The San Diego Coordinated Services Integration Intervention

THE HIV, HOUSING, & EMPLOYMENT PROJECT

Background & Intervention Context

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

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

The Coordinated Services Intervention (CSI) was implemented by Family Health Centers of San Diego, a RWHAP Part C recipient based in San Diego, California.

The San Diego Coordinated Services Integration (CSI) Intervention

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THE HIV, HOUSING, & EMPLOYMENT PROJECT

FAMILY HEALTH CENTERS OF SAN DIEGO

This manual describes a HRSA intervention to increase housing and employment for people with HIV.

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Introduction

Purpose of This Manual

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This manual describes an innovative coordinated services model to improve health outcomes for people with HIV in San Diego County. The unique partnership was led by Family Health Centers of San Diego (**FHCSD**), one of the 10 largest Federally Qualified Health Centers in the country and the largest provider of Ryan White HIV/AIDS Program (**RWHAP**) services in San Diego County. The intervention, involving the National Alliance on Mental Illness, Townspeople, the San Diego Workforce Partnership, San Diego Employment Solutions, and the Institute for Public Health, aimed to increase housing and employment for people with HIV who are unstably housed and support them in reaching viral suppression. The model was part of the Health Resources and Services Administration (**HRSA**)/Special Projects of National Significance (**SPNS**) Initiative "Improving HIV Health Outcomes through the Coordination of Supportive Employment and Housing Services." The manual focuses on the need for this initiative, the current services landscape in San Diego County, intervention implementation, and a framework for other agencies to implement a similar intervention.

Audience

The audience for this manual includes RWHAP service providers, county, city, and state agencies who are interested in improving the access to and quality of care and services to people with HIV who are experiencing homelessness or are unstably housed.

SPNS Initiative Overview

SPNS programs are charged with the development of innovative models of HIV treatment, in order to quickly respond to emerging needs of clients served by RWHAPs. SPNS advances knowledge and skills in the delivery of medical and support services to underserved populations with HIV infection. Through demonstration interventions such as the one described in this manual, SPNS evaluates the design, implementation, utilization, cost, and health-related outcomes of treatment models, while promoting dissemination and replication of successful interventions.

This SPNS initiative supports the design, implementation, and evaluation of innovative interventions that coordinate HIV care and treatment, housing, and employment services to improve HIV health outcomes for low-income, uninsured, and underserved people with HIV.

Coordinated Services

The implementation of system-level changes that optimize client experiences and improve health outcomes through integrating:

- Employment
- Housing
- HIV Medical Care

Family Health Centers of San Diego, Logan Heights Clinic

Background and Intervention Overview

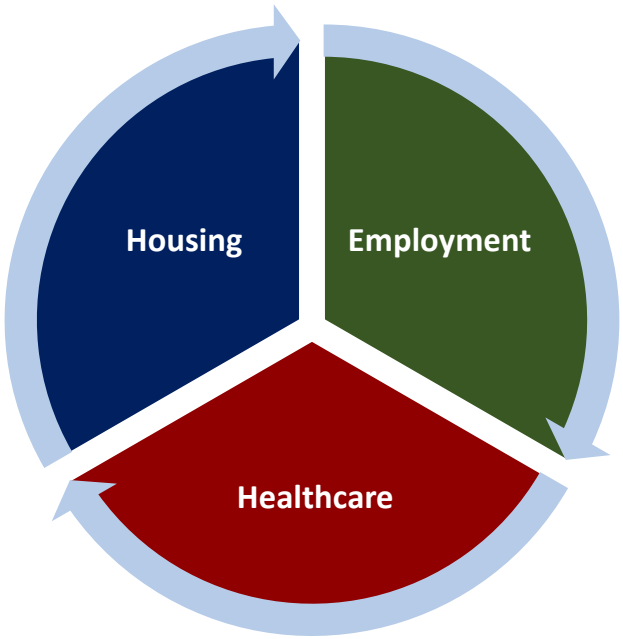
Demonstration Site & Partners

Coordinated Services Integration Model

This manual describes an innovative coordinated services model aimed at improving HIV-related health outcomes for people with HIV in San Diego County. Specifically, the intervention sought to increase housing and employment stability for people with HIV and support them in reaching viral suppression as part of the SPNS Initiative titled "Improving HIV Health Outcomes through the Coordination of Supportive Employment and Housing Services."

Together, the demonstration and partner sites created an integrated intervention termed the Coordinated Services Integration, or **CSI**, to integrate healthcare, housing, and employment services.

Figure 1. Service Integration Model



Partners

Healthcare: Family Health Centers of San Diego (FHCSD), Demonstration Site

FHCSD is a Federally Qualified Health Center and San Diego's largest provider of RWHAP care and services, as well as a provider of the federal Healthcare for the Homeless services. FHCSD operates 24 clinic sites, seven of which currently provide HIV care, and serves approximately 1,300 people with HIV per year. More than half of people with HIV receive case management services at any given time. FHCSD is also one of the nation's ten largest providers of healthcare to uninsured Americans.

Housing: Townspeople, Inc.

Townspeople, Inc. is San Diego's leading Housing Opportunities for Persons with AIDS (**HOPWA**) program provider. Townspeople's mission is to finance, build, manage, and operate affordable housing and supportive services for people with special needs to achieve stability and self-sufficiency. Townspeople offers affordable housing, emergency housing, HIV/AIDS housing, veterans housing, and supportive services.

Housing: National Alliance on Mental Illness (NAMI), San Diego

NAMI San Diego is a part of the grassroots, nonprofit, national NAMI organization, and an affiliate of NAMI California. NAMI has a three-fold mission to (1) support people with mental illnesses and their families by helping them find coping mechanisms for their daily struggle with brain disorders, (2) educate people who have mental illness, their families, and the general public about mental illness with the goal of dispelling ignorance and stigma, and (3) advocate for more research and an improved system of mental health services across the nation.

Employment: San Diego Workforce Partnership

The San Diego Workforce Partnership (**SDWP**) is designated by the City and County of San Diego as the Workforce Development Board serving the region in which FHCSD operates. The mission statement is to empower job seekers to meet the current and future workforce needs of employers in San Diego County. The SDWP is a Department of Labor-funded employment services organization that offers services for both job seekers and businesses including career centers, hiring assistance, on-the-job training, and events/workshops.

Employment: San Diego Employment Solution

San Diego Employment Solution (**SDES**), a part of Mental Health Systems, integrates mental health, rehabilitation, and recovery services for adults who have psychiatric disabilities. SDES offers supported employment, individual placement, and recovery services. The services are funded by the California State Department of Rehabilitation and San Diego County Health and Human Services Agency (**HHSA**) Behavioral Health Services.

Intervention Evaluation: Institute for Public Health, San Diego State University

Established in 1992, the Institute for Public Health (**IPH**) serves as a bridge between the public health academic community and public health practice. It supports the development of mutually beneficial partnerships between the San Diego State University School of Public Health, local public health agencies, and private organizations. IPH's mission is to improve the public's health by promoting best practices through quality evaluation, training, technology, practice-based research, and effective partnerships that bridge academic and community knowledge.

Townspeople, Inc. Vista Del Puente
(location of permanent housing for many CSI clients)

Need

Almost 14,000 people with HIV were living in San Diego County through December 31, 2016, 53% of whom were racial/ethnic minority.[1]

The county's racial/ethnic minority people with HIV exhibit a profound need for stable housing.

- Among FHCSD's 1,642 positive patients and clients in 2018-19, 29% were experiencing homelessness.
- In the San Diego County 2014 Needs Assessment Survey, 19% of people with HIV and 44% of out-of-care people with HIV surveyed reported being currently or recently homeless.[2]
- Unfortunately, while housing remains the most prevalent need among racial/ethnic minority people with HIV, *San Diego County lacks sufficient affordable housing units and coordination among providers.*[3]

San Diego's racial/ethnic minority people with HIV also experience poverty and unemployment.

- Over half (53%) of San Diego's people with HIV reported an average monthly income, including benefits payments, of $1,000 or less.[4]
- Fifty-six percent (56%) of people with HIV in San Diego County reported being unemployed, unable to work, or full-time students.[5]
- Racial/ethnic minority people with HIV serving on FHCSD's RWHAP Community Advisory Board (**CAB**) recently described barriers to employment such as fear of discrimination, lack of transportation, anxiety, multiple disabilities, and health stressors. Other studies identified loss of disability income benefits and/or publicly funded health insurance as perceived barriers to employment for people with HIV.[6]

FHCSD's CAB, comprised of people with HIV, suggested offering skills-building, career navigation, and job search assistance for people with HIV who are preparing to return to work. Also, the San Diego County HIV/AIDS Housing Plan recommended that RWHAP case managers and housing providers work with clients to create employment plans and coordinate with existing workforce development trainings and employment services systems. The plan notes that employment and education training are key services that have been *underutilized among people with HIV* and recommends that the *HIV housing community seek to improve linkages to the employment service system*. CSI aimed to address each of these issues.

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1 County of San Diego, Health and Human Services Agency (2016). HIV/AIDS Epidemiology Report.
2 County of San Diego, Department of Housing and Community Development. (July 2009). *San Diego County HIV/AIDS Housing Plan Update 2009*.
3 County of San Diego, Department of Housing and Community Development. (July 2009).
4 County of San Diego, San Diego HIV Planning Group. (June 2014). *2014 HIV/AIDS Needs Assessment*.
5 County of San Diego, Department of Housing and Community Development. (July 2009).
6 Brooks, R.A., Martin, D.J., Ortiz, D.J. & R.C. Veniegas. (Sept 2010). Perceived barriers to employment among persons living with HIV/AIDS. *AIDS Care*, 16(4): 756-766.

Intervention

Goals

CSI functioned as an interdisciplinary team of service providers: the linkage coordinator, housing navigator, and employment agency staff. These partners worked together to provide housing, financial, employment, and healthcare assistance to racial and ethnic minority people with HIV. CSI goals are outlined below. For CSI objectives, see the Appendix.

Goal I: Improve retention in HIV medical care among racial and ethnic minority people with HIV in the target region and improve retention in antiretroviral therapy (ART) and viral suppression among those receiving HIV medical care.

