**44**	

[23] For services between July 1, 2018 and December 31, 2019

Health outcomes

We report HIV health outcomes here for patients receiving medical care through Fenway Health. Given the high acuity of need for our clients, we are pleased that these outcomes are not far off the overall Massachusetts HIV cascade. We also note that the standard we use here for full retention in care (two HIV lab tests in the year after enrollment, at least three months apart) is quite high; some patients have evidence of lower levels of engagement in care.

Viral suppression category	n	%
Virally suppressed at last test	39	68%
Not virally suppressed	12	21%
No info	6	11%
Total	57	100%

Retention in care category [24]	n	%
Retained/engaged in care	16	64%
Some evidence of care	7	28%
No conclusive evidence of care	2	8%
Total (reached 12 months of enrollment)	25	100%

We note that having access to HIV health outcomes through externally referring health centers and hospitals is both a significant challenge as well as vitally important in addressing multiple areas of need. One of the avenues we are taking to address this is to begin consistently surveying clients receiving housing assistance about their physical health, behavioral health, and social determinants of health. We encourage other programs to replicate this approach if they do not have consistent access to medical records for clients receiving non-medical services.

[24] Retention/engagement in care was measured as having at least two HIV lab tests (viral load and/or CD4) in the year after enrollment in the project, dated at least 90 days apart. Some evidence of care was measured as above, using at least one test date in the year after enrollment. No conclusive evidence of care was selected when no HIV lab tests were recorded in the year after enrollment

Lessons learned

Multiplicity of barriers

As introduced above, we identified that providers were largely already doing high-quality work in the areas of HIV medical care, housing, and employment. However, numerous individual-level and systemic barriers prevent some clients from engaging across these systems successfully towards positive outcomes. These barriers have included:

Individual-level:

- Literal homelessness, which is linked to difficulty in adhering to medications, difficulty in communications with providers (for example, phones are frequently lost or stolen);
- Behavioral health challenges, which are sometimes linked to periods of engagement with providers and periods of reduced motivation;
- Substance use, stigma and marginalization, which may exacerbate and be exacerbated by the remainder of these challenges
- Readiness for change in terms of employment
- Fear of losing benefits if employed

System-level:

- Shortage of safe affordable housing, which may lead to clients being displaced to communities beyond the urban core;
- Shortage of housing resources compared to need, leading to waitlists for housing search and advocacy services;
- Disparities in cultural competence of providers
- Service areas and teams operating in silos, requiring buy-in from both leadership and front-line staff in order to increase integration
- Partner organizations competing for the same funding sources to provide services to the same populations, who then have little incentive to engage in collaborative efforts

No wrong door approach

We found that clients with multiple areas of need frequently bring up these needs when interacting with any part of the intervention system. For example, our evaluation staff administered questionnaires with participants asking them about areas of need; participants then frequently asked for help with these areas. While we re-directed clients to the appropriate provider whenever possible, we also recognized that staff from each part of the intervention also needed to communicate those needs back as well. This entailed greater flexibility in our roles. We call this the “no wrong door” approach; it directly informs the remainder of the lessons learned.

While we re-directed clients to the appropriate provider whenever possible, we also recognized that staff from each part of the intervention also needed to communicate those needs back as well. This entailed greater flexibility in our roles. We call this the “no wrong door” approach; it directly informs the remainder of the lessons learned.

Co-location of services/one-stop shop

As discussed previously, clients often have difficulty navigating a fragmented service system. Therefore, whenever possible, it is best to offer multiple services in one location so that clients can access needed resources in one place. Clients eligible for this program often have multiple needs and the ability to address them in one location provides a productive and beneficial experience for clients. The addition of MassHire's drop-in hours allowed SPNS clients that had difficulty connecting and following up with MassHire to meet the employment navigator and begin working towards employment goals. Clients were also able to meet with their behavioral health provider, housing advocate, and MCM at the same location in the same day.

As discussed previously, clients often have difficulty navigating a fragmented service system. Therefore, whenever possible, it is best to offer multiple services in one location so that clients can access needed resources in one place.

Collaboration among providers

Coordination and collaboration among internal and external providers is crucial for this type of intervention.

Creating space for regular meetings that are part of the integrated program structure, as well as joint training opportunities are examples of action steps developed with the goal of increasing internal collaboration across programs.

We learned that collaboration with external providers for new service areas relies on two primary levels of buy-in: a) leadership showing interest and prioritizing the project, and b) front-line staff seeing concrete benefit for their clients and patients. In particular, we learned that the most consistent sources of referrals were our closest partners. One organization was literally in an adjoining building and staff accompanied clients to meetings several times. In contrast, our largest referring partner for pre-existing housing programs only made two referrals to this project directly; housing staff made fifteen referrals for patients from that health center after receiving housing referrals. This mirrors our early experience with internal medical case managers, who initially largely viewed the project as an additional burden on their limited time and busy schedules. Once they began to see concrete benefit for their patients, collaboration increased.

Value of data sharing among providers

Within Fenway Health, various departments use different data systems to track client outcomes, case notes, and demographic information. Working with an external provider added an additional data system to the mix, making the development of data sharing practices a critical aspect of the program. Using disparate data systems increased the barriers between systems of care. We addressed data sharing not only to reduce the burden on staff working across multiple systems, but also to enhance the "no wrong door" approach for clients.

Dissemination activities

- Presentation to the local Ryan White Planning Council, including entire council and consumer advisory committee
- Internal presentations
- Preparing a Ryan White Conference poster
- Tabled at a conference of the New England AIDS Education and Training Center (NEATC)

Attachments

Job descriptions

Organization chart

SPNS Referral form

Dissemination materials

Patient flyers

Partner organization flyers

Data collection forms

SPNS case coordination TouchPoint

Medical case management Acuity tool

Housing Search & Advocacy Navigator Acuity form

Rental Assistance Programs Service Care Plan form

MassHire Career Rx®

Sample data dashboards and visualizations

Sample client-level employment outcomes dashboard

Medical case management RW tracking dashboard (Tableau)

Quality improvement materials

Housing Search program current state process map

Housing Search program ideal state process map

Systems barriers priority matrix

Appendix

POSITION DESCRIPTION

Position Title	Department	Date
SPNS Study Project Coordinator	Housing/Public Health Research	July 2018

Function:
Under the direction of the SPNS Project Manager, the Project Coordinator works with internal staff and external colleagues to coordinate eligibility screening, referrals and ongoing case coordination.

