Project CORE: Coordination of Resources & Employment

A Structural Intervention

THE HIV, HOUSING, & EMPLOYMENT PROJECT

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PROJECT C.O.R.E.
COORDINATION OF RESOURCES AND EMPLOYMENT

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 Avenue 360 Health and Wellness, a RWHAP-funded site, in partnership with AIDS Foundation Houston, and University of Houston Graduate College of Social Work.

The Project CORE intervention was implemented by Avenue 360 Health and Wellness (and AIDS Foundation Houston), a RWHAP Parts A, B, and F recipient based in Houston, Texas.

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THE HIV, HOUSING, & EMPLOYMENT PROJECT

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Introduction

Purpose

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) developed a companion guide highlighting the similarities and differences of the intervention programs for dissemination to the wider Ryan White HIV/AIDS Program (RWHAP) community, Department of Housing and Urban Development (HUD) programs, Department of Labor (DOL) programs, and other key stakeholders.

Audience

Service providers, county, city and state agencies who are interested in improving the access and quality of care and services to people living with HIV/AIDS who are homeless or unstably housed.

Overview of the SPNS Initiative

This initiative supported 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 underserved people living with HIV (PLWH) in racial and ethnic minority communities. The overall goal of this coordinated services intervention is to decrease the impact of the social determinants of health (such asunmet housing or employment needs) that affect long-term HIV health outcomes for PLWH impacted by employment and housing instability in racial and ethnic minority communities. To promote long-term health and stability for PLWH, this initiative supported one Evaluation and Technical Assistance Provider (ETAP) and 12 demonstration sites across the United States that have implemented, evaluated, and disseminated innovative strategies for integrating HIV care, housing, and employment services into a coordinated intervention.

Background and Intervention Overview

Background

Description of the Demonstration Site & Relevant Partners

Project CORE – Key Partners

Avenue 360 Health & Wellness

AVENUE 360 began its corporate life in 1998 as an AIDS Service Organization (ASO), which placed a special emphasis on serving Communities of Color, in particular African American and Hispanic people living with HIV (PLWH), to ensure culturally competent, linguistically appropriate, high quality services in the areas of HIV-related prevention and care services including: primary care, pharmacy, behavioral health, social work, peer education, HIV Counseling Testing & Referral (HIV/CTR), and housing-related services. As a Federally Qualified Health Center (FQHC), AVENUE 360's RWHAP Parts A, B, and D programs became integrated within the entire health center. This integration provided additional services to PLWH beyond what RWHAP could pay for as well as timely coordination of care via the agency's Electronic Health Record (EHR) supporting evidenced based care, including state of the art care for the treatment of HIV disease as well administering pre-exposure prophylaxis (PrEP). As the demonstration site, Avenue 360 Health and Wellness used the Community Centered Health Home model and their Electronic Health Records system to propose the implementation and needs assessments of the population at hand.

AIDS Foundation Houston

The mission of AIDS Foundation Houston, Inc. (AFH) is to lead the innovative efforts in the prevention of new HIV infections and empowers individuals, families, and communities affected by HIV/AIDS to create and sustain healthy lives. Our impact focus is to provide access to a community of services for those affected by HIV and that experience inequity caused by social injustice. Our goal is to prevent new HIV infections and increase viral suppression. AFH has been in the fight against HIV/AIDS since the first reported cases of AIDS in 1981. As the first AIDS Service Organization in Texas, AFH began as a grassroots organization comprised of individuals who aided those dying of AIDS by delivering food, helping find housing for those who did not have a roof over their head, advocating for treatment, and by comforting those whose bodies could no longer fight the incurable disease. Over the last 35 years, AFH has grown into a robust community-based organization focusing on the "Human Side of HIV." Today, AFH is a multi-faceted health and human services organization that provides supportive services for over 4,000 men, women, and children living with or affected by HIV/AIDS.

The agency also offers HIV prevention education to almost 92,000 individuals and testing to 1600 annually, most of whom come from marginalized populations, including people in the Texas prison system and gay, bisexual, and transgender men and women. For this project, AIDS Foundation Houston was the home site for the Project CORE team, consisting of the Outreach specialist, the Data specialist, and the Network Navigator. AFH acted as a hub for Coordinated Access to Housing for PLWH. This site was also responsible for hosting employment workshops, in partnership with Workforce Solutions. Other duties included non-medical case management provided by the Network Navigator. AFH was also able to assist with food assistance services, income support assistance, legal assistance, and healthcare assistance by way of resources or referrals, providing wrap around services.

University of Houston Graduate College of Social Work

The University of Houston Graduate College of Social Work (GCSW) prepares diverse leaders in practice and research to address complex challenges and achieve sustainable social, racial, economic, and political justice, locally and globally, through exceptional education, innovative research, and meaningful community engagement. For this project, Dr. Samira Ali, Assistant Professor at GCSW, served as the Evaluator.

Project CORE – Referral and Outreach Partners

Workforce Solutions

Workforce Solutions is a Department of Labor funded organization that helps employers meet their human resource needs and individuals build careers, so both can compete in the global economy. The Workforce Solutions are the public workforce system in the 13-county Houston-Galveston region of Texas that offers workforce development services to job seekers at various community locations and provides the opportunity for individuals to achieve and sustain economic prosperity. By providing creative tools that help navigate today's job market, participants will assess their needs and employment skills to create a targeted job search plan.

WorkFaith Connections

WorkFaith Connections is a non-profit, Christ-centered organization that exists to encourage disadvantaged job seekers in their hope for a better future and to equip them with the skills needed to conduct a successful job search and become productive employees. Specific attention is focused on serving those caught in the cycle of poverty, formerly incarcerated, recovering from addiction, or transitioning out of homelessness. The WorkFaith Connection provides an intensive 8-day classroom experience, followed by an intensive 90 day follow-up support and coaching during the job search. Once employed, they stay in touch with the participant for at least two years to offer advice and encouragement.

Career and Recovery

Career and Recovery assist clients in achieving their professional career potential by researching occupational choices,sharpening job search skills, and helping clients understand and overcome the barriers that may keep them from reaching their career and financial goals. Throughout the Employment Services program, participants are provided workshops for job readiness training and to resolve and manage personal issues and life skills.

Project CORE – Clinic Partners

Project CORE also had clinical partners. These clinics played an instrumental role in referring participants to Project CORE. The clinics are listed below:

- Legacy Community Health
- Thomas Street Clinic
- St. Hope
- AIDS Healthcare Foundation

Description of Need

Houston, Texas

- 27,057 people are living with HIV in Houston, with 56% who are uninsured and 66% living in poverty
- The HIV epidemic has disproportionately impacted the following communities of color Houston: 49% African American, 28% Hispanic/Latinx, and 17% White.
- 75% of PLWH are men and 24% are women. *Data do not specify if transgender communities are included in this number.*
- As of 2018, 64% of PLWH were linked to HIV care.
- As of 2018, 59% of PLWH were virally suppressed.
- All data are from www.aidsvu.com

Disparities

Similar to other regions of the US, large disparities among racial/ethnic groups, gender and sexual orientation exist. The rate of black males living with HIV is 4 times more than white males and the rate of black women is 17 times more than that of white women. Hispanic/Latinx communities follow similar trends with the rates of 1.4 and 2.7 when compared to white men and women, respectively. Black and Latinx Men who have sex with men (*CDC language, though the more community-centered inclusive term is same gender loving/gay men*) account for the largest community living with HIV, about 56%. Black women are also disproportionately impacted (139,866 in 2017). Black and Latina transgender women are also disproportionately impacted. They accounted for 80% of transgender women HIV diagnosis. The Latinx communities might face additional barriers due to a documentation status. This is due to socio-structural factors, suchas stigma, lack of social protections, and discrimination faced with healthcare providers.

Demographic Comparison of people living with HIV		
Category	**Houston (EMA)**	**National**
Hispanic/Black	77%	69%
Living in Poverty	66%	75%
Women	24%	23%
MSM	60%	69%

Housing

Housing continues to be a dire need among people living with HIV in Houston. **The rise of costs in housing coupled with discrimination around HIV, gender and sexuality has created a difficult scenario for people living with HIV who are living on a low income/poverty**. While statistics on experiences of unstable housing among people living with HIV are not readily available in Houston, **research conducted in other cities show that 30% to 70% of people living with HIV have faced unstable housing**. Among certain communities, such as those who have incarceration histories, obtaining housing might present additional barriers due to ineligibility of receiving certain government subsidized housing benefits or stigma around those who are incarcerated. **Ultimately, unstable housing experiences lead to poor physical and mental health outcomes among people living with HIV.** (Aidala, A. A., Wilson, M. G., Shubert, V., Gogolishvili, D., Globerman, J., Rueda, S., ... & Rourke, S. B. (2016). Housing status, medical care, and health outcomes among people living with HIV/AIDS: a systematic review. American journal of public health, 106(1), e1-e23.)

Employment

Employment is another important need. Similar to the rest of the US, discrimination and stigma continue to be barriers for people living with HIV who are seeking employment. The U.S. Equal Employment Opportunity Commission reports that people living with HIV might experience problems with stamina, increased restroom use, vision/difficulty seeing, or cognitive impairment/unable to concentrate. However, they don't always feel comfortable sharing their HIV status due to fear of discrimination. Overall, there is need to educate and make aware of client rights to ask and prepare a request for reasonable accommodations. Transgender women face additional barriers due to transphobia. Additionally, those who have incarceration histories face discrimination due to their jail/prison history.

Summary of Community Needs

Based on research and communities' experience

Description of Project CORE Intervention

Goals

The overall goal of Project CORE was to enhance the coordination of employment and housing services to ultimately improve People Living with HIV wellbeing, housing stability, and employment experiences.

Goal I: Through the Clinical/Community Population Health Intervention Model Project CORE/AVENUE 360 & AFH will increase the coordination of HIV primary care, housing and employment services for PLWH in racial or ethnic minority communities.

Objective: Avenue 360 and AFH will increase the access and/or coordination of RWHAP care, HOPWA, and employment services through increased data sharing and data coordination within the first 6 months of the grant period.

Goal 2: Through the Getting to Work: A Training Curriculum for HIV/AIDS Service Providers and Housing Providers, Project CORE will improve employment outcomes, housing stability, and viral suppression for PLWH in racial or ethnic minority communities.

Objective: AFH in collaboration with Workforce Solution will implement a 4-session employment training series for 7 cohorts of 25, totaling 150 PLWH to improve their employment outcomes by the end of the 3 year grant period.

Project CORE Key Intervention Components

Outreach	Strong Partnerships	Employment Coordination	Housing Coordination	One-Stop Shop
• Outreach Specialist • Social Network Strategy	• Avenue 360/AFH/UH • Workforce Solutions - DOL Funded • Houston Area Clinics	• DOL Funded Workshops • Referral to employment Services	• Access to housing programs • Case management	• Wrap around Services • AFH - Food Pantry, PrEP and other social services • Avenue 360 - medical services and housing services

Outreach

Participants were recruited from different settings with various strategies. This was to ensure we were able to get the word out and provide the services to as many eligible people as possible. Below is the summary of the outreach sites strategies.

Sites: Sites of outreach for recruitment in Project CORE

Avenue 360
AFH
Health Fairs
Clinic Partners

Strategies: Social Network Strategy (SNS)

SNS is an approach which utilizes existing participants as recruiters to broaden and boost recruitment. See page 32 for more details.

Strong Partnerships

Avenue 360 - Clinical Partner

AFH – Social Support/Wrap Around Services Partner

University of Houston Graduate College of Social Work – Evaluation Partner

Workforce Solutions – DOL - Funded Employment Partner

Houston Area Clinics and Organizations – Recruitment and Referral Partners

Employment Coordination

Project CORE was designed to enhance current case management service delivery and to connect individuals to employment or to improve a person's income through employment. Such services include resume building, job search assistance, and resource rooms with internet and resume writing tools, job training or education programs, accessibility and special accommodation services for people with disabilities. Employment services were based on the Department of Labor's "Getting to Work" initiative; focuses on the following:

1) Increasing the client's value of work
2) Implementing employment services effectively via trained service providers;
3) Increasing and maintaining strong collaborations with outside employment services.

Housing Coordination

Avenue 360 and AFH already had housing related programs, such as HOPWA housing that Project CORE could refer participants to for housing.
Avenue 360 offered integrated behavioral health, physical health and housing services, a unique aspect for an organization in Houston.
Avenue 360 Housing Services

- Continuum of Care Permanent Supportive Housing
- Emergency Shelter
- HOPWA

One-Stop Shop

PLWH often need a host of services in addition to HIV treatment. These include food support services, social support services, counseling and case management. These services, if offered, have been found to be associated with positive health outcomes (citations below). AFH is known as a one stop shop that offers a host of services, including:

Food Pantry
Benefits and Resource
Counseling Case Management
Housing
Nutrition
Assistance PrEP
Social Support Services

Rachlis, B., Burchell, A. N., Gardner, S., Light, L., Raboud, J., Antoniou, T., ... & Ontario HIV Treatment Network Cohort Study. (2017). Social determinants of health and retention in HIV care in a clinical cohort in Ontario, Canada. AIDS care, 29(7), 828-837.

Zeglin, R. J., & Stein, J. P. (2015). Social determinants of health predict state incidence of HIV and AIDS: A short report. AIDS care, 27(2), 255-259.