Goal 2: Improve housing outcomes for people with HIV in the target region.

Goal 3: Improve employment outcomes for people with HIV in the target region.

Priority Populations

The priority population for CSI included adult San Diego County residents of color (racial/ethnic minority) with HIV who were: (1) not fully engaged in HIV care, (2) unemployed or underemployed, and (3) experiencing housing instability.

Theoretical Framework

Service delivery incorporated elements from the Department of Labor's (**DOL**) *Getting to Work* initiative and the evidence-based Client Focused Considering Work Model.[7]

[7] Goldblum, P. & Kohlenberg, B. (2005). Vocational counseling for people with HIV: The client-focused considering work model. Journal of Vocational Rehabilitation, 22(2), 115-124.

Logic Model

To achieve intervention goals, CSI staff developed a logic model with the assumption that *coordinated services lead to better client health outcomes*.

Inputs	Activities	Outputs	Outcomes

• Vocationalizing Plan
• Community advisory board
• Public benefits
• Linkage coordinator (100%)
• Patient-centered medical home
• Intervention management
• Client incentives
• Electronic health record
• Partners
  • San Diego Workforce Partnership
  • Townspeople housing navigator (75%)
  • National Alliance on Mental Illness (assist clients with emergency housing funds/applications, 38%)
  • Local evaluator
• Temporary housing support pool
• HOPWA housing
• *Getting to Work* model
• Leveraged community resources
	Client
	• Recruit clients
	• Individual Care Plans
	• Benefits education and enrollment
	• Referrals to HIV primary care medical home, supportive services, other needed services
	• Financial literacy education
	• Representative payee and/or SSI liaison services
	• Housing case management
	• Employment training and support
	• Client discussion groups
	Staff
	• Jointly provide CSI services
	  • Case conferences
	  • Staff meetings
	• Streamline client intake and assessments
	• Link clients to medical care
	• Track referral completion
	Structure
	• Community advisory board participation
	• HIV appointment reminders
	• Staff training
	• Conduct vocational, housing, and vulnerability assessments
	• Collect evaluation data
		Client
		• Receipt of coordinated housing, employment, medical home, and HIV medical care
		• Individual, housing, employment, and sustainability plans completed
		• Linkage to HIV medical care and antiretroviral treatment
		• Employment training and support received
		• Referrals received
		• Housing support utilized
		Staff
		• Number and type of trainings
		Structure
		• Community advisory board assistance notes
		• HOPWA and Employment Directory
		• Improved path to housing for people with HIV
		• Improved path to employment for people with HIV
		• Improved referral pathways
		• Information technology systems updates
		• Intervention evaluation findings
		• Findings dissemination
			Client
			• Increased stability
			• Employed
			• Permanently housed
			• Retained in HIV medical care
			• Adherent to HIV medical care
			• Viral load suppressed
			Staff
			• Established referral sources/relationships
			• Trained to confront multiple complex client needs
			Structure
			• Best practices developed and sustained
			• Increased institutional capacity
			• Department of Housing and Urban Development, HRSA, RWHAP, and Department of Labor integration
			• Local evaluation informs San Diego replication
			• Systems-level change
			• New community referral pathways established and utilized

Family Health Centers of San Diego, Hillcrest on Third Avenue (co-located program headquarters)

Pre-Implementation Activities

Asset Assessment

Step 1: Agency & Funding

On advisement from the CAB, FHCSD wished to further address housing, employment, and HIV medical care needs of people with HIV. FHCSD applied for and received funding from the SPNS Initiative titled "Improving HIV Health Outcomes through the Coordination of Supportive Employment and Housing Services."

Step 2: Survey Available Benefits and Programs to Leverage

Prior to this intervention, regional housing organizations worked together to provide a variety of housing services and benefits, FHCSD provided medical care, and both SDWP and SDES provided employment services.

- The San Diego County Housing Authority, Department of Housing and Urban Development (**HUD**), RWHAP, and other local funding sources provided emergency, temporary, and permanent housing resources, as well as rental assistance and care home programs.
- FHCSD provided a comprehensive array of primary care and specialty medical, substance use, and behavioral health services within the existing system of care. CSI services were enriched through RWHAP Parts A, B, and C programs; CDC and SAMHSA projects; and multiple County of San Diego contracted programs.
- SDWP and SDES both provided an array of employment and employment supportive services.

This intervention also followed on the heels of two previous SPNS interventions: Building a Medical Home, which sought to better integrate clients into care, and Practice Transformation with the aim of expanding the HIV workforce at FHCSD. See Table 1 for a list of existing programs that were leveraged.

Step 3: Plan the Intervention Setting

FHCSD integrated this intervention into its existing HIV Services Department, which already provided medical and non-medical care and support services to thousands of San Diego residents annually. Services were housed in the same building as the RWHAP case management program in order to bolster client receipt of services.

CSI leveraged existing programs as noted in the table that follows.

Table 1. List of Existing Programs Leveraged, 2017-2020

Program/Activity	Leverage Details
Department of Labor	Employment agency and Department of Rehabilitation
RWHAP Parts A, B, and C at FHCSD	▶ Case management (medical and non-medical) ▶ Peer navigators to assist linking clients to the CSI team for follow-up ▶ Mental health and substance use disorder counseling as needed ▶ Partially fund the CSI coordinator position ▶ Nutritional services ▶ Primary and specialty medical care ▶ Behavioral health services
Mental Health Systems	SDES offered supported employment, individual placement and recovery services
San Diego Housing Authority	Long-standing relationship with the San Diego Housing Authority (the housing authority possesses flexibility in its use of Section 8 vouchers as well as HUD funds)
NAMI	▶ Provided RWHAP Part A Emergency Assistance Resource Pool (**EARP**)/Partial Assistance Rental Subsidy (**PARS**) programs ▶ Long-standing relationship with NAMI for seamlessly coordinating temporary housing ▶ Payee services
FHCSD Homeless Services Program	Staff were trained on how to provide services and what program resources existed from the following FHCSD programs: ▶ Connections Housing model, which connected people with social services and permanent housing ▶ Healthcare for the Homeless program (to provide glasses and dentures among other services)
FHCSD SPNS Grants	FHCSD previously received two SPNS grants, which provided lessons learned for this intervention
Moving Services	A local nonprofit offered moving services

Step 4: Involve Consumers

Racial/ethnic minority people with HIV were engaged in intervention decision-making.

- Racial/ethnic minority RWHAP CAB members were included in the decision to search for funding for this intervention.
- Surveys were reviewed by racial/ethnic minority staff and native Spanish speakers for feedback.

In addition to this direct intervention involvement, FHCSD also involved consumers by:

- Utilizing feedback from the racial/ethnic minority individuals on the RWHAP CAB. These individuals were highly engaged in the HIV community and provided valuable input into the design and implementation of CSI services.
- Conducting a focus group of RWHAP patients who provided critical insight into the needs and barriers experienced by racial/ethnic minority people with HIV around housing and employment. FHCSD staff incorporated their input into the design of the intervention.
- Gathering additional feedback from people with HIV by reviewing results from the Consumer Needs Assessment survey, which is administered every two years by the County of San Diego among individuals with HIV and providers.
- Distributing patient comment cards to collect feedback about quality of service and coordination between HIV health, housing and employment service providers.

Step 5: Plan to Address Barriers

Intervention clients faced many barriers to receiving services. A successful intervention will plan for and address these barriers:

Client Readiness

Being ready for housing and employment required clients to be able to attend multiple meetings, be sober at certain times, and manage their own stress related to the new aspects and responsibilities of being housed and searching for employment. Common problems included:

- Having no place to get physically clean or organized prior to searching for employment.
- Not feeling settled enough to search for employment while unhoused.
- Being too tired to participate.

Homecoming represents a new beginning for clients.

Client Motivation Level

Client motivation needs to be high in order to search for employment and complete the steps needed to obtain both employment and housing. Clients sometimes did not:

- Complete information packets for housing or other needed intervention items on time.
- Follow-through with referrals.

Substance Use Disorder and Mental Health

Active substance use disorder or mental health difficulties can result in the inability to complete steps and meetings needed to engage in housing and employment systems.

Time and Logistical Needs

The intervention will need to address various logistical difficulties:

- Time constraints due to (1) the many governmental systems clients needed to interact with to obtain services or items needed for applications (e.g., welfare, social security, DMV, etc.), (2) managing their own or their children's' healthcare, (3) attending behavioral or case management meetings, and (4) using public transportation.
- Transportation difficulties related to public transportation in terms of cost ($6 for a one-day pass), time, and in some cases ambulatory difficulties or difficulties traveling with infants.
- Loss of telephone service, frequent moves, insufficient contact information, and lack of emergency contact information hampered follow-up and follow-through.

Overcoming One Housing Assistance Barrier

EARP assisted clients with temporary shelter, usually in a hotel, until a more stable HOPWA housing opportunity became available. Occasionally, EARP would run out of funds, so FHCSD, NAMI, and other local RWHAP service providers would advocate at the County of San Diego RWHAP Planning Council for more funding.

Additional CSI funding was used to bridge the gap when EARP was depleted prior to permanent housing availability.

Background

A client's background limits opportunities available to them:

- Immigration status limits employment and housing opportunities.
- History of felonies limits housing opportunities (the intervention did not serve sex-offenders for this reason).
- Leasing agencies can limit housing availability (e.g., not approving clients with felonies or poor credit), which can greatly extend the waiting time for housing.

Step 6: Plan to Address Housing Barriers for Person Lacking Documentation

FHCSD's housing intervention needed to determine how to provide services for clients who lacked legal documentation to reside in the United States, or possessed visas that did not permit eligibly for HUD housing. This was an insurmountable obstacle to permanent housing for some clients, even those with children who were citizens.

Interventions may need to search for services and housing aid available to clients who lack legal documentation.

