The CASE (**CA**re, hou**S**ing, **E**mployment) Management Initiative

Bexar County Hospital District
San Antonio, Texas

THE HIV, HOUSING, & EMPLOYMENT PROJECT

Authors

We would like to acknowledge everyone who contributed to the program and to this program manual. The following is a list of authors who worked tirelessly on this manual to tell the stories of our clients.

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Introduction

Purpose

This program manual provides a guide of strategies to assist people with HIV (PWH) find sustainable housing and employment. The goal of our program is to improve the health and livelihood of clients through employment and housing. This manual will describe how local Ryan White HIV/AIDS Program (RWHAP) Part A program and various community partners worked on managing and providing the care for enrolled clients within our program.

- Our hope is that readers who are interested in improving access and quality of care for their clients will be better equipped to serve those in need of housing and employment. This manual will share approaches that were created to find the most affordable, livable, and safest spaces, as well as approaches to finding employment that provide sufficient income to sustain a way of life.
- The HIV primary care services are fulfilled by The Ryan White HIV/AIDS Program (RWHAP) Part A partners within the San Antonio Transitional Grant Area (SATGA) in support of the grant needs for care. Our focus is to eliminate the barriers to accessing housing assistance, employment assistance and medical care that are directly responsible for the observed health disparities within these populations where poverty is most prevalent.

Funding Acknowledgement

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number H97HA31463 and was part of Improving HIV Health Outcomes through the Coordination of Supportive Employment and Housing Services: CAre, houSing and Employment (CASE) with a total award amount of $891,901. This information or consent and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Background and Intervention Overview

Background and intervention context

- The Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV primary medical care, essential support services, and medications for low-income people with HIV who are uninsured and underserved. The Program funds grants to states, cities/counties, and local community-based organizations to provide care and treatment services to people living with HIV to improve health outcomes and reduce HIV transmission among hard-to-reach populations.
- The intervention outlined in this manual was part of the "Improving HIV Health Outcomes through the Coordination of Supportive Employment and Housing Services" Initiative (otherwise known as the "HIV, Housing & Employment Project"). This HRSA Special Projects of National Significance (SPNS) Initiative was funded by the U.S. Department of Health and Human Services (HHS) Minority HIV/AIDS Fund, and the intervention was conducted and evaluated within a RWHAP-funded site.
- The CASE Management Initiative intervention was implemented by Bexar County Hospital District, a RWHAP Parts A, B, and D recipient based in San Antonio, Texas.

- When this opportunity was granted to us, it allowed for staff of various backgrounds to come together as a multi-faceted team and serve a population that most of the team had no experience in serving before. A plan was created to go out and meet the community and agencies conducing patient care to see and hear what they were accomplishing in their housing and employment efforts. Upon meeting with the recipients on local RWHAP Parts A, B, and D, the team continued to meet with agencies at different levels from city, county, state, and non-profit entities.
- Around the time the program began, program staff learned that partnering agencies were doing impactful work within the clinical aspects of serving PWH, but they needed assistance in coordinating housing and employment needs for the clients. As clients began to be enrolled in the program, it was quickly learned that some clients' needs went far beyond finding shelter or earning some income above minimum wage. Some clients' experiences ranged from dealing with lack of documentation to coping with a lack of familial or peer support and even sometimes an unwillingness to seek treatment for mental health or substance misuse. These additional needs prompted the team to look for other resources in the community to better assist clients in helping them reach their ultimate goals of sustainable housing and employment.

Description of the demonstration site & relevant partners

- The Bexar County Hospital District (BCHD) - University Health is comprised of four counties including Bexar, Comal, Guadalupe, and Wilson, which make up the SATGA. The CASE Management Initiative (**CA**re, hou**S**ing, and **E**mployment) employs multiple interventions carefully designed to improve health outcomes of people with HIV (PWH) by coordinating access to services that provide assistance in obtaining suitable housing, gainful employment and adequate HIV primary care. This transformation will improve health outcomes among those disproportionately affected by the HIV epidemic. Low-income minority communities within the SATGA possess large numbers of PWH lacking health insurance.
- University Health is one of twelve sites in the nation participating in a multisite study coordinated by Boston University, Boston, MA and funded by the Health Resources Services Administration, Washington, D.C. About four years ago, prior to beginning this particular SPNS program, the Ryan White HIV/AIDS Program Part A agencies were directly under the administration of the Bexar County Judge as its administrator. The RWHAP was beginning its transition to University Health as it would eventually become the new administrator of the RWHAP.
- The Ryan White HIV/AIDS Program (RWHAP) Part A partners include the following agencies: Alamo Area Resource Center (AARC), Black Effort against the Threat of AIDS (BEAT AIDS), Centro Med, Family-Focused AIDS Clinical Treatment Services (FFACTS), and San Antonio Aids Foundation (SAAF). Each of these partners give the population access to adequate care and provide the CASE program with client referrals.
- Initial connections were made with agencies that would be a good source of distinct housing and employment services for clients, but also established new connections with agencies as program staff learned of different services that may be needed by clients. University Health had established partnerships with the San Antonio Food Bank (SAFB who provides nutritional needs and job training assistance), Haven for Hope (a major shelter for those experiencing homelessness and offers an array of services), United Way, San Antonio Housing Authority (SAHA which provides federal housing assistance)), University Health CareLink (a financial assistance program), and Project Quest (job training and placement). New connections were established with additional agencies that addressed specific needs for clients which included Goodwill Industries (job training and employment assistance), Dress for Success (clothing assistance), Refugee

and Immigrant Center for Education and Legal Services (RAICES assisting with immigration legal aid), South Alamo Regional Alliance for the Homeless (SARAH) Housing Strategic Workgroup, Texas Rio Grande Legal Aid (immigrant legal assistance), Putting an End to Abuse through Community Efforts (P.E.A.C.E.) Initiative offering services for domestic violence), Salvation Army, San Antonio Police Department – Homeless Outreach Positive Encounters (SAPD-HOPE), Alamo Workforce Solutions (assistance with job training and placement). The presence of a large minority population creates communities within the SATGA that experience a disproportionate amount of negative health outcomes due to multiple social determinants of health that prevent the ability to effectively address the HIV epidemic.

Partner organizations

Alamo Area Resource Center
303 N. Frio St.
San Antonio, TX 78207
210-625-7200
www.aarcsa.com

The Alamo Area Resource Center (AARC) was founded in Bexar County to serve individuals experiencing homelessness, disability, or any life-altering illnesses, including, but not limited to HIV/AIDS. AARC uses a wrap-around care model which includes medical providers, social workers, housing specialists, mental health counselors, psychiatrists, and various supportive services on-site. AARC provides housing referral and placement services through Housing Opportunities for Persons with AIDS (HOPWA) Short Term Rental, Mortgage, Utility, assistance (STRMU), Tenant-Based Rental Assistance (TBRA), and housing case-management.

B.E.A.T AIDS
208 W. Euclid Ave.
San Antonio, TX 78212
210-212-2266 www.beataids.org

B.E.A.T AIDS, also known as “Black Effort against the Threat of AIDS” is committed to meeting people where they are in the community whether it be recovery, homelessness, incarceration, abuse/neglect, isolation, or actively addicted. They provide a wide array of programs and services including, but not limited to HIV/AIDS education and prevention, case management, support groups, clinical services, mental health and substance use disorder services, and patient navigation/linkage to care.

CentroMed
315 N. San Saba #103
San Antonio, TX 78207
210-922-7000
www.centromedsa.com

El Centro del Barrio, commonly referred to as CentroMed is a non-profit Federally Qualified Health Center (FQHC) founded in San Antonio in 1973. Through the Ryan White Care Act, CentroMed is funded for Ryan White HIV/AIDS Program Parts A, B, and C. Their services include outpatient/ambulatory, medical/nonmedical case management, referrals for healthcare services, and support services among many others.

Family-Focused AIDS Clinical Treatment Services (FFACTS)
903 W. Martin St.San Antonio, TX 78207
210-358-3400
www.universityhealthsystem.com

University Health's outpatient HIV/AIDS clinic, named Family-Focused AIDS Clinical Treatment Services (FFACTS), provides comprehensive health services to improve the health and livelihood of people with HIV/AIDS in San Antonio and South Texas. Such services include case management, primary and specialty medical care, psychiatric and mental health counseling, substance use disorder counseling, women's healthcare, nutrition counseling, access to specialty pharmacy, and referral to other specialty clinics as needed. The FFACTS clinic is funded in part by the Ryan White Treatment and Modernization Act.

San Antonio AIDS Foundation
818 E. Grayson St.
San Antonio, TX 78208
210-225-4715
www.sanantonioaids.org

The San Antonio Aids Foundation (SAAF) is a 501c3 nonprofit organization providing services for those affected by HIV/AIDS in Bexar County and surrounding counties. SAAF provides a continuum of care model to low-income men, women, and transgender individuals who have HIV. They provide community-based, dietary, education, and testing services. Such services include case management, mental health counseling, mobile testing, and housing. SAAF provides transitional, short-term housing through the Carson House, a sober-living environment where residents can stay for periods of 90 days. They also provide long-term rental assistance through administered HOPWA funds.

Strategies for Creating Collaborative Partnerships

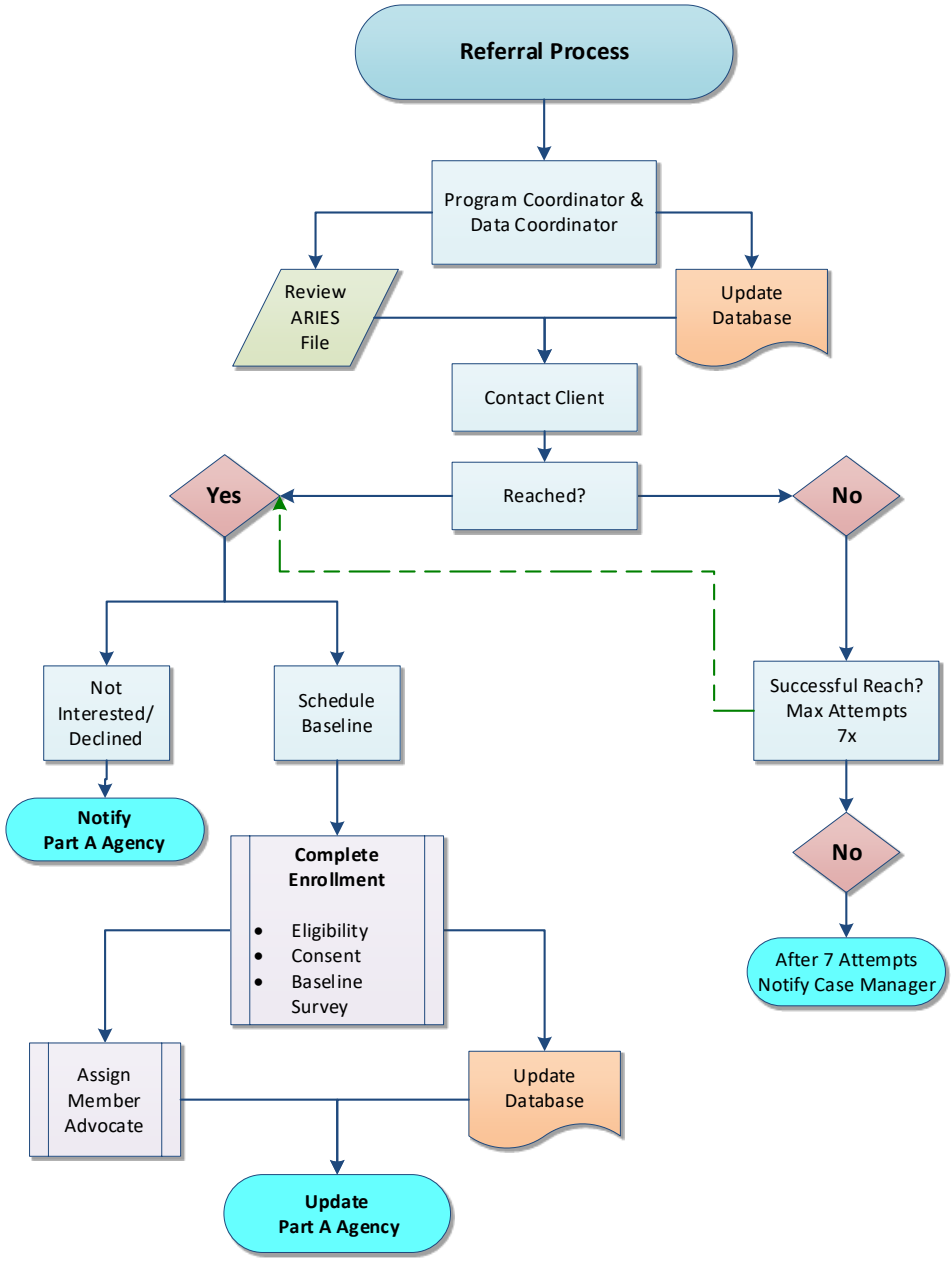
The success of the program can in part be attributed to the collaborative partnerships formed with community organizations. Below are a list of strategies created including partnerships and processes that any future program can utilize to create their own collaborative partnerships.

- Develop strategies for communicating with collaborating agencies and internal or external stakeholders (employment, housing, healthcare, behavioral health, police, hospitals, landlords, and/or other support services)
  - Keep ideas open as clients bring many different needs
  - Update resources often as services may change
  - Share information with others when new or unknown agencies are found
- Initiate agency briefings to share program goals and objectives
  - Make clear what program is about and what your goals are when working with the agency
  - Program should immediately provide briefings to new agencies
- Create reoccurring meetings with updates informing providers and partnerships of program goals and progress
  - Meetings can be weekly to quarterly, depending on program need

        - Initial meetings were more frequent compared to end of program
    - Be consistent and available for any additional information as needed
- Engage with local Department of Labor (DOL) and Department of Housing and Urban Development (HUD)
    - Check with local state agencies that support federal departments for additional assistance or programs
    - Check with local city and county agencies for employment and housing assistance
    - Locate agencies who have access to Homeless Management Information System (HMIS) to ensure clients are enrolled for assistance
- Create Memorandum of Understanding with partnering agencies to address available agency support
- Develop training protocols targeting TGA's service delivery providers
    - Establish specific needs of program and share that with applicable trainings for providers
    - Develop a fundamental baseline of trainings for staff to give a better understanding of specific client needs
    - Share training opportunities with other partner agencies while simultaneously networking with them
- Share the eligibility requirements for client recruitment with key agency personnel
    - Clearly set forward the requirements needed for providers and others
- Allow open access between Member Advocate and the partner agency's case management team
    - Build relationships with other agency members as well as with clients
    - Create reoccurring communications with agency members especially if client is active in seeking help
    - Provide daily and/or weekly digital updates within established client reporting system
- Provide partner agencies with program briefs to share program progress
    - Initially, provide briefs often and then reduce frequency as grant closes out

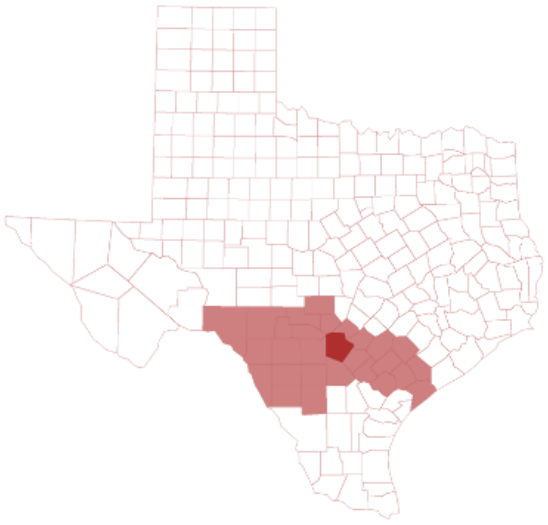
Referral Process

The referral process shown below was the initial intake of enrollment prior to program intervention. The information below depicts how referrals were contacted and enrolled into the study. The majority of our referrals came from partner agencies (AARC, B.E.A.T AIDS, CentroMed, FFACTS, and SAAF). However, referrals were received from other agencies including the Strong Arm Program,Ryan White Administrative Staff, Haven for Hope, and Alamo Area Council of Governments. The main source of referrals were through email (83%) followed by calls (8%), then client call-ins (6%), and finally from ARIES (3%).