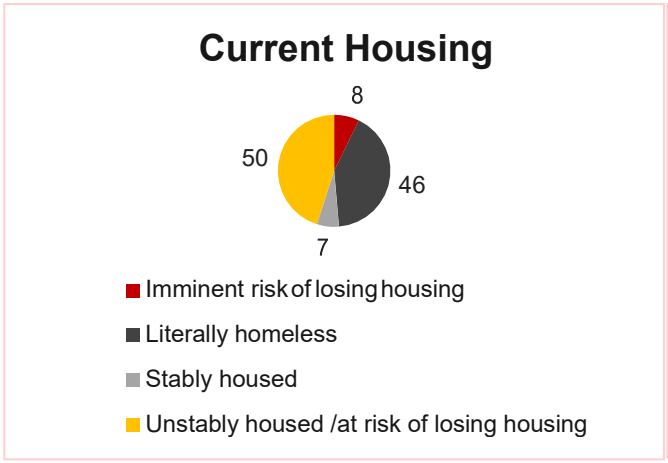
Project CORE Intervention

Priority Populations

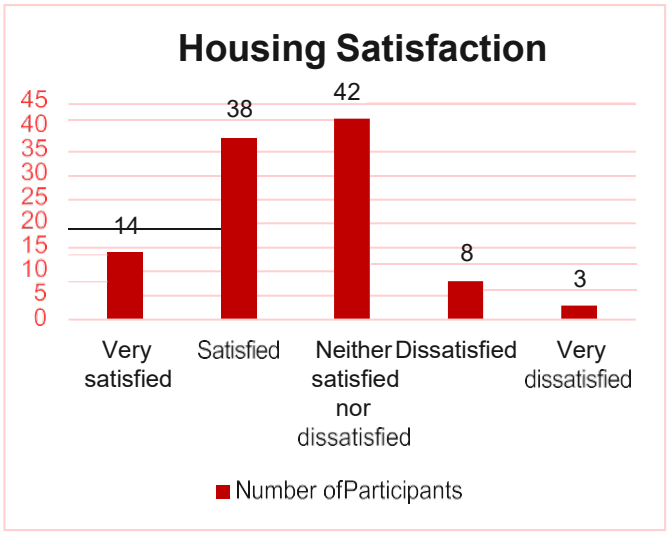
We did not have a specific priority population for Project CORE as we thought it was important for the project to be available to all of those individuals that were eligible. Consistent with the eligibility criteria previously stated in this document, there was an initial goal to recruit solely from the clientele of one centralized Federally Qualified Health Center (FQHC) (Avenue 360). However, as the program progressed, we realized we could expand the reach and impact of Project CORE by recruiting from other FQHCs, ASOs and other agencies that served clients that would meetthe eligibility criteria.

Project CORE Demographic Information at Baseline (111 participants)

Demographic Information of Priority Population	Number	Percent
Age		
16-25	**14**	**12.6%**
26-35	**37**	**33.3%**
36-45	**26**	**23.4%**
46-55	**29**	**26.1%**
55 & up	**5**	**4.5%**
Race/Ethnicity (*participants checked all that applied)		
Black/African American	**84**	**75.7%**
White	**20**	**18.0%**
American Indian/Native American	**12**	**10.8%**
Mexican	**3**	**2.7%**
Other	**9**	**8.1%**
Gender Identity		
Cis Gender Female	**18**	**16.2%**
Cis Gender Male	**84**	**75.7%**
Genderqueer/Gender Non-Binary	**1**	**0.9%**
Transgender Man/Transman	**1**	**0.9%**
Transgender Woman/Transwoman	**7**	**6.3%**
Sexual Orientation		
Asexual or Celibate	**1**	**0.9%**
Bisexual	**12**	**10.8%**
Heterosexual/Straight	**34**	**30.6%**
Lesbian, Gay, or Homosexual	**59**	**53.2%**
Pansexual or Fluid	**1**	**0.9%**
Unsure	**3**	**2.7%**
Declined	**1**	**0.9%**

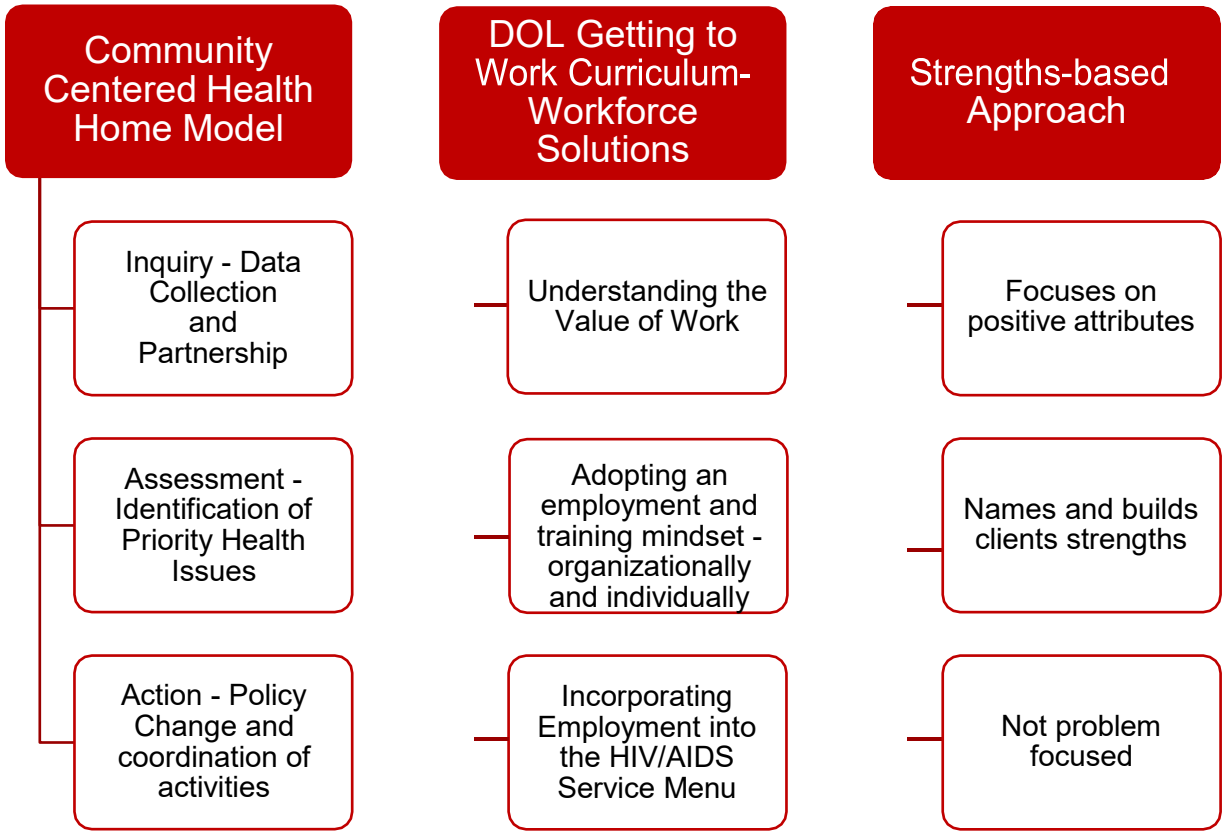

Current Housing
8
50
46
7
Imminent risk of losing housing
Literally homeless
Stably housed
Unstably housed /at risk of losing housing


Do you wish to be employed?
No 6
Decline
Yes 104


Housing Satisfaction
45
40
35
30
25
20
15
10
5
0
14
38
42
8
3
Very satisfied
Satisfied
Neither satisfied nor dissatisfied
Dissatisfied
Very dissatisfied
Number of Participants

Project CORE Intervention

Theoretical & Evidence Informed Frameworks



Community Centered Health Home Model – A model that takes a broader approach to prevention by including care within the clinic but also community wide prevention strategies across the community. It also values aligning goals with multiple social sectors to improve the health of communities.
DOL Getting to Work Curriculum – This curriculum assists service providers in understanding the specific experiences of People living with HIV and employment. All staff were trained on this and we partnered with Workforce Solutions to deliver the employment intervention
Strengths-based Approach – An approach that focuses on the positive attributes, social and community networks in service provision to ultimately improve an individual's health and wellbeing.

Pre-Implementation Activities

Asset Assessment

- The assets assessment is divided by theme and then described in detail.
- **Agency**
  - Initially, both organizations (AFH and Avenue 360) came together to determine what services were being offered, by whom and how effective were these organizations at coordinating care to ensure stable housing and meaningful employment for the community. Also taken into consideration were the current services being offered at AFH and Avenue 360 to ensure that services were not duplicated and to assess the actual services being offered.
- **Funding**
  - Some staff (Program Manager, COO, Project CORE AFH Coordinator, HOPWA assessor, as well as leadership staff) salaries were offset by other grant funding, such as RWHAP and HRSA funds
  - Space - Often times space funded by other entities at both AFH and Avenue 360 were used for Project CORE (workshops, meetings etc)
- **Survey Available Resources in the Area**
  - Housing - permanent supportive housing programs, HOPWA services at AFH; Avenue 360 - rapid re-housing program; HOPWA; housing case management
  - Food assistance programs - AFH
  - Employment - Income now program (coordinated access, but barriers to use it); Workforce Solutions offer free employment referrals and employment workshops, pay for education; Dress for Success;
    Career Gear; vocational training; certification programs
  - Medical Care - Free County Clinic; FQHC (Avenue 360 amongst others); Gold Care (sliding fee scale); Harris Health Hospital District
  - Respite Care/Hospice - Avenue 360; Harbor Light
- **Setting**
  - There were existing clientele of several operating FQHCs and ASOs due to the fact that this initiative incorporated several existing goals being addressed at the time. Therefore, Project CORE could serve as additional support further increasing the chances of the desired outcome of clients achieving self-sufficiency through housing stability, increasing skills and/or income and achieving medical adherence.
- **Potential Funders to Leverage**
  - Foundation Funders – Houston is known as one of the most philanthropic cities in the United States. During year 3, leadership will determine what foundations are most appropriate to seek funding for this project. For example, the Episcopal Health Foundation funds collaborative initiatives to make a collective impact. Their funding cycle happens 3 times of year, 2 of which are appropriate for this project, Activate Communities and Strengthening of a Health System.
- **Consumer Involvement**
  - Community Advisory Board (CAB) at Avenue 360
    - Marketing material was discussed with CAB
  - Integrated involvement in other projects set a model for Project CORE

Gaining Buy-In

- **AIDS Foundation Houston**: Project CORE was officially integrated into AFH's existing service model, so in many ways Project CORE was an extra support that actually assisted the caseload for other case managers which secured buy in. Furthermore, having an in house referral source also helped to secure buy in with follow up and tracking being an added benefit; Charleston Stoker, who supervises case managers and is a senior program coordinator for Project CORE, was able toprovide insights and frame the benefits of Project CORE to other staff, yet another method of securing buy in.

  AIDS Foundation Houston has 6 Housing programs (First responders, Project TXTMSG, BRI, etc.) served as referral sources with additional staff to assist with follow- up and tracking also benefitting from the mission of Project Core. Outreach workers - Cynthia Grant and data specialist described Project CORE to the different projects within AFH.Vested interest from Leadership staff responsible for the approval of service plans directed to promote use of Project Core to reinforce HUD goals and outcomes further assisted with buy in.

- **Avenue 360**: Project CORE is presented at the monthly meetings, when in-service trainings where all clinical members of the agency are involved. They are also presented to the case management teamthroughout the project. Diane Arms, Project Director, oversees other case management. The AFH teammet with the case management team a few times in the beginning of Project CORE, which also helped with buy in.

- **Workforce Solutions**: Workforce Solutions became an integral partner. Project CORE staff met with Workforce Solutions to brainstorm potential partnerships. Initially Workforce Solutions wanted our clients to take the program at their office. However, this proved problematic because our clients face barriers, such as no transportation, homelessness, and the long waits at the workforce just to see an employment counselor. The Project C.O.R.E team had to brainstorm a way to have services offered in house to assist our clients. It would prove more convenient to have a Workforce Solutions representative to come in to provide employment resources to our client including specific classes tailored to fit our client needs. After a few meetings, the Project CORE team was able to help Workforce Solutions understand the importance of delivering services at AFH. The team quickly scheduled the first class and it was a hit. The clients were interested and that is how the partnership began with The Workforce Solutions. One of many benefits of the Workforce Solutions is they not only provide assistance with employment, they also provided tuition assistance, childcare, financial assistance for employment expenses as well as vocational trainings amongst their wide array of services.

- **Career & Recovery:** Career & Recovery is an organization that has always expressed an interest in a partnership with AFH. They offer training classes,and assist those clients who are experiencing substance abuse issues as well as those recently released from incarceration. We were able to have a collaborative agreement with them to ensure that our participants had access to their services and essentially maximize resources as a joint venture to monitor the service in a cost-effective program.

- **Legacy and St. Hope Foundation:** Both of these FQHCs were approached to be part of this collaboration because of their successful work with RWHAP patients and other patients in the Houston area. Their CEOs received a letter from the CEO of Avenue 360 requesting their participation. An MOU was also signed to formalize the relationship. We received referrals from both of these organizations.

Sustainability, Promotion, Staffing

Planning for Sustainability

We used an integrated model of sustainability. This means that all services were integrated as part of AFH's usual service provision. Project CORE while new, enhances service provision, creates coordination between AFH and Avenue 360. It is integrated within the AFH, which is one step to promoting sustainability. Although there is capacity for both organizations to absorb some of the funding related to this project, the key to sustainability will be outside funding.

Promoting the Intervention

- Marketing and Communication Plan
  - Creation of a brand – We thought that branding was very important from the beginning of Project CORE. Establishing a strong, community centered, accessible, and descriptive brand has been keyin previous projects.
  - Marketing Plan
    - To promote Project C.O.R.E. through marketing there were two directions that we were going in. In order tomake it a success to become known, one concept is centered around fostering hope and the second is about creating connections. Marketing materials are included in Appendix

PROJECT C.O.R.E.
COORDINATION OF RESOURCES AND EMPLOYMENT

HOUSING CARE EMPLOYMENT

    - Concept 1: Forging a Brighter Future. This concept is rooted in the notion that Project CORE will establish a solid foundation for a participant to grow and thrive. The mark takes its visual cues from the sprawling landscape of Houston, inspired by its typography, and culture. The logo and design are bold and humanistic.
    - Concept 2: Creating Connections. This concept is rooted in the need to create connections, and focuses on using calligraphic styled overlapping circles, like a Venn diagram, with custom, hand-drawn elements (used to denote the program services). Thismark takes a more classically contemporary angle in its execution which bodes well when designing for longevity of relevance.
    - Concept 3: Appealing to a Broad Audience. We did not want to stigmatize.