Representative Duties:

1. Assists in Recruitment and Screening of Study Participants
- Works with Program Evaluation and Medical Case Management staff to identify and refer Fenway patients eligible for this study.
- Works with program managers and coordinators in the Housing Department to identify and refer eligible clients.
- Coordinates with identified partners at external clinical sites to identify and refer eligible clients.
- Provides training on eligibility criteria and referral process to new staff.
- Identifies alternative methods for reaching potential study participants, as needed.
- Reviews all referrals and confirms eligibility.
- Participates in design of study-specific recruitment materials.

2. Coordinates Referrals throughout Project Components
- Completes referrals to employment services partner, JVS
- Coordinates with Medical Case Managers to ensure appropriate housing services referrals are made.
- Refers all eligible clients to the Evaluation Assistant.
- Ensures completion of and follow-up on all referrals related to this project.
- Identifies barriers to effective referral completion and suggests changes to process.

3. Facilitates ongoing Case Coordination
- Serves as the liaison with each partner: Fenway case managers, external case managers, housing services providers, and JVS employment services providers.
- Serves as the liaison to the evaluation component by coordinating with the Evaluation Assistant.
- Establishes systems for communication between providers.
- Facilitates regular communication between providers through case conferences and other methods of case coordination.
- Provides a bridge between the clients' access to services and participation in the multi-site evaluation.

4. Coordinates data entry for intervention work
- Documents eligibility and responds to all referrals in REDCap.
- Enters all client-level data through encounter forms in tracking system.
- Coordinates encounter forms for intervention work performed by direct service staff.

5. Facilitates relationship with study team and ETAP
- Maintains regular communication with project manager and collaborators.
- Meets regularly with study team to review adherence to the project design, conduct of the project, and quality assurance of the interventions.
- Provides regular updates on recruitment and engagement progress.
- Participates in compilation of monthly reports to the Evaluation Technical Assistance Provider.
- Participates in monthly all-grantee ETAP calls.
- Participates in monthly site calls with ETAP and project officer.
- Participates in compilation of annual reports to the funder (HRSA).
- Assists with logistics of study team meetings and conference calls.
- Manages and completes other tasks related to the projects as needed.

6. Meets Agency Participatory Expectation

- Adheres to all agency and departmental policies and procedures.
- Participates in quality assessment and improvement activities as requested.
- Adheres to the highest principles of patient and client confidentiality.
- Adheres to established safety policies, procedures and precautions; identifies potential or actual unsafe situations in the environment and takes measures to rectify the situation.
- Attends all required meetings and professional trainings.
- Maintains professional competence necessary to perform job responsibilities; seeks training and development opportunities within and outside of the organization to increase knowledge.
- Serves on agency committees and in professional organizations when requested.
- Prepares for internal and external monitoring visits.
- Supports monitoring visit on-site inquiries and visit follow-up.

Requirements:

- BA or BS in related field required.
- Excellent communication, facilitation and interpersonal skills
- Working knowledge of HIV, homelessness, and/or employment services highly desirable
- Strong computer skills including Word, Excel, Outlook and ability to learn new database systems quickly
- Strong attention to detail
- Ability to function autonomously in a collaborative interdisciplinary team
- Excellent writing skills
- Ability to work in a fast paced environment
- Capacity for detail oriented multitasking
- Experience working in an ethnically, culturally, and racially diverse environment preferred
- Ability to work harmoniously with diverse groups of individuals required

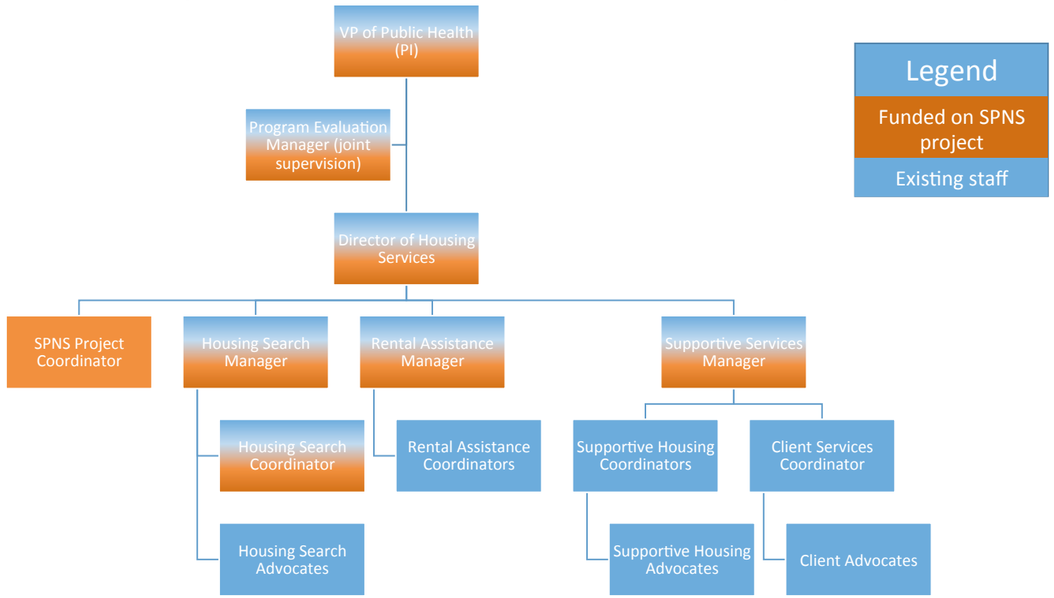
Physical Requirements:

- Ability to meet the following physical requirements with or without reasonable accommodations:
  - Sit at a computer station for extended periods of time
  - Ability to keyboard for extended periods of time