Housing for Persons Lacking Legal Documentation

Find services such as:

- HOPWA programs that do not require legal residency documentation.
- Employment partners who can assist persons lacking documentation with searching for employment.
- Rapid re-housing programs for persons with enough income to cover their full rent after being employed (San Diego had such programs).
- Assistance programs like the Landlord Engagement and Assistance Program (LEAP), funded by the San Diego Housing Commission. LEAP aids in searches for permanent housing units and provides incentives for landlords with rental housing units who rent to San Diegans experiencing homelessness.

CSI was critical for unhoused families.

Gaining Buy-In

CSI leadership garnered buy-in for this new intervention.

Step 1: Create an Organizational Vision

FHCSD first needed to create an organizational vision for addressing the social determinants of health, mainly housing and employment.

FHCSD recently completed two SPNS grants addressing fostering medical homes and building HIV medical capacity, and this grant supported the next logical step to better serve clients by meeting employment and housing needs alongside medical care. As a result, organizational buy-in already existed before the CSI intervention was funded. However, the following helped to foster a more unified organizational vision:

- Met with staff and medical providers from other programs and departments within FHCSD to explain the intervention.
- Educated the existing staff about this new intervention.
- Met with staff to discuss how intervention staff could work with existing staff to better serve clients.
- Met with information technology staff to improve tracking of employment and housing status among HIV patients receiving medical care.

Step 2: Educate and Train Employment Partners

Social service organizations that partnered with FHCSD recognized the housing and employment needs that affected populations with HIV they served. The bi-yearly People with HIV Needs Assessment conducted by the County of San Diego also attested to the needs of the population. CSI staff ensured that funded partners:

- Understood their role in the intervention as well as what services were available to people with HIV, and what services were limited.
- Learned about cultural competency as it related to working with vulnerable and unstably housed or homeless people with HIV (for example, how to be sensitive to persons lacking identification and other records or who are undocumented immigrants).

Overcoming Obstacles with Employment Partners

There were some difficulties in developing relationships with the newer employment partners:

- The SDWP employment partner did not have much previous experience working with FHCSD or homeless individuals.
- Clients did not travel to the employment partner site despite urging (staff felt this may have been due to fear or intimidation as some did not speak English, some were undocumented, and others may have been embarrassed due to their internalized stigma of being homeless).
- Employment partners were not paid subcontractors. If they had been FHCSD would have requested:
    - Services be brought to the FHCSD site.
    - Changes to employment agency practices that may have helped clients (for example, having one bilingual person assigned to receive visitors, or having the employment staff telephone clients to introduce their services).

FHCSD overcame this barrier to some extent by partnering with another employment agency (SDES) who served persons with substance use and mental health issues. FHCSD also encouraged and supported clients in their own job search if the client was not comfortable accessing employment services.

Staff supported clients in overcoming obstacles.

Planning for Sustainability

Tip 1: Maintain Referral Mechanisms with Partners

FHCSD plans to continue to foster the relationships with Townspeople, NAMI, SDWP, SDES, and other community partners to maintain sustainability beyond the three-year intervention period.

- The newly formalized partnerships and collaborations developed with this intervention have strengthened referrals between these organizations and expanded the services available to the clients of each organization.
- FHCSD developed protocols that included warm handoffs when clients moved between organizations to ensure the continuity of care for clients. If a client desired to change or engage a new organization, FHCSD connected them to the organization by directly by speaking with staff at that organization and providing the client with paperwork necessary for the transition.
- CSI staff will also share lessons learned from this intervention with local and county funders in order to support more targeted housing and employment partnerships for people with HIV in need.

Tip 2: Collaborate with City/County Housing Agencies

FHCSD will continue to collaborate with Townspeople to find housing and recourses for clients. As a landlord, Townspeople works directly and closely with the San Diego Housing Commission to provide housing units and implement the Commission's housing programs. Both agencies will continue to provide feedback to the Commission, participate in the Joint City-County HIV Housing Committee, and elicit help from the San Diego Housing Authority when needed to advocate for client needs.

> ***The CSI linkage coordinator and program manager established close relationships with the San Diego Housing Commissions' housing navigators at Townspeople. The linkage coordinator met with the housing navigators many times, both in-person and via telephone, in order to successfully navigate clients through Rapid Re-housing and other programs.***
>
> ***CSI and Townspeople staff worked with the San Diego Housing Authority when the property management agency refused to approve housing placements.***

Tip 3: Utilize Existing Programs to Reach Homeless Populations

Near the end of the CSI intervention, FHCSD opened San Diego's first Housing Navigation Center (**HNC**). The HNC was centrally located on the outskirts of downtown San Diego near various housing service providers. Community partners, including housing, employment, and other nonprofit agencies, were stationed at HNC daily in order to provide onsite engagement and assistance in their various programs.

The HIV Services Team had a peer navigator and/or case manager on-site regularly in order to engage with homeless clients or other potential clients and provide warm-handoffs to the other local service providers as needed.

Tip 4: Institutionalize Knowledge

CSI staff regularly collaborated with RWHAP case managers and discussed how to work with housing providers during their ongoing communication. CSI staff also created and updated *a Housing and Employment Directory* for case managers and coordinators across the agency detailing resources and methods for linking to services. The directory included resources from the SDWP website.

> ***Create a formal document that details information about housing and employment resources so new staff or staff from other programs can benefit from intervention knowledge.***

Staff are trained in motivational interviewing.

Tip 5: Search for Funding

One part of CSI that will be lost as the intervention ends is the provision of additional funds for emergency housing and housing retention. These additional funds were crucial; they allowed persons to receive extra housed time until permanent housing became available and they were used to keep persons housed when needed. Specifically, these funds were used to:

- Extend emergency housing stays.
- Pay back-rent for clients whose rents were raised unexpectedly by the San Diego Housing Commission.
- Pay rent for clients while they continued to search for work and other available housing options.
- Pay for security deposits.
- Fund various other needs to keep clients housed.

The partners will seek additional resources to meet this need, as the additional housing-specific financial support was invaluable in keeping clients from losing their housing.

> **"Without the additional CSI financial support, undoubtedly some clients would have been lost to follow-up prior to being housed."**
>
> *CSI Staff*

CSI funding extended emergency stays at hotels such as Travel Time Motel.

Intervention Promotion

Share and Promote Model

FHCSD shared and promoted the intervention model across the community and at service provider meetings.

FHCSD staff were able to promote the intervention through outreach to regional organizations. Staff conducted presentations around the community at support group meetings and trade organization gatherings such as:

- The RWHAP People of Color Case Management meetings.
- The Transitional Case Management Annual Meeting, which highlighted community resources for parole officers.

Presentations to Promote the Intervention

Staff promoted the intervention model at the following locations:

- California Department of Corrections' Transitional Case Management Program, all staff annual meeting
- FHCSD all staff meeting
- Kaiser Permanente San Diego Medical Center
- RWHAP People of Color meeting
- RWHAP Planning Group
- San Diego Employment Solutions
- San Diego Housing Commission
- San Diego Workforce Partnership
- Skilled Nursing Facilities
- Sober Living facilities
- South Bay Community Services
- The San Diego LGBT Community Center
- University of California San Diego's Antiviral Research Center
- University of California San Diego's Mother Child Adolescent Program

Staff also promoted the intervention internally at each of FHCSD's clinics, RWHAP service sites, and other programs that served people with HIV. Lastly, FHCSD promoted the intervention at the Joint City-County Housing Community Housing Committee Meeting, and at the San Diego County Strategies Committee Meeting. An example of the agenda and presentation can be found in the Attachments.

Planning Costs

Planning included activities associated with bringing the intervention online:

- Developing the work plan and logic model
- Creating outreach materials
- Conducting outreach to identify potential clients
- Creating methods to track services delivered and client outcomes
- Promoting the intervention
- Maintaining a client wait list prior to service provision (keeping in contact with potential clients)
- Conducting monthly internal and partner planning meetings

Staffing for the planning phase is detailed below followed by the planning budget.

- Associate Director of Special Populations, 5%
  - Responsible for recruiting and engaging subcontractors, and ensuring contracts and deliverables are in place at start of project. Assists in development of work plan and logic model.
- Intervention Manager, 10%
  - Plans and conducts regular internal and partner meetings, and assists in development of work plan and logic model. Works with Intervention Coordinator to establish day-to-day duties for staff, expectations of internal and external staff, reporting requirements, and marketing materials. Works with Data Manager to establish regular data reports needed to reflect productivity.
- Intervention Coordinator, 15%
  - Trains internal staff and external partners regarding program documentation and expectations. Oversees day-to-day activities of Linkage Coordinator, assists with clients as needed. Regularly works with subcontractors to answer questions. Works with Linkage Coordinator to promote the program to internal stakeholders and external agencies.
- Linkage Coordinator, 100%
  - Responsible for day-to-day activities needed to implement the program including outreach and recruitment, client contact, documentation of client activities, and follow up with clients.
- Data Manager, 15%
  - Responsible for data needed to ensure agency capacity and need for services.

- Townspeople, subcontract
  - Attend planning meetings, create housing documents, refine referral processes, advocate with San Diego County Housing Commission for direct placement of project clients.

The planning phase continued for eight months while awaiting approval for intervention implementation from two human subjects boards. If human subjects reviews were not needed, the planning phase and subsequent costs would have been greatly reduced. In addition, subcontracted partners may not be needed for the full planning phase. Program evaluation time is not included in the costs outlined below:

Planning Cost Item (8 months operation)	Planning Cost
FHCSD Personnel	$57,809
FHCSD Personnel - $47,703	
FHCSD Fringe Benefit (21.2%) - $10,106	
Transportation for Staff	$107
Materials (office supplies, printing, postage)	$1,282
Equipment (computers, software, office equipment)	$1,491
Housing Assistance (Townspeople, Inc. subcontract)	$14,670
Training (travel and training in Washington DC, one staff)	$1,560
Total Direct Costs	**$76,919**
Overhead/Indirect (36% of direct costs)	$27,691
Total Costs	**$104,610**

Staff at CSI planning meeting.

Staffing Plan

Recruitment and Hiring

Please see the job descriptions, job postings, and minimum qualifications in the Attachments Section. The staffing plan below represents the plan developed for the grant application. This staffing plan includes evaluation efforts but does not include adjustments made during the actual administration of the grant.