Staffing

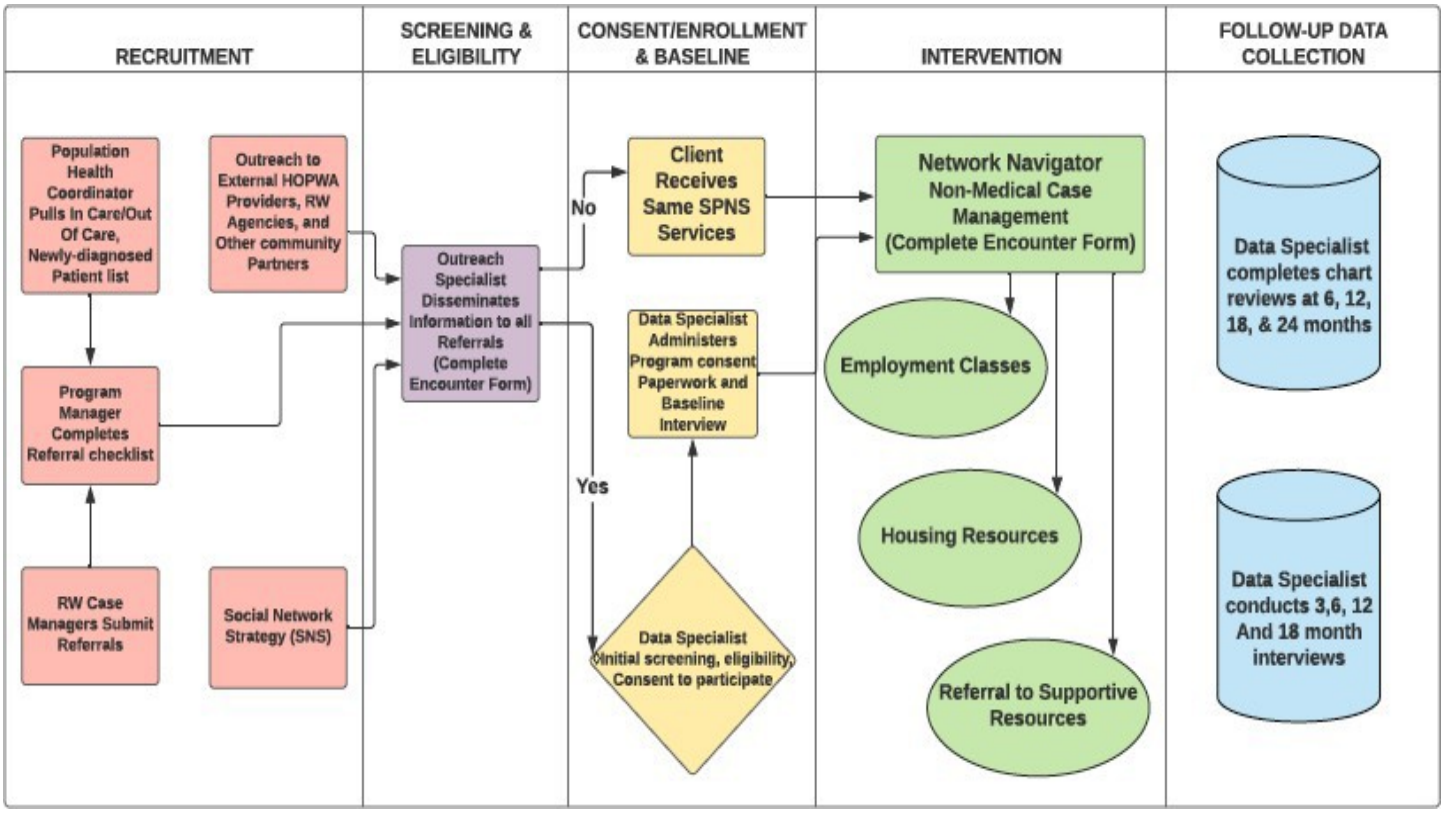
- Recruitment and Hiring
  - Job descriptions and postings: Job descriptions for the below positions were developed by the Director of Housing at AIDS Foundation Houston (in accordance with the previously submitted work plan) and submitted for posting (by AFH's Human Resource Dept.) Positions were then posted internally for three business days before being posted to United Way, Job Bank online, as well as to the websites of the partnering agencies (AFH and Avenue 360). Below are brief descriptions of posted positions that can be viewed in their entirety in the appendix along with the minimum qualifications for each posted position and organizational flowchart.
    - **Network Navigator**: This position primarily acts as an advocate for clients to secure needed services and financial enhancement opportunities (such as employment) or entitledbenefits.
    - **Outreach Specialist**: This position is primarily responsible for conducting, coordinating,facilitating the delivery of employment services to the clients of Project CORE.
    - **Data Specialist**: This position is primarily responsible for data compliance, programintake and assessments for the clients of Project CORE.
  - Minimum qualifications are located in each staff member's job description as well as included in theposting for the job vacancy.

- **Staff onboarding, training, and continuing education:**
  - Antiracism - All Project CORE Staff stationed at AFH completed Culturally and Linguistically Appropriate Standards (CLAS) & Achieving better health outcomes by effective implementation ofnavigation and linkage to care services provided by Proceed Inc.
  - Trauma Informed Practice - All Project CORE line staff stationed at AFH obtained certification in April2019 facilitated by Mental Health America
  - Competency assessment and development plans - Staff completes performance evaluations at 60 day, 6 month and annual intervals, and completes goal setting with supervisor following their60 day evaluation.
  - Mentorship plans - Project CORE staff were integrated into a multidisciplinary team that allowed them to have constant contact as well as work collaboratively on a weekly basis with Licensed Chemical Dependency Counselor (LCDC), Case Manager (CM), Licensed Master Social Worker.

- **Supervision structure**
  - Clinical supervision provided monthly by the Housing Program Lead. These meetings discussed a host of programmatic content as well as Secondary Trauma/Stress/Burnout.

Intervention Implementation/Service Delivery Model

Project CORE Flow Chart



Project CORE Key Components

Outreach	Strong Partnerships	Employment Coordination	Housing Coordination	One Stop Shop
• Outreach Specialist • Social Network Strategy	• Avenue 360/AFH/UH • Workforce Solutions - DOL Funded • Houston Area Clinics	• DOL Funded Workshops • Referral to employment Services	• Access to housing programs • Case management	• Wrap around Services • AFH - Food Pantry, PrEP and other social services • Avenue 360 - medical services and housing services

Individual Level Components

Component	Service	Lead Person
Outreach	Project CORE Introduction; Eligibility Screening; Social Network Opportunity Introduction	Outreach Specialist
Strong Partnerships	While partnerships were not a particular service offered, they were essential toproviding coordinated services	All
Employment Coordination Network Navigation Role	Network Navigator/Interventionist met with the participant once a month for the first 3 months. This is where goals and needs were discussed as well as development of a service plan. Assessments (Coordinated Access Points) Review self-sufficiency matrix from Homeless Management Information System (HMIS) Develop Individual Case Management PlanProvide Referrals to internal/external services Follow up with clients at 30, 60, 90days Coordinate employment services for each client (i.e Workforce Solutions) Document and maintain client files	Network Navigator; Workforce Solutions

	Identify appropriate agencies to refer for employment Provide bus vouchers for those that need them to get back and forth from job interview etc.	

	Refer clients to vocational training to strengthen their job readiness skills, and follow up Connect clients with Coordinated Access Points, complete referrals to housing providers (Montrose, Avenue 360) as appropriate and based on need and urgency and follow up Maintain relationship and communication with Workforce Solutions	
Employment Coordination Workforce Solution	Workforce Solutions Workshops – 4 sessions. – 1.5 hours long – See Appendix **Process** • The Workforce Solutions regional facilitator came in to provide Project CORE participants looking for work with creative tools that help navigate today's job market. • Classes were held once a week at AIDS Foundation Houston Corporate office where the participants can attend smaller class sizes and they are able to receive one on one assistance from the Regional Facilitator. • Upon completion of each workshop, the participants received a Certification of Completion and were able to start their job search with the assistance of the Regional Facilitator and the Network Navigator. • Participants were able to repeat classes for additional learning and to expand on their learning. **Employment Workshops** • The Workforce Solutions Employment Workshops consist of 4 modules/workshops geared to prepare participants to secure and retain employment. The classes include: • A Target Plan: This module is designed to review current labor market information, and assess the participants needs and employment skills to create a targeted job search plan. • Job Readiness Toolkit: This module will allow the participants to evaluate and practice effective communication on	Employment Specialist

	applications, resumes, basic introductions and interviewing. • Sharpening Your Interview Skills: This module focuses on the interview process and uses the employer's perspective to determine proper interview attire and prepare answers to common interview questions. • Closing The Deal: This module discusses networking, how to use social media as a networking tool and how to follow up with the employer after the interview.	
Housing Coordination	Worked with housing department to link people to housing and housing services Followed up about housing services Ensured satisfaction at housing placement	Network Navigator/Interventionist
One Stop Shop	Food Pantry and snacks available during every appointment Employment workshops - lunch Hygiene kits from prevention team Safer sex kits Clothing as available Various social service reports	Case Managers and other staff

Systems Level Components

Component	Service	Lead Person
Partnerships	Project CORE staff members developed several partnerships throughout the community by attending Resource/Job fairs, Client Meetings, Case Management Meetings, Health Fairs and InterAgency Meetings. This allowed the team to receive several referrals and the opportunity to come in contact with individuals that are eligible for the program. With the partnerships we developed over time, we were able to maintain the relationships by having open communication (sharing information about our program and the services we provide); providing feedback (following up with Case Managers regarding the clients progress); attending community events where our presence is seen and we can provide information to other community partners about the services we offer.	All
Organizational Function	Project CORE team attends two meetings on a weekly basis. The first “Weekly Report out” is attended as part of the Housing and Supportive services team reporting on current workload and progress on assignments, as well as updating teammates and leaders as to what is priority for the week and/or requesting/providing support. The second meeting is a meeting for solely the Project CORE team to touch base, perform client staffing, divide tasks and ensure that the program is on pace to meet its goals or brainstorm methods to ensure that the goal will be met by any deadlines.	

Communication

Component	Service
Partnerships	Workforce Solutions – We had open communication and created a culture of problem solving from the beginning of the relationship. This helped to ensure that we were setting up the best services for participants to obtain the skills related to job readiness. General Partnerships – We also created partnerships with various providers in the area. This helped to create a network of referral sources. This collaboration also led to reaching a common goal – to build relationships to ensure the success of participants and Project CORE
Methods of internal and external communication with partners	Email Biweekly in Person Meetings Workforce Classes Phone Calls
Use of EMR	We used the EMR with Project CORE participants who were Avenue 360 clients – Information was extracted from the EMR

Project CORE Implementation

Standard of Care, Documentation

Transitioning to Standard Care

When considering transitioning a participant to standard care, we assessed the participant and their overall needs. Once a participant was enrolled in Project C.O.R.E, we follow up with the client weekly. With the Network Navigator, the participant received an assessment and a Case Management Plan which was created with goals to accomplish the next 90 days. Following the drafting of the assessment and Case Management Plan, the Network Navigator followed up with participants monthly. The Network Navigator continued to monitor the participants progress during this time to determine if the participant was on target with achieving theirgoals or if modifications are needed. Overall, Project CORE gauged participants success based on the clients attending the employment workshops, obtaining housing and viral suppression. Once a client obtained employment, housing, and viral suppression, we followed up with the client every 3 months to see if they maintained and if any additional resources were needed.

Documentation

The team kept and used a host of documentation:

- The Electronic Medical Records at Avenue 360 was used for chart reviews for the participants to examine their viral loads.
- Progress Notes were also used for a variety of purposes noted below (See Appendix for Sample Progress Notes and Case Management Plan
- Documentation Technical Assistance Requests
  - We received assistance in multiple areas
    - Recruitment strategies – what worked and what didn't.
    - Tracking systems for participants

Intervention Implementation

Modifications made during implementation

Recruitment Strategy

Within the first six months of Project CORE implementation, we decided to broaden the recruitment. Originally, we were only going to recruit from Avenue 360, however given the low recruitment and desire to broaden the reach, we decided to recruit from other clinics as well. This provided us with the opportunity to not only broaden our reach, but also develop new, lasting partnerships.

Social Network Strategy

We employed SNS due to low recruitment numbers. According to the Center for Disease Control and Prevention, Social Network Strategy (SNS) can be understood as a method of increasing engagement and motivating individuals to agree to receive supportive services. SNS assumes individuals in the same social networks will share similar characteristics, such as social and behavioral factors (Centers for Disease Control and Prevention, 2018). See recruitment section for more details.

Workforce Solutions Class Location

Initially classes were located at AFH, however they are now offered in Workforce Solutions – See appendix

Addition of Food

Upon interviewing the clients at Avenue 360, there were several clients that stated they were hungry and had to leave to get something to eat or asked if we had anything for them to eat. Realizing this is a barrier for the clients, we asked the funders if there was any way we could feed the clients by taking them food when we meet them whether at a food place or whatever the destination would be if we can purchase food for them as well as have food on hand for onsite visits. This request was approved to provide the clients with food which became a huge success. We purchased food such as Tuna kits, Crackers, Gatorade, Sandwich Crackers.

Staff Changes

In addition to the project director changing mid-year through year 2, the program manager was also changed on the Avenue 360 side. On the AFH side, the CEO, CPO, COO and Director changed. Additionally, the data manager was replaced by the employment specialist and that role was filled by the outreach specialist.

Project CORE Implementation

Participant Recruitment

Overview of Participant Recruitment

Screening

1. Case managers from Avenue 360 screen; 2. Review List of eligible clients from Avenue 360 list

Eligibility & Enrollment

Outreach Specialist and Data Specialist spent 3 days a week at Avenue 360 to enroll eligible people.

Referrals

Referral forms for Project CORE and other services are at Avenue 360; Outreach specialist supported with this and also follows up about various referrals.

Recruitment Details

Screening

- There were two procedures that were critical for screening the most suitable clients.
  - 1. The case managers of the clinic from various program areas were informed about Project C.O.R.E. and the resources it provides from the staff attending various workshop or Community Advisory Board meetings. They were encouraged to make referrals to the program. Upon receiving the referrals,The Outreach Specialist will then contact the client in person or by phone to educate the client on Project C.O.R.E.
  - 2. The second procedure was then introduced to the Data Specialist to begin the pre assessment process to qualify for the research assessment. To attract more clients from Avenue 360, the outreach specialist begin recruiting through gathering a compiled list of Avenue 360'sclients who may have been suitable candidates to assist. This list of clients was pulled together by determining every client of the clinic who currently had viral loads that were

greater or equal to 200 copies/mL and showed a history of being out of care. In addition to viral loads, the list provided names, contact information, and the appointment dates of the clients' last visit to the clinic.