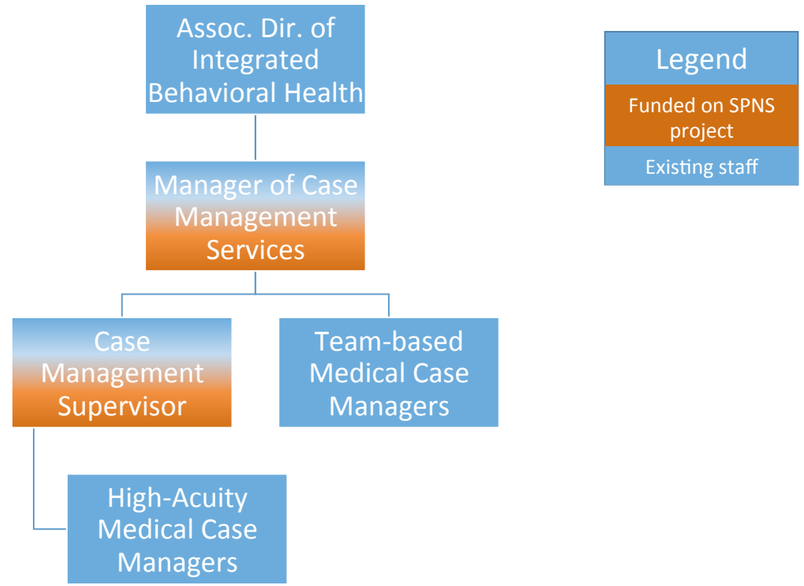
Supervisory Responsibility

None

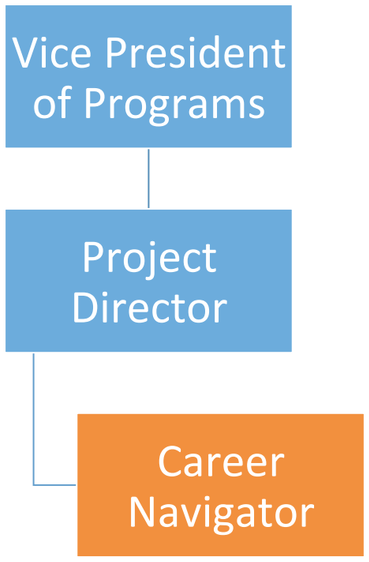
SPNS housing and coordination org chart



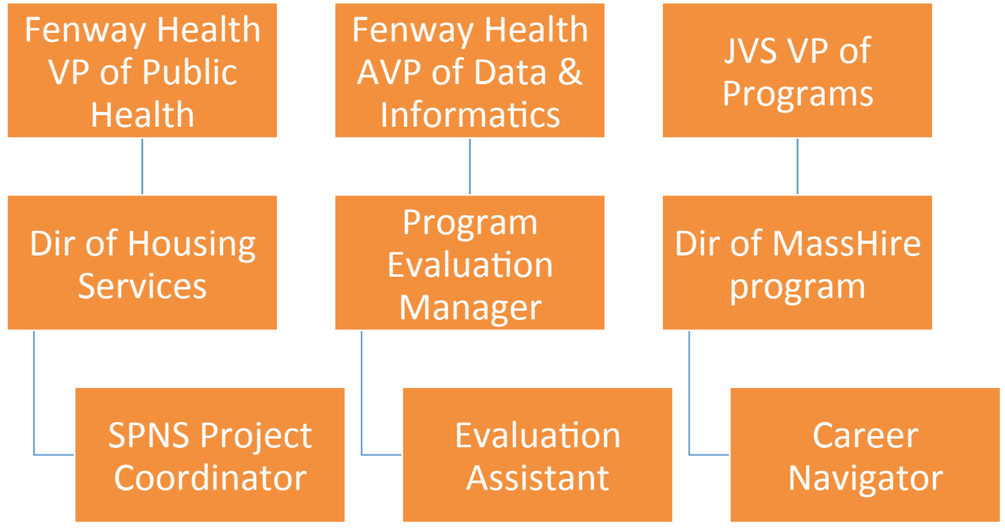
Medical case management org chart



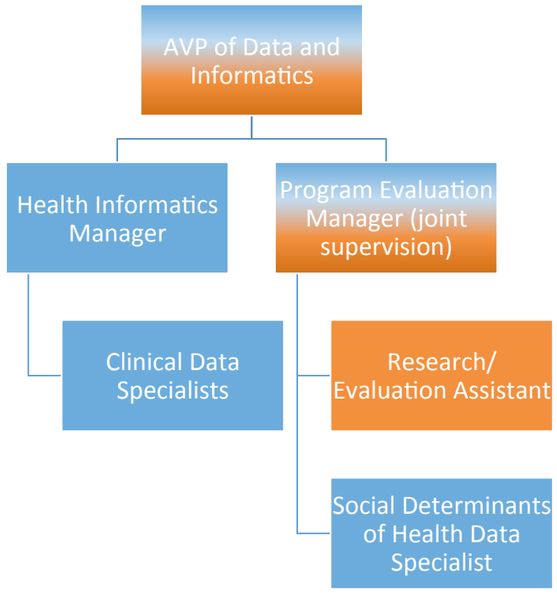
Employment services org chart



SPNS project funding org chart



Data and evaluation support org chart



Fenway SPNS housing and employment referrals

Please complete the referral form below to refer patients/clients to the Fenway Health SPNS Housing and Employment project.

Thank you!

General information

Referring case manager name

Referring agency
- ◯ Fenway Health
- ◯ AIDS Action housing/case management programs
- ◯ Boston Medical Center
- ◯ Health Care for the Homeless
- ◯ JRI
- ◯ Other

Other referring agency

Referrer's phone number

Referrer's email address

Where does the patient/client get their medical care (if somewhere other than your agency)?

Contact name at the clinical agency (usually the medical case manager)

Contact phone number at the clinical agency

Contact email at the clinical agency

Patient/client name

Patient/client date of birth

Patient/client phone number

Eligibility information

Is the patient/client 18 years or older?
- ◯ Yes
- ◯ No

Is the patient/client HIV-positive?
- ◯ Yes
- ◯ No

Is the patient/client Ryan White-eligible?
- ◯ Yes
- ◯ No

Is the client not fully engaged in care, based on the following guidelines?