FHCSD

FHCSD did not post any positions as all CSI staff were internal hires or transfers. FHCSD recruited the CSI linkage coordinator internally from another program. Existing staff were assigned to the intervention for a percentage of the time:

- Director of Special Populations, 5%
- Assistant Medical Director for Research and Special Populations, 10%
- Associate Director of Special Populations, 10%
- Intervention Manager, 15%
- Intervention Coordinator, 30%
- Linkage Coordinator, 100%
- Data Manager, 15%
- Software Engineer III, 2.5% (Year One only)
- Evaluator, 15.5% (Year One), 6.5% (Year Two), 1% (Year Three)

Roles and Responsibilities: Program Management

The associate director, assistant medical director, and intervention manager were responsible for intervention planning, budget development, structure, and integration into FHCSD services.

The intervention manager conducted budget oversight and monitoring, lead day-to-day operations, and organized the hiring of the linkage coordinator

Roles and Responsibilities: Client Services

The linkage coordinator regularly met with clients to assess their needs and follow up on linkages to services, in addition to working in collaboration with the RWHAP case managers on a regular basis. The linkage coordinator focused on client employment and housing needs while the RWHAP case managers focused on medical needs. During the client recruitment phase, RWHAP case managers introduced existing clients to the linkage coordinator in-person, a benefit of being co-located in the same office building.

The intervention coordinator managed the linkage coordinator, aided in serving clients when needed, and solved day-to-day problems with serving clients.

Roles and Responsibilities: Data Management

The data manager liaised with the software engineer regarding upgrades to the electronic health record system to incorporate housing and employment. The data manager also worked with the information technology department to obtain and report agency-wide data for the local intervention evaluation.

The local evaluator created data collection tools, designed and managed a tracking system for client-level intervention outcomes, and provided data quality assurance and report writing assistance.

Townspeople

The housing navigator previously worked for Townspeople and was not a new hire. The housing navigator provided the following effort for this intervention:

- Housing Navigator, 75%

The housing navigator was responsible for working with CSI clients to assist with their housing needs, readiness and eligibility. This included regularly monitoring San Diego County housing lists, determining client's eligibility, and working with clients to ensure they were ready for move-in. The housing navigator assisted the client with move-in paperwork required by the housing management company, and worked with the clients to maintain their housing once they moved in.

NAMI

As the payee for all housing assistance programs, various existing NAMI staff were included in the budget:

- Director of Financial Services, 7%
- Assistant Program Manager, 23%
- Program Coordinator, 4%
- Program Assistant, 4%

NAMI staff not only assisted with EARP and PARS funding, but also utilized CSI funding to support uncovered housing related payments and keep clients housed. NAMI staff assisted clients to be sure that all needed housing documentation was completed.

Suggestions for Staffing

Staffing for Success

Plan for more linkage coordination time than expected to:

- Deal with bureaucratic public housing systems and resulting housing barriers that arise.
- Help extremely vulnerable clients with many barriers and needs (mental health, emotional support, self-esteem, substance use, transportation, etc.).
- Meet with clients as often as clients need.
- Follow-up with hard-to-reach clients facing barriers of their own.
- Provide enough support behind-the-scenes to ensure clients stay enrolled and keep up with various intervention requirements (paperwork, learning about interventions, advocating).
- Continue to follow clients once housed and employed as situations may change.
- Depending on ongoing reporting requirements and roles, time may be needed for evaluation staff.

When planning this intervention, it was not possible to know the intervention's exact staffing needs. While the funding was appropriate for most positions, *linkage coordination needed more*. Owing to the much higher than expected amount of time needed to complete the process of linking persons to housing, the need to search for non-responsive clients, and the desire to provide more comprehensive employment aid, CSI suggests:

- **Funding two full-time linkage coordinators** to serve 90 clients over three years, helping them each obtain housing and employment.
- **Funding an employment specialist or agency** to provide on-site services.

"There was just not as much communication as I would have liked with clients because I had too many cases. Unless a client called or I needed something from them, sometimes there was no contact."

CSI linkage coordinator

Staff Trainings

All staff underwent training in:

- Human subject research
- Cultural competency
- The United States Department of Housing and Urban Development and Department of Labor *Getting to Work* curriculum
- Monthly training sessions provided by Boston University throughout the intervention related to housing and employment

The linkage coordinator and intervention coordinator were additionally trained in the following:

- Employment assessment techniques (Department of Labor's Getting to Work curriculum)
- Trauma-informed care and practices (Coldspring Training Center curriculum)
- Motivational interviewing (various curricula in-house educators and Mental Health Systems)
- Comprehensive needs assessment (in-house case manager training, and AIDS Education and Training Center Program)
- Strengths-based case management (in-house)

> **"I suggest having all persons who will serve the clients participate in HUD's *Getting to Work* training."**
>
> *CSI program manager*

CSI staff touring San Diego Workforce Partnership.

Table 2. Trainings Completed by CSI Staff

Training Topic	Training Type	Source / Curriculum
Aligning Affordable Housing Efforts with Actions to End Homelessness	Webinar	San Diego Regional Task Force on the Homeless
Clinical Concerns for Case Management Patients	Presentation	FHCSD: In-house
Department of Labor Getting to Work	Webinar	U.S. Department of Housing and Urban Development / U.S. Department of Labor
Emergency Rental Assistance Program	Presentation	NAMI
Employment 201: Employment as Treatment that Works	In-Person	Department of Labor presentation at program recipient meeting in Washington DC
Harm Reduction in San Diego: A Listening Session	Conference	Harm Reduction Coalition
Hepatitis C and Comorbidity	Webinar	Black AIDS Institute
HIV 101	Presentation	FHCSD: In-house and Gilead Sciences
HIV and Substance Use: Methamphetamines	Webinar	MidAtlantic AIDS Education and Training Center
HIV and Pre-Exposure Prophylaxis	Presentation	FHCSD: In-house
Housing 201: HOPWA Program Rental Assistance Highlights	In-Person	Department of Housing presentation at program recipient meeting in Washington DC
Immigration and Documentation	CSI Webinar	HRSA
Implications of the Opioid Crisis in the U.S. Latino Population	Webinar	National Hispanic and Latino Addiction Technology Transfer Center Network
The Intersection of Housing & Employment for Clients with Incarceration Histories	CSI Webinar	HRSA
Making the Case for Affordable Housing and Ending Homelessness	Webinar	United States Interagency Council on Homelessness
Mental Health First Aid	Presentation	San Diego Adult Protective Services
The Present and Future of Public Charge for Immigrants Living with HIV	Webinar	AIDS United
RWHAP Conference (2019)	Conference	HRSA
RWHAP Payee Service Training	Presentation	NAMI
Social and Behavior Research Best Practices for Clinical Research	Webinar	Collaborative Institutional Training Initiative (CITI)
Stages of Change & Motivating Clients	CSI Webinar	HRSA
Sustainability and Integration	CSI Webinar	HRSA
Trauma Informed Care	Presentation and Online	Coldspring Center (coldspringcenter.org) and Matt Bennett

Supervision Structure

Clinical Supervision

Management ensured that staff were not only up-to-date in best practices through webinars and in-house trainings, but also equipped to deal with the stresses related to working with special populations. To this end, management provided the following opportunities:

- Case meetings with all staff to discuss issues, barriers and successes with clients
- Supervision meetings with marriage/family therapists
- Elective learning trainings/webinars through FHCSD's internal training and development system
- Opportunities and time to attend all relevant trainings offered by HRSA and other sources
- Mandated trainings on dealing with secondary trauma and burnout experienced by staff
- Mandated cultural competency training
- Access to Employee Assistance Program

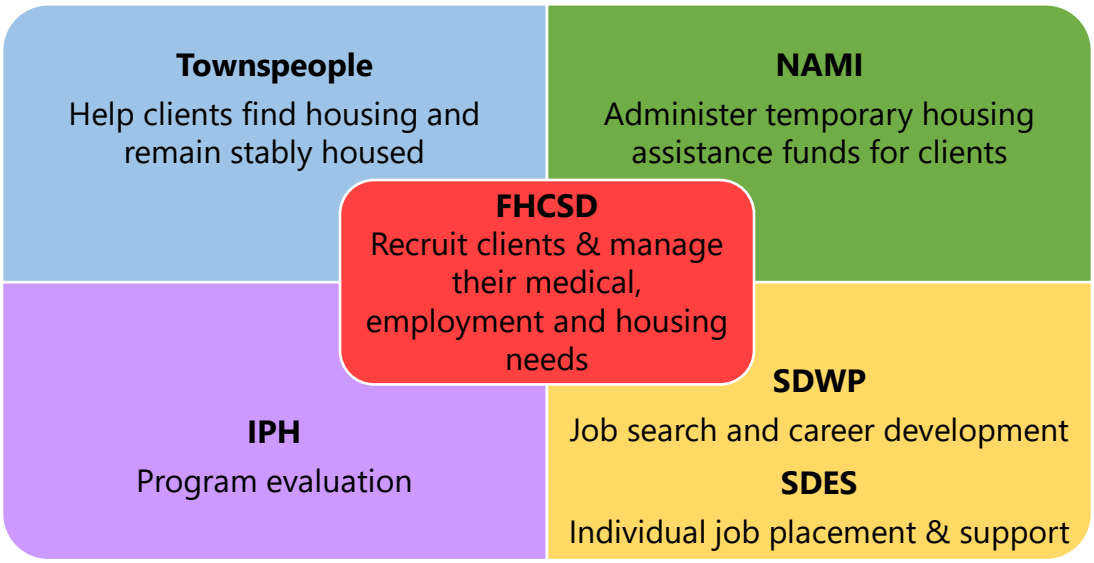
Other types of clinical supervision were not needed for the activities funded by this grant, but were in place for all clinical, mental health, and healthcare professionals at FHCSD. RWHAP case management staff engaged in monthly clinical supervision with an FHCSD Licensed Clinical Social Worker, and clinical mental health and substance use disorder providers engaged in weekly one-on-one supervision.