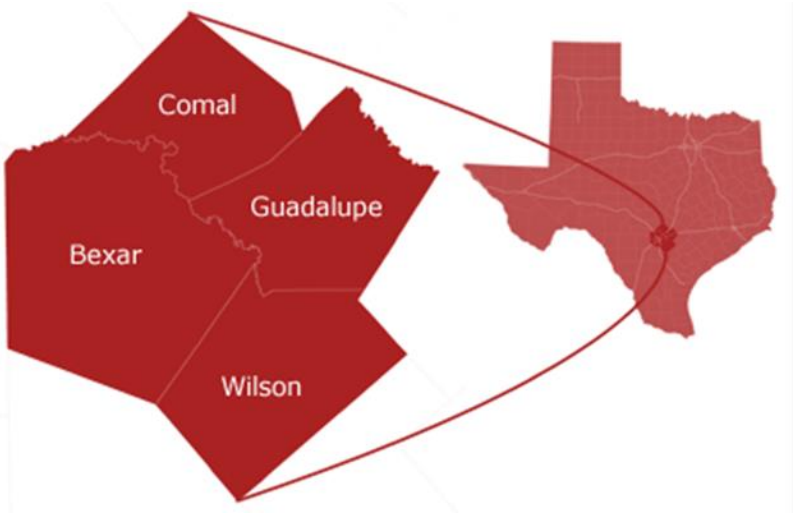
Description of need

- Before addressing the need for the program, it is important to shed some light on University Health and the location in which clients were served. San Antonio is the seventh largest city in the United States and Bexar County is the fourth most populous county in Texas, making it slightly larger than the entire state of Rhode Island and the 17th largest county nationally. Bexar County Hospital District dba University Health is South Texas' only safety net health system including a Level 1 Trauma Center and Texas' third largest hospital system with a 28 county service region across South Texas. University Health employs over 900 physicians and residents and more than 8,000 employee. University Health is the first and only health system to earn Magnet status from the American Nurses Credentialing Center in South Texas.



Bexar County Hospital District's 28 county service region.

- The SATGA is comprised of four counties which include Bexar, Comal, Guadalupe, and Wilson. In Bexar County, the proportion of Hispanics (60.5%) is significantly higher than that of Texas (37.6%) and the nation (16.3%). In 2018, 6,470 PWH lived in the San Antonio Transitional Grant Area (SATGA), an 18% increase since 2014 with 505 new HIV/AIDS diagnoses occurring in that year. Black and Hispanic men who have sex with men (MSM) and Black and Hispanic heterosexual women comprised more than 7 in 10 of those with HIV. Both Blacks and MSM of all races/ethnicities demonstrate persistently higher burdens of HIV. Bexar County, home to San Antonio, is the population center of the region with almost 2 million residents. It is also the epicenter of the HIV epidemic, with 94% of the PWH being identified within the San Antonio metropolitan region.



The SATGA's four counties: Bexar,Guadalupe, Wilson, and Comal.

- The SATGA does not have a client service hub center to process and coordinate services for client's housing and employment requests to a level of being able to connect services to improve their lives. Clients already go through many different agencies trying to get services as each agency has different services or program requirements. A centralized hub would help clients save time and travel which would allow them to begin services sooner. The Ryan White HIV/AIDS Program Part A partners do not all get housing assistance funds and if they do, each have internal policies regarding its distribution. A need for employment readiness navigators is essential since our RWHAP programs lack staff for specific employment needs. A local concern of need is the cost of living versus the hourly wages earned which inhibits clients from reaching self-sustainability. In order to cover the average monthly rent of $1102, clients must make $14 to $17 per hour, which for some is difficult to achieve.

Intervention

Goals and Objectives

Goal I: Structure an intervention to transform the TGA's HIV service delivery system.

Objective: Sustainability of SPNS demonstration program.

Goal 2: Develop an innovative program by integrating CASE Service Coordinators (Member Advocates) into current collaborator funded programs.

Objective: Transformation of the TGA's service delivery system.

Goal 3: Educate clients in essential skills to secure employment and housing.

Objective: Sustainability of SPNS demonstration program and transformation of TGA's service delivery system.

Goal 4: Develop bilingual, bicultural, low-literacy client focused employment entry/re-entry curriculum customized to meet the needs of the SATGA community.

Objective: Workforce readiness preparation for all PWH in CASE program with rollout to all CASE managed clients at the end of the program.

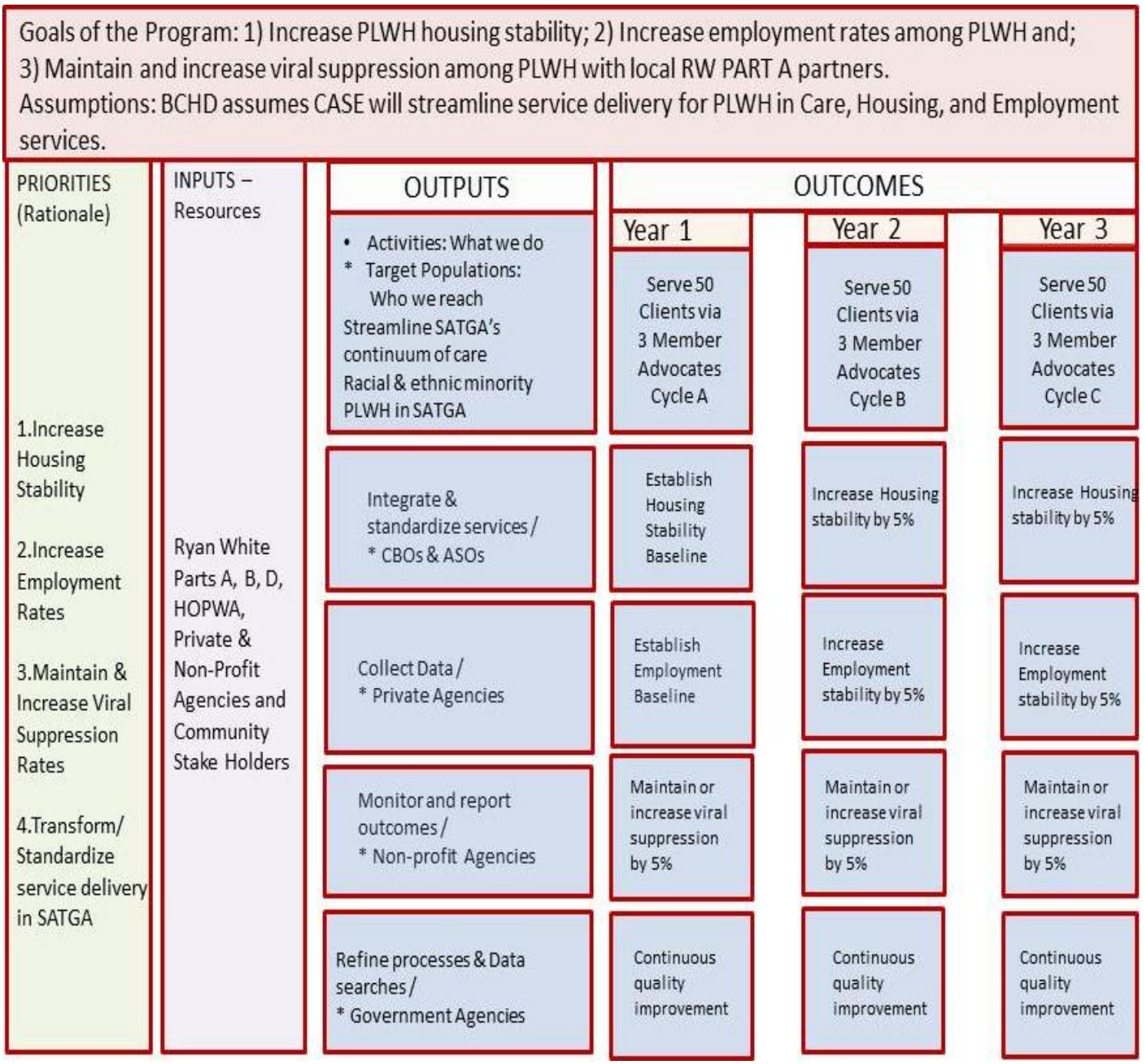
Goal 5: Sponsor second-chance job fairs to connect employers with job seekers.

Objective: Provide CASE Service Coordinators (Member Advocates) with a comprehensive listing of 2nd chance employers.

Goal 6: Convene CASE Advisory board.

Objective: Review, discuss, and improve data sharing.

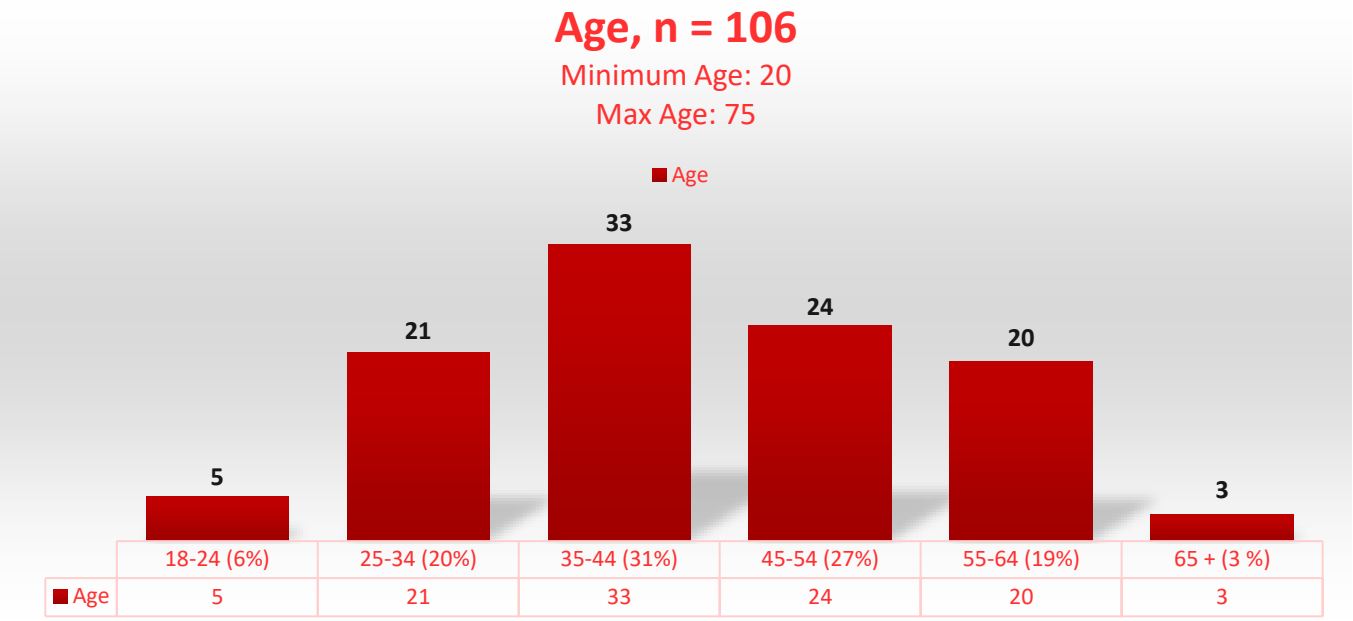
Logic Model

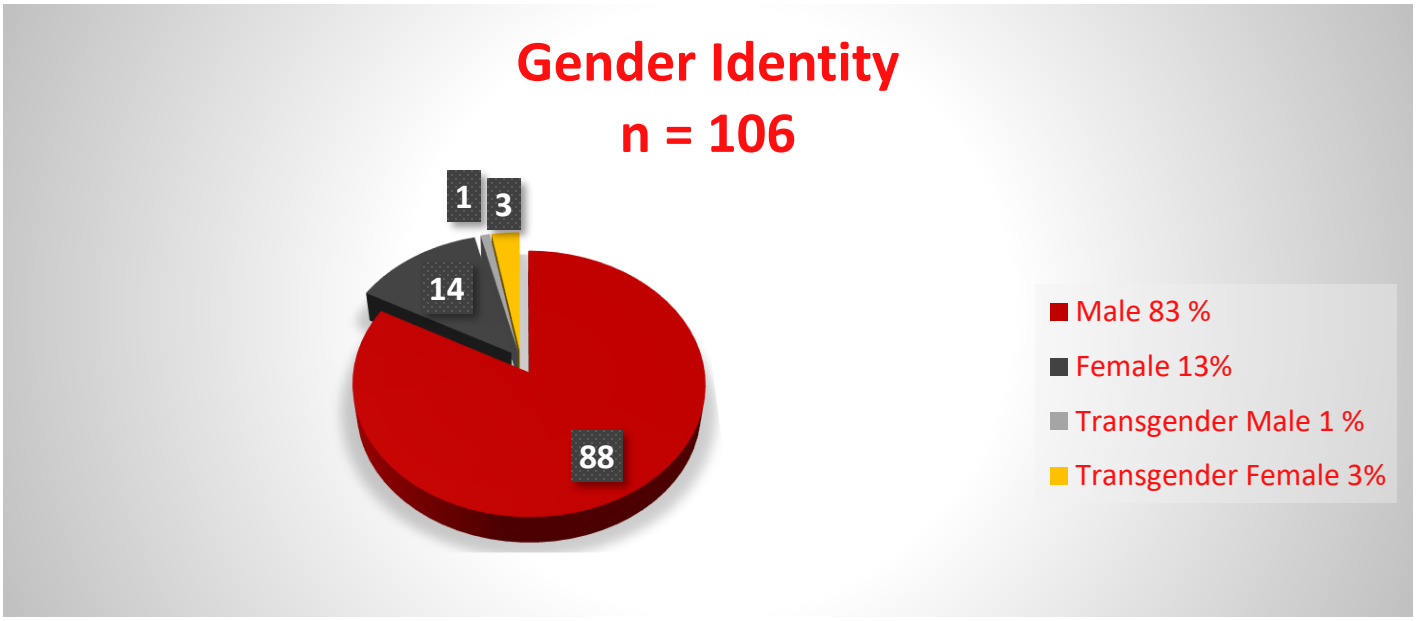

Goals of the Program: 1) Increase PLWH housing stability; 2) Increase employment rates among PLWH and; 3) Maintain and increase viral suppression among PLWH with local RW PART A partners.
Assumptions: BCHD assumes CASE will streamline service delivery for PLWH in Care, Housing, and Employment services.
PRIORITIES (Rationale)
1.Increase Housing Stability
2.Increase Employment Rates
3.Maintain & Increase Viral Suppression Rates
4.Transform/ Standardize service delivery in SATGA
INPUTS – Resources
Ryan White Parts A, B, D, HOPWA, Private & Non-Profit Agencies and Community Stake Holders
OUTPUTS
• Activities: What we do
* Target Populations: Who we reach
Streamline SATGA's continuum of care
Racial & ethnic minority PLWH in SATGA
Integrate & standardize services / * CBOs & ASOs
Collect Data / * Private Agencies
Monitor and report outcomes / * Non-profit Agencies
Refine processes & Data searches / * Government Agencies
OUTCOMES
Year 1
Serve 50 Clients via 3 Member Advocates Cycle A
Establish Housing Stability Baseline
Establish Employment Baseline
Maintain or increase viral suppression by 5%
Continuous quality improvement
Year 2
Serve 50 Clients via 3 Member Advocates Cycle B
Increase Housing stability by 5%
Increase Employment stability by 5%
Maintain or increase viral suppression by 5%
Continuous quality improvement
Year 3
Serve 50 Clients via 3 Member Advocates Cycle C
Increase Housing stability by 5%
Increase Employment stability by 5%
Maintain or increase viral suppression by 5%
Continuous quality improvement