	Yes	No
They were diagnosed within the last 12 months	◯	◯
They are NOT currently virally suppressed (viral load >= 200)	◯	◯
They have had gaps in HIV care of 6+ months in the past 2 years	◯	◯
They missed their last appointment in the past 6 months or last 2 appointments in the past 12 months	◯	◯
They are leaving incarceration	◯	◯

Is the patient/client homeless, unstably housed, or at imminent risk of homelessness, based on the following guidelines?	Yes
Their primary night-time residence is an emergency shelter	◯
Their primary night-time residence is a place not designed for human habitation	◯
They are exiting an institution after a stay of less than 90 days, and previously resided in a shelter or place not meant for human habitation	◯
They are in a transitional housing program	◯
They have not had a lease, ownership interest, or occupancy agreement in permanent and stable housing in the last 60 days	◯
They have received a shut-off notice in the past 60 days	◯
They have had 2 moves or more in the past 60 days	◯
They will lose their residence within 14 days if they do not receive assistance	◯
They received eviction notice (Notice to Quit) from landlord or have been summoned to court for an eviction case	◯
They are fleeing or attempting to flee domestic violence and have no other residence	◯

Is the patient/client unemployed or underemployed, based on the following guidelines?	Yes
They do not have a job, are actively looking for work in the prior 4 weeks and currently available for work	◯
They are on SSI/SSDI but demonstrates an interest in earning additional income via a type of paid employment	◯
They have part-time employment or temporary work but would like to earn additional income	◯
They are working on a cash basis for per-diem work	◯
They do not have enough paid work or are not doing work that makes full use of skills and abilities to meet their essential needs	◯

Referrals	
Referral to Housing Search & Advocacy	◯ Referred ◯ Not intending to refer ◯ Referral in process
Referral to rental assistance programs	◯ Referred ◯ Not intending to refer ◯ Referral in process (May include rental start-up, homelessness prevention, or utility assistance)
Patient/client release form for MassHire (formerly JVS)	(Please upload patient/client release of information form for JVS)
Patient/client release of information form from your clinic	(Please upload a release form attachment to allow us to retrieve information from your clinic/agency)
Has the SPNS project been explained to the patient/client?	◯ Yes ◯ No (Please add any additional info in notes field below)
Notes about HIV care, housing, and employment	_____ (Optional - no identifying info please! Please provide best times/ways to contact the client.)

Are you living with **HIV**?

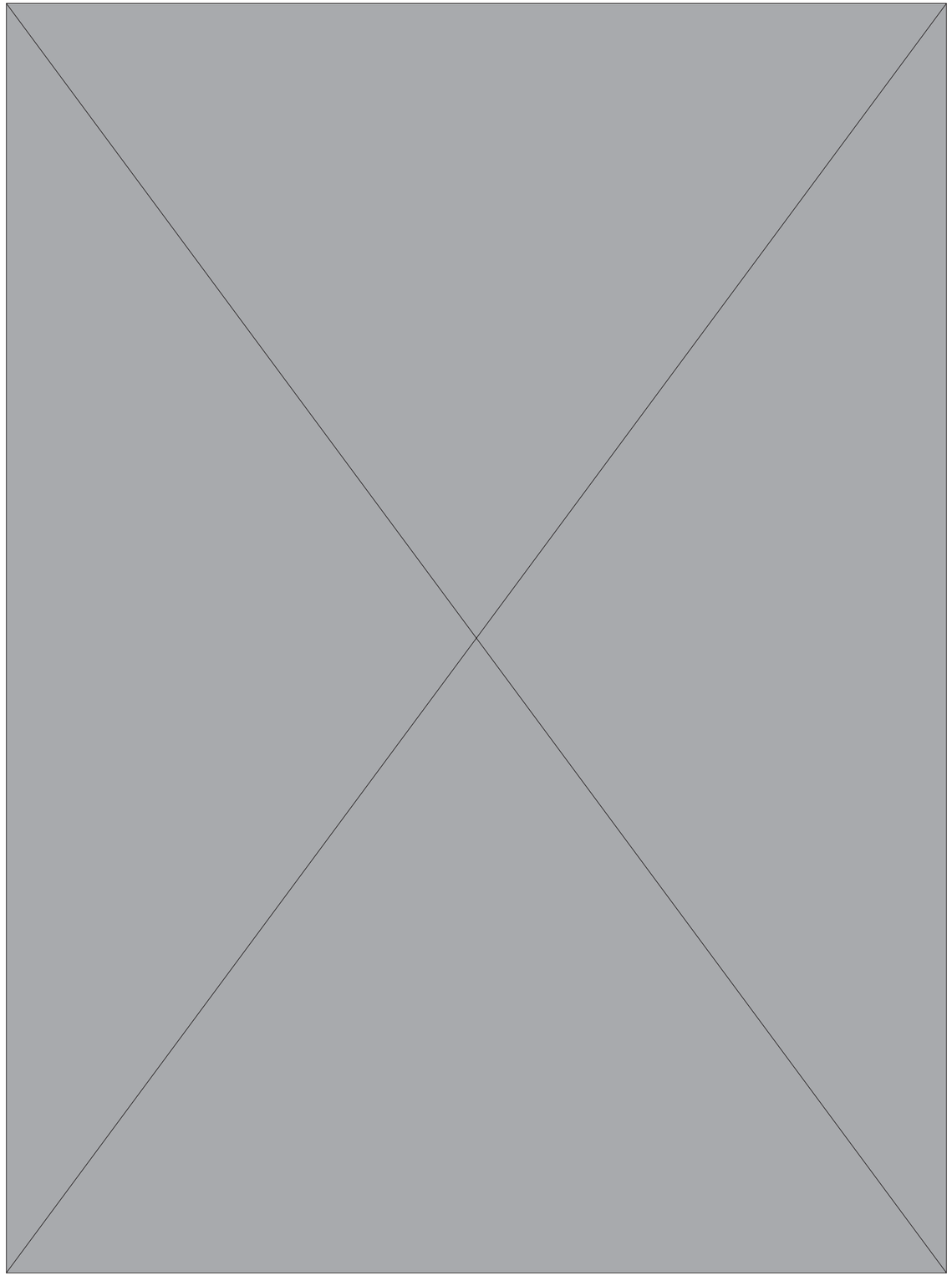
Are you looking for help finding stable **housing**?

Are you looking for help finding a **job**?

AACPA-75

Please talk to your case manager to learn about programs that might be available!