Eligibility and Enrollment

- Beginning June of 2018, the program Outreach Specialist and Data Specialist began to attend Avenue 360 Health and Wellness three days out of the week, as a means of being on-site for recruitment and enrollment purposes. Based on the knowledge provided about Project C.O.R.E., case managers of theclinic were encouraged to make referrals to the program for clients who may meet the program criteria.Case managers or staff sending the recommendations were provided with screening referral forms that asks about four basic eligibility points. This checklist is provided to determine whether the client is overthe age of 18, HIV Positive, Homeless/Unstably Housed, and Underemployed/Unemployed.

Referrals (internal and external) for program Internal Referrals

- Referral forms are provided to staff at Avenue 360. This form asks about four basic eligibility points and checklist determines whether the client is over the age of 18, HIV Positive, Homeless/Unstably Housed, and Underemployed/Unemployed. These forms are placed in the hands of the Outreach Specialist. Referral can be submitted several ways. When the Outreach Specialist is on site, the case manager is able to directly hand the form off, and there is a possibility to speak with the client. In the event the Outreach Specialist is not available, referral forms were provided on return, or faxed in a secured format. The Outreach Specialist then attempts to contact the client to share information aboutthe program and get them enrolled.
- Project CORE utilized partners' referrals and we also did a lot of outreach in the community.

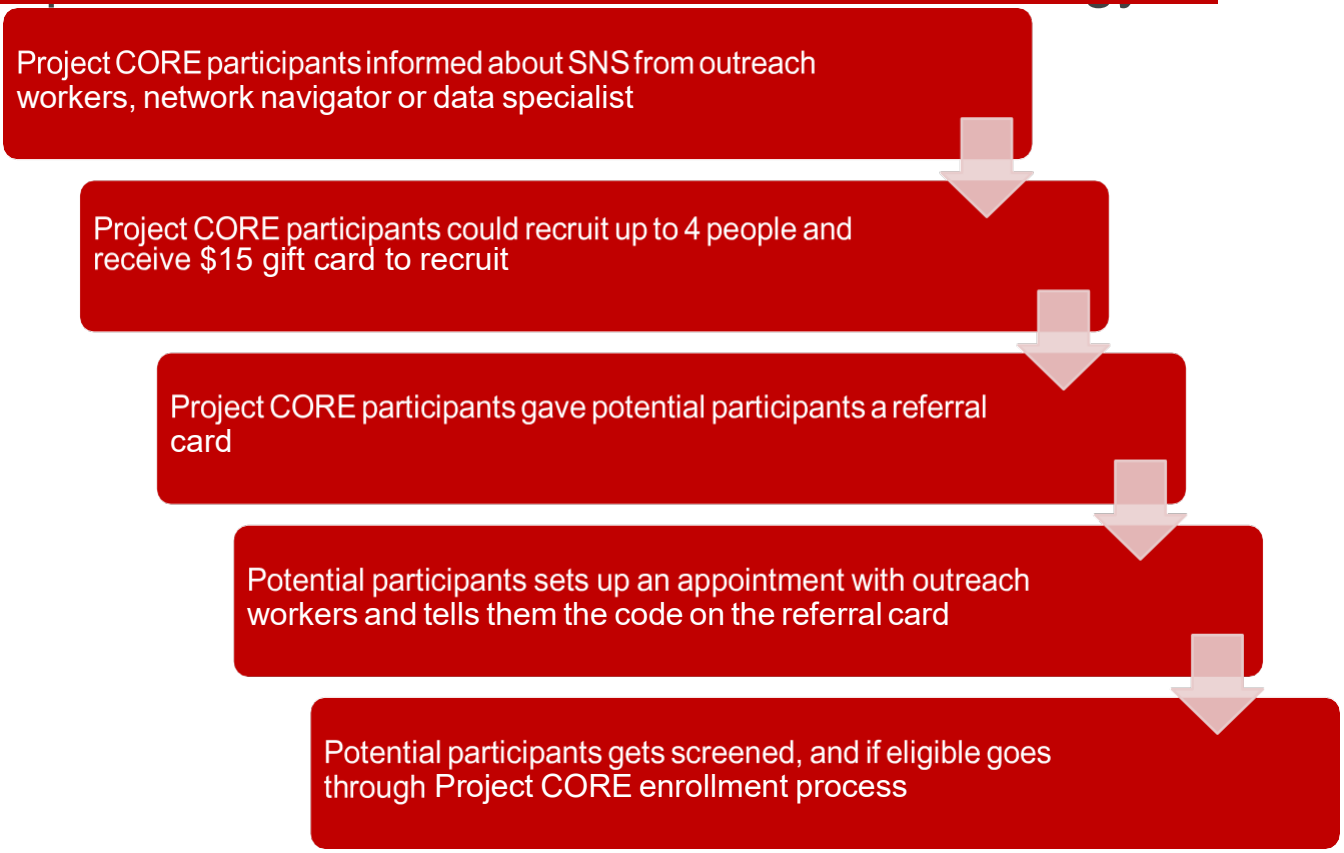
Managing Flow of Participants

- Recruitment-Referrals were received from a variety of different clinics within the Houston/Harris County area. Upon receiving the referrals, the Outreach Specialist (Cynthia Grant) contacted theclient in person or via phone to provide an overview of Project C.O.R.E.
- As a method of attracting more clients from Avenue 360, the outreach specialist began recruiting by gathering a compiled list of Avenue 360's clients who may have been suitable candidates. The outreach specialist along with the Data Specialist would also meet clients at a public place or at their homes when needed. After meeting with the Outreach Specialist, clients are then routed to the Data Specialist.
- At this point, the evaluation was explained as it correlates to the programmatic component of Project CORE. Clients were considered recruited after a full explanation of the program's process. Critical information is then gathered consisting of: Consent,

- HIPAA release, release of medical records form, participant birthday, and contact information. Following the assessment, participants then meet with theNetwork Navigator to discuss any case management needs.

Project CORE Implementation

Participant Recruitment: Social Network Strategy



Social Network Strategy: The Need

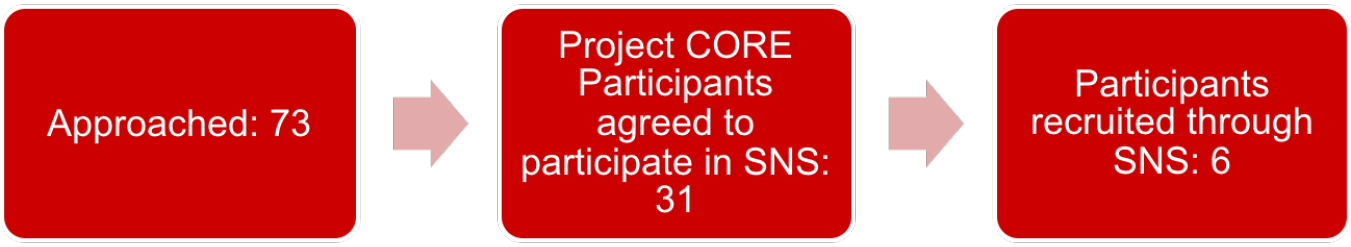
Due to low numbers of recruitment, Project CORE decided to implement SNS to increase the number of Project CORE participants as well as participant engagement. By implementing this strategy, we expected to recruit more participants by offering incentives to the Project CORE participants who referred the individual to Project CORE. The newly referred and enrolled participants referred individuals to Project CORE.

Social Network Strategy: The Implementation

Project CORE Implementation

Participant Recruitment: Social Network Strategy

Description of SNS Flow



Project CORE Local Evaluation Plan

Project CORE

Local Evaluation

SNS Process Evaluation

Project CORE conducted local evaluations to better examine more context specific factors.

Process evaluation

- Barriers and challenges
  - Slow to start but eventually increased
  - Potential participant had to present the referral card
  - Potential participant had to make an effort to come in person for the initialinterview/assessment.
- Facilitators of success
  - Collective team effort
  - Need came from the ground
  - Entire team was involved in planning the implementation of SNS
  - Clear communication
  - 6 recruited!

Feasibility Study

- The major aim of this sub-study is to examine the feasibility of Project C.O.R.E. Since this project was new and innovative and a coordination between a community-based organization and a FQHC has not happened in this way, a feasibility study was appropriate to examine the project's acceptability, demand, and integration.
- Theoretical model
  - This sub-study is guided by the Consolidated Framework for Implementation Research (Damschroder et al., 2009)
  - Interview staff; examination of process and procedures
    - Retrospective

The sub-study on feasibility was guided by the Consolidated Framework for Implementation Research.

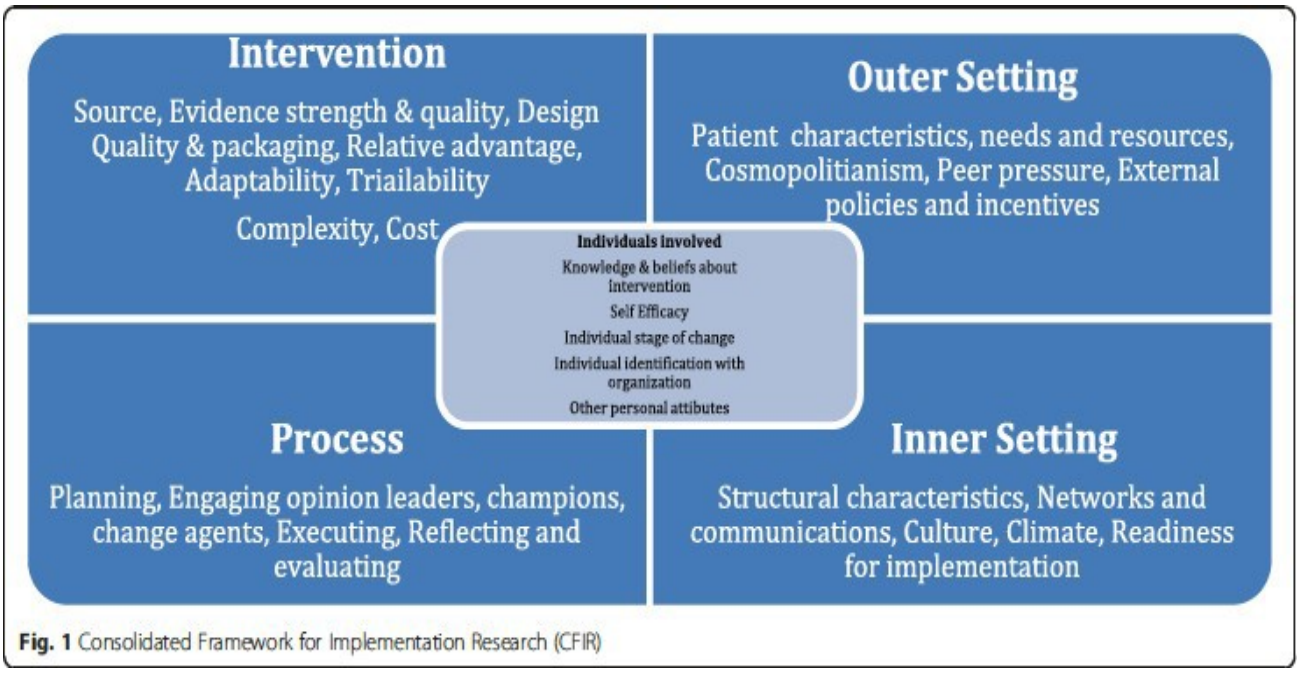
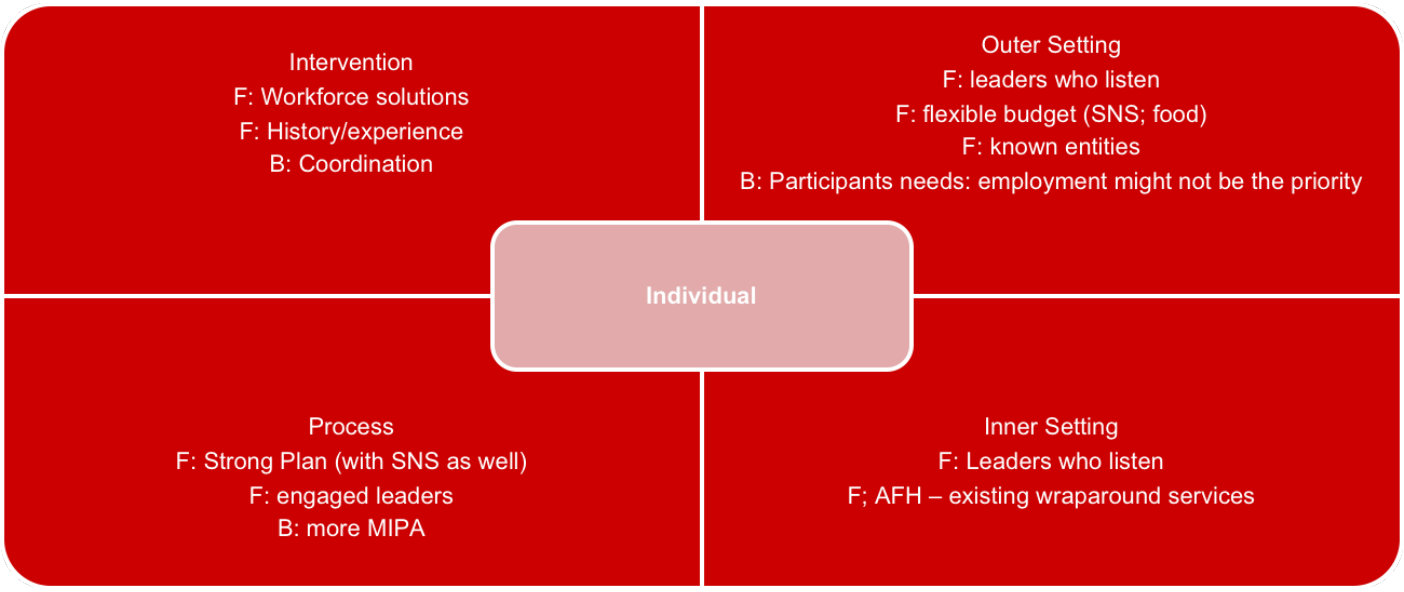


Fig. 1 Consolidated Framework for Implementation Research (CFIR)

Protocol for the Feasibility Study: We used the following questions as a part of our protocol.