Priority population(s)

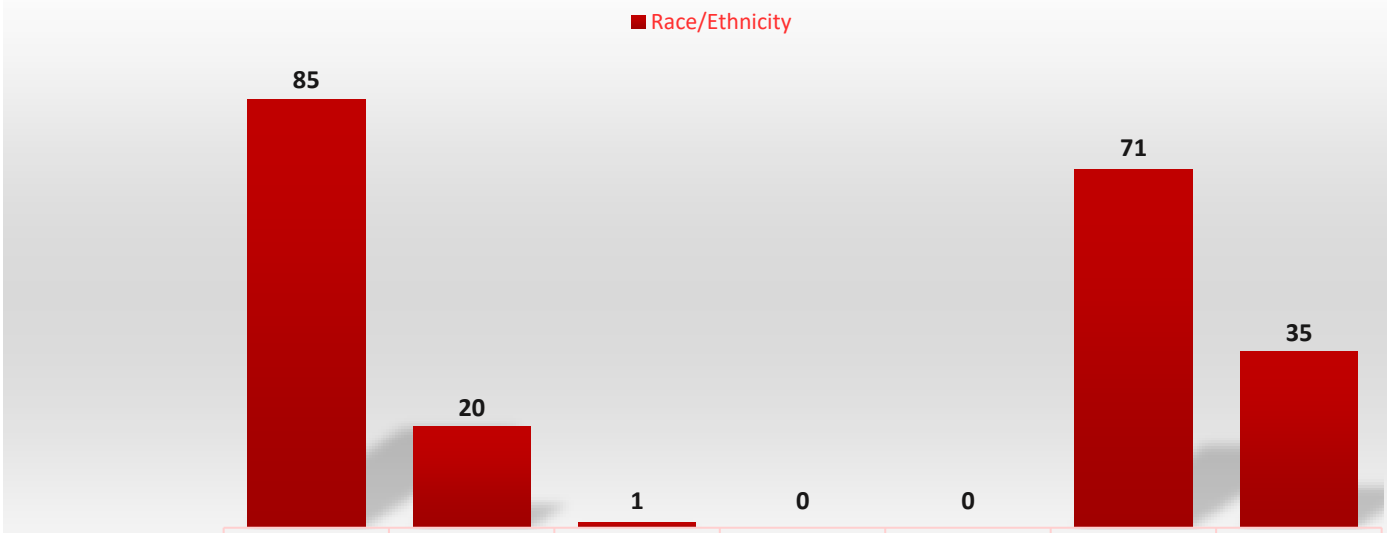
Demographics

The following series of graphs depict the story of the clients who enrolled in the study with regards to their age, gender identity, race/ethnicity, referral source, and housing status (as of June 2020 – prior to the program ending).



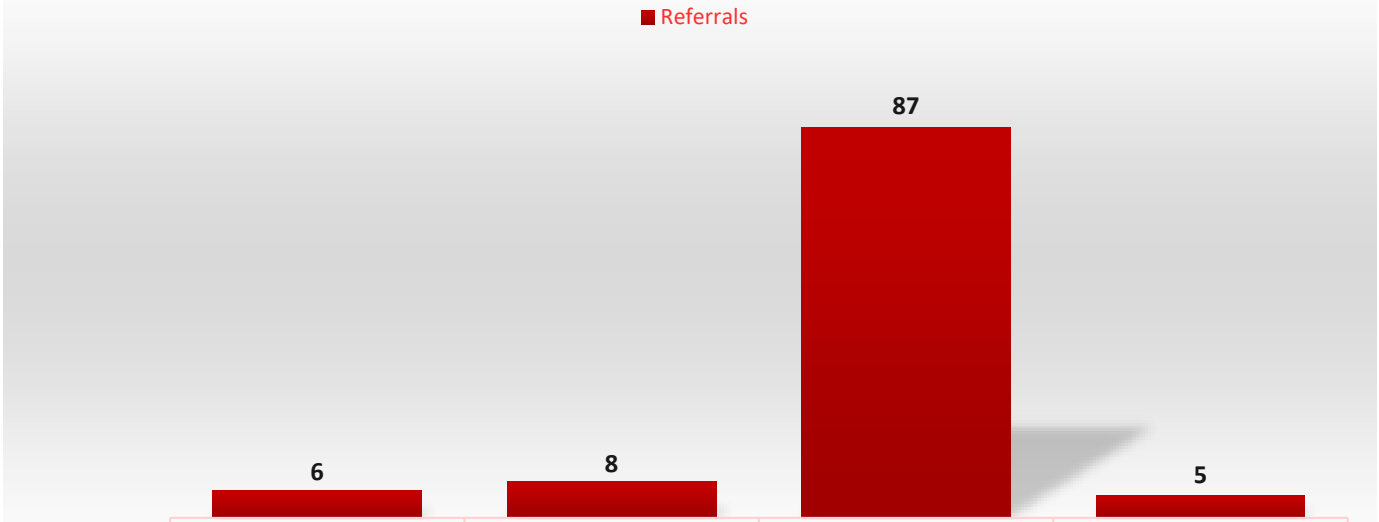


Race/Ethnicity, n = 106

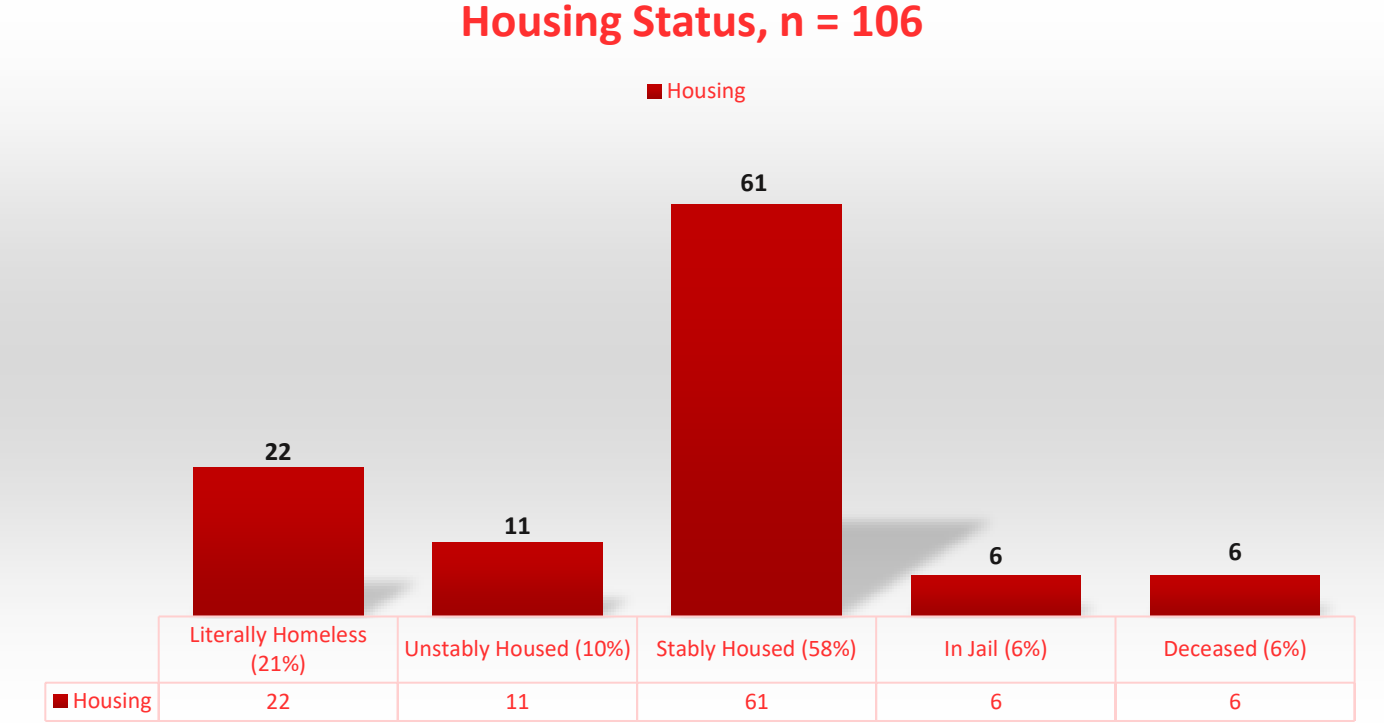


	White (80%)	Black/ African Amer (19%)	Amer Indian/ Native Amer (1 %)	Pacific Islander	Asian Amer	Hispanic (67 %)	Non-Hispanic (33 %)
Race/Ethnicity	85	20	1	0	0	71	35

Referral Source, n = 106



	Client Call In (6%)	Other Call In (8%)	Email (82%)	Data List (5%)
Referrals	6	8	87	5


Housing Status, n = 106
Housing
22
11
61
6
6
Literally Homeless (21%)
Unstably Housed (10%)
Stably Housed (58%)
In Jail (6%)
Deceased (6%)
Housing
22
11
61
6
6

Pre-Implementation Activities

Staffing the CASE program

Overview

Although the initial planning meetings brought multiple ideas on who should be hired for the program, it was ultimately decided on that it was important to have a diverse work experienced team that could address the primary goals of housing and employment. One of the initial hires was a department team member who had great experienced with different levels of benefits programs. The two other additional applicants were chosen for their specialized skills as one was a licensed realtor and the other was a legal social security employee. It was felt that these special work experiences would be beneficial to clients as it would improve the chances of engaging clients in their overarching employment and housing goals.

Recruitment and Hiring

Program Coordinator

- Job Description: Assists department leadership in the implementation, management, and oversight of community programs. Assists management in all aspects of the CASE Program including program operations, budgeting, reporting, program process measures, outcome measures, data analysis and program evaluation. Additional responsibilities include coordinating program activities between the program community stakeholders, external vendors, University Health services, and program staff.

- Minimum Qualifications: Bachelor's degree preferred, or appropriate combination of experience in health services, community outreach, with a minimum of 3 years' experience in research, project coordination and/or grant programs. Health research data experience is preferred, and knowledge of program administration, evaluation, and financial management is preferred. Effective communication skills are required.

Member Advocate

- Job Description: Serve as an advocate to assist and/or represent People with AIDS/HIV (PWA) on their behalf, in navigating housing and employment resources and providing education and support to access necessary services. To include communication via correspondence as needed. This individual may work closely with the Program Coordinator and Case Managers and supporting personnel from partnering agencies. They may also assist the member in accessing non-covered services, such as those provided in other social service or community programs. Additionally, they may be called upon to participate in other processes as needed. Ensures compliance with the Health Insurance Portability and Accountability Act (HIPAA) related policies regarding all aspects of operations within University Health.

- Minimum Qualifications: Bachelor's degree in business, health care or related field with at least two years' experience in the health care insurance and/or disability benefits is required. Minimum of five years' experience in the health care insurance and or disability benefits industry may be substituted for college education. Working with PWA experience is preferred.

Data Manager

- Job Description: The Data Manager will facilitate all activities related to the implementation of an HIV client level services system, ARIES. The Data Manager will complete all RSR reports, conduct ARIES/TxPHIN trainings, and provide technical assistance.

- Minimum Qualifications: This position will require extensive experience in training and program management with client level data systems. The FTE must have expertise in ARIES, TxPHIN and training in complex data concepts with diverse populations

Data Coordinator

- Job Description: The Data Manager will facilitate activities related to client retention including contacting clients, survey completion and data reporting.

CASE Staffing Plan

Program Director (10% FTE): The Program Director will be responsible for program guidance and management, including overseeing subcontracts, fiscal management, and ensuring program integration. The Program Director is responsible for administrative, financial, operational activities and regulatory compliance for grant-funded funded programs at BCHD.

Administrative Manager (20% FTE): The Administrative Manager will manage program operations, oversee program finances and ensure compliance with program protocols.

CASE Program Coordinator (100% FTE): The Program Coordinator will assist HRSA and the CAre, houSing and Employment (CASE) Program Director in implementing and managing the program and populations served. The Program Coordinator will identify and develop partnerships with organizations throughout the County, Region and State and provide capacity building assistance to reach medically underserved individuals through defined program activities. Additional responsibilities will include conducting consent and surveys, overseeing CASE Coordinators, CASE Program Evaluator, CASE Data Manager, and CASE Data Coordinator. The Program Coordinator will provide analysis, advice and recommendations on how to implement and improve the program.

CASE Member Advocates (3 FTEs at 100%): The CASE Member Advocates are responsible for coordinating housing, employment and care services at the local level and will report all CASE activities according to the protocol. Each CASE Member Advocate will maintain a client chart for every client receiving services under the SPNS contract. These charts will be available for review by the CASE administrative team (Program Director, Administrative Manager, CASE Program Coordinator, CASE Program Evaluator and CASE Program Data Manager) during formal site visits. Each chart will contain all pertinent documentation as it pertains to the CASE program.

CASE Data Coordinator (25% FTE): The Data Coordinator will be responsible for conducting consent and baseline, 6 month and 12 month surveys. They will travel to our collaborating agencies, or a private space that is convenient for the client to conduct the consent and surveys.

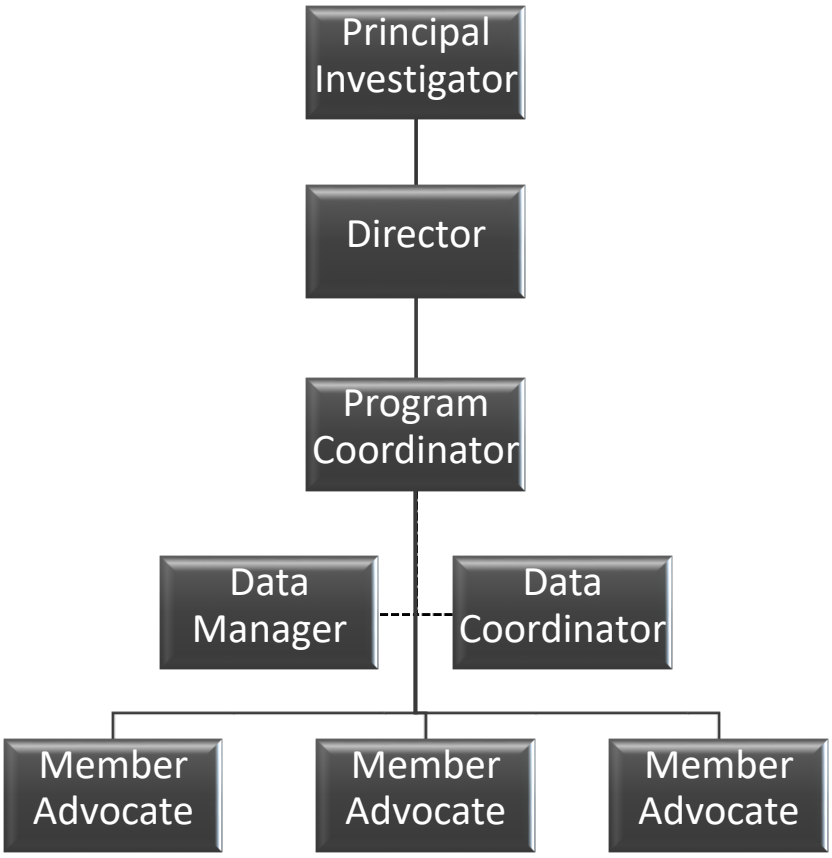
CASE Program Data Manager (25% FTE): The Data Manager will facilitate all activities related to the implementation of an HIV client level services system, ARIES. The Data Manager will complete all RSR reports, conduct ARIES/TxPHIN trainings,

complete medical chart reviews and provide technical assistance. This position requires extensive experience in training and program management with client level data systems. The remainder of FTE will be charged to Ryan White Part D Program.