Partner Organizations

Roles and Responsibilities

FHCSD partnered with community organizations to provide services that were not already a part of the FHCSD healthcare system. Following client assessment, FHCSD referred clients internally for HIV care or HIV support services and externally for financial, housing, and employment services. Partner roles are shown in Figure 2 and further specified in the table that follows.

Figure 2. Partner Integration Model: Fitting Roles and Responsibilities Together



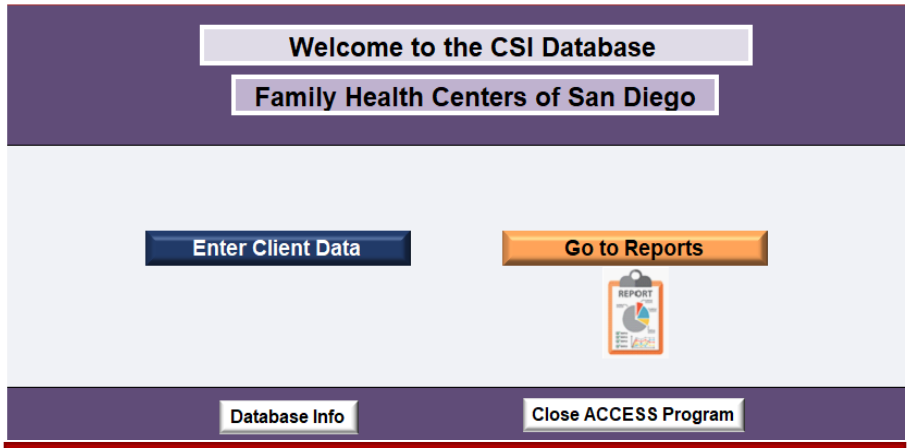
Townspeople, Inc: 51st Street Project
(apartments for persons with very low income)

Table 3. Partner Roles and Responsibilities

Site	Intervention Roles and Responsibilities
FHCSD	*Recruited clients and managed their coordinated care* ▶ Created and managed person-centered coordinated service plans ▶ Provided intensive case management, navigation, follow-up, and peer support
Townspeople, Inc.	*Helped clients find and remain stably housed* ▶ Conducted in-depth housing assessments ▶ Assisted clients with individual housing plans ▶ Provided housing services (eligibility screening, identification/location of housing, wait listing, placement, and retention support) ▶ Aided clients with income support and food ▶ Provided information regarding HOPWA housing options
NAMI	*Administered a temporary housing assistance funds for clients* ▶ Assist with Emergency Assistance Resource Pool (**EARP**)/Partial Assistance Rent Subsidy (**PARS**) programs ▶ Ensured that RWHAP Part A housing services were accessed appropriately ▶ Provided peer employment training to clients ▶ Provided budgeting training and assistance ▶ Served as a payee for clients' housing services as needed ▶ Served as a representative-payee as needed
SDWP	*Offered job search and career development resources to clients at their center* ▶ Performed employment assessment and plans ▶ Provided clients with appropriate employment services (soft skills training, job placement assistance, vocational training, and retention support)
SDES	*Offered supported employment, individual placement, and support and recovery services to clients* ▶ Performed employment assessment and plans ▶ Provided with appropriate employment services (soft skills training, job placement assistance, vocational training, and retention support)

In addition to the service agencies listed above, FHCSD partnered with the IPH to provide intervention evaluation services. Specifically, the IPH developed a client tracking database and conducted quality assurance/quality improvement activities such as cleaning, entering, and double-checking data. Monthly data reports were produced by the tracking database that allowed for real-time intervention monitoring.

IPH staff used Microsoft Access to create a database tracking system, which was housed at FHCSD on the central server. Intervention and evaluation staff entered information into the system on a regular basis. The system was used to track clients over time and included quality assurance checks, as well as reporting features. See the Attachments Section of this report for more screen shots.



CSI local tracking database: opening screen

Identification of Stakeholders

Stakeholders were recruited and informed of the intervention and outcomes via:

- Internal presentations
- In-services at community board meetings
- External presentations to local community-based organizations providing HIV services

For example, staff provided an intervention overview at the San Diego Housing Joint City-County HIV Housing Committee meeting, at an FHCSD departmental team meeting, and at a CAB meeting.

Strategies for Partnering and Informing Stakeholders

Stakeholders included both community members and San Diego-based organizations that address community health and housing needs, food, legal services, etc. Without connections with local stakeholders such as Mama's Kitchen, a local RWHAP-funded food delivery service, and other organizations, many clients would be unable to live healthy, productive lives in their newly acquired housing. Partnerships with stakeholders help close the gaps in supportive goods and services that many clients need in order to thrive. A complete list of stakeholders can be found in the Attachment Section.

FHCSD maintained regular communication with community organizations that could potentially provide client or intervention support and enrich services:

- Once referrals/warm handoffs were made to stakeholders, clients were encouraged to follow up on their own, but the linkage coordinator would intervene as needed and at client request.
- FHCSD RWHAP case managers worked regularly with many of the stakeholders for years, so existing relationships with many organizations were leveraged for this intervention.

Partners Coming Together to Help Maria

Several different agencies partnering together (University of California, San Diego - **UCSD**, FHCSD, Townspeople, Mama's Kitchen) aided one woman, Maria (not her real name), achieve success:

- Maria had survived domestic violence and was the mother of two children. The UCSD Mother, Child and Adolescent HIV Program referred her to CSI.
- Maria was housed in an apartment with Townspeople.
- Through encouragement from CSI staff, Maria found employment cleaning houses and working for a Taquero at events.
- Maria also accessed nutritional food from Mama's Kitchen and attended regular medical appointments at UCSD's HIV medical clinic. She became medication adherent and reached viral suppression.

Engaging DOL & HUD

The local DOL agency, SDWP, assisted the intervention by being a referral resource and tracking clients who visited their site. SDWP attended the CSI monthly interagency planning meetings for the first intervention year. Unfortunately, CSI did not fund SDWP, which resulted in SDWP's inability to provide dedicated and tailored activities for CSI clients.

> ***If funding were available, the DOL agency may have been able to provide services to clients and offer classes/mini job fairs at the FHCSD site, which would have greatly increased client involvement in their services.***

Intervention staff engaged HUD programs in several ways:

- Intervention staff worked closely with the San Diego Housing Commission to find housing placements for clients and solve barriers to placement.
- Staff also utilized HUD resources through the HOPWA program and Townspeople.
- CSI staff attended the quarterly Joint City-County HIV Housing Committee Meetings with other agencies including the San Diego Housing Commission, HIV/AIDS service providers, housing providers, substance use disorder treatment providers, and the local resource linkage provider 2-1-1. During these collaborative meetings, each agency provided updates about their program and activities. FHCSD formally introduced CSI and provided regular intervention updates thereafter.

Image of core CSI staff.

Intervention Imple-mentation

Core Components

Individual Level

Step 1: Generate internal referrals for the intervention from RWHAP case managers.

FHCSD's Care and Support Services provides case management services to over 700 people a year. Internal referrals from care and supportive services clients were the largest referral source for potential CSI clients. Case managers referred to CSI via warm handoffs to the linkage coordinator whenever possible. Some referrals also originated externally from local service organizations, medical providers, and other organizations working with people with HIV.

Sources of Referrals to CSI

- FHCSD (various programs)
- UCSD's Mother, Child and Adolescent HIV Program
- UCSD's Antiviral Research Center
- Neighborhood House Association (RWHAP case management provider)
- Transitional Case Management Program
- External medical providers & social workers
- Townspeople
- Josue Homes

Step 2: Provide coordinated linkage services.

CSI provided intensive linkage coordination, follow up, and peer support to clients with the goal of stabilizing them in HIV care, employment, and housing. Linkage coordination activities included:

- Developing care plans (see Attachments Section of this report).
- Completing a comprehensive assessment with clients.
- Providing clients with support service referrals.
- Meeting with clients regularly until their goals were met.

The linkage coordinator attempted to communicate with clients at least monthly and reassessed clients as needed to determine which support services would be most appropriate at that point in their care plan. Coordination staff completed many duties for clients when they were not present, such as filling in client paperwork, scheduling meetings for the clients, collaborating with Townspeople, and coordinating funds for emergency housing. The linkage coordinator met with Townspeople staff regularly to review housing options for the clients awaiting housing. The linkage coordinator also provided aid to clients with urgent health or social needs.

Linkage Coordination

CSI provided comprehensive linkage coordination to clients with the goal of stabilizing their medical care, employment and housing.

The linkage coordinator worked with clients by offering guidance, positive reinforcement, and emotional support to help those who felt unemployable see themselves as valuable and worthy of employment. This work took place as a natural part of the meetings and contacts with clients.

Intervention staff made every effort to meet with clients monthly; some individuals met with staff more often and some less often due to instability and barriers (such as lack of transportation, lack of telephone, problems with mental health, domestic violence, and employers refusing time off requests). Clients could remain in the intervention with ongoing communication until they achieved stable HIV care, housing, and employment.

Linkage Coordination: Increasing Self Esteem

- Trauma-informed practices
- Strengths-based case management
- Setting realistic goals
- Praising small steps towards success
- Accompanying, helping, and encouraging clients to address their internal barriers and persevere against bureaucratic challenges

Linkage Coordination: Planning for Success

- Clients had many needs and benefitted from additional navigation time.
- Lower case loads are needed so that housing and employment can both be addressed.
- Staff will benefit from ongoing training regarding all available local programs and funding sources for housing and employment; these change over time.
- Substance use must be addressed; it was helpful to have a navigator who was trained in substance use disorder treatment.
- Staff or staff time is needed to advocate for client needs and systems changes.

Step 3: Conduct a housing acuity scale to identify the most vulnerable and their needs.

Townspeople administered an acuity scale to clients, standard for all persons seeking homeless services in San Diego County. The tool, the Vulnerability Index-Service Prioritization Decision Assistance Tool (**VI-SPDAT**) enabled the County to refer clients to appropriate housing resources, if they were available, through a coordinated entry system. Many intervention clients were housed through a separate agreement between Townspeople, the coordinated entry system administrators, and FHCSD in order to allow intervention clients to obtain housing at Townspeople which was set aside for this intervention. Not all clients were housed in this manner.