Meaning Making	Collaboration/ Coordination	Organizational Change	Inner Setting	SNS
• What does Project CORE mean to you?	• Barriers • Facilitators • Language • Transparency?	• Has organizational culture changed since the Project? Influenced?	• Culture • Leadership	• thoughts on SNS • facilitators • Barriers? • Supported?

Facilitators and Barriers to Initial Implementation of Project CORE as noted by the Project CORE team



F: Facilitator. B: Barrier

*The above graphic details the facilitators and barriers to the initial implementation of Project CORE.

Intervention Outputs and Outcomes

Project CORE

Intervention Outputs and Outcomes

Intervention outputs

- How many people did we conduct outreach to? An estimated 800 people
- Number of trainings offered for participants? **43**
- Type of trainings
  - Workforce Development training classes which include: Resume/Cover Letter Writing, Getting Back to Work, Interviewing, Job Search 101 – **64 people enrolled in Workforce Solution**
- On average, Number of intervention sessions (dosage) per participant (workforce plus meetings with LaNikka) 1 session per week for 1 hour and 30 minutes. Usually 5-7 participants per class. The participants met with LaNikka after the class to discuss their employment goals or achievements.
- Number of participants served and demographics (i.e. number recruited; number enrolled; number who met service requirement; demographics of enrolled clients)
  - **Recruited: 140**
  - **Enrolled: 111**
  - **# of participants that met the coordinated service eligibility requirements: 111**

Outcome questions

- 57 (39%) of participants were able to get housing through Project CORE
- 43 (39%) of participants were able to get employment through Project CORE.
- 15 (14%) of participants were able to get newly connected to medical care through Project CORE.

Lessons Learned & Reflections

Facilitators to Project CORE's Success

- Strong partnerships were key to our success. The partnership with Avenue 360 enabled the coordinated services and the partnership with Workforce Solutions ensured the implementation of the employment intervention. In addition, the strong partnerships with surrounding organizations also helped with boosting recruitment and referrals.
- Open communication helped to create a culture of transparency and growth.
- Problem solving and quick thinking on our feet helped us overcome challenges around recruitment and other components of the intervention.
- Thinking outside of the box was also key to ensure that we used strategies and tactics that are community centered and reaching those that are most in need.
- The wraparound services offered by AFH as a part of their standard of care also was a facilitator and ensured that participants' needs were met.
- ETAP and HRSA also were key to our success as they provided essential technical assistance.

Challenges/Opportunities to Grow

- Recruitment was a challenge as we lacked referrals and there were multiple competing needs.
- Client participant was low in the workforce solution workshop and in the future, we should think through innovative ways to boost this attendance.
- Often clients were in need of housing and employment was a secondary priority. Though we were able to support with both, housing was a key aspect of the service provision.
- We lost client contact with some participants due to their number changing or moving.
- We experienced staff turnover which resulted in delays at times.
- Working across multiple systems and structures also resulted in different priorities at times.

Lessons Learned: Below are the lessons learned from Project Core

- Partnership is key to success.
- Problem solving and thinking outside of the box facilitates projects.
- Communication and coordination takes time.
- Leveraging existing resources and workshops can be a sustainable aspect of a project.

Dissemination Activities

We carried out a host of dissemination activities:

1. **Peer-reviewed Paper**
    a. Ali, S., Aquino-Adriatico, G., Lewis-White, R., Stoker, C., Arms, D., Grant, C., & Green-Sofola, L. (2021). Multilevel factors associated with anxiety symptoms among people living with HIV in the US South. *AIDS care*, 1-7.

2. **Published resources about the intervention**
    a. Project CORE Poster presented at the 2019 meeting HRSA grantee meeting.

3. **Presentations about the intervention**
    a. Blue, N., Ali, S., & Kotlarich, P. (2018). *Project CORE (Coordination Of Resources & Employment): A clinical, non-profit and university collaborative structural intervention*. Posterpresentation at the North American Housing & HIV/AIDS Research Summit IX: Structural Interventions and Ending the Epidemic, Washington, DC.
    b. Ali, S., Stoker, C., Arms, D., Green, L., & Grant, C. (2020). *Project CORE: A coordinated housing, employment, and HIV care intervention.* Workshop presentation at the 2020 National Ryan White Conference on HIV Care & Treatment.
    c. Arms, C., Stoker, C., Green, L., & Grant, C. (2020). *Project CORE – The importance of collaboration to End the Epidemic.* Poster presentation at the 2020 National Ryan White Conference on HIVCare & Treatment.

Appendix

Appendix
(Hyperlinked)

1. **Job descriptions**
2. **Houston Demographic Information**
3. **Project CORE Curriculum Documents**
4. **Project CORE Program Model**
5. **Project CORE Marketing Assets**
6. **Progress Notes & Case Management Plan Templates**
7. **Social Network Strategy Protocol**
8. **Local Evaluation – Feasibility Study**

Appendix 1 - Job Description

ADP TOTALSOURCE / AIDS FOUNDATION HOUSTON, INC. JOB DESCRIPTION

JOB TITLE: Data Specialist

Reports to: Director of Housing **Status: Exempt**
Department: Programs **Date: 2018-03**

SUMMARY: This position is primarily responsible for data compliance, program intake and assessments for the clients of Project Core. The position will assist in evaluating the program along with the evaluator (along with the evaluator) to ensure compliance with policies and procedures of both AIDS Foundation Houston and AVENUE 360. This position uses professional judgment and decision-making skills to provide data integrity to clients currently out of care. This position requires travel.

CORE COMPETENCIES: **Ethical-**Treats people with respect; keeps commitments; inspires the trust of others; works with integrity and ethically; upholds organizational values. **Leadership**-Exhibits confidence in self and others; inspires and motivates others to perform well; accepts feedback from others; gives appropriate recognition to others. **Professionalism**-Approaches others in a tactful manner; reacts well under pressure; treats other with respect and consideration regardless of their status or position; accepts responsibility for own actions; follows through on commitments. **Initiative**-Volunteers readily; undertake self-development activities; seeks increased responsibilities; takes advantage of opportunities; asks for and offers help when needed. **Interpersonal/Communication Skills**-Focuses on solving conflict, not blaming; maintains confidentiality; listens to others without interrupting; keeps emotions under control; remains open to new things; manages difficult or emotional situations; responds timely to client needs; solicits feedback to improve service; meets commitments. **Oral Communication** -Speaks professionally in positive or negative situations; listens and gets clarification; responds well to questions; demonstrates group presentation skills; participates in meetings. **Written Communication** -Writes clearly and informatively; edits work for spelling and grammar; varies style to meet needs; presents numerical data effectively; able to read and interpret written information. **Problem solving**-Identifies and resolves problems in a timely manner; works well in-group problem solving situations; uses reason when dealing with emotional topics. **Judgment**-Displays willingness to make decisions; exhibits sound and accurate judgment; supports and explains reasoning for decisions; includes appropriate people in decision-making process; makes timely decisions and assessment skills.

ESSENTIAL DUTIES AND RESPONSIBILITIES:
Core duties and responsibilities include the following. Other duties may be assigned.

DUTIES AND TASKS

Planning and Implementation

1. Prioritizes and plans work; uses time efficiently; plans for additional resources; sets goals and objectives.
2. Create position, program, department, and agency plan, as assigned.
3. Utilize position and knowledge to add to the development of case management and group services.
4. Read and implement the agency Strategic, Annual and Departmental plans.
5. Use calendar to schedule work duties, meetings, and planning activities.

Daily Duties

1. Execute all regular transaction processes necessary to maintain operations records and databases.
2. Perform extracting, importing, and exporting of data in various database applications.
3. Provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness.
4. Complete assessments and intake for all incoming clients of Project Core.
5. Audit data on a regular basis to ensure data integrity and quality.
6. Perform quantitative and qualitative data analysis. Document and maintain accurate information in client files and databases on a timely basis.
7. Analyze and resolve routine data problems and execute processes to resolve complex data and system problems
8. Other duties as assigned

Program Compliance Expectations

1. Implement policies, best practices, guidance, standards to create framework for effective case management services.
2. Implement department programming and selected service model.
3. Understand and implements program /department organizational development to increase efficacy, better services, and outcomes.
4. Use and ensure the compliance of all protocols as required by funding sources.
5. Complete and submit timely and accurate documentation; financial/program paperwork, forms, letters, surveys, reports, meeting notes, and all other required correspondence, ensuring it is according to departmental standards.
6. Knowledge of general office practices and procedures and uses them effectively to streamline work.
7. Report to the program supervisor on the overall successes and issues regarding program.
8. Through the Quality Management Program look for ways to improve and promote quality; demonstrates accuracy and thoroughness.

Agency Compliance

1. Consistently at work and on time; ensures work responsibilities are covered when absent; arrives at meetings and appointments on time.
2. Follow instructions; takes responsibility for own actions; keeps commitments; commits to complete additional work when necessary to reach goals; completes tasks on time or notifies appropriate person with an alternate plan.
3. Read, understand, and follow AFH Policies and Procedures.
4. Maintain appropriate levels of documents regarding files, reports, correspondence, personnel, and financial paperwork.
5. Understand and meet the expected client outcomes.
6. Attend meetings as scheduled.
7. Communicate proactively and professionally with peers and stakeholders through phone and emails.

8. Follow all regulatory requirements for reporting suspected abuse or neglect.

Stakeholder Interactions/Relationships

1. Form professional relationships with all stakeholders – clients, target populations, donors, volunteers, interns, vendors, and community partners.
2. Ability to be culturally and linguistically competent in serving the needs of diverse clientele including but not limited to all racial, minority, and ethnic groups, substance abusers, homeless, gay/lesbian, bi-sexual, transsexual, and transgender populations.
3. Provide professional level presentations to internal and outside groups on homelessness, housing and HIV and AFH services.

Team Relationships

1. Balances team and individual responsibilities; exhibits objectivity and openness to others' views
2. Gives and welcomes feedback.
3. Act respectfully and supportively towards other team members efforts to meet the mention.
4. Work as a highly cooperative member of the AFH staff and volunteers to accomplish agency and departmental goals.
5. Accept responsibility and willingness to be accountable by not blaming others for work product or issues.

EDUCATION AND/OR EXPERIENCE

Level of Education: Bachelor's Degree in a social science, communications, marketing or field strongly preferred. Areas of study include social work, psychology, public administration, healthcare, and/or public health. Community Health Worker certification preferred.

Work Experience: With the minimum of a Bachelor's degree, one year of case management experience. With less than a bachelor's three years of experience in social services with a record of producing results. Data entry, report writing and compliance experience preferred.

Additional Requirements: NA

ADDITIONAL QUALIFICATIONS

Computer Skills

To perform this job successfully, an individual should have basic proficiency in database software; Internet software; Spreadsheet software and Word Processing software. Knowledge and experience in database development and/or data management, preferably in a nonprofit setting.

Language Skills

Ability to read and write at a professional level: to read, analyze, and interpret and implement general business documents, professional journals, technical procedures, or governmental regulations and write reports, business correspondence, and procedure manuals. Ability to gather data, analyze information and interpret information to build useful and required reports or presentations. Ability to effectively present information and respond to questions from groups of managers, clients, customers, and the public.

Mathematical Skills

Ability to add, subtract, multiply, and divide in all units of measure, using whole numbers, common fractions, and decimals. Ability to compute rate, ratio, and percent and to draw and interpret bar graphs. Ability to adapt a budget into a tracking form and understands the basics of a budget.

Reasoning Ability

Ability to prioritize multiple tasks by using reasoning to determine priorities. Ability to solve practical problems and deal with a variety of concrete variables in situations where only limited standardization exists. Ability to interpret a variety of instructions furnished in written, oral, diagram, or schedule form.

PHYSICAL DEMANDS

The physical demands described here are representative of those that must be met by an employee to perform successfully the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. While performing the duties of this job, the employee is regularly required to talk or listen. The employee is frequently required to sit. The employee is occasionally required to stand and walk. The employee must regularly lift and/or move up to 10 pounds. Specific vision abilities required by this job include close vision.

1. Ability to perform routine bending/stooping while filing and performing office/outreach duties.
2. Ability to perform routine twisting/reaching while working at computer/desk and performing office/outreach duties.
3. Ability to perform routine walking/standing during course of day and while performing office/outreach duties.
4. Ability to hear and speak well enough to converse over telephone and while performing education and outreach duties 100% of the time.
5. Ability to see well enough to use computer efficiently and read computer reports and correspondence 100% of the time.

WORK ENVIRONMENT

The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. The noise level in the work environment is usually moderate.

Print Name Signature Date

ADP TOTALSOURCE / AIDS FOUNDATION HOUSTON, INC. JOB DESCRIPTION

JOB TITLE: NETWORK NAVIGATOR

Reports to: Coordinator/Supervisor **Status:**
Regular/Full Time/Exempt
Department: Programs **Date: 2017-18**

SUMMARY: Non-Medical Case Management Services (NMCM) provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. Non-Medical Case management services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication including face-to-face, phone contact, and any other forms of communication deemed appropriate by the RWHAP Part recipient. Key activities include:
•Initial assessment of service needs
•Development of a comprehensive, individualized care plan
•Continuous client monitoring to assess the efficacy of the care plan
•Re-evaluation of the care plan at least every 6 months with adaptations as necessary
•Ongoing assessment of the client's and other key family members' needs and personal support systems

PROGRAM GUIDANCE:
Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed employment services with the objective of improving employment outcomes.