CASE Program Evaluator (15% FTE): The Program Evaluator will provide technical and methodological program design consultation, statistical analysis and results interpretation/reporting for a variety of internal and external projects including the ETAP. Responsibilities include using databases for the identification of appropriate study populations, data management, analysis planning and statistical analysis of data collected from data sources, patient surveys and grant funding source reports. The Evaluator will also develop complex reports from large, relational databases and prepare policy statements and recommendations to assist BCHD to improve the quality of patient services, specifically the CASE Program.

Supervision structure

Program Supervision Structure



Management approach to team care

Self-Care among HIV Providers and Staff

Enhance self-care in a HIV service environment safety-net by focusing on:

- Burnout +
- Secondary trauma =
- *Compassion fatigue*

- Signs include:
  - Feeling numb or detached
  - Overwhelmed
  - Hopeless or helplessness
  - Sleep disturbances
  - Withdrawal from others
  - Low energy
  - Sadness

- Absence of formal self-care (Emory University study, JM Sales, August 21, 2019, in a large HIV clinic)
  - Lack of resources to manage stress
  - Opportunities to debrief
  - Formal mechanisms to voice concerns
  - Support for dealing with complex patients
  - Formal mechanisms for feedback
  - Time for self-care

Member Advocates Emotional Toll Self-Thoughts

- Feelings of shock and helplessness with the amount of barriers, trauma, and multi-level needs of the client(s)
- "Was I too late?" in locating the client or in locating the San Antonio Police Mental Health Crisis Team
- "Should I reply?", "Who do I call first to assist this crisis?"
- Thinking "How did this happen to a healthcare professional?" after moments of defeat
- "How can I help regain everything lost?" in reference to employment, housing, utilities, insurance

Create Self-Care Strategies and Practice

- Adequate sleep
- Good nutrition
- Physical Activity
- Meditation
- Positive thought patterns
- Self-compassion
- Personal support
- Setting priorities
- Team debriefs/meditations
- Coping techniques

Helpful Resources and Trainings

- Agency employee mental/behavioral health services

- Check local resources/helplines especially for crisis situations
- Trauma-informed care
- Motivational interviewing
- Suicide awareness and helplines
- Search for free mobile apps such as Insight Timer, Headspace, or Calm

Addressing Secondary Trauma, Stress, and Burnout

Weekly and end of week check-in

- Provide staff with time to share in a safe space, if needed.
    - Provide staff with a place to support each other due to intense client experiences.
- Provide staff with a period of meditation/mindfulness when needed or on a scheduled basis for such activities.
    - Provide staff with a time to take short walks away from administrative areas as a way to refresh and reset.
- Offer other wellness services for staff.
    - Access to employee wellness of care is offered through University Health.

Intervention Implementation and Service Delivery Model

Core components of the intervention

Individual level

- Program staff provided direct housing and employment services to clients through a system of processes which included completion of an intake assessment form, navigation to link to community resources, legal services, and collaboration with medical and non-medical case management from partner agencies.
- Member Advocates share client success stories and best practices in dealing with various challenges and barriers. Sharing these experiences with other members of the team can benefit the team by identifying the needs of the clients. Below are a few examples of the challenges and successes our member advocates faced with clients.

Client A:

Background

A cis gender male in his 30's originally from South America came to the US on a provisional 2-year visa. After the relationship he was in became abusive, client spent jail time over a domestic violence charge. The incident placed his US visa in jeopardy. He was in disbelief how his life seemed to turn upside down after losing his marriage, his housing and the only person he knew in the states. Client was now homeless and sleeping out of his car.

Needs Request

- Housing: Living in his car was not safe or conducive to living a heathy life
- Immigration law legal aid: to manage current visa and keep legal status
- Resume building: to promote work opportunities and secure employment
- Employment: Needed to earn an income that would allow him to get back on his feet

Goals/Plans

- Address homelessness by referring client to Carson House which is a transitional short-term housing facility owned and operated by the San Antonio AIDS Foundation.
- Connect client to Goodwill Career Services' resume writing workshop
- Refer client to RAICES Texas legal aid specializing in immigration law
- Refer client to Career Gear of San Antonio for professional clothing for interviews
- Locate Oficina Latina to assist with translation of transcript
- Create character letter for US Permanent Resident Application

Challenges/Barriers

- Cost of translating Spanish transcripts to English
- Cost of visa renewal and US permanent residency application

- Location employment with a provisional visa
- Obtaining HOPWA assistance

Best Practices

- Locate organizations doing immigration legal aid and pro bono work in the area
- Seek education on immigration naturalization process for staff to build confidence in navigation services
- Empower clients to capitalize on their education and transition careers if needed
- Promote positive thoughts in order to get positive outcomes
- Believe in your client, even if they seem far from their end goals

Client B

Background

Client is a 28 year old married white male struggling with substance use disorder and was staying with friends until he was asked to leave. Client and husband were accepted to live in a transitional housing but were struggling to follow the house rules.

Needs Request

- Obtain full time employment with medical benefits
- Obtain form of stable transportation
- Leave transitional housing and find own apartment/house as a couple
- Complete substance use disorder program

Goals/Plans

- Stay at the transitional housing (Carson House) since it was a sober living house
- Obtain full-time employment by applying at nearby call center downtown
- Sustain self- sufficiency
- Keep up with all medical appointments

Challenges/Barriers

- Apartment income limit requirements
- Inability to share the same room with husband
- Client became impatient with time-frame to obtaining stable housing
- Client was surrounded by peers who either had bad intentions or were a bad influence on him

Best Practices

- Address the barriers upfront with resolutions
- Encourage client to be patient
- Highlight the importance of maintaining sobriety and thinking positive
- See the big picture when goals are reachable
- Build and keep good client relationship

System level

- To better serve the clients, it was important to understand the service capabilities of our community organizations. It was quickly realized that many different types of services were needed for the clients as there was not a “one size fits all” approach to take when developing organizational partnerships. Each client had their own set of complex needs, and it was important to create partnerships with organizations that would be able to address each of those needs. The team made sure to know the specific details for each agency whether that be those in the city, county, state, non-profit or private sector. Researching these specific details prepared the team for the unexpected or unknown needs of clients and allowed program staff to better address those needs in a timely manner. When new services or agencies were found, the team made it a point to provide updated briefs with each other through weekly meetings or immediately via email. This was an important in building relationships with both the client and the agencies who were providing those services for the clients.
- Organizational partnerships were created with local community agencies including, but not limited to, Bexar Necessities, SAMMinistries, Haven for Hope, and Goodwill Industries. Partnerships are maintained by implementing organizational staff meetings with the program team and principal investigator as well as monthly Advisory Board meetings. Below is a list of housing, employment, and miscellaneous agencies we utilized as well as information on each and eligibility/intake requirements for clients.

Housing Resources		
Agency	Agency Information	Eligibility/Intake Requirements
Haven for Hope 1 Haven for Hope Way San Antonio, Texas 78207 210-220-2100 www.havenforhope.org	• Rapid re-housing • Residential intake • Courtyard intake	• Clients informed to completed intake at main office. • Priority given to clients with small children for residential intake. • Courtyard is open and more accessible if a client is less committed at the time.
SAAF Carson House 627 E. Carson San Antonio, Texas 78208 210-637-9028 www.sanantonioaids.org	• Room share – affordable housing • Residents expected to pay 30% of their income as rent	• Clients must be committed to sober living. • Drug test and tuberculosis tests conducted. • Client works with medical case manager and housing case manager to complete on-boarding process.
The Salvation Army Emergency Family Shelter 515 W. Elmira St. San Antonio, Texas 78212 www.salvationarmysanantonio.org	• Immediate, short-term housing for women and families experiencing homelessness.	• Rooms come available on a first-come, first-served basis.
The Salvation Army Dave Coy Shelter for Men 226 Nolan St. San Antonio, Texas 78202 210-226-2291 www.salvationarmysanantonio.org	• Emergency shelter and transitional housing • Up to 131 men experiencing chronic homelessness and/or lack a stable housing environment.	• 3:00 PM intake • First three nights are free, stays after three rights are $11/day. • Client receives three meals and clean clothes • Guests are required to participate in small groups and prayer.
SAMMinistries Homeless prevention: 210-377-1616 Main office: 210-340-0302 www.samm.org	• Homeless prevention services • Transitional housing • Rapid re-housing • Veterans' housing stability program • Permanent supportive housing	• Eligibility varies per program
Alpha Home 419 E. Magnolia Ave. San Antonio, Texas 78212 210-735-3822 www.alphahome.org	• Residential substance use disorder treatment facility • Helps women, ages 18 and older acquire safe coping skills to lead a life of recovery.	• Assessments can be scheduled through phone or email
My Mariposa Home at Providence Place 6487 Whitby Rd. San Antonio, Texas 78240 (844)-546-8697 www.provplace.org	• Assists women who are survivors of human trafficking, domestic violence, or sexual assault • Transitional housing • Trauma-informed supportive services	• Women at least 18 years of age • Permanent resident or U-Visa status • Not under imminent threat from others • Not an imminent threat to herself or others • Has maintained sobriety for 30 days
Alamo Community Group 4606 Centerview Dr., Suite 170 San Antonio, Texas 78228	• Local housing organization	• Deputy Director provides member advocates with weekly listings of affordable apartments with current availability.

210-731-8030 www.alamocommunitygroup.org		

Employment Resources		
Agency	Agency Information	Eligibility/Intake Requirements
Workforce Solutions Alamo 100 N Santa Rosa St. San Antonio, Texas 78207 210-224-4357 www.workforcesolutionsalamo.org www.twc.texas.gov	• Mini career fairs at locations throughout the city • Unemployment benefits assistance	• Phone or online applications
Goodwill Industries San Antonio 406 W. Commerce St. San Antonio, Texas 78207 210-924-8581 www.goodwillsa.org	• Resume workshops • Career fairs • Second chance employers • Entry level job opportunities	• Eligibility screener provides member advocates with current job openings for clients.
ABM Industries 121 Interpark Blvd. Ste. 1001 San Antonio, Texas 78216 210-733-6015 www.abm.com	• Local facilities management services provider.	• Recruiter provides member advocates with upcoming hiring events and onsite hiring opportunities for clients.

Other Resources		
Agency	Agency Information	Eligibility/Intake Requirements
San Antonio Food Bank 5200 Enrique Barrera Pkwy. San Antonio, Texas 78227 210-431-8300 www.safoodbank.org	• Provides community with various food services • Offers assistance with federal benefit applications and renewal • Job assistance • Senior programs • Nutrition health and wellness	
San Antonio Community Resource Directory (SACRD) www.sacrd.org	• Online directory of community resources for care, education, food, goods, health, housing, legal, partner, transit, and work.	

Christian Assistance Ministry
Downtown office: 110 McCullough Ave.
San Antonio, Texas 78215
210-223-4099
www.christianassistanceministry.org
	• Provides financial assistance for utilities, prescriptions, ID recovery, and other miscellaneous emergencies	• All are welcome, no appointments necessary, and no demographic restrictions.
		• For financial assistance:
		  ○ Photo ID required
		  ○ Social security card for all members in household is required
		  ○ Other documents required (utility bill or lease agreement, SSI award letter, food stamp notification letter)

H.O.P.E Team (SAPD) 617 S. Santa Rosa Ave. San Antonio, Texas 78204 210-901-9982	• Restore lost or stolen ID through San Antonio Police (SAPD) • Outreach to people who are homeless • Food, transportation, and other assistance provided.	• Cost depends on the need. • Document recovery fees may apply
United Way of San Antonio and Bexar County 700 S. Alamo St. San Antonio, Texas 78205 210-352-7000 or 2-1-1 www.unitedwaysatx.org	• Emergency food, shelter, and/or clothing • Crisis call center • Disaster response • Emergency utility assistance • 2-1-1 social service hotline connects people to local resources	
Bexar Necessities (Prior approval and training required before access is allow)	• Electronic bulletin board through United Way which features various community agencies posting their need for assistance or their community resources	

Advisory Board

- An Advisory Board was developed to provide updates on the progress of the program, share ideas of community resources that could aid the Member Advocates in securing housing or employment for the clients, and share updates and information from the respective partner agencies. Advisory Board members were recruited through meeting with specific partner agencies at the start of the program. During said meetings, program staff would essentially ask the agencies if they would be interested in joining the Advisory Board in the near future which did result in recruitment of some members.
- Members of the Advisory Board included a housing case manager, AIDS clinic manager, Director of Client Services, and the Community Development Initiatives Director from San Antonio Housing Authority. People with HIV community members were also included and were an integral part in serving clients, a medical case manager, an HIV prevention coordinator, a disability specialist and a community partnership manager from Alamo Workforce Solutions. Finally, from The Ryan White HIV/AIDS Program, a licensed clinical social work manager and a career services manager from Goodwill Industries was included. Having these key advisory board members provided a wealth of knowledge and experience from various professions and allowed to better serve clients based off their input and suggestions. At the beginning of the program, the Advisory Board was only scheduled to meet on a quarterly basis. However, upon realization that a quarterly meeting was not enough, the Advisory Board recommended monthly meetings which continued on for the duration of the three year program.

Staff activities

The Program Coordinator planned and scheduled the following meetings for program staff:

- Weekly meetings with Member Advocates or as needed
- Monthly meetings with Vice President, Principal Investigator, Director, and SPNS team
- Quarterly/monthly meetings with partner agencies for updates and to share successful program strategies
    - Meeting details included how often staff met with clients, duration of intervention, notice of community outreach workgroups, research of potential housing and employment opportunities
- Meetings with supporting or resource agencies as needed

Tangible reinforcements

- Tangible reinforcements were implemented as part of our program in the form of small personal hygiene and food items. These small items of support appear to be minimal but have great impact on the client. Often times, it's the little things that have the largest impact, and that was true for these kits. As appointments were scheduled with clients, these kits were distributed to each client when they met with the team. Clients were appreciative of these items and the team believe that the kits helped foster relationships and allowed clients to stay the course of reaching their housing/employment goals.

Program staff provided clients with Homeless Assistance Kits which included miscellaneous personal items ranging from personal hygiene items to snacks, water, and clothing.

Documentation

Dashboard

- As a program team, a dashboard was created on an office dry erase board to give each other the opportunity to meet and discuss key components of the program. From this dry erase board, a live, virtual dashboard was created that carried the stories of what was happening in real-time with clients. This space allowed the team to have both impromptu and scheduled meetings that sparked discussion around self-care, reflection, healing, meditation, and other ways to strengthen ourselves for our work. This dashboard became a "war board" as the teamwould refer to it and the reality was that it was a war of daily survival for clients to just simply live. This board and what it encompassed was important for the team as it was acknowledged that these numbers were not only numbers, but rather the reality of serving others.
- The following picture depicts our dashboard which was used to document all enrolled and completed clients including information regarding demographics, employment status, and housing status.