The VI-SPDAT and other helpful housing tools for working with clients, including budgeting, crisis planning, risk assessments, exit worksheets, and trainings, are available from www.orgcode.com/products.

Housing: Planning for Success

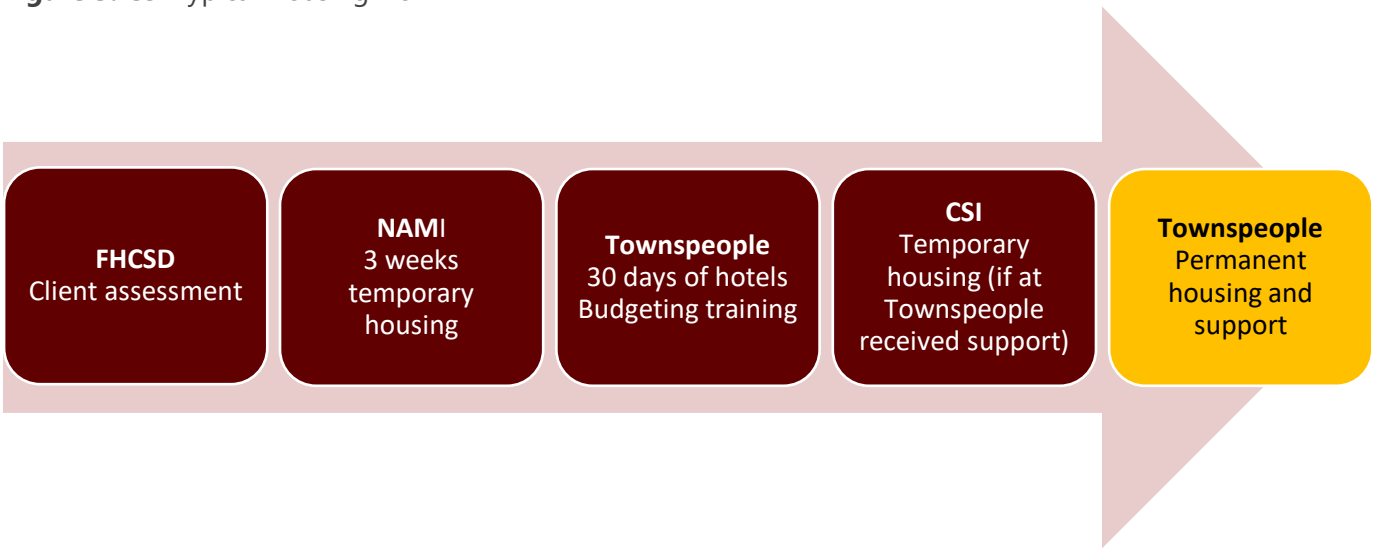
- Provide tailored housing placements for high acuity clients with HIV and support their housing stability with coordinated wraparound services.
- Create a temporary housing assistance pool to assist clients who may have exhausted RWHAP Part A housing assistance.
- Create agreements with external housing organizations if the coordinated entry system in the County limits availability of housing for intervention clients (for example, if clients are placed far down on the waiting list).

Step 4: Conduct housing navigation.

The linkage coordinator accompanied clients to the initial meeting with the Townspeople housing navigator and linked them to other resources needed to complete their housing application. NAMI provided payee services to clients as needed and managed the applications and provision of temporary housing services. FHCSD received a small private grant that assisted in purchasing housing goods such as kitchenware, shoes for youth, and bedding for clients. The linkage coordinator accompanied clients to subsequent housing navigation meetings as needed.

By the end of the intervention, **68.6%** (83/121) of the CSI clients were housed (59 in permanent housing and 24 in temporary housing) compared to **47.1**% at intake (57 in temporary housing). While not all clients became permanently housed by the end of the intervention, the typical process is outlined in Figure 3.

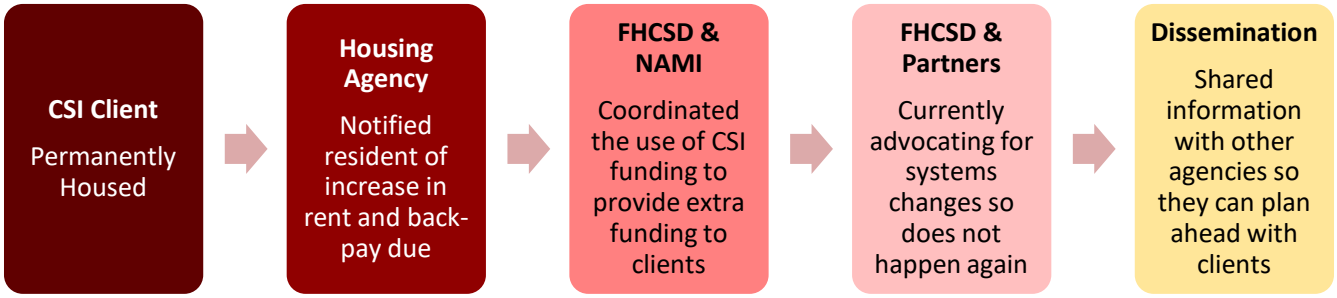
Figure 3. CSI Typical Housing Flow



Step 5: Initial housing retention.

The housing process expanded in some cases where undocumented immigrants, who had already been permanently housed for several months, were suddenly presented with a bill for increased rent along with back-pay, thus jeopardizing their housing stability. An unforeseen lack of voucher payments for undocumented immigrants created the rent increase, which was not reported to clients until after they were housed. See the housing problem and resolution flow in Figure 4.

Figure 4. Housing Problem and Resolution



Considerable staff time was needed to help each client apply for and obtain housing, complete all of the necessary paperwork and steps, and encourage clients to maintain motivation to finish all steps of the process. Original intervention planning for a case load of 50 clients proved unrealistic, as the process of linking to housing and employment can be time-consuming and may take over a year to complete.

Furthermore, the linkage coordinator and other staff at FHCSD needed to spend additional time advocating for clients and systems changes related to the housing process. In replicating this program it is suggested to factor in the additional time needed to serve clients to the extent they need while preventing provider burn out.

See Case Study: Steven (Case1) for an example of housing an individual.

Staffing: Planning for Success

Plan carefully for linkage coordinator, housing navigator and other staffing, especially when serving populations that are homeless or have multiple needs and barriers.

- Establish a realistic case load for navigation and coordination so that clients may receive sufficient care.
- Provide support to prevent staff burn out.

Step 6: Provide employment navigation.

SDES and SDWP offered a variety of employment support activities, including accompaniment to interviews, professional clothing, employment skills workshops, and résumé writing support. The intervention linkage coordinator referred clients to the employment partners and offered encouragement to attend.

Clients faced many challenges related to employment: the high and continuous level of motivation needed to seek employment, low self-esteem, feelings of not being ready to be employed when faced with housing or life instability, and fear of not finding an employment partner who would be compassionate to their needs. Undocumented immigrant clients especially reported that they were fearful of utilizing DOL employment programs due to their citizenship status.

While SDWP offered a large array of services, clients needed to be self-motivated and functional in order to partake in the services as they were largely self-directed. As a result, very few clients completed the referral and received help from this partner. By the intervention end, **30.6%** (37/121) of the CSI clients were employed (8 full-time, 28 part-time and one part-time 'under the table'). The coordinator reported that many clients 'found their own jobs,' encouraged by their more stable housing conditions and intervention staff reassurance.

Department of Labor Integration

DOL integration was not fully achieved for this intervention due to various barriers:

- Clients often needed more assistance than the DOL site could provide.
- Clients would have benefited from on-site assistance rather than assistance at the DOL agency.
- Non-citizen clients needed additional aid that the agency could not always provide.

> **"Most clients who became employed found the employment themselves."**
>
> *CSI program coordinator*

Because of client barriers, intervention staff decided to partner with SDES in addition to SDWP. SDES offered a higher level of assistance and personalized aid throughout the employment and skill-building process. SDES staff could drive clients to interviews, provide funds for interview clothing, and offer case management for up to nine months after being employed.

Part of the SDES mission was to serve persons with mental health and trauma issues, which made SDES a better fit for the client population. After this relationship was formed, CSI required clients to attend SDES services. SDES also offered training and meetings on-site at FHCSD.

Employment: Planning for Success

- Offer mini-job fairs, workshops, and other employment skill-building opportunities at sites where clients are comfortable.
- Find employment partners who have experience with the priority population.
- Hire in-house or pay for employment expertise and activities.

FHCSD experienced problems, as many clients were unwilling to utilize services at the DOL employment partner site.

Step 7: Provide navigation services in an employment-friendly agency.

- Job notices were posted in health clinics to ensure clients were aware of opportunities.
- FHCSD created a Housing and Employment Director for the agency.
- FHCSD and other RWHAP-funded agencies often shared available job opportunities with clients and/or posted job fair notices throughout offices.

Step 8: Support job readiness with tangible reinforcements.

To promote job readiness and self-esteem, CSI staff provided hygiene kits with toothbrushes, toothpaste, soap, lotion, deodorants, razors, wipes, and washcloths. CSI staff also provided referrals for clothing through partnerships with community organizations, such as thrift stores and supportive services for families. Townspeople provided home goods such as towels, shower curtains, mattresses, and other necessities to the clients they housed.

Step 9: Continue to support clients.

RWHAP case managers, in addition to the intervention linkage coordinator, provided referrals to necessary services such as medical care, behavioral health, substance use disorder services, and counseling.

Most of the CSI clients who were permanently housed, were housed at a property managed by Townspeople, Inc. Townspeople offered all of their renters, including CSI clients, supportive housing, which included case management, connection to resources, and access to a resident services coordinator. Case management focused on developing

tailored case plans and connecting residents to resources (e.g., employment, mental health, substance use treatment, healthcare) aimed at promoting self-sufficiency. The resident services coordinator and case manager would provide transportation, assistance in completing paperwork for employment or disability, aid in obtaining bank accounts or identification, and support for completing medical appointment among other services. Townspeople case managers met with residents at least once per month and more often as needed.