AIDS ACTION



SPNS Case coordination

Name:

Date: ____/____/_____

0 General

1 Fenway/AAC Location

( ) Amory Street
( ) Green Street
( ) MALE Center
( ) Youth on Fire
( ) Other Location
( ) Ansin Building
( ) Fenway South End
( ) Sidney Borum

2 Specify other location

SPNS Case coordination

3 Contact Method for navigation or coordination

( ) In Person Meeting
( ) Called Client
( ) Emailed Client
( ) Faxed Client
( ) Sent Mail to Client
( ) Called Other Agency/Provider
( ) Emailed Other Agency/Provider
( ) Faxed Other Agency/Provider
( ) Sent Mail to Other Agency/Provider
( ) Preparation for Client
( ) Other Contact Method
( ) Accompanied Client to Appointment
( ) Contacted Other Agency/Provider

4 Specify other contact method

9 Time spent

Hours: :Minutes

10 Areas of case coordination

[ ] Clinical/health
[ ] Housing
[ ] Employment
[ ] Other
[ ] Transportation and other social services
[ ] Educational and emotional support

Report Prompts:
TouchPoint: SPNS Case coordination

SPNS Case coordination

11 Specify other areas of case coordination

12 Encounter activity

13 Encounter activities: general

[ ] Find client/outreach
[ ] Client needs assessment

14 Encounter activities: healthcare

[ ] Collect, update, and/or confirm information about HIV specific services for documentation purposes
[ ] Collect, update, and/or confirm information about non-HIV medical services for documentation purposes
[ ] Linking newly-diagnosed client to first HIV medical appointment
[ ] Accompany client to a medical appointment
[ ] Discuss medical appointments
[ ] Assist with making appointment for health care
[ ] Create or update client individualized care plans
[ ] Follow up or reminder about a healthcare service or referral
[ ] Assist client with obtaining medications (HIV or non-HIV)
[ ] Collect, update, and/or confirm information about mental health, substance abuse treatment, or psychosocial support services for documentation purposes
[ ] Accompany client to a mental health appointment
[ ] Accompany client to a substance use treatment appointment
[ ] Assist with making appointment for mental health care
[ ] Assist with making appointment substance abuse treatment
[ ] Follow up about a mental health or substance use treatment service or referral

SPNS Case coordination

15 Encounter activities: housing

[ ] Collect, update, and/or confirm information about current housing
[ ] Provide support for maintaining housing
[ ] Create or update goal plan for housing services
[ ] Accompany client to housing service appointment or other housing-related activity
[ ] Assist with fair housing counseling or help with housing discrimination
[ ] Assist client with housing application
[ ] Discuss housing needs or assist with obtaining housing
[ ] Follow up or remind about a housing service or referral
[ ] Assist client with a move

16 Encounter activities: transportation and other social services

[ ] Assist with obtaining and arranging transportation services
[ ] Assist with obtaining and arranging other support or social services (e.g. childcare)

17 Encounter activities: educational and emotional support

[ ] Relationship building (e.g. checking in with client; providing emotional support/ counseling)
[ ] Talk with a client about disclosure
[ ] Coaching on living skills
[ ] Provide basic HIV treatment education, support and/or advocacy
[ ] Provide harm reduction education (safer sex, substance use)
[ ] Mentoring/coaching on provider interactions

Report Prompts:
TouchPoint: SPNS Case coordination

18 Encounter activities: employment and social support

[ ] Assist client with finding employment
[ ] Assist the client with obtaining skills training or job/vocational training
[ ] Assist with job placement services
[ ] Assist with obtaining resume activities
[ ] Assist client with accessing resources for employment purposes (i.e. getting clothing, getting a haircut)
[ ] Assist client with obtaining cell phone
[ ] Assist client with budgeting/financial planning
[ ] Assist client in obtaining legal assistance or advocacy
[ ] Assist client with obtaining legal documents (i.e. an ID or Social security card)
[ ] Assist client with obtaining benefits (medical insurance, food stamps)
[ ] Social networking event (lunch/meal gathering, activity)
[ ] Coordinate and assist with obtaining skills to prepare for interviews and employment

19 Other activities or topics:

20 Outcomes and Notes

21 What barriers prevented the client from accessing the service? (Choose all that apply)

[ ] Hours of operation
[ ] Insufficient/lack of culturally appropriate services
[ ] Insufficient/lack of language capacity (including sign language)
[ ] Insufficient/lack of services for people with disabilities
[ ] Services inappropriate for people with or challenges related to substance abuse issues
[ ] Transportation
[ ] Lack of child care
[ ] Need not documented
[ ] Program reached capacity
[ ] Program unable to provide service due to limited resources/priority-setting
[ ] Services inappropriate for people with or challenges related to mental health issues
[ ] Services not appropriate for client
[ ] Client missed appointment
[ ] Issues related to insurance/cost
[ ] Other (specify)
[ ] Client could not obtain an appointment
[ ] Immigration issues
[ ] Criminal or sex offender status
[ ] Client was denied service

22 Health outcomes

[ ] Client becomes hospitalized
[ ] Client accesses substance use treatment program
[ ] Client accesses behavioral health program
[ ] Other health outcomes

23 Please specify other health outcomes

24 Housing outcomes

[ ] Client secures and/or moves into housing
[ ] Client is prevented from becoming homeless (eviction avoided, utility turned back on, etc.)
[ ] Client loses housing
[ ] Other housing outcomes

25 Please specify other housing outcomes

26 Employment outcomes

[ ] Client successfully referred to MassHire
[ ] Client schedules Welcome session at MassHire
[ ] Client attends Welcome Session at MassHire
[ ] Client begins a training program
[ ] Client completes a training program/obtains certification
[ ] Client obtains job
[ ] Client loses job
[ ] Client begins volunteer opportunity
[ ] Other employment outcomes

27 Please specify other employment outcomes

28 Other social determinants of health outcomes

[ ] Client arrested or incarcerated
[ ] Other outcomes

29 Please specify other social determinants of health outcomes

30 Navigation and coordination notes

	RW Case Management Acuity Tool			
	Level of need			
Category	Intensive Need (3)	Moderate Need (2)	Basic Need (1)	Self Management (0)
HIV Medication Adherence				
Health Insurance and HDAP Status				
Sexual and Reproductive Health Status				
Mental Health Status				
Substance Use				
Housing Status				
Legal Status				
Support System and Relationships				
Income Finance Status				
Transportation Status				
Nutrional Status				