A. Study & Services	Study	Services	Total	BCHD – UHS: SPNS PROGRAM	Study	Service	Total		Study	Service	Total
				B. Completed				D. Accumulative Client Completed			
Enrolled				Enrolled				Enrolled			
Race/Gender				Income/Employment				Housing			
				Unemployment Benefits				Literally homeless			
Transgender				SSDI/SSI/RSDI				Family/Friends			
Hispanic				SSDI/SSI Pend				Stably Housed:			
White				Unemployed				HOPWA			
Black				Employed				Rental			
				Full-time				Homeowner			
Male				Part-time				E. Transitional Housing			
Hispanic				SSDI/SSI & Part-time				Carson			
White				College Students				Oxford			
Black				C. No Contact				Hotel			
				Incarcerated				Rehab			
Female				Deported							
Hispanic				Moved				Incarcerated			
White				Out of State				F. Acuity Status	High	Med	Low
Black				Out of City				Study			
								Services Only			
Deceased				Discharged/ Transferred to standard of care				Totals			
				TOTAL NO MORE FOLLOW UPS							

Revised Date:

Table Key:
A. Study and services: Study client is one that consented to the study and data was collected. A service only client had no consent and no data collected. Both study and service only clients received services for housing and employment.

B. Completed: Current active clients that were housed and employed.

C. No contact: Any client with no active communications.

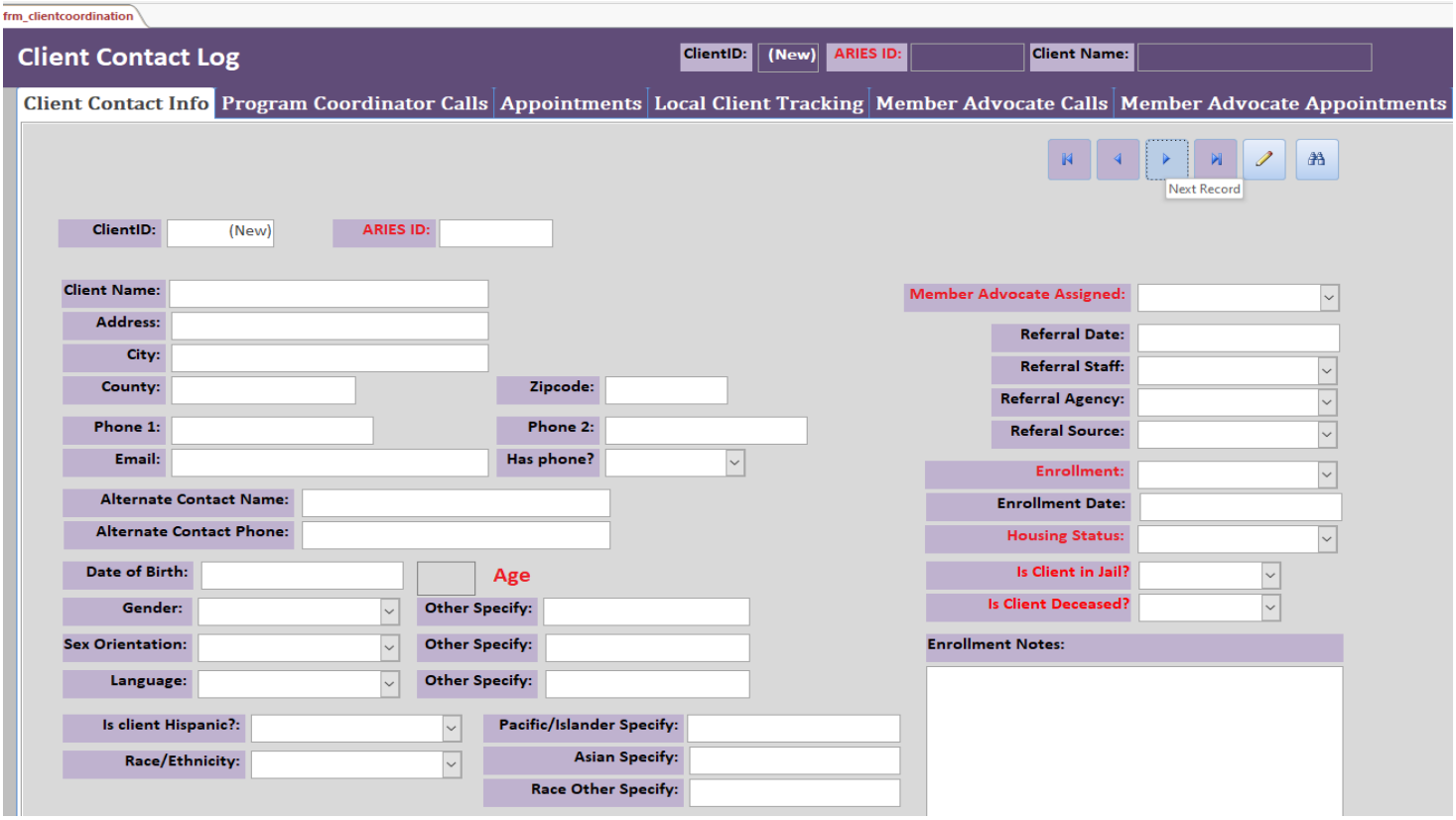
D. Accumulative client completed: Indicates clients completed the goal of housed and employed more than once.

E. Transitional housing: Temporary housing for certain homeless clients.

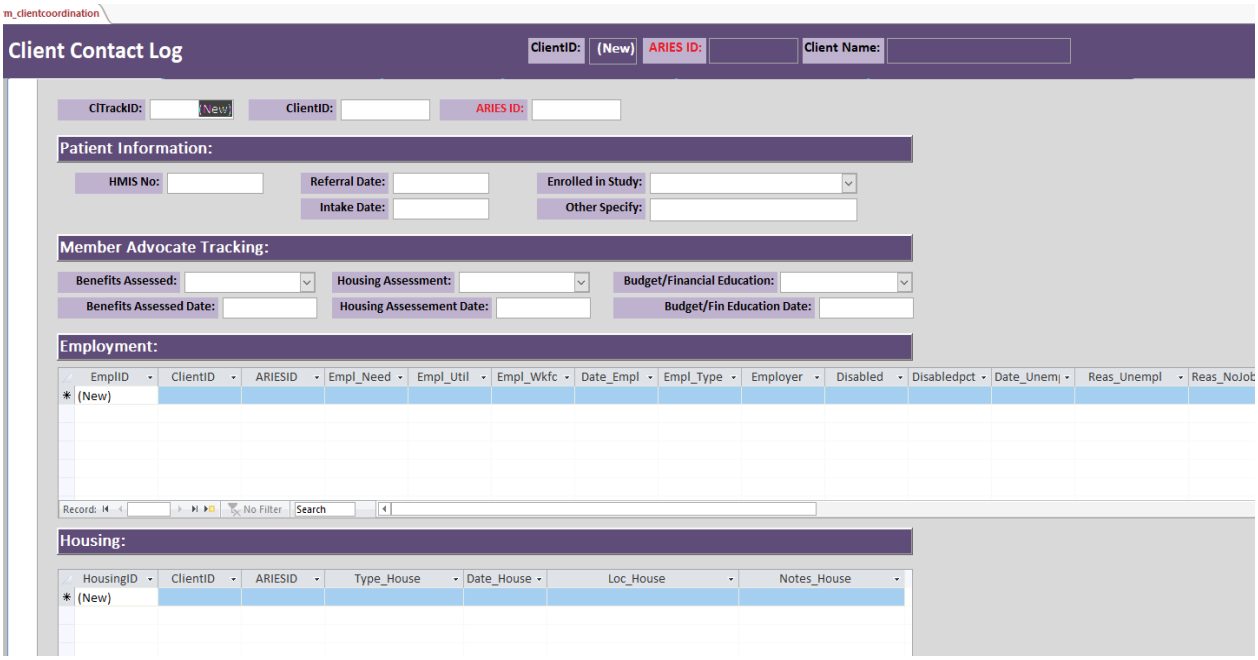
F. Acuity status: Measurement system of three levels: high, medium, and low. All are assigned according to the client's needs and these statuses can change at any point.

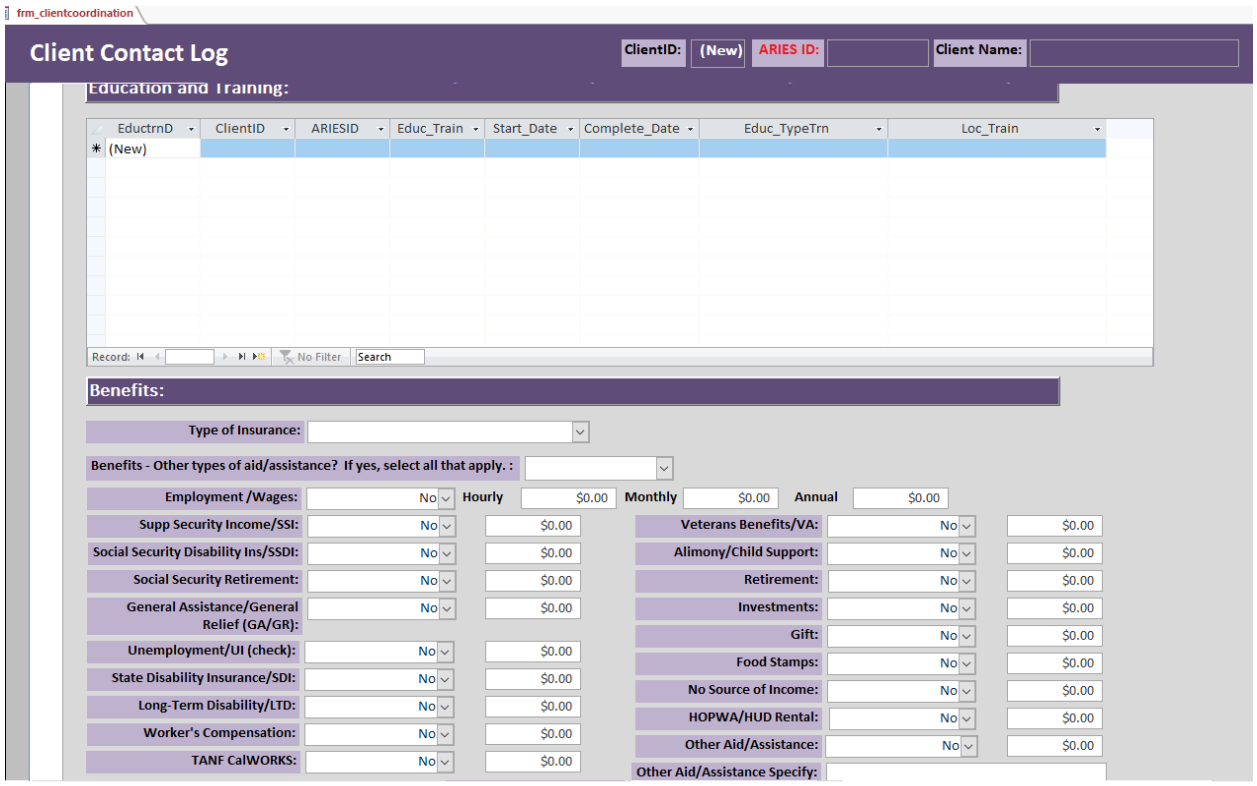
Local Tracking Database

- Case notes are maintained in a local tracking system, (Microsoft Access Database) along with the encounter form within REDCap. The Member Advocates, Program Coordinator & Data Coordinator entered client demographics, client enrollment information, client communications, appointments, and bus pass distribution.

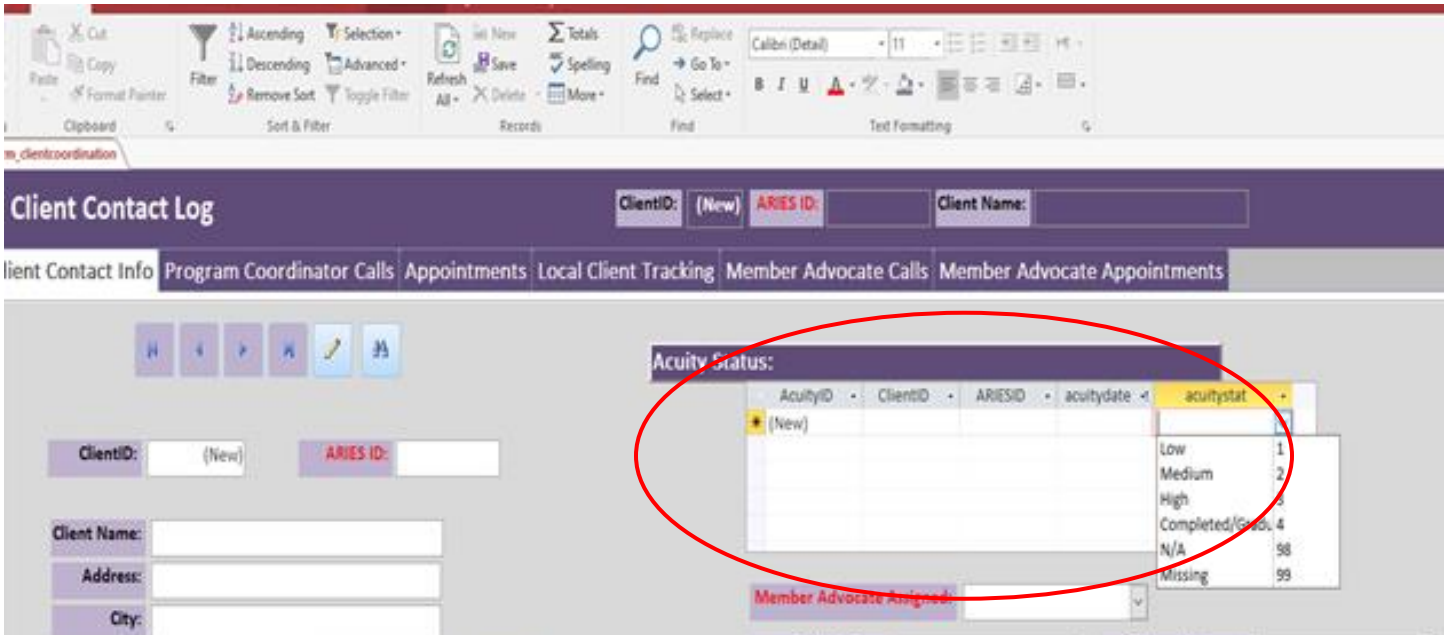


- The Member Advocates track client employment and housing statuses using the local tracking system. Member Advocates can also enter information regarding education/job training and any benefits the client may be receiving.