CORE COMPETENCIES: **Ethical-**Treats people with respect; keeps commitments; inspires the trust of others; works with integrity and ethically; upholds organizational values. **Leadership**-Exhibits confidence in self and others; inspires and motivates others to perform well; accepts feedback from others; gives appropriate recognition to others. **Professionalism**-Approaches others in a tactful manner; reacts well under pressure; treats other with respect and consideration regardless of their status or position; accepts responsibility for own actions; follows through on commitments. **Initiative**-Volunteers readily; undertake self-development activities; seeks increased responsibilities; takes advantage of opportunities; asks for and offers help when needed. **Interpersonal/Communication Skills**-Focuses on solving conflict, not blaming; maintains confidentiality; listens to others without interrupting; keeps emotions under control; remains open to new things; manages difficult or emotional situations; responds timely to client needs; solicits feedback to improve service; meets commitments. **Oral Communication** -Speaks professionally in positive or negative situations; listens and gets clarification; responds well to questions; demonstrates group presentation skills; participates in meetings. **Written Communication** -Writes clearly and informatively; edits work for spelling and grammar; varies style to meet needs; presents numerical data effectively; able to read and interpret written information. **Problem solving**-Identifies and resolves problems in a timely manner; works well in-group problem solving situations; uses reason when dealing with emotional topics. **Judgment**-Displays willingness to make decisions; exhibits sound and accurate judgment; supports and explains reasoning for decisions; includes appropriate people in decision-making process; makes timely decisions.

NON-MEDICAL CASE MANAGEMENT FOR THE FOLLOWING PROGRAMS AND/OR SERVICES.

□ HOPWA housing programs – Manages client load at two housing programs located throughout Houston. Travel required.
□ PSH housing programs – Manages a client load a housing program located throughout Houston. Travel required.

ESSENTIAL DUTIES AND RESPONSIBILITIES:
Core duties and responsibilities include the following. Other duties may be assigned.

DUTIES AND TASKS
Planning and Implementation

9. Prioritizes and plans work; uses time efficiently; plans for additional resources; sets goals and objectives.

10. Create position, program, department, and agency plan, as assigned.
11. Utilize position and knowledge to add to the development of non-medical case management and group services.
12. Read and implement the agency Strategic, Annual and Departmental plans.
13. Use calendar to schedule work duties, meetings, and planning activities.

Client Services

1. Responsible for the successful implementation, monitoring, evaluating and adapting of employment services for low-income individuals with HIV/AIDS and/or other disabilities.
2. Creates and maintains accurate, complete client records, individual care plans and inputs into appropriate databases.
3. Develop a career plans with program a participant that includes educational materials, social, community, legal, financial, referrals and linkage to employment services and programs through the Department of Labor.
4. Identify and connect clients to appropriate self-help and support groups as indicated or needed. Assist clients who are on treatment plans and /or behavioral contracts to adhere to the conditions of those plans and contracts to maintain stable housing.
5. Track progress of all HIV+ individuals referred to outside employment resources.
6. Employment linkage; this includes, but is not limited to, referrals, employment outcomes,gaining work skills, interviewing and job readiness, etc.
7. Develops effective individualized care plans for program participants and non-medical case management that includes but is not limited to career enhancement techniques to ensure successful employment skills.
8. Use volunteers and interns to provide services.
9. Act as a mentor to assist clients who are able to and want to seek employment by equipping clients with tools that will help them become gainfully employed (Resume writing, job fairs, employment seminars, referrals to job service centers and providing job leads).
10. Act as an advocate for clients to secure needed services and financial enhancement opportunities (such as employment) or entitled benefits.
11. Connect clients to community resources and services and/or employment opportunities.

Program Compliance Expectations

9. Implement policies, best practices, guidance, standards to create framework for effective non-medical case management services.
10. Implement department programming and selected service model.
11. Understand and implements program /department organizational development to increase efficacy, better services, and outcomes.
12. Use and ensure the compliance of all protocols as required by funding sources.
13. Complete and submit timely and accurate documentation; financial/program paperwork, forms, letters, surveys, reports, meeting notes, and all other required correspondence, ensuring it is according to departmental standards.
14. Knowledge of general office practices and procedures and uses them effectively to streamline work.
15. Report to the program supervisor on the overall successes and issues regarding program.
16. Through the Quality Management Program look for ways to improve and promote quality; demonstrates accuracy and thoroughness.

Agency Compliance

6. Consistently at work and on time; ensures work responsibilities are covered when absent; arrives at meetings and appointments on time.

7. Follow instructions; takes responsibility for own actions; keeps commitments; commits to complete additional work when necessary to reach goals; completes tasks on time or notifies appropriate person with an alternate plan.
8. Read, understand, and follow AFH Policies and Procedures.
9. Maintain appropriate levels of documents regarding files, reports, correspondence, personnel, and financial paperwork.
10. Understand and meet the expected client outcomes.
14. Attend meetings as scheduled.
15. Communicate proactively and professionally with peers and stakeholders through phone and emails.
16. Follow all regulatory requirements for reporting suspected abuse or neglect.

Stakeholder Interactions/Relationships

4. Form professional relationships with all stakeholders – clients, target populations, donors, volunteers, interns, vendors, and community partners.
5. Ability to be culturally and linguistically competent in serving the needs of diverse clientele including but not limited to all racial, minority, and ethnic groups, substance abusers, homeless, gay/lesbian, bi-sexual, transsexual, and transgender populations.
6. Provide professional level presentations to internal and outside groups on homelessness, housing and HIV and AFH services.

Team Relationships

6. Balances team and individual responsibilities; exhibits objectivity and openness to others' views.
7. Gives and welcomes feedback.
8. Act respectfully and supportively towards other team members efforts.
9. Work as a highly cooperative member of the AFH staff and volunteers to accomplish agency and departmental goals.
10. Accept responsibility and willingness to be accountable by not blaming others for work product or issues.

EDUCATION AND/OR EXPERIENCE

Level of Education: Bachelor's Degree in a social science field strongly preferred. BSW degree preferred. Areas of study include social work, psychology, public administration, healthcare, and/or public health. Community Health Worker certification preferred.

Work Experience: With the minimum of a Bachelor's degree, one year of case management experience. With less than a bachelor's requires three years of experience in social services with a record of producing results. Data entry, report writing and compliance experience preferred.

Additional Requirements: NA

Computer Skills

To perform this job successfully, an individual should have basic proficiency in database software; Internet software; Spreadsheet software and Word Processing software. Knowledge and experience in database development and/or data management, preferably in a nonprofit setting.

Language Skills

Ability to read and write at a professional level: to read, analyze, and interpret and implement general business documents, professional journals, technical procedures, or governmental regulations and write reports, business correspondence, and procedure manuals. Ability to gather data, analyze information and interpret information to build useful and required reports or presentations. Ability to effectively present information and respond to questions from groups of managers, clients, customers, and the public.

Mathematical Skills

Ability to add, subtract, multiply, and divide in all units of measure, using whole numbers, common fractions, and decimals. Ability to compute rate, ratio, and percent and to draw and interpret bar graphs. Ability to adapt a budget into a tracking form and understands the basics of a budget.

Reasoning Ability

Ability to prioritize multiple tasks by using reasoning to determine priorities. Ability to solve practical problems and deal with a variety of concrete variables in situations where only limited standardization exists. Ability to interpret a variety of instructions furnished in written, oral, diagram, or schedule form.

PHYSICAL DEMANDS

The physical demands described here are representative of those that must be met by an employee to perform successfully the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. While performing the duties of this job, the employee is regularly required to talk or listen. The employee is frequently required to sit. The employee is occasionally required to stand and walk. The employee must regularly lift and/or move up to 10 pounds. Specific vision abilities required by this job include close vision.

6. Ability to perform routine bending/stooping while filing and performing office/outreach duties.
7. Ability to perform routine twisting/reaching while working at computer/desk and performing office/outreach duties.
8. Ability to perform routine walking/standing during course of day and while performing office/outreach duties.
9. Ability to hear and speak well enough to converse over telephone and while performing education and outreach duties 100% of the time.
10. Ability to see well enough to use computer efficiently and read computer reports and correspondence 100% of the time.

WORK ENVIRONMENT

The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. The noise level in the work environment is usually moderate.

Print Name Signature Date

ADP TOTALSOURCE / AIDS FOUNDATION HOUSTON, INC. JOB DESCRIPTION

JOB TITLE: Outreach Specialist – HRSA

THE HIV, HOUSING, & EMPLOYMENT PROJECT

Reports to: Coordinator **Status:**
Exempt/Salaried
Department: Programs **Date:**
2017-18

SUMMARY: This position is primarily responsible for conducting, coordinating, facilitating the delivery of the employment services to the clients of Project Core. The position will assist in the monitoring and evaluating of the program to ensure compliance with policies and procedures of both AIDS Foundation Houston and AVENUE 360. This position uses professional judgment and decision-making skills to outreach employers and to provide non-medical case management services to secure partnerships with potential employers and link clients currently out of care into healthcare. This position requires travel.

CORE COMPETENCIES: **Ethical-**Treats people with respect; keeps commitments; inspires the trust of others; works with integrity and ethically; upholds organizational values. **Leadership**-Exhibits confidence in self and others; inspires and motivates others to perform well; accepts feedback from others; gives appropriate recognition to others. **Professionalism**-Approaches others in a tactful manner; reacts well under pressure; treats other with respect and consideration regardless of their status or position; accepts responsibility for own actions; follows through on commitments. **Initiative**-Volunteers readily; undertake self-development activities; seeks increased responsibilities; takes advantage of opportunities; asks for and offers help when needed. **Interpersonal/Communication Skills**-Focuses on solving conflict, not blaming; maintains confidentiality; listens to others without interrupting; keeps emotions under control; remains open to new things; manages difficult or emotional situations; responds timely to client needs; solicits feedback to improve service; meets commitments. **Oral Communication** -Speaks professionally in positive or negative situations; listens and gets clarification; responds well to questions; demonstrates group presentation skills; participates in meetings. **Written Communication** -Writes clearly and informatively; edits work for spelling and grammar; varies style to meet needs; presents numerical data effectively; able to read and interpret written information. **Problem solving**-Identifies and resolves problems in a timely manner; works well in-group problem solving situations; uses reason when dealing with emotional topics. **Judgment**-Displays willingness to make decisions; exhibits sound and accurate judgment; supports and explains reasoning for decisions; includes appropriate people in decision-making process; makes timely decisions.

ESSENTIAL DUTIES AND RESPONSIBILITIES:

Core duties and responsibilities include the following. Other duties may be assigned.

DUTIES AND TASKS

Planning and Implementation

1. Prioritizes and plans work; uses time efficiently; plans for additional resources; sets goals and objectives.
2. Create position, program, department, and agency plan, as assigned.
3. Utilize position and knowledge to add to the development of case management and group services.
4. Read and implement the agency Strategic, Annual and Departmental plans.
5. Use calendar to schedule work duties, meetings, and planning activities.

Daily Duties

1. Conducts at least 12 employer contacts each week to learn about local businesses and employer needs, to talk about specific consumers who are looking for work and or to talk about employer services offered by the program.
2. Participate in regular outreach activities to link clients into care and enroll in available healthcare services.
3. Assess clients for housing needs and help link individuals as needed with shelter, transitional, or permanent housing.
4. Designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness.
5. Recruit for program and provide orientation to new incoming clients explaining the program and expectations.
6. Identify and facilitate initial meeting with employers provide referral services for clients.
7. Assists staff with client or programmatic issues that arise.
8. Conduct outreach events and education presentations as appropriate to the goals and objectives of the program.
9. Document and maintain accurate information in client files and databases on a timely basis.
10. Cultivate and maintain relationships with employers in order to increase employment opportunities for clients of Project Core. Includes preparing an employer outreach strategy, reaching out to employers via phone/email and in-person (being an initial contact with employers) to acquaint them with our services.
11. Educate the public and employers on benefits of working with Project Core.

Program Compliance Expectations

1. Implement policies, best practices, guidance, standards to create framework for effective case management services.
2. Implement department programming and selected service model.
3. Understand and implements program /department organizational development to increase efficacy, better services, and outcomes.
4. Use and ensure the compliance of all protocols as required by funding sources.
5. Complete and submit timely and accurate documentation; financial/program paperwork, forms, letters, surveys, reports, meeting notes, and all other required correspondence, ensuring it is according to departmental standards.
6. Knowledge of general office practices and procedures and uses them effectively to streamline work.
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4. Maintain appropriate levels of documents regarding files, reports, correspondence, personnel, and financialpaperwork.
5. Understand and meet the expected client outcomes.
6. Attend meetings as scheduled.
7. Communicate proactively and professionally with peers and stakeholders through phone and emails.
8. Follow all regulatory requirements for reporting suspected abuse or neglect.

Stakeholder Interactions/Relationships

1. Form professional relationships with all stakeholders – clients, target populations,

donors, volunteers, interns, vendors, and community partners.
2. Ability to be culturally and linguistically competent in serving the needs of diverse clientele including but not limited to all racial, minority, and ethnic groups, substance abusers, homeless, gay/lesbian, bi-sexual, transsexual, and transgender populations.
3. Provide professional level presentations to internal and outside groups on homelessness, housing and HIV and AFH services.

Team Relationships

1. Balances team and individual responsibilities; exhibits objectivity and openness to others' views
2. Gives and welcomesfeedback.
3. Act respectfully and supportively towards other team members efforts to meet the mention.
4. Work as a highly cooperative member of the AFH staff and volunteers to accomplish agency and departmentalgoals.
5. Accept responsibility and willingness to be accountable by not blaming others for work product or issues.

EDUCATION AND/OREXPERIENCE

Level of Education: Bachelor's Degree in a social science, communications, marketing or field strongly preferred. Areas of study include social work, psychology, public administration, healthcare, and/or public health. Community Health Worker certification preferred.

Work Experience: With the minimum of a Bachelor's degree, one year of case management experience. With less than a bachelor's three years of experience in social services with a record of producing results. Data entry, report writing and compliance experience preferred.

Additional Requirements: NA

ADDITIONAL QUALIFICATIONS

Computer Skills

To perform this job successfully, an individual should have basic proficiency in database software; Internet software; Spreadsheet software and Word Processing software. Knowledge and experience in database development and/or data management, preferably in a nonprofit setting.