HSA Housing Barriers Acuity Assessment (draft)

CORI

	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self-Management (0)
	Incarcerated within the last five years		Recent non-violent convictions that may require appeal/mitigation		Very old charges that can possibly be sealed (Misdemeanors 3+ years, felonies 7+ years)		Has not interacted with law enforcement, does not require further attention
	Recent violent and/or drug related convictions		Client is unsure of criminal history		Old (7+ years) non-violent charges that are unlikely to interfere with housing search		Client feels confident there is no CORI
	Currently on probation or parole						

Credit

	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self-Management (0)
	Client has experienced credit fraud and needs to contest with credit agencies		Client has multiple lines of credit in moderate/poor credit		Client has 1-2 accounts in poor standing that are not related to housing (i.e., student loans, credit cards)		Client has one or two lines of credit in good standing
	Client has one or more accounts in collections		Client is unsure of credit score		Client does not have credit		Credit score is good enough that it will not affect housing search
	Client has filed for bankruptcy in the past						

HSA Housing Barriers Acuity Assessment (draft)

Housing History / References

	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self-Management (0)
	Client was evicted within the last three years		Client has complicated housing history which will require intensive research for contacts		Client has no-fault eviction that may require documentation		Client has simple housing history with good references
	Client has no landlord references		Client was evicted over three years ago		Client will need to do minor research to gather contact info for past landlords		Client's housing history will not be a barrier
	Client has been doubled up in subsidized housing, cannot provide landlord information		Client has been doubled up and will need to gather letters from where they had lived				

Eligibility for Federally Funded Housing (Immigration Status/SORI).

	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self-Management (0)
	Client has ineligible immigration status		Client does not know their immigration status		Client is in the process of attaining immigration status (i.e., recently married citizen, won asylum case, etc…) that will change eligibility.		All household members are eligible for federally subsidized housing
	Client is a lifetime registered sex offender		Client does not have documentation of immigration status		Client has sex offender status but not a lifetime registration requirement		
			Client does not know SORI registration requirement		Client has a family member who is not eligible, will need to discuss pro-rated rent		

HSA Housing Barriers Acuity Assessment (draft)

Owed rent/utilities/fees to landlords

	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self-Management (0)
	Client owes over $1000 to prior landlord		Client owes between $500-$1000 to a current or prior landlord		Client owes under $500 to a current or prior landlord		Client does not owe any money to past landlords
	Client cannot turn on utilities because of unpaid bills		Client has large utility bill, requires payment plan		Client owes a moderate amount but is on a payment plan with landlord		Client has shut off protection and is up to date with utility payments
	Client is currently facing eviction: has notice to quit, or is in current legal proceedings; is working with or needs to be referred for legal assistance		Client owes arrears to current landlord, requires HPP application		Client is up to date with utilities but needs reduced rate/medical shut off protection		

Gathering documents

	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self-Management (0)
	Client has no identification documentation		Client may need to request one missing document from gov't agency		Client has Birth Certificate/ SSC/Green Card but missing some disability letters		Client has copies of all documents needed for housing search
	Client has no means of paying for documentation and will need to seek additional resources		Client has documentation but needs to replace damaged paperwork		Will need to request accessibility and/or ADA letter from Doctor		
	Client is missing green card and will need to apply for a new copy		Client has documentation but needs to locate it		Client has documentation but needs to bring copies in for file		

HSA Housing Barriers Acuity Assessment (draft)

Reasonable Accommodation / Modification

	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self-Management (0)
	Client will need a fully accessible unit		Client will need a building with an elevator or limited steps.		Clients unit will need minor accessible features (i.e. handrails installed).		Client will not be requesting reasonable accommodation
	Client is currently in an inaccessible unit		Client will need a unit on the first or second floor (can handle one flight of stairs).				
	Client requires policies and rules to be changed in order for them to comply due to a disability.		Current housing requires reasonable modification				

Homelessness

	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self-Management (0)
	Client is currently chronically homeless		Client is currently literally homeless in shelter		Client has experienced literal homelessness in the past		Client has never been literally homeless
	Client is currently homeless but will need help gathering documentation to verify		Client has experienced chronic homelessness in the past		Client is concerned they may become homeless		Client is not concerned about becoming homeless
	Clients medical/behavioral health concerns are greatly exasperated by stress due to homelessness		Client is experiencing some emotional/behavioral instability due to homelessness		Occasionally misses appointments.		

HSA Housing Barriers Acuity Assessment (draft)

Access to client/ ability to make contact

	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self-Management (0)
	Even with closely working MCM, client is often inaccessible		Client is only accessible through a MCM		Client is accessible by phone but does not always return calls		Client is fully accessible by phone/email directly
	Client does not have a working phone or email address		Based on client's needs, must meet client in the community.		Clients phone is often shut off or the voicemail is full		Client keeps all scheduled appointments
	Have not developed a method of regularly meeting with client to work on housing		Client frequently misses appointments				Client is able to meet AAC staff at Amory

Client Acuity Score: _____ Level of Need: _____

Acuity Scoring:

0: Self-management

1 – 9: Basic need

10-18: Moderate need

19-27: Intensive need

If two or more categories score as a 3, the client is considered Intensive need and High Acuity

Service Care Assessment

Rental Assistance Program Application

PAGE 1 OF 2

Name of Client_____

Name of Case Manager/Advocate: _____

Case Manager/Advocate Agency: _____

What are the barriers that are currently hindering your ability to pay your rent/mortgage/utility? (You must select at least one, please select no more than three).

- ☐ Substance use
- ☐ Domestic violence
- ☐ Loss of income
- ☐ Other:
- ☐ Mental health
- ☐ Money management
- ☐ Immigration issues
- ☐ Medical health (including healthcare costs
- ☐ Change in household composition
- ☐ Waiting for benefit payments to begin

How have these barriers affected your ability to pay your rent/mortgage/utility?

_____

_____

_____

_____

_____

_____

_____

Ryan White Part A funds are **Payer of Last Resort**. Which other programs or resources did this household apply for before RAP?