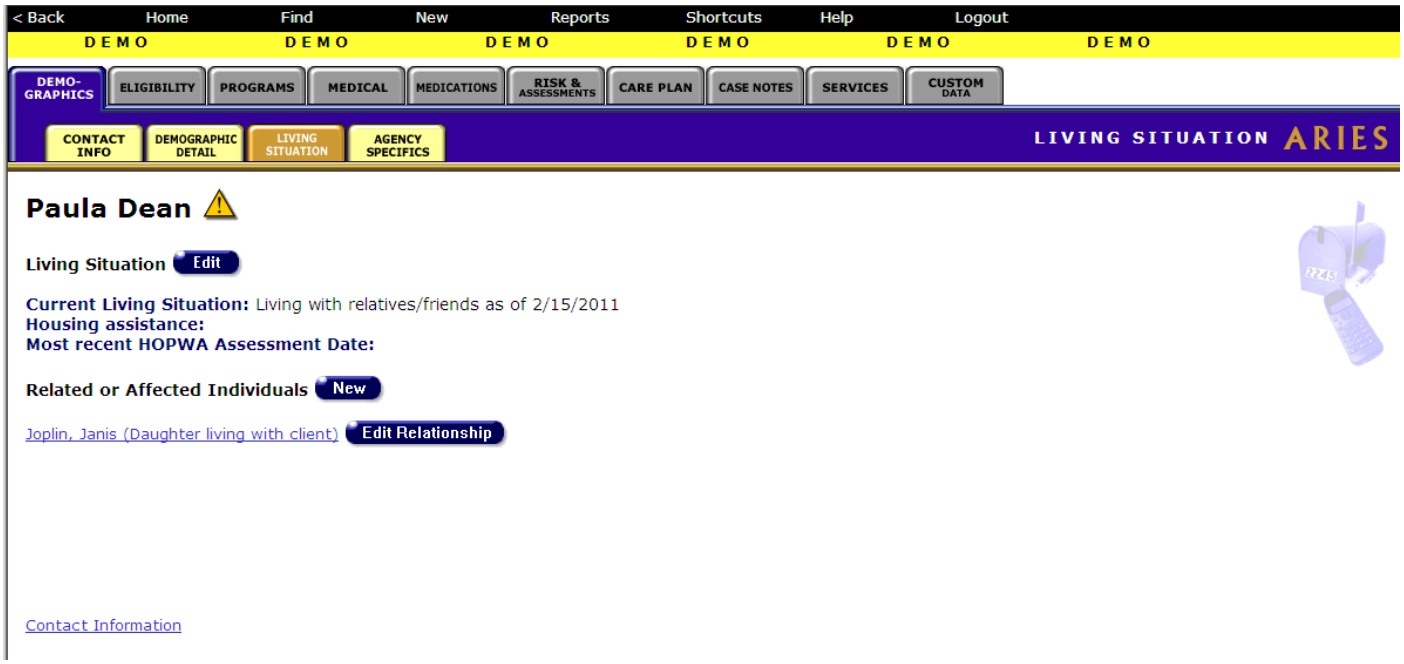


- In an effort to better assess client needs, the Member Advocate updates client case statuses in the local tracking database under the "Acuity Status". These acuity tools were incorporated into the local tracking database to capture client status changes using a "***High***, ***Medium*** & ***Low***" acuity scale. Implementing this tool allows the Member Advocate to indicate and track a client's immediate need allowing for a faster assessment during client encounters.

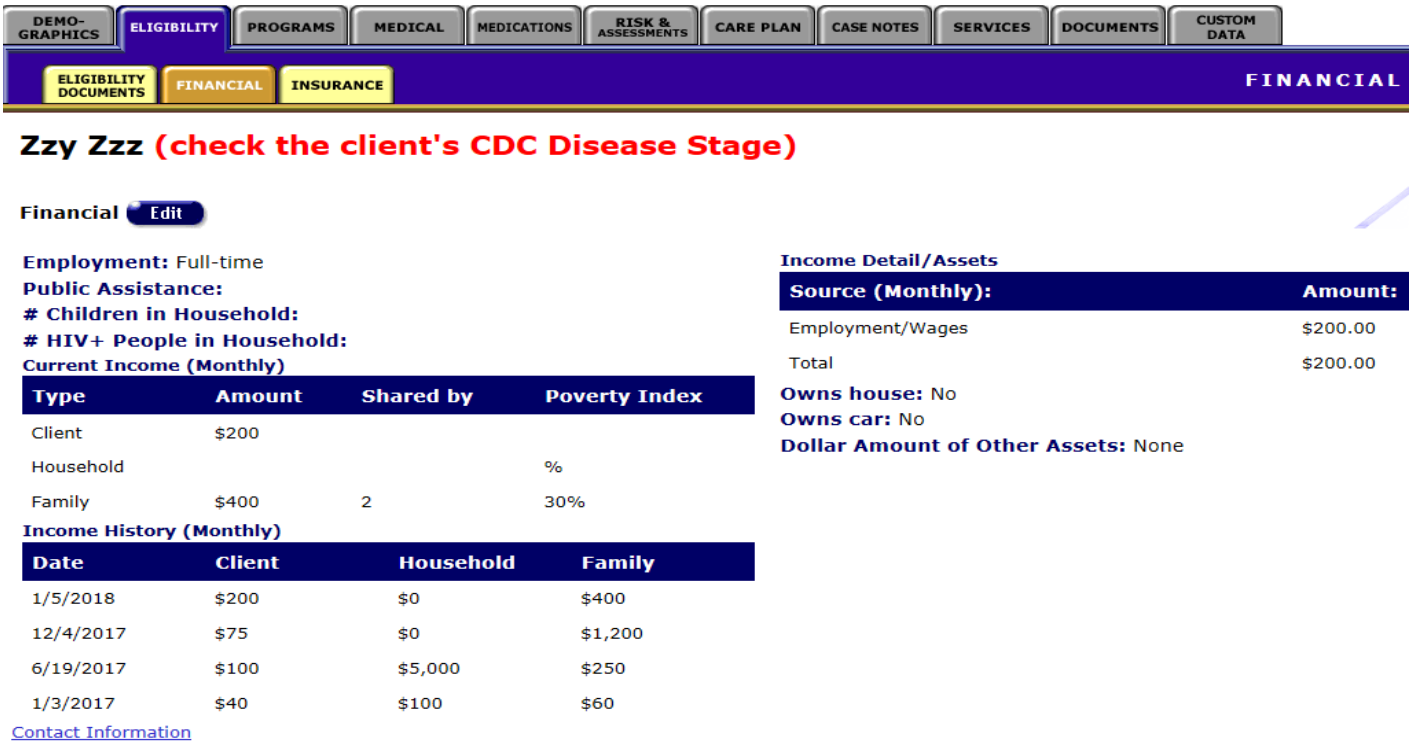


ARIES

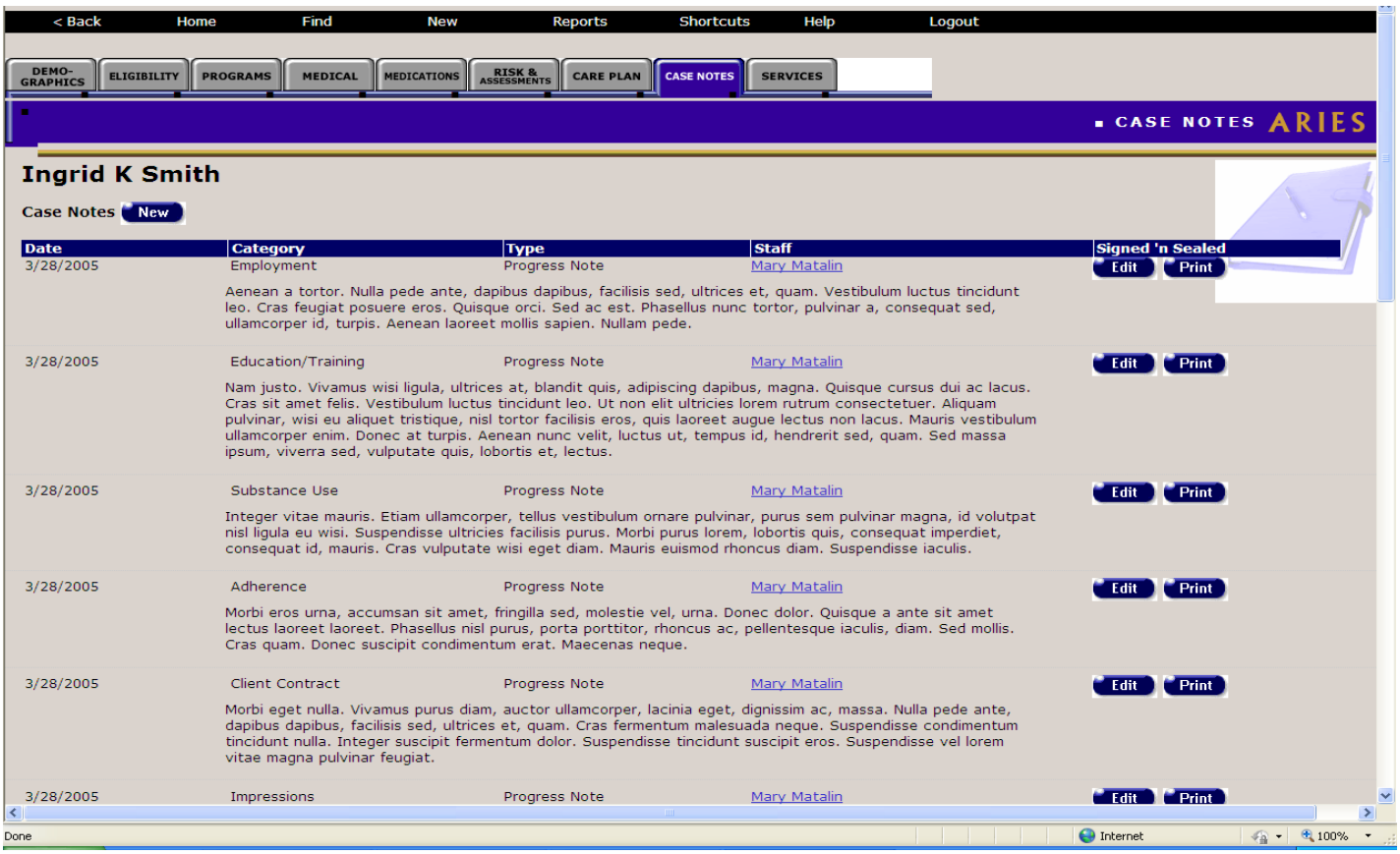
- As a team, we became super-users of the Texas Department of State Health Services, AIDS Regional Information and Evaluation System (ARIES) to help enhance the services for clients with HIV by helping providers automate, plan, manage, and report on client data.
- Members Advocates complete an annual ARIES certification course to be able to input client interaction notes, which allows Ryan White HIV/AIDS Program (RWHAP) Part A partners the ability to see their client's notes.



- The ARIES system provides Member Advocates with financial, employment, and housing histories for each client. The information provided is beneficial to the Member Advocate in assisting the client with finding employment and housing.



- Client case notes are a valuable tool that provide information about a client and the services they have received. This information can then be shared within agencies and in some case between agencies. Case notes are used to track a client's progress in care and give an overview to agencies on the client's background if they have been referred by another agency. By default, "**Legal**", "**Substance Abuse**" and "**Mental Health**" notes are not shared between agencies.



Client Alert

- The program staff began using the client alert option in ARIES to contact clients that have been difficult to locate. When an alert is entered, a yellow icon (⚠) appears next to the client's name in the "Client Details" section. Clicking on this icon will open an alert box containing the alert message. This allows agency staff and Case Managers to inform clients that the CASE program is attempting to reach them.

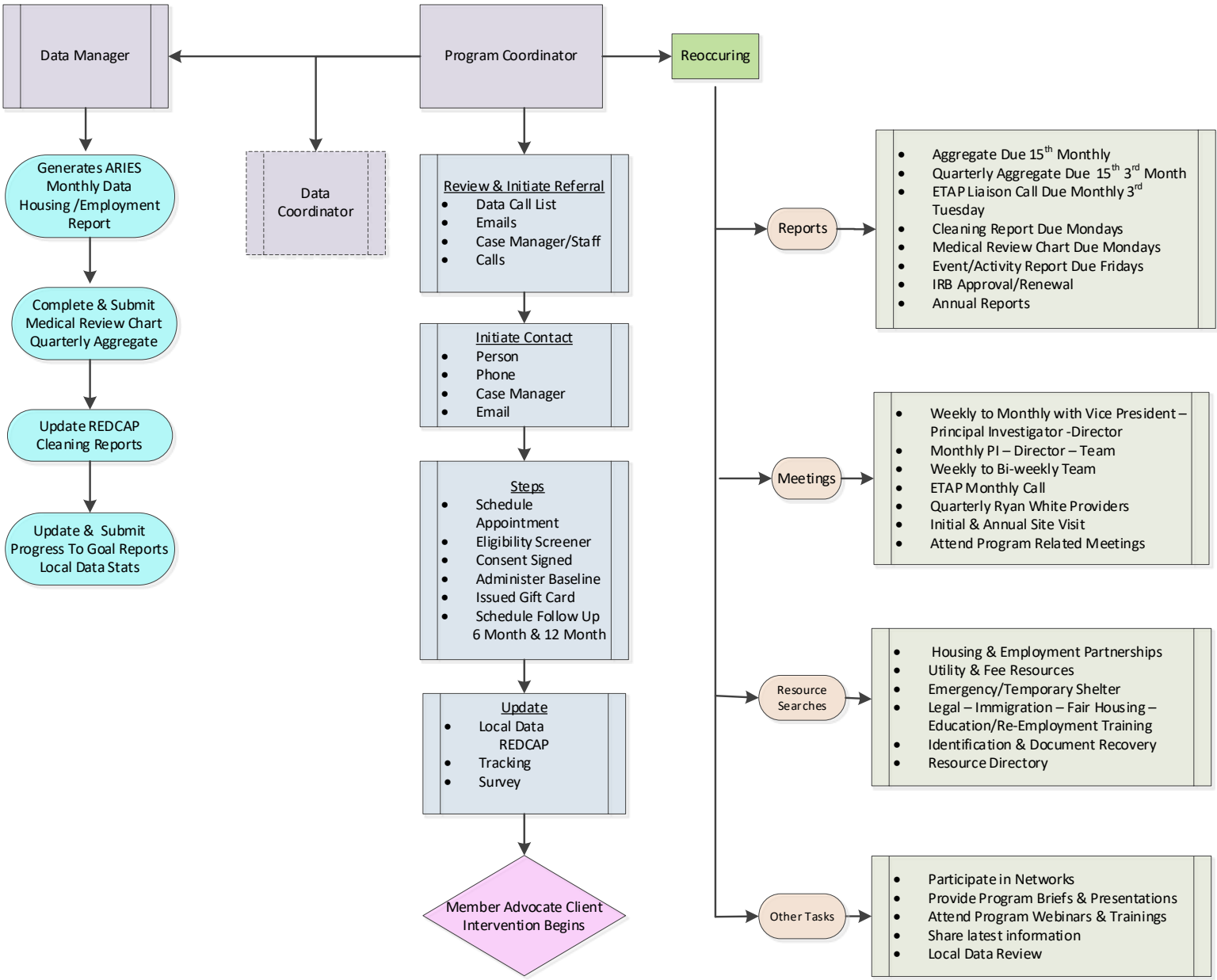
File management

- File management is maintained within the office files with a locking mechanism. The office door is only accessible by employees that have been granted access. Each client has their own file which includes the consent and receipts for local grocery store gift cards and bus transportation.