Language Skills

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4. Ability to hear and speak well enough to converse over telephone and while performing education and outreach duties 100% of the time.
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WORK ENVIRONMENT

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Print Name Signature Date

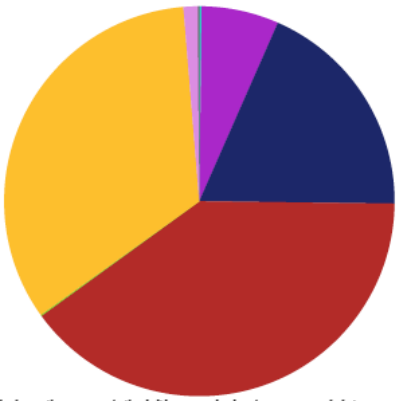
Appendix 2 - Houston Demographic Information

Total Population

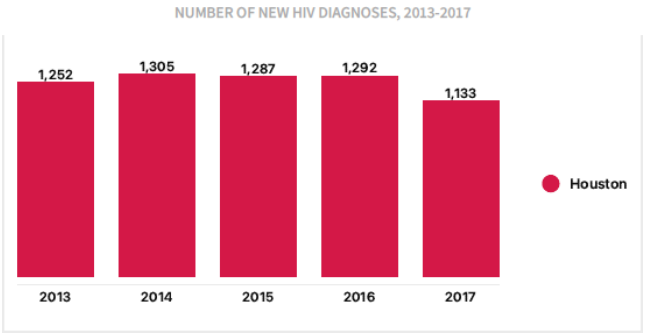
4,363,661

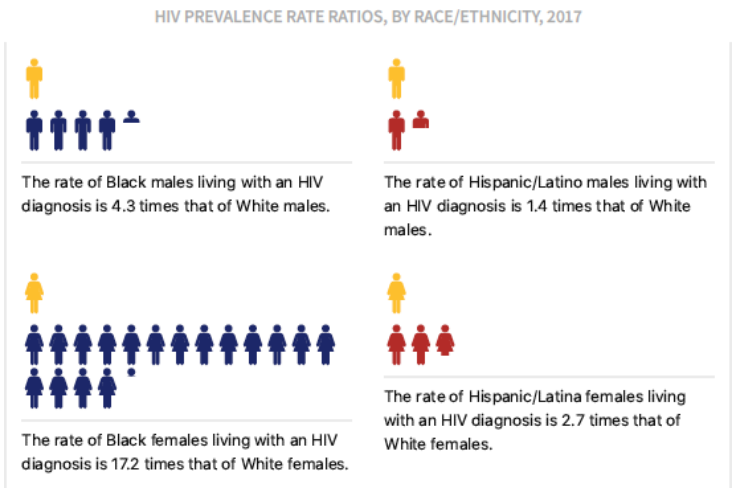
City Population by Race/Ethnicity

- American Indian / Alaska Native (0.2%)
- Asian (6.4%)
- Black (18.6%)
- Hispanic / Latinx (39.8%)
- Native Hawaiian / Other Pacific Islander (0.1%)
- White (33.6%)
- Multiple Race (1.2%)
- Other* (0.1%)



*Includes other races/ethnicities or missing/suppressed data

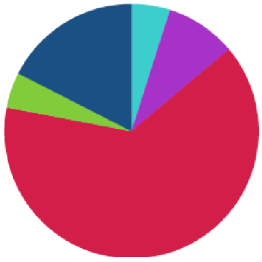




PEOPLE LIVING WITH HIV, BYTRANSMI SSION CATEGORY, 2017

Percent of People Living with HIV, by Transmission Category, 2017

Male Transmission **Categorie s**



- **Injection Drug Use (4.9 %)**
- **Hete rosexua l Contact (9.0%)**
- **Male- to-M ale Sexual Con tact (64.1%)**
- ! ; e tact&
- 0 11-.er• (17.5%)

Female Transmi ssion **Categories**

- **Inject ion Drug Use (1CA%)**
- **Heterosex ual Contact (62.3%)**
- Other• (37.3%)

"JndidM risk factat" notreported orldeltirt&d, Mong IMth hemoplJJa, blll)od nMllls/on, *petina◆e,tposure, or wissilg/fUPpnSNd* daoh

PEOPLE NEWLY DIAGNOSED WITH HIV, BY TRANSMISSION CATEGORY, 2013-2017

Percent of people newly diagnosed with HIV, by Transmission Category, 2013-2017

Male Transmission Categories

- Infection **Drug** Use (1.0%)
- Htlte ros; ua1 Contac t (4.7¼)
- **Male- to-Male Sexual Contact (66.4%)**
- :;:· ; :te:C - tact &
- Other' (26.1%)

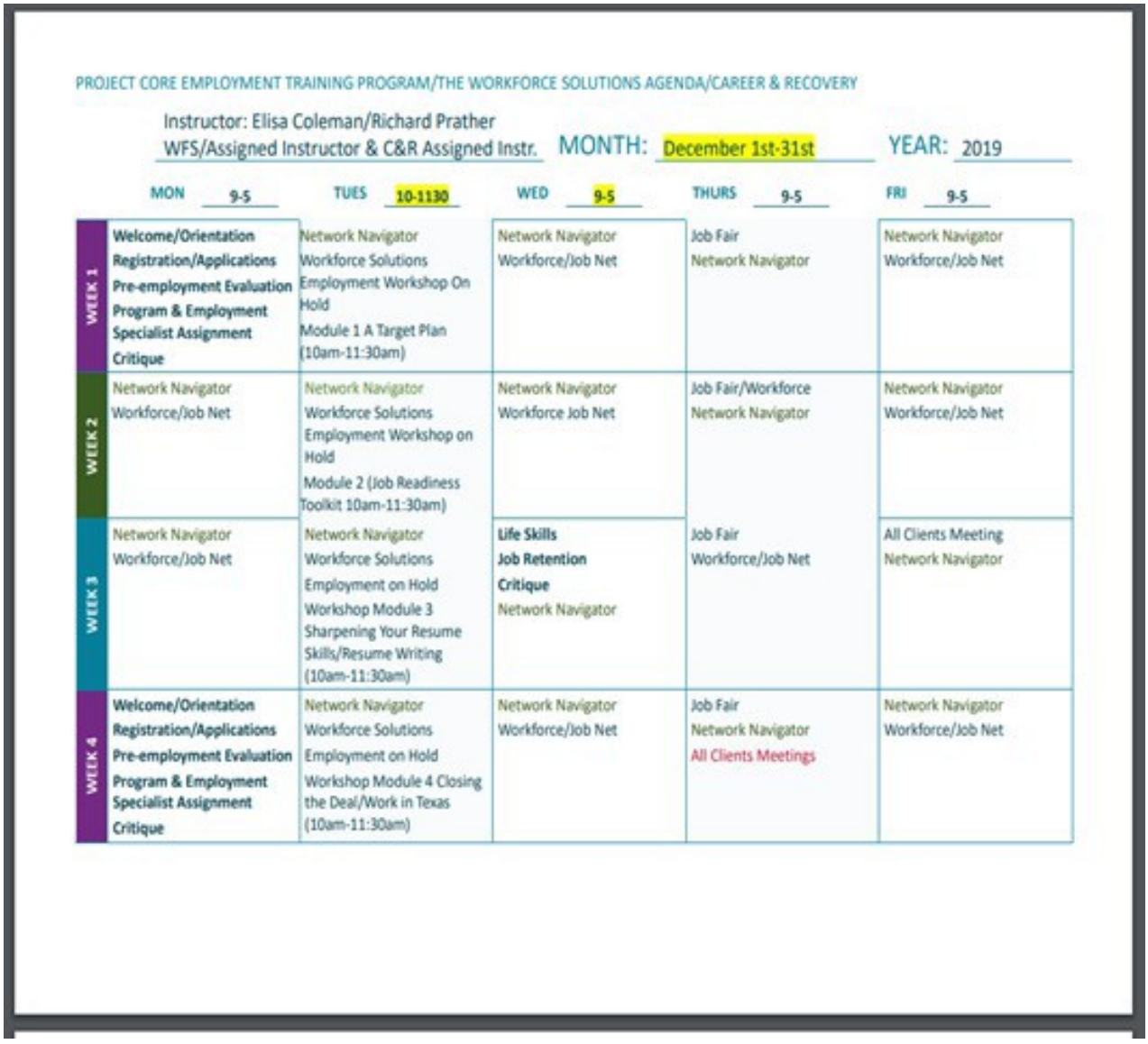
Female Transmission Categories

- Infection Drug Use (3.0%)
- **Htlte ros;exua l Co ntact (31.4%)**
- Other• (65.6%)

"Includes *rbl,, factor notreported* Ill" *Aden1fed, d0ng* wlft *hemophlla, blood nnstusian, petlnatM* uposun,, *or n'Juitgfsuppnss«J data*

Appendix 3: Project CORE Curriculum Documents

Project CORE Employment Training Content

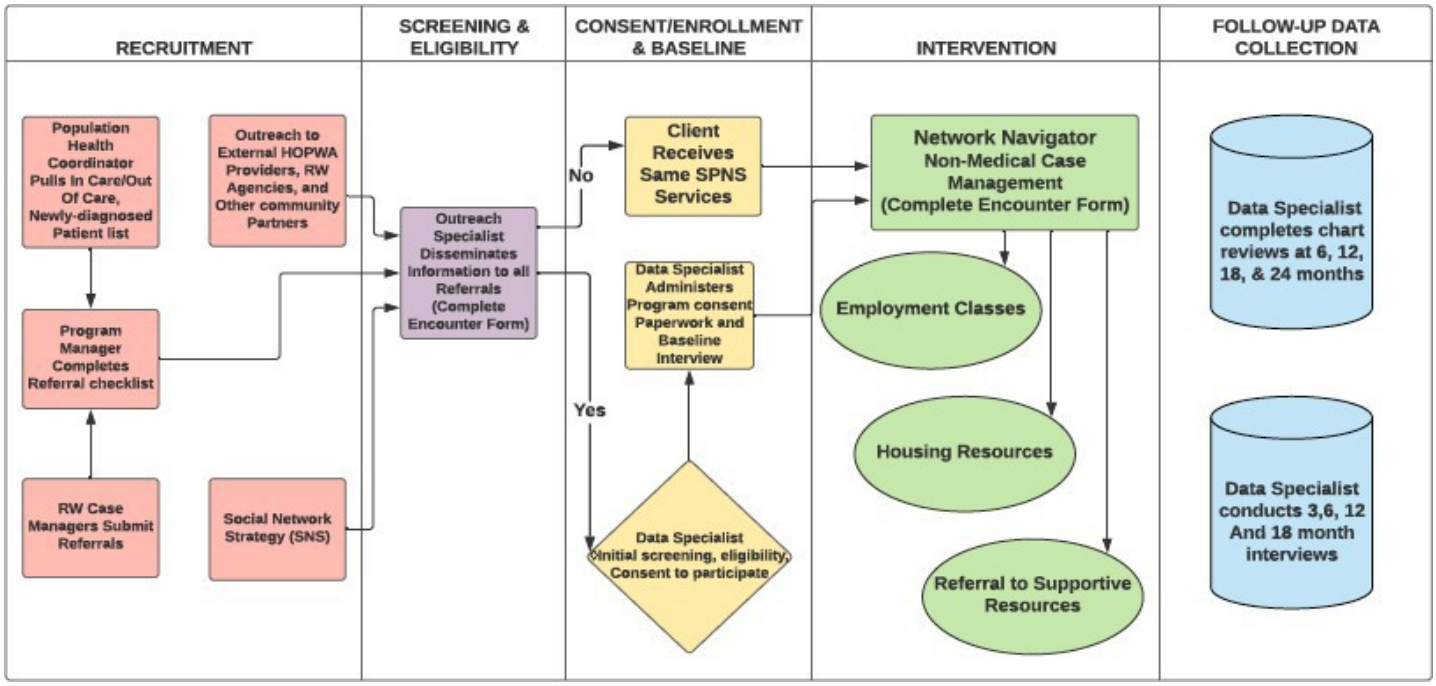


PROJECT CORE EMPLOYMENT TRAINING PROGRAM/THE WORKFORCE SOLUTIONS AGENDA/CAREER & RECOVERY

Instructor: Elisa Coleman/Richard Prather
WFS/Assigned Instructor & C&R Assigned Instr. MONTH: December 1st-31st YEAR: 2019

	MON 9-5	TUES 10-1130	WED 9-5	THURS 9-5	FRI 9-5
WEEK 1	**Welcome/Orientation** **Registration/Applications** **Pre-employment Evaluation** **Program & Employment Specialist Assignment** **Critique**	Network Navigator Workforce Solutions Employment Workshop On Hold Module 1 A Target Plan (10am-11:30am)	Network Navigator Workforce/Job Net	Job Fair Network Navigator	Network Navigator Workforce/Job Net
WEEK 2	Network Navigator Workforce/Job Net	Network Navigator Workforce Solutions Employment Workshop on Hold Module 2 (Job Readiness Toolkit 10am-11:30am)	Network Navigator Workforce Job Net	Job Fair/Workforce Network Navigator	Network Navigator Workforce/Job Net
WEEK 3	Network Navigator Workforce/Job Net	Network Navigator Workforce Solutions Employment on Hold Workshop Module 3 Sharpening Your Resume Skills/Resume Writing (10am-11:30am)	**Life Skills** **Job Retention** **Critique** Network Navigator	Job Fair Workforce/Job Net	All Clients Meeting Network Navigator
WEEK 4	**Welcome/Orientation** **Registration/Applications** **Pre-employment Evaluation** **Program & Employment Specialist Assignment** **Critique**	Network Navigator Workforce Solutions Employment on Hold Workshop Module 4 Closing the Deal/Work in Texas (10am-11:30am)	Network Navigator Workforce/Job Net	Job Fair Network Navigator All Clients Meetings	Network Navigator Workforce/Job Net