- ☐ **RAFT**
  Result: _____
- ☐ **HomeBASE**
  Result: _____
- ☐ **ESG (SHC, HomeStart)**
  Result:_____
- ☐ **Catholic Charities**
  Result: _____
- ☐ **Salvation Army**
  Result:_____
- ☐ **ABCD**
  Result:_____
- ☐ **OTHER(S):** _____
  _____
  Result(s): _____

PLEASE CONTINUE TO THE SECOND PAGE

Service Care Assessment

PAGE 2 OF 2

How will you address the barriers discussed on page 1 so you are able to make your rent/utility payments in the future?

Goals to Resolve this Barrier	Action Steps	Timeline to Achieve
1		
2		
3		

Utility Only

UTL Name: _____ **Account Number:** _____

UTL Name: _____ **Account Number:** _____

Does the applicant have a housing subsidy? ☐ Yes ☐ No

The utility bill(s) enclosed are in the applicant's name? ☐ Yes ☐ No If no, please explain: _____

The utility bill(s) enclosed are for the applicant's current living situation: ☐ Yes ☐ No If no, please explain: _____

Signature of Client: _____ **Date:** _____

Signature of Case Manager/Advocate: _____ **Date:** _____

MASSHIRE
DOWNTOWN BOSTON CAREER CENTER

Career Rx | Updated October 4, 2018

For best results, register for a workshop (or 2!) and track your progress. If needed, we will check-in on your progress at a follow-up appointment.

Category	Workshop	Priority	Event Date	Registered
Job Search	21st Century Job Search 2.0			
	AAUW Salary Negotiation			
	Cover Letter and Communication 1.0			
	How to Land a Federal Job 1.0			
	Job Fair Preparation 1.0			
	Job Fairs and Employer Recruitment Events			
	Job Search with the Boston Business Journal 2.0			
	Managing Stress & Negativity in the Job Search 2.0			
	Using Age to Your Advantage 2.0			
	1:1 Job Search Planning (fee)			
Resume	Resume 1.0: Why and How to Create a Resume			
	Resume 2.0: Creating a Targeted Resume			
	Resume 2.0: Get Your Resume Into Human Hands			
	Resume Writing 3.0 (fee, 2 parts)			
	1:1 Tuesday Resume Review			
	1:1 Resume Writing 4.0 (fee)			
Networking	Crafting Your Elevator Pitch 2.0			
	Healthcare Networking Group 1.0			
	HIRE Opportunity 2.0: Strategies, Support, Success (6 week cohort, must apply online)			
	Is Your Network Working? 2.0			
	Job Seekers Networking Group 1.0			
Interview	Interview 1.0: Mastering the Basics			
	Interview 2.0: Behavioral Questions			
	1:1 Tuesday Mock Interview			
Career Exploration	Opportunities in Construction 1.0			
	Opportunities in Healthcare 1.0			
	SkillScan 2.0			
	Training & Re-Employment Opportunities 1.0			
	Your New Career 3.0 (1st session free, 2nd and 3rd sessions have a fee)			
	1:1 Career Counseling 4.0 (fee)			
	1:1 Assessment Testing 4.0 (fee)			
Computer Basics	Introduction to Microsoft Excel 1.0			
	Introduction to Microsoft Word 1.0			
	Online Applications Explained 1.0			
	Online Application Lab 1.0			

75 Federal Street, 3rd Floor • Boston, MA 02110 • 617.399.3100 • www.MassHireDowntownBoston.org

SPNS HIV health, housing and employment project
Project Logic Model

Fenway Health
Designed July 2018, Revised March 2019

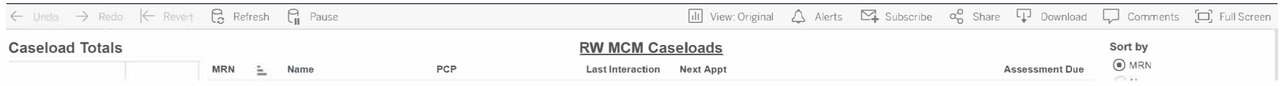
Inputs	Activities	Outputs	Short-term outcomes		Medium-term outcomes		Long-term outcomes	Impact
Good statewide[1] and organization-level HIV health outcomes[2]; widespread health coverage[3]	Care coordination to locate clients; Coordination for more effective client engagement	Clients contacted	Participant-level	Clients better engaged in care	Participant-level	Clients improve medical health and social determinants of health	Clients' housing stability and careers serve as platform for increased engagement in care; Clients' viral suppression improves[4]	Improved community-wide viral suppression; reduced transmission of new HIV infections
Clients with multiple areas of crisis, impacting ability to remain engaged with and adherent to HIV care								
Clients with multiple social determinants of health challenges and various readiness for change	Case conferencing on areas of need[5]	Case conferences conducted		Clients more firmly engaged in wraparound care (identify barriers)				
Extreme local housing cost burden[6]; FH/AAC extensive knowledge of housing market, assistance programs, supportive services	Outreach to clinical providers to proactively recruit participants; Initiate referrals to employment partner; coordinate and support referrals for housing	Clients connected to the right housing services for them		Stabilizing existing housing situations (rental assistance) Clients receive appropriate supportive services		Clients connected to stable housing		
MassHire knowledge of and ability to provide direct employment services		Clients connected to workforce development on the right track		Clients increase preparation for workforce and obtain short-term jobs		Clients build careers		
Lack of coordination and communication between providers of HIV medical care and CBOs providing housing & employment		for them[7]						
Multiple benefit systems with various eligibility levels[8]	Benefit coordination; case coordination to discuss how changes in employment will impact benefits eligibility	Client informed about and supported in reporting income changes and adjusting to modified eligibility		Clients improve access to income and benefits; clients avoid cliff effects[9]		Client economic situation improves		
Inconsistent local systems-wide data collection on employment for People Living With HIV/AIDS (PLWH)	Coordinate with local Ryan White Planning Council on needs assessment questions on employment	Employment needs assessment data gathered	System-level	Increased system-wide data availability on employment for PLWH	System-level	Improved coordination and planning of employment, housing, and health planning for PLWH		
	Development of referral system to include basic uniform employment data, cross-referenced with health data[10]							
Inadequate local systems-level coordination of employment with health systems	Development of tools to increase knowledge of benefit interaction	Tool developed and used by partners for benefit interaction		Improved system-wide knowledge of cliff effects				
	Train providers on referrals; Train providers on factors affected employment for PLWH	Providers trained on creating referrals, need for coordination, employment factors		Improved system-wide knowledge of factors affecting employment and support for employment activities				