Intervention strategies

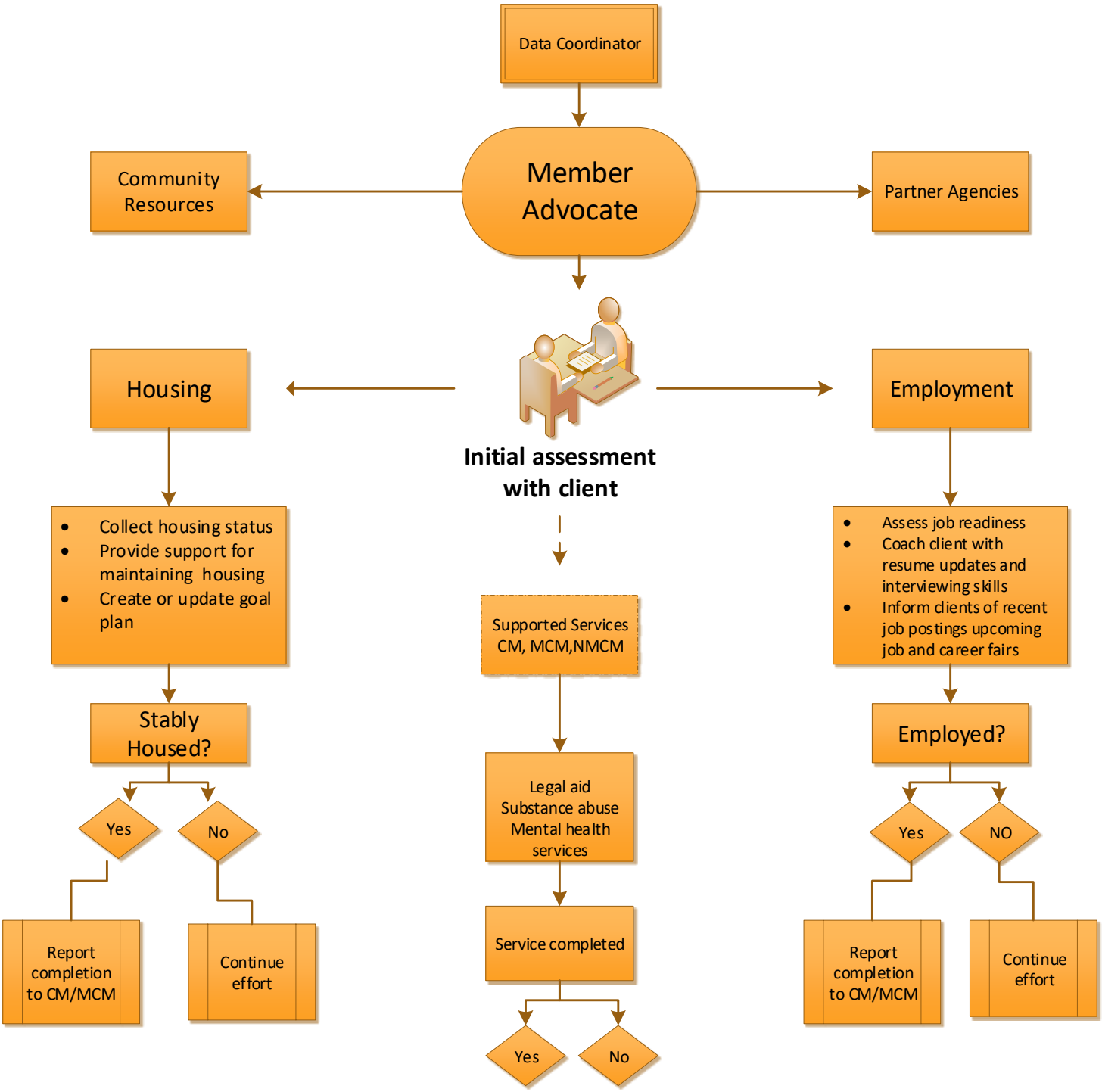
Program Coordinator Operations

The Program Coordinator is responsible for receiving new client referrals and determining client eligibility. This flowchart shows a multi-level program involvement from interactions and coordination efforts with from senior management to the client level. These operation tasks may remain constant or may be updated with additional duties or changes throughout the program period.



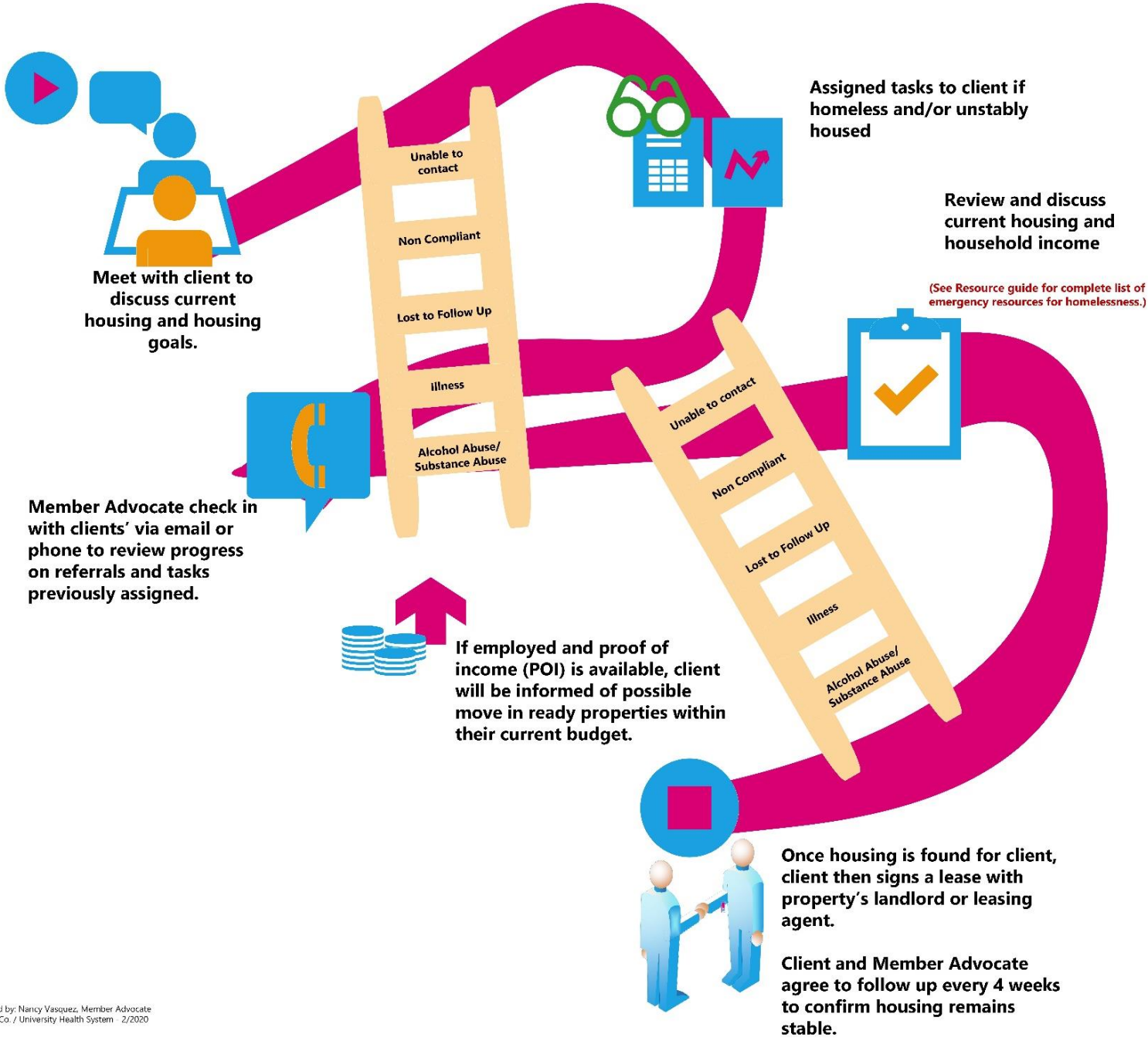
Member Advocates

After client eligibility is determined by the program coordinator, the Member Advocates are responsible for assisting the client with any housing and/or employment needs. The flowchart below details the processes the member advocates take from assessing to completing clients' goals.



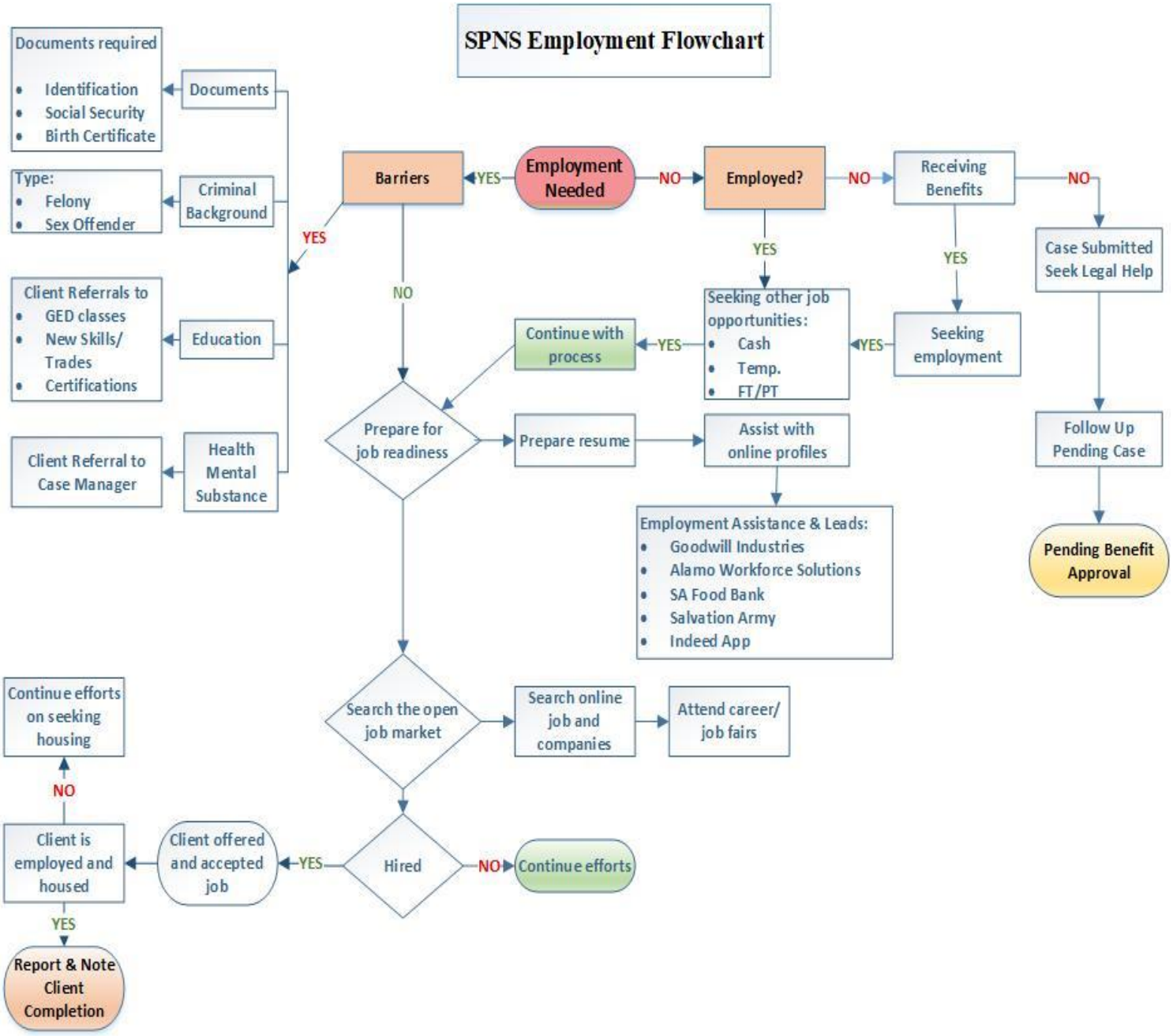
Housing Processes

The flowchart below depicts the strategies that member advocates utilize when assessing a client's housing needs.



Employment Processes

The flowchart below depicts the strategies that Member Advocates utilize when assessing a client's employment needs.



Client Follow-Up

The Data Coordinator and Program Coordinator contact clients due for their 6 month and 12 month follow-up surveys via telephone and/or email. If the contact attempt is successful, the interview is scheduled. Clients tend to schedule interviews at times when they will be in the area or on the same days as appointments with their agency case manager. The option to complete surveys over the phone is available to those clients who express schedule conflicts or lack of transportation.

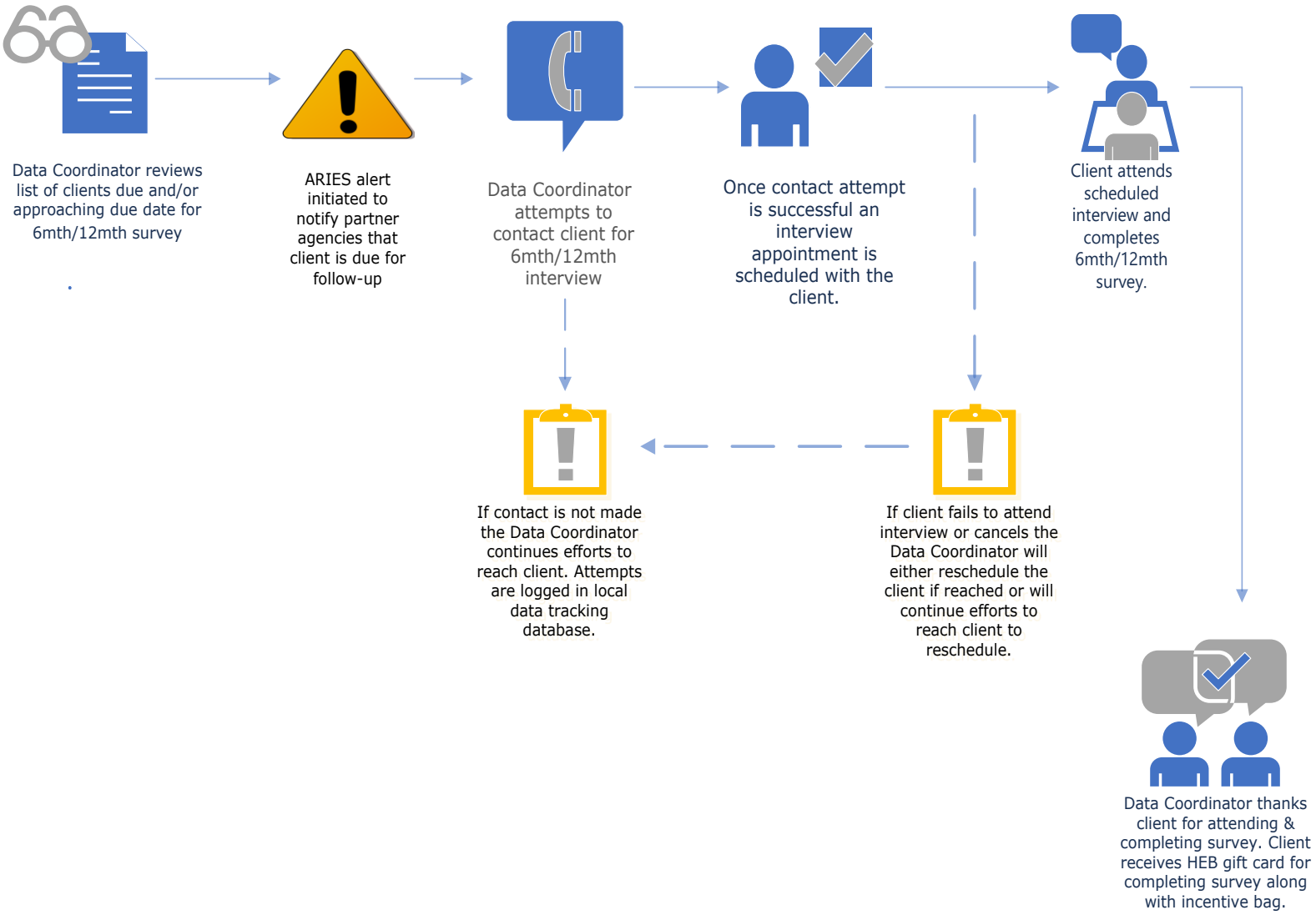
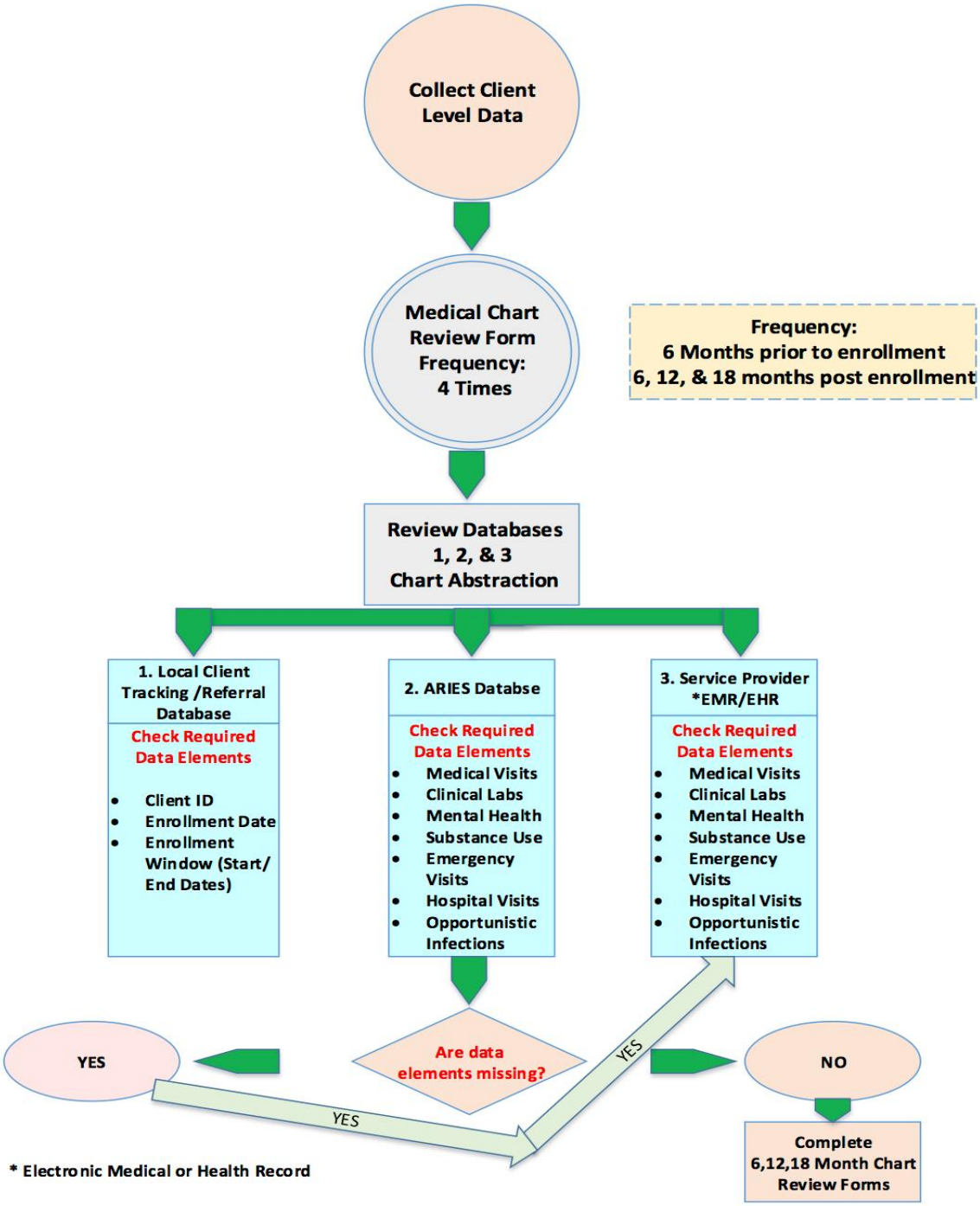