Appendix 4 - Project CORE Program Model

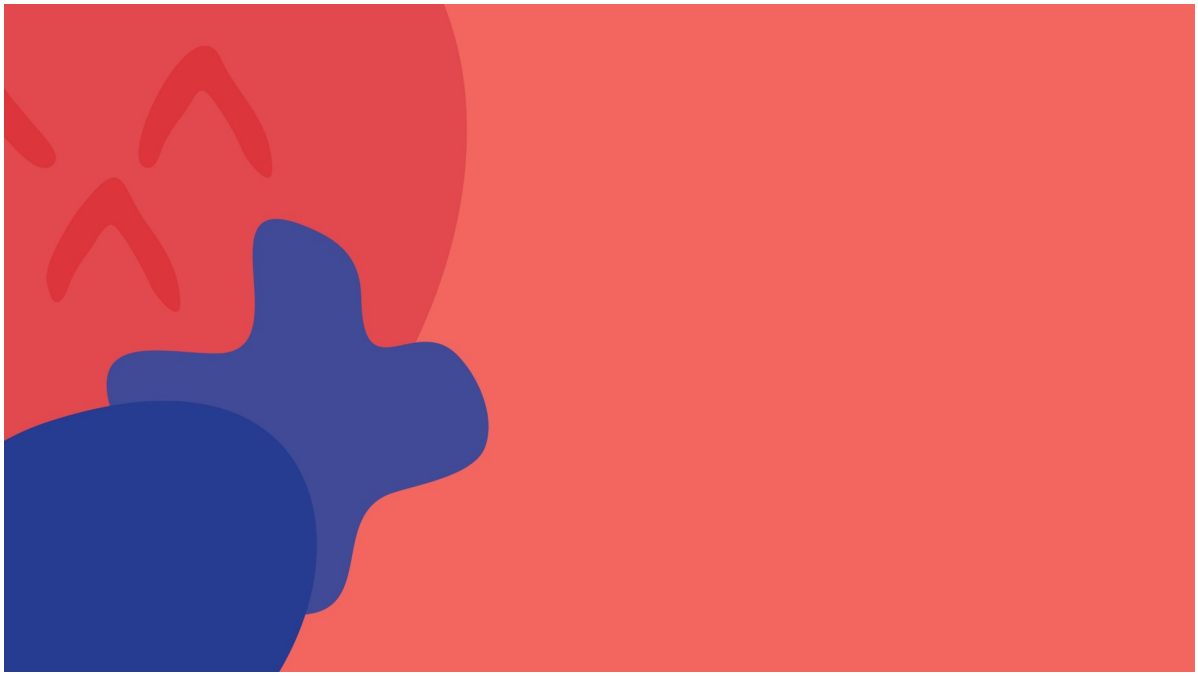


Appendix 5 - Project CORE Marketing Assets

Logo

PROJECT C.O.R.E.
COORDINATION OF RESOURCES AND EMPLOYMENT

PowerPoint Slide



Flyer


LEARN MORE
PROJECT
C.O.R.E.
832.334.5566
EMAIL@EMAIL.COM
We're here to help.
A SERVICE OF – AVENUE 360 & AF HOUSTON

Tote Bag

Appendix 6 – Progress Notes & Case Management Plan Templates

Progress Notes

Project CORE - PROGRESS NOTE

DATE	TIME	NOTES
10/08/18	12:35pm	Client is currently homeless and seeking stable housing and employment. Referred client to AFH POC for a housing assessment Client has been referred to a shelter for the time being. Client is interested in any type of full time employment. Network Navigator will provide the client with date/times of the Employment Workshops. Client is medically adherent.
10/10/18	1:45pm	Client has been scheduled to attend the Workforce Solutions Employment Workshop and will follow up with Network Navigator weekly on his employment process. Client has also been schedule an apt with the AFH POC for a housing assessment on 10/16/18. Will follow up with client to check the status of the AFH housing assessment. Client is still currently living on the streets. Referred client to a number of shelters until he can obtain housing.
10/17/18	11:15am	Followed up with client re housing assessment appointment. Client was a no show to his housing assessment appointment and is still currently homeless. Clients appointment has been rescheduled and will follow up with the client to confirm if the assessment was done.
10/18/18	1:00pm	Client completed housing assessment and has been accepted into the Star of Hope. Client is still currently seeking employment and attended the Workforce Solutions Employment Workshop on 10/16/18.
10/22/18	2:25pm	Client is still currently at the Star of Hope, however the client was referred to Avenue 360 for a housing assessment. The referral was sent over to Avenue 360 and the client has been assigned a case manager. The case manage will assess the client and will see what the client qualifies for. Will follow up with the client to check the status of the assessment.
10/26/18	11:30am	Client housing assessment at Avenue 360 was complete. Spoke with clients Avenue 360 Housing Case Manager. The client is eligible to receive housing assistance through their HOPWA grant. The client will receive PHP (Permanent Housing Placement) and will receive assistance with his deposit and his first month of rent. The client has 60 days to find a place to stay in order to receive the assistance. Client states that he has found an apartment and is in the process of submitting his documentation.
11/08/18	3:15pm	Followed up with client regarding the status of his housing assistance. Client has submitted the required documentation and is pending a decision from Avenue 360 Case Manager.
11/21/18	11:30am	Client came stating he has a job interview and was seeking a bus pass. Client received a bus pass and discussed with Network Navigator his current housing status. Client is still

Case Management Plan

INDIVIDUALIZED CLIENT CARE PLAN
REV090129

Client Name: Client A 14-Char Code: _____ Date: 04/26/19

GOAL: TO FIND STABLE AND AFFORDABLE HOUSING

PROBLEM	OBJECTIVE
Client reports he is stably housed	Client will continue to remain stably housed and report and changes in residency

	KEY ACTION STEPS	PERSON RESPONSIBLE	TARGET DATE	COMPLETION DATE
1.	Report any change of residency to staff	Client	07/26/19	
Outcome				

GOAL: MEDICAL ADHERENCE

PROBLEM	OBJECTIVE
N/a (Client reports he is medically adherent)	Client will continue to be medically adherent and continue to take medications.

	KEY ACTION STEPS	PERSON RESPONSIBLE	TARGET DATE	COMPLETION DATE
1.	Client will keep next doctor's appointment	Client	07/26/19	
2.	Client will submit medications and lab results to Network Navigator	Client	07/26/19	
3.	Network Navigator will file submitted documentation	Network Navigator	07/26/19	
Outcome				

GOAL: INCREASE EMPLOYMENT SKILLS AND OBTAIN FULL TIME EMPLOYMENT

PROBLEM	OBJECTIVE
Client is working part time but seeking full time employment.	To find full time and stable employment

	KEY ACTION STEPS	PERSON RESPONSIBLE	TARGET DATE	COMPLETION DATE
1.	Attend weekly Employment Workshops at AIDS Foundation Houston *Classes are on Tuesday from 10am-11:30am*	Client	05/07/19	
2.	Submit at least (5) job searches weekly *Job searches need to be faxed in by Friday*	Client	05/21/19	
3.	Network Navigator will follow up with the client weekly to check progress	Network Navigator	05/21/19	

Appendix 7-Social Network Strategy Protocol
Project CORE- Social Network Strategy (Pilot strategy)
Avenue 360, AIDS Foundation Houston, UH
GCSW A version of this was submitted to IRB

Social Network Strategy (SNS): What is it?

According to the Center for Disease Control and Prevention, Social Network Strategy (SNS) can be understood as a method of increasing engagement and motivating individuals to agree to receive supportive services (originally it was conceived to recruit more people to get tested for HIV) . SNS assumes individuals in the same social networks will share similar characteristics, such as social and behavioral factors (Centers for Disease Control and Prevention, 2018).

Why is Project CORE implementing SNS?
Due to low numbers of recruitment, Project CORE has decided to implement SNS in order to increase the number of Project CORE participants as well as participant engagement. By implementing this strategy, we expect to recruit more participants by offering incentives to the Project CORE participants who refer the individual to the Project CORE. The newly referred and enrolled participants can also then refer individuals to Project CORE.

How will Project CORE implement SNS?

- Project CORE participants (eligible and currently enrolled in Project CORE) will recruit individuals from their social network to participate in Project CORE and will receive $15.00 gift card for recruiting individuals. Participants can recruit up to 4 individuals.
- Project Core participants will be provided the information about the opportunities to recruit from their network to receive an incentive in a few ways: a) by the recruiting case managers b) during initial outreach and c) during the baseline interview which is conducted by the Data Specialist.

Logic of this SNS sub study

- **Recruiter Engagement**
    - New Project CORE participants should be informed about participating in SNS during the all of the following interactions:
        - a) by the recruiting case managers
        - b) during initial outreach and
        - c) during the baseline interview which is conducted by the Data Specialist
    - Existing Project CORE participant should be informed about participating in SNS

- Things to consider when discussing SNS with the recruiter:
  - A few background factors: We need to ensure that the person who is being recruited (their network) - their status is not revealed, thus we cannot ask the recruiter about the information regarding if they qualifications for Project CORE
  - The narrative around recruiting recruiters should be around housing and employment needs and people in their networks
  - The recruiter should be required to bring the person who they are recruiting in person OR that person who is going to be recruited for Project CORE can come by themselves
    - The Project CORE recruiter can work with Cynthia to say we can hand the person off - everything behind the close doors - "I have this friend so its this person" - never tell their name - can totally work with people's safety zones around that stuff. Once the person comes in, they get the incentives no matter what (thanks for bringing them in) - we could get the description of that person
      - Fake name of that person (code name); description of the person so Cynthia knows who it is
    - Have some sort of report - (Cynthia) - to be the person to be doing outreach - sits down with them and helps them think about who is going to recruit - code of people being recruited - so and so refers me here… something to go back to -

Recruitment and Enrollment

- Referred person physically meets with Cynthia/LaNikka
- Referred person completes screening eligibility
- Project CORE participant can refer up to 4 people

How will Project CORE track referrals?

Project CORE has created a referral tracking sheet.

- The tracking sheet will identify WHO is making the referrals, along with the names and contact information for people they think may qualify for the program.
- Once the referred individuals are identified and enrolled in the program, the Outreach Specialist will contact the person who submitted the referral to let them know that they may go to Avenue 360 to retrieve the incentive

Incentive Details

The gift cards will be distributed the following ways:

- Participants will be able to pick up their card at from a Project CORE member either Avenue 360 or AFH (still figuring out the logistics)
- If the participant is unable to come in person, the Outreach Specialist or Data Specialist will meet the participant where they are.

Referral Incentive Narrative

Project CORE will incorporate a narrative to explain the SNS to those being screened.

"Thank you for your interest in the program. In addition to receiving your $30.00 Walmart gift card as compensation for completing the interview, there's another incentive we would like to inform you about! Project CORE is also offering a $15.00 gift card incentive for referrals made to our program. That means that you will receive a gift card to ask people you know and who could be eligible to meet with us and enroll in Project CORE. If you know anyone who will benefit from the program, please refer them to our Outreach Specialist, Cynthia Grant at (713) 623-6796 X 311. You may refer up to four potential participants, totaling $60, for just referring people. This incentive will be given until funds are no longer available."

How will Project CORE reach out individuals previously screened?

There are a total of X participants enrolled in Project CORE. The network navigator, LaNikka, will contact each of these participants to discuss this referral incentive. This process will allow Project CORE the opportunity to further recruit from those individuals who were screened eligible before the implementation of this strategy.

Appendix 8 – Local Evaluation – Feasibility Study

Project C.O.R.E – Avenue 360, AIDS Foundation Houston, UH GCSW

Local Evaluation – Feasibility Sub-Study

Compiled by Samira Ali, PhD – Evaluator

- The major aim of this sub-study is to examine the feasibility of Project C.O.R.E. Since this project was new and innovative and a coordination between a community-based organization and a FQHC has not happened in this way, a feasibility study was appropriate to examine the project's acceptability, demand, and integration. This sub-study is guided by the Consolidated Framework for Implementation Research (Damschroder et al., 2009)
- Data Collection: Qualitative interviews with staff; Data Analysis: Thematic Analysis
- Interview Protocol (select questions) – Questions to staff included:
    - What does Project CORE meant to you?
    - Coordination/Collaboration - What have your experiences been with the coordination and collaboration with various entities? Facilitators? Barriers?
        - What matters in a collaboration?
        - Language/Communication? Agenda settings? Transparency? Role Transparency?
    - Organizational Change – Had anything about the organization culture change since Project CORE started?
    - Inner setting - How did the network/relationships and communication shape your experience in Project CORE
        - Culture - What are the norms and values of the organizations? Did they shape the work that you do in Project CORE?
        - Leadership - How is the climate with leadership?/ Are you empowered to make changes?
    - Social Network Strategy- specific questions
        - What do you think about SNS?
        - What were facilitators to implement
        - What were barriers?
        - Did you feel supported

Consolidated Framework for Implementation Research (Palinkas et al., 2015)

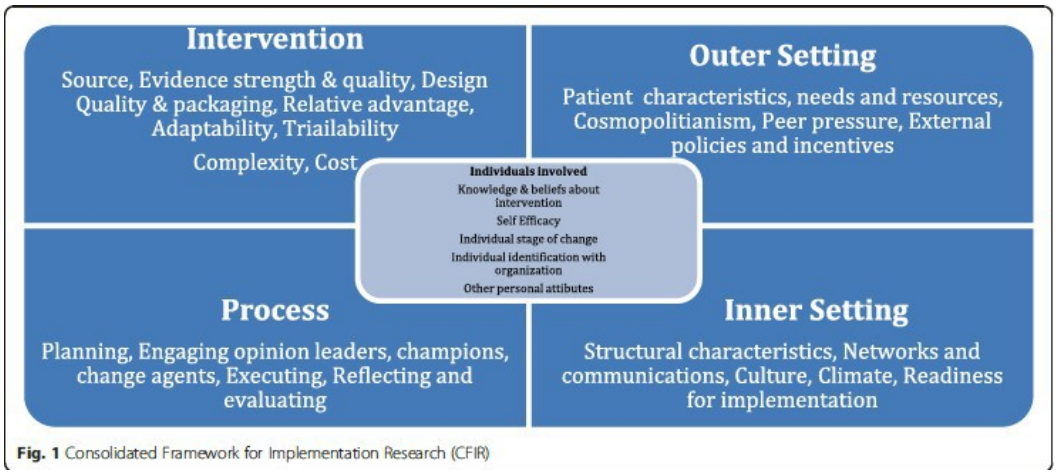


Fig. 1 Consolidated Framework for Implementation Research (CFIR)

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