[1] As of 2015, 86% of those engaged in care in Massachusetts and 89% of those retained in care were virally suppressed. See "Massachusetts Integrated HIV/AIDS Prevention And Care Plan, HIV/AIDS Services In The Commonwealth: 2017-2021," Massachusetts Department Of Public Health (MDPH);Bureau Of Infectious Disease And Laboratory Sciences (BIDLS);Office Of HIV/AIDS (OHA), p 33. https://www.mass.gov/files/documents/2016/12/vz/mass-hiv-aids-plan.pdf
[2] In 2018, 88.9% of Fenway patients living with HIV were virally suppressed.
[3] Per American Community Survey (2017, 5-year estimates), 97% of Massachusetts civilian noninstitutionalized population was insured at time of interview. "2013-2017 American Community Survey 5-Year Estimates, Selected Characteristics Of Health Insurance Coverage In The United States," Census Factfinder.
[4] "HIV Care Continuum: The Connection Between Housing And Improved Outcomes Along The HIV Care Continuum." HOPWA, Office of Community Planning & Development. https://www.hudexchange.info/resources/documents/The-Connection-Between-Housing-and-Improved-Outcomes-Along-the-HIV-Care-Continuum.pdf
[5] Using lessons learned from AIDS Action previous LEAP model of internal case conferencing, applying to external agency relationship
[6] According to Massachusetts Housing Partnership analysis of Census data, 49.4% of Boston renter households were cost-burdened (paying > 30% income for rent) and 25.1% were severely cost-burdened (> 50% income), inclusive. Massachusetts Housing Partnership, "DataTown", from U.S. Census Bureau American Community Survey, 2013-2017 5-year estimates. https://mhpcenterforhousingdata.shinyapps.io/DataTown/
[7] Through MassHire Career Rx
[8] SSI/SSDI, Ryan White income limits, MassHealth, etc.
[9] For an explanation of cliff effects (in a non-HIV context) please see *The "Cliff Effect" Experience: Voices of Women on the Path to Economic Independence*, Crittenton Women's Union/Economic Mobility Pathways, Boston, April 2019. Available at http://s3.amazonaws.com/empath-website/pdf/Research-CliffEffectExperienceVoicesWomenEconomicIndependence-0409.pdf
[10] Based on comprehensive assessments such as Ryan White case management assessment or MDPH acuity assessment

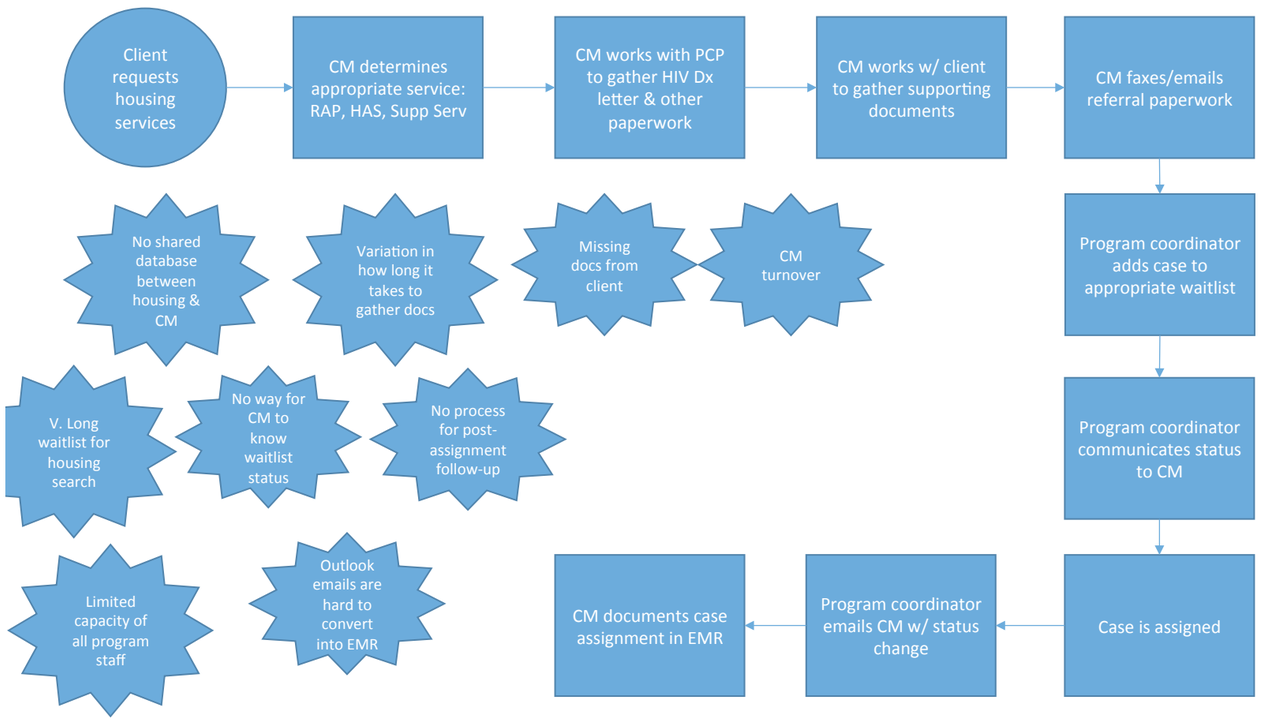
Employment outcomes client-level

[Client name]; [Client ID]

Date	Response#	Employment outcomes
9/14/2018	5	Client successfully referred to MassHire|
9/21/2018	1267	Client obtains job|
12/14/2018	134	Client schedules Welcome session at MassHire|
12/31/2018	183	Client missed Welcome Session at MassHire|
4/17/2019	1268	Client loses job|
9/17/2019	1227	Client attends employment drop-in session|
10/16/2019	1317	Client obtains job|



MCM to Housing current state



Potential Impact

	Low impact	High impact
Low difficulty/effort	**Fill-ins** CM immediately sends new client info to Housing Search Outlook syncs to EMR	**Quick wins** Shared reports Standard outreach attempts Standard documentation of housing refferals
High difficulty/ effort	**Thankless tasks**	**Major projects** Shared database Standardized attempts to acquire documents Waitlist management

Housing Search Ideal State