In the second intervention year, NAMI provided a budgeting and financial guidance class to enrolled clients. While not all clients received this class, we recommend that budgeting classes be incorporated into services.

Step 10: Track client data accurately; use information to assess and improve services.

The evaluation partner provided support in terms of aiding intervention staff in tracking client outcomes, creating local data collection forms, and developing a client services tracking system (Microsoft Access database). These systems allowed CSI to accurately report intervention outcomes regularly via database reports, clean data, and double-check data entry. Lists of missing data were generated to facilitate completion, and medical data were imported into the database to save staff time. Client tracking allowed staff to know which clients still needed services, and reporting allowed staff to understand intervention successes and shortcomings in order to improve services.

Tracking for Success

- Develop and utilize streamlined intake and assessment procedures across RWHAP, DOL and HOPWA providers.
- Identify reasons and patterns of services utilized and not utilized so improvements can be made.

Staff tracked and documented client outcomes with a custom database.

Case Study: Steven

Steven (not his real name) initially came to FHCSD for medical case management services in August 2018. Steven was a 42-year old Hispanic man. He thinks he acquired HIV through IV drug use and unprotected sexual activities, receiving a diagnosis of AIDS in 2014.

For some time, Steven lived with his wife and daughter. The marriage turned dysfunctional and ended in divorce in 2017. Steven obtained full custody of their daughter who was about six years old.

Later, he stopped working full time as a line cook in a restaurant because of complications from diabetes, recurring foot ulcers, surgeries, and partial toe and foot amputations. Due to these health issues, Steven was approved for social security disability benefits; however the benefits were not enough to maintain housing. Consequently, Steven and his daughter became homeless, couch surfing and sleeping in his vehicle. In addition, Steven suffered discrimination from his siblings and other relatives because of his HIV infection.

The RWHAP Medical Case Management and CSI staff members collaborated with Townspeople to provide emergency shelter for Steven and his daughter. After being sheltered, Steven was able to complete all housing prerequisites and obtain approval for Permanent Supportive Housing. Steven thought this experience taught him patience, optimism, and hope while tackling numerous obstacles (medical/recovery, mental health, financial, delays on move-in date, etc.).

In March 2019, Steven finally received a Project Based Voucher from San Diego Housing Commission (SDHC) to move to a subsidized two-bedroom apartment with the Townspeople, Vista Del Puente housing program.

Steven was also rehired by his former employer for part-time employment as line cook. Steven's work earnings, disability benefits and support from CSI enabled him to thrive and provide for his nine-year old daughter.

The project empowered clients to take the steps they needed to maintain long-term housing.

System Level

Step 1: Establish formal partnerships with funding and subcontracts.

The first system-wide change was the formal partnership between FHCSD, Townspeople, and NAMI. This partnership was established, formalized (with subcontracts and funding) and further developed as FHCSD held regular meetings (first monthly then quarterly) to ensure the coordination and support of services among the employment, housing and linkage staff.

Partnerships were formed with SDWP and SDES as well, although the relationships were not formalized with subcontracts for funding.

Tips for Working with Leasing Partners

- Meet in person to establish a rapport.
- Whenever possible, identify a main contact person and their primary contact information.
- Follow up regularly when client issues arise and ask what can be done to assist the clients.
- Document all issues as they arise and provide referrals to an organization that offers housing case management services.
- Advocate for clients whenever possible.

Step 2: Conduct regular interagency team meeting.

FHCSD, Townspeople, NAMI, and the IPH began meeting monthly prior to implementation in order to coordinate services and design the intervention. Meetings were later reduced to quarterly. These meetings ensured that all relevant parties regularly received information about any changes or updates.

As the intervention progressed past the first year, partner meetings changed in focus to client coordination and only included the staff coordinating services. These meetings took place formally each quarter and informally as often as three times per week to coordinate housing applications. FHCSD continued to communicate with the employment and evaluation partners as needed about administrative and non-client level intervention matters.

> ***Regular meeting with intervention leaders and service delivery staff were conducted to discuss program implementation challenges, solutions and proposed changes.***

Step 3: Determine documentation needs.

FHCSD utilized several resources to ensure thorough and accurate documentation of intervention activities. Care plans (example in Attachments), modeled after other RWHAP programs, were documented with progress notes in client charts:

- Care plans were updated at least yearly or more often if appropriate.
- Client encounter information was logged into tracking sheets initially and later entered into the electronic health record (**EHR**) system.
- The VI-SPDAT information was gathered using the County of San Diego form and entered into the homeless services housing management information system. While CSI was not able to integrate data from the housing management information system with the linkage coordination data, the housing navigator and linkage coordinator met regularly to share information.
- Details about HIV medical care were captured routinely as part of the EHR system or gathered from other health agencies via releases of information.
- Individual-level client information such as cluster of differentiation 4 (**CD4**), viral load, tuberculosis test results and client progress notes were also entered into the State of California HIV/AIDS client management system (ARIES) as required by local governments.

Step 4: Enhance data management structure.

As a result of CSI and a RWHAP grant, FHCSD staff improved the agency-wide EHR data management system.

- The first upgrade enabled employment and housing needs to be gathered for every person with HIV served at the organization.
- The second upgrade, in intervention year three, involved adding entry modules so that RWHAP case management and CSI information could be included in the EHR system.
    - This change significantly improved the coordination of housing services among not only RWHAP case management programs, but all other FHCSD programs, such as the Housing Navigation Center, and Healthcare for the Homeless programs.
    - All medical providers at FHCSD gained easy access to case manager/linkage coordinator assessments and care plans. With up-to-date information about employment and housing, providers could make more informed medical decisions and encourage follow-through with case management plans.
- Also in intervention year three, a RWHAP Part C Capacity Building Grant specifically allocated funding to improve data sharing capabilities through EHR. New features included:
    - Notices when certain HIV medical care needs were overdue.
    - An HIV data dashboard to allow for standardized reporting of HIV quality metrics.
    - Sharing referral and referral completion information real-time between service sites and staff.

Step 5: Train RWHAP case managers about housing and employment needs and resources.

CSI staff trained RWHAP case managers to work more effectively with local HOPWA and other housing providers through sharing information at staff meetings and huddles:

- During weekly all-staff huddles (RWHAP services providers), CSI staff provided brief intervention and client updates.
- During the case managers' monthly meeting, CSI staff provided more in-depth details, such as intervention accomplishments, intervention changes, challenges, and lessons learned. RWHAP case managers would ask questions, gather information, and discuss concerns regarding the housing and employment process.

> ***CSI staff developed and regularly updated a Housing and Employment Directory resource for case managers and coordinators across the agency.***

Establish Regular Communication Channels

Step 1. Determine methods of communication.

Communication regarding problems, solutions, and case conferences happened frequently between the housing navigator, linkage coordinator, and NAMI staff. Staff communicated in-person, over the phone, and via email. This allowed all parties to track client progress and ensure a seamless provision of services. At one time the housing navigator and linkage coordinator met up to three times per week to coordinate housing applications and share information.

Collaboration was critical in ensuring success.

> ***The FHCSD linkage coordinator accompanied clients to the housing partner appointment and would coordinate behind the scenes* regularly with both NAMI and Townspeople to ensure that each clients' housing needs were met.***

*Completing tasks such as filling in or sending paperwork, planning appointments, and coordinating the multiple aid agencies involved.

Step 2. Determine how to track partnership activities.

Partner organizations, as well as the linkage coordinator, provided written activity and success reports to the intervention manager monthly in a prescribed reporting format (see Attachments).

Step 3. Determine how to track intervention activities.

Intervention staff at FHCSD utilized the internal EHR system for tracking client medical care linkage, retention, and outcomes. A separate Microsoft Access database was used for reporting specific intervention activities and additional outcomes.

Step 4. Adapt activities and documentation for priority target populations.

FHCSD adapted RWHAP Medical Case Management and Targeted Services for People of Color Program activities and documentation for this intervention. Care plans were modeled after the existing RWHAP plans, and the client assessment was modified to include enhanced employment and housing sections. Activities modeled after the RWHAP care model included linkage coordination (modeled after case management), navigating complex systems of care, referral services, and transportation. Mental health and substance use treatment services were provided by the RWHAP program.

Transitioning to Standard Care

All CSI clients were made aware at the time they enrolled that the intervention was limited in time, and they would eventually be transitioned back to the standard RWHAP case management programs. For many clients, this meant that they would no longer meet with the CSI linkage coordinator in addition to their RWHAP case manager. Additionally, the few clients still receiving extra housing assistance via CSI funds will need to find other financial support if it is available.

CSI staff and case managers assisted clients by providing employment resources and searching for additional funding programs where possible.

Intervention Implementation Costs

The second program year represented 12 months of program intervention and was used to complete this section. Staffing details are below followed by the intervention budget, note that program evaluation effort is not included in this budget.