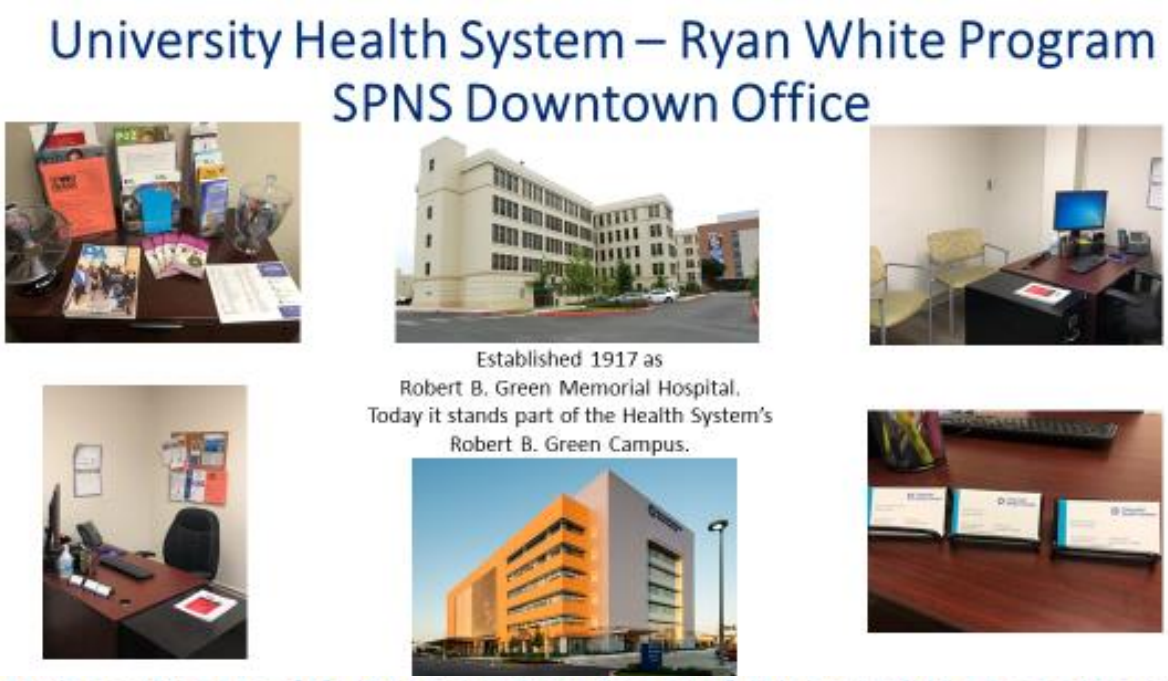
Chart Review

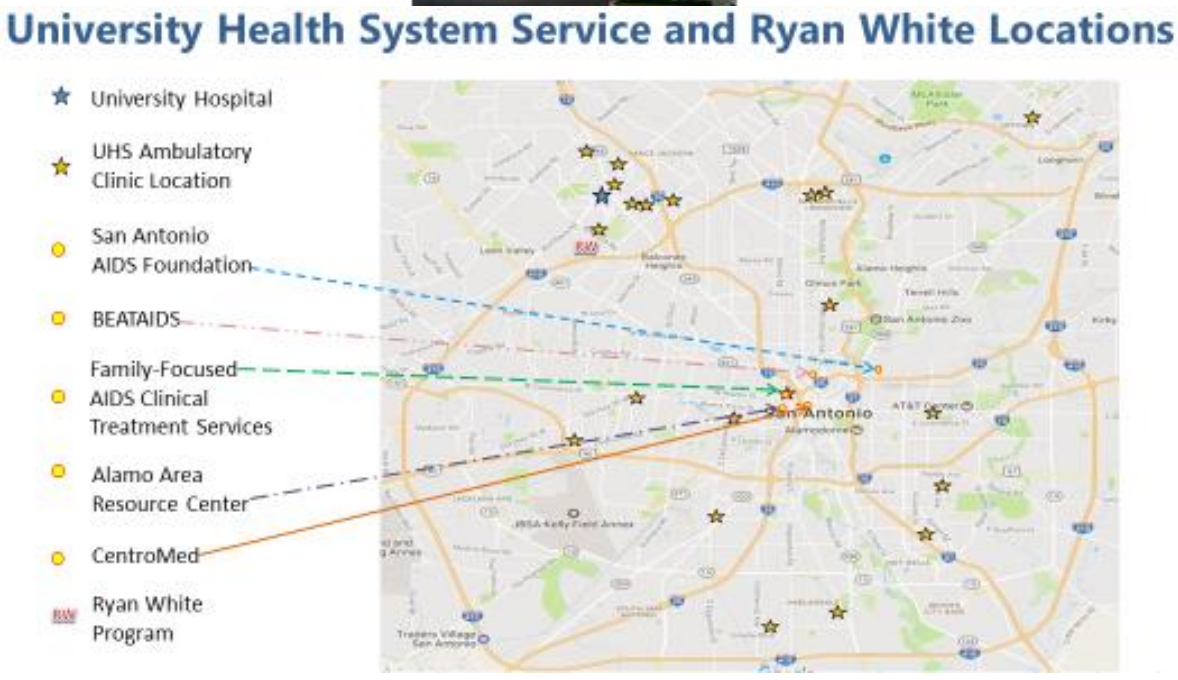
The Data Manager performs client chart review at 6 months prior to enrollment and 6 months post-enrollment as well as at 12 months and 18 months post-enrollment. The Data Manager extracts client health outcomes from the local tracking database, the ARIES database, and service provider electronic medical health records. They will also contact partnering agencies via email for missing or out of date medical information needed to complete chart review.



Intervention model output

Clients meet with program staff at a centrally located office in the heart of downtown San Antonio, conveniently located near partner agencies.





Local Evaluation Plan

Challenges and lessons learned

- While it may sound simple that clients are ready to work and ready to be housed, there were many challenges or delays to our clients' success. The assumption that every client referral was 100% ready to work and find housing was not always true. Communication was key throughout the whole process, and the team would attempt all possible ways to communicate with the clients. Many of the clients do not possess a personal cell phone or have limited talk and text capabilities. This was addressed by communicating with clients via email or with assistance from partner agencies who then relayed information to clients. The team found that clients who do have email often times access it from public transportation hotspots or libraries where internet access is free. Although this method of communication was more successful, it was a slower form of communication as Member Advocates usually had to wait for clients to check their email, which could take several hours or days. In some instances, Member Advocates would refer a client back to their Case Managers to address client's mental health needs before completing the program. The team would often visit key places where clients were known to go for appointments or meals in attempts to reach them if they were not responding to calls or emails.
- Throughout the duration of this program, the team was able to identify various housing and employment challenges that were faced with the clients as well as resolutions to those challenges. Regarding housing challenges, it was found that background checks were often an issue for clients needing to apply for housing. Some specifically had trouble with accessing housing due to their background checks. One resolution to address this challenge was to identify landlords who offered "2nd chance" housing and would work with our clients to obtain an apartment without a large deposit or strict background check. The gentrification of neighborhoods which led to a lack of affordable housing was also a challenge that many clients of ours faced. It was often difficult for clients to secure a rental property when the cost of living was beyond their means. The team often utilized the TGA's housing network to secure affordable housing for clients and referred clients to employment opportunities to help support housing costs and other expenditures such as utilities, food, and phone bills. Finding agencies that offered assistance with application fees and extra costs also proved to be helpful for clients as some lacked the resources to afford those upfront costs. There were also local agencies that assisted clients with startup necessities such as furniture, food, cleaning products, kitchen items, and bath items.
- Regarding employment challenges, one of the most significant barriers faced was that clients were simply unwilling to work or find work. However, those who were willing to work faced a wide array of challenges. The team found that background checks were a major barrier for some of our clients. The team utilized "2nd chance" employers for clients who needed this extra assistance in finding a job. Recovering personal documents such as a driver's license or social security card to obtain employment was a challenge for our homeless or unstably housed population. However, the team was able to identify community organizations that would issue replacement documents at little to no cost. Some clients also struggled with having reliable transportation to go to and from work, and most relied on public transportation such as the city bus, but often times, did not have enough funds to cover a daily bus pass. The team was able to provide bus passes for clients and also find local agencies that would issue out bus passes when needed. Member Advocates also assisted clients in finding proper work clothes/gear and a place to shower for work. Lastly, it was a challenge finding employment for clients beyond the minimum wage of $7.25 in Texas. The team utilized client's past experiences and past employment to help them find jobs starting around $15 per hour in order to avoid having more than one job and achieve a self-sustaining income.

Sustainability of the program

Throughout the program's implementation there were multiple lessons learned and best practices identified and it was important to continue serving PWH Housing needs. This has been exacerbated by the pandemic and individuals losing their jobs, unable to find work and left without a source of income. The tax credits offered by the government were not enough to survive off and housing and employment needs increased. This prompted University Health staff to identify ways to continue this program. Leading up to the end of the CASE program, Ending the HIV Epidemic: A Plan for America was announced and it was the intention of University Health to apply for funding. Ending the HIV Epidemic is a ten-year program, beginning in March 2020 and ending in 2030. The focus of this initiative is to end the HIV Epidemic by four (4) pillars: 1) Diagnose individuals living with HIV as early as possible; 2) Treat individuals who are newly diagnosed and engage those who are out of care; 3) Prevent new infections through PrEP and Syringe Services Programs; and 4) Respond to any clusters identified by working with CDC and local agencies to identify individuals and provide ART to those newly diagnosed. University Health has been funded for pillar 2 and 4 (the only funding opportunities eligible for). The original grant proposal submitted to HRSA incorporated both housing and employment activities, primarily based on the existing CASE program. The award was received however the funding was drastically cut; only 42.5% of the initial proposal was awarded. Due to the COVID-19 pandemic, a housing shortage was identified in year 1 as a major barrier to address co-morbidities in people with HIV/AIDS. Unfortunately, because of this the housing and employment was cut from the final revised proposal with the intention to incorporate it back if additional funding became available. In year two of Ending the HIV Epidemic, locally called Operation BRAVE (Bexar County Response and Victory in Ending the Epidemic), the housing aspect of the original CASE program was included in activities beginning in March of 2021. The timing of this was perfect as it provided a 1-month overlap between the end of CASE and the start of Operation BRAVE. The intention is to incorporate employment activities if additional funding is made available in a future funding year. Support for housing activities will follow guidelines and best practices from HOPWA (Housing Opportunities for Persons with AIDS), as well as best practices learned from the CASE program, for Operation BRAVE patients. The population of focus are PWH who are newly diagnosed or out-of-care. PWH who qualify for this strategy are those identified through our LVN, Care Coordinator, individuals who are newly diagnosed through University Health's ambulatory clinics or private primary care providers, and individuals identified through partnering ASO's. Additional recruitment acres will be identified as the program infrastructure is build. An enhancement to the CASE program is providing funds to clients on a short-term basis. The intent is to allocate $194,104 towards these efforts in year 2. The program will be able to support individuals who need housing and/or utility assistance for up to 6.5 months to eligible persons or households that have been economically impacted because of their HIV/AIDS health condition. If the patient is not eligible for program funding, the Housing Coordinator for Operation BRAVE will assist the patient in finding another source of housing assistance.

“I THOUGHT BEING 100% TRUTHFUL TO MY EMPLOYER WOULD HELP ME KEEP MY JOB”

A client suffered many injustices and discrimination from a past employer after informing them he was HIV positive. The client enrolled in the SPNS program after being hospitalized and losing his employment, housing, and financial stability.

The client is a handworker, often putting in sixty hours a week at his assembly line job until he became very ill and hospitalized. Soon after being hospitalized, the client learned of his HIV diagnosis, and received the news with much regret. The client reported back to work and provided the doctor’s excuse for his missed days and felt being 100% truthful with his employer would secure his job. He was informed that his excuse was not enough and needed a release from all of the doctors who had treated him. After providing multiple doctor’s releases and none being “good enough” for the employer, the client gave up.

Luckily, the client’s case manager referred him over to SPNS .The client was very hesitant to report the employer and only wanted to move forward. He collected unemployment benefits for six months, during which he ignored calls and emails from the Member Advocate. When the client’s benefits were soon to expire, he again felt open to pursue job opportunities. Fortunately, the SPNS team was organizing an Employment and Housing Summit in which the Member Advocate personally invited the client to attend. The client showed up and was able to hear various presentations from community partners and local agencies that help with employment and housing resources. The client was thrilled to have been invited and was very eager to land a job soon. As the event wrapped up, the Member Advocate informed the client of an available job opportunity that was a perfect fit for his job experience and skills.

The Member Advocate received a call four days later informing her that the client received a job offer and he would be training very soon. The client remains employed and has earned a 15% increase in pay for his hard work and dedication as he completed his first six months with the company. The client has also secured housing and is currently saving money to purchase a house. He is very grateful and says he loves hearing from his Member Advocate as she checks in once a month.

-Story by Nancy Vasquez, Member Advocate