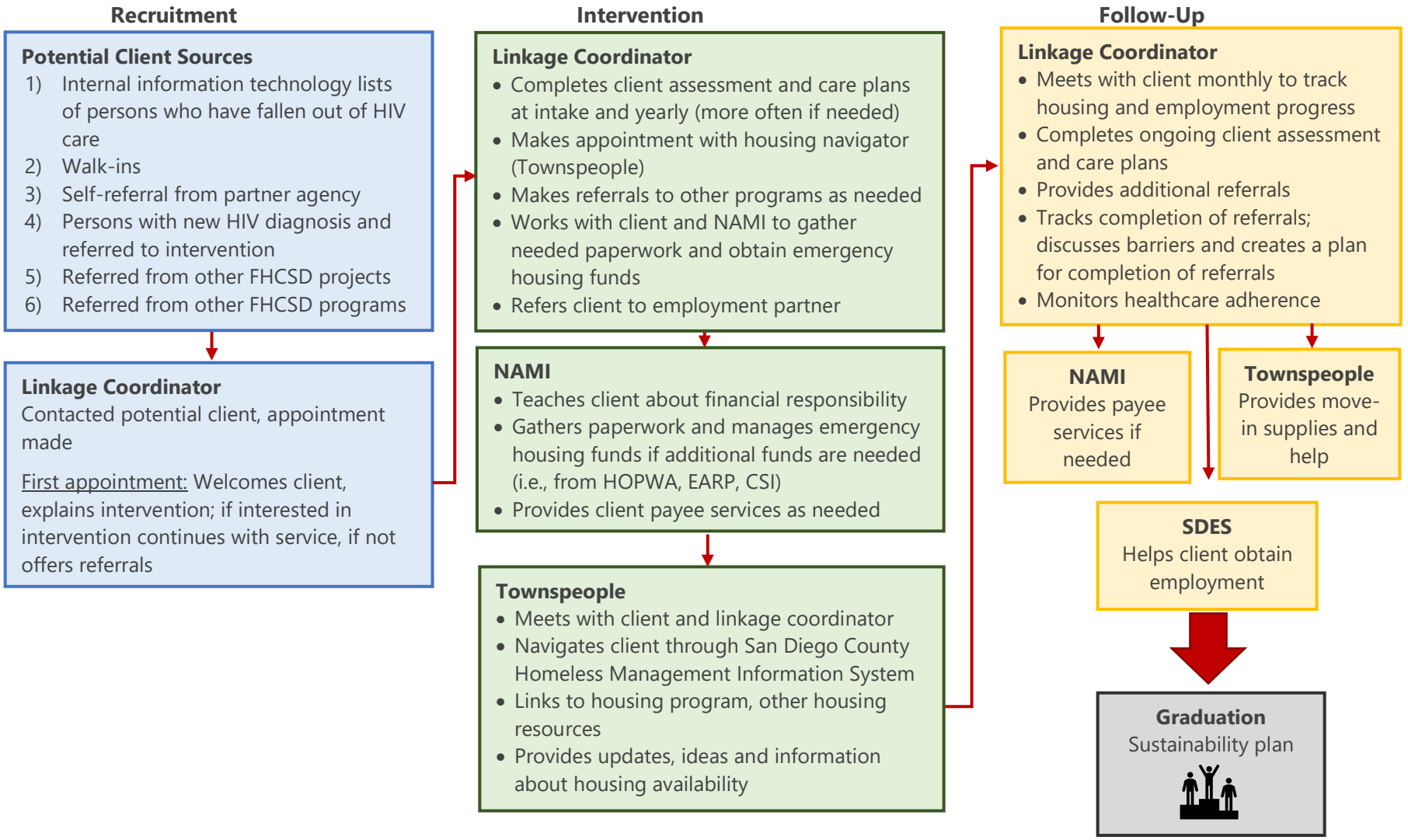
While the linkage coordinator was employed at 75% during the second program year, as discussed in lessons learned, the program needed much more than 75% effort in order to be able to fully manage and serve the 121 enrolled CSI clients.

- Director of Special Populations, 1.4%
  - Provided oversight of all aspects of the project implementation.
- Associate Director of Special Populations, 5%
  - Responsible for recruiting, engaging and managing subcontractors, and ensuring contracts and deliverables are met.
- Intervention Manager, 15%
  - Plans and conducts regular internal and partner meetings. Works with Intervention Coordinator to establish day-to-day duties for staff, expectations of internal and external staff, reporting requirements, marketing materials, etc. Works with Data Manager to establish regular data reports needed to reflect productivity.
- Intervention Coordinator, 10%
  - Trains internal staff and external partners on program documentation and expectations. Oversees day-to-day activities of Linkage Coordinator, assists with clients as needed. Regularly works with subcontractors to answer questions. Works with Linkage Coordinator to promote the program to internal stakeholders and external agencies.
- Linkage Coordinator, 75%
  - Responsible for day-to-day activities needed to implement the program including outreach and recruitment, client contacts, documentation and follow up.
- Data Manager, 15%
  - Responsible for data management related to electronic health records of CSI clients.
- Townspeople, subcontract
  - Create client housing plans, manage client housing progress, obtain housing for clients.
- NAMI, subcontract
  - Manage and provide emergency housing funds for clients, provide payee services, and offer budgeting classes.

Intervention Cost Item (12 months, implementation year two)	Intervention Cost
FHCSD Personnel	$84,274
FHCSD Personnel - $69,074	
FHCSD Fringe Benefit (22%) - $15,200	
Transportation for Staff	$6
Educational Materials	$465
Materials (office supplies, printing, postage)	$462
Housing Assistance (Townspeople, Inc. and NAMI subcontracts)	$94,286
Total Direct Costs	**$179,493**
Overhead/Indirect (37.4% of direct costs)	$67,130
Total Costs	**$246,623**

The CSI intervention helped families in need.

Intervention Flow Chart



Evaluation focused on implementation actions, challenges and successes.

Local Evaluation Plan

The local evaluation effort coordinated with the Evaluation and Technical Assistance Provider (**ETAP**), Boston University, and focused on implementation actions, challenges, and successes. The evaluation tracked client outcomes related to housing, employment, retention in care, and HIV viral load. Local evaluation findings were used in an ongoing manner to inform continuous quality improvements using Plan-Do-Check-Act/Adjust cycles.

Logic Model

Please see the logic model in the background section of this report (logic model).

Process Evaluation

The local process evaluation focused on intervention processes and outputs, barriers, challenges, and facilitators of success.

Intervention Processes and Outputs

Intervention processes and outputs measured included number of persons recruited and served, demographic characteristics of persons served, the types of services provided, the number of encounters completed, receipt of employment opportunities, and individual plan completion. The output data were collected by intervention staff and entered into an intervention tracking database. The evaluation partner checked data for completion on a regular basis and reported the findings in the final report.

Barriers and Challenges

The process evaluation plan also tracked implementation challenges and successes. Barriers and challenges were collected by intervention staff in narrative form monthly from all intervention partners and reported in yearly reports.

Facilitators of Success

Facilitators of success were collected by intervention staff in narrative form for the monthly progress reports and discussed in yearly reports.

Outcome Evaluation

The outcome evaluation plan included measures of:

HIV Health Outcomes

- Linked to HIV medical care
- Engaged in HIV medical care
- Viral load suppression

Employment Outcomes

- Became employed
- Retained employment
- Educated or trained
- Participation in employment programs

Housing

- Obtained housing by housing type (emergency, temporary/transitional, permanent)
- Maintained housing
- Receipt of housing assistance

The data related to these objectives were collected by staff during case management contacts and entered into the intervention tracking database. Data were cleaned and analyzed by evaluation staff. Automated database reports, which summarized intervention outcomes were reviewed monthly. Client outcomes were reviewed quarterly so staff could adjust the intervention as needed.

Major outcomes included linking clients to housing.

Intervention Outputs and Outcomes

Process Evaluation

Client-Level Outputs

Table 4. CSI Client Outputs (n=125 clients screened)

Output	Measurement	Number Unique Clients Receiving Service
Recruitment	Racial and ethnic minority people with HIV recruited and screened for eligibility	**125**
Enrollment	Racial and ethnic minority people with HIV enrolled in the coordinated services intervention	**121**
Individual Care Plan Development	Individual, housing and employment care plans completed and uploaded to the electronic health record system	**121**
Referrals Provided	Referrals provided to medical care	**121**
Engaged in HIV Medical Care	Linked to HIV medical care (n=17) or retained in HIV medical care (n=92)	**109**
Employment Referrals	Encouraged to look for employment and referred to the employment services partner	**121**
Housing Support	Received temporary or emergency housing support while waiting for permanent housing availability	**85**
Employment Training/Support	Received employment/training support	**55**

Table 5. CSI Client Demographic Characteristics (n=121 clients served in CSI)

Demographic Characteristic		Number	Percent
Gender	Cisgender Man	**82**	**67.8%**
	Cisgender Woman	**27**	**22.3%**
	Transgender Woman	**9**	**7.4%**
	Genderqueer/Gender Nonconforming	**3**	**2.5%**
Race / Ethnicity	Hispanic	**60**	**49.6%**
	Black / African American (non-Hispanic)	**36**	**29.8%**
	American Indian / Alaskan Native	**11**	**9.1%**
	Asian / Pacific Islander	**9**	**7.4%**
	White (non-Hispanic)	**1**	**0.8%**
	Other [1]	**4**	**3.3%**
Employment at Enrollment	Unemployed	**95**	**78.5%**
	Part-Time, Seeking Additional	**23**	**19.0%**
	Employed (Unstably Housed)	**3**	**2.5%**
Services Received at Enrollment	SSI/SSDI	**31**	**25.6%**
	HOPWA or Other HUD Rental Assistance	**3**	**2.5%**

[1] Other included: African, Middle Eastern, Russian and Jewish.

Encounter data revealed that of the 112 clients with encounter information, the lowest number of encounters was one and the highest was 41, with an average of 12.3 encounters per person. Note that encounters may or may not include contact with the client (an encounter can include collateral, meaning work is done on the client's behalf when the client is not present). The average number of encounters per month is shown in Table 6.

Using this encounter data, the length of service was calculated and is portrayed in Table 7. The length of time between enrollment and the latest encounter (which can include collateral) averaged 12.6 months (ranging from 0 to 27.2 months).

Table 6. CSI Client Encounter Frequency (n=112 clients with encounter information)

Average Number of Encounters Per Month *(includes collateral – source ETAP's Visual Participant Tracking Report)*	**Number**	**Percent**
<1.0 encounters per month	**62**	**55.4%**
1.0 – 1.9 encounters per month	**31**	**27.7%**
2.0 – 2.9 encounters per month	**7**	**6.3%**
3.0 – 3.9 encounters per month	**3**	**2.7%**
4.0 – 4.9 encounters per month	**2**	**1.8%**
5.0 – 5.9 encounters per month	**2**	**1.8%**
6.0 + encounters per month	**5**	**4.5%**

Table 7. Client Length of Service (n=112 clients with encounter information)

Number of Months in Intervention between Enrollment Date and Latest Encounter *(includes collateral – source ETAP's Visual Participant Tracking Report)*	**Number**	**Percent**
< 1.0 months	**14**	**12.5%**
1.0 – 4.9 months	**9**	**8.0%**
5.0 – 9.9 months	**19**	**17.0%**
10.0 – 14.9 months	**32**	**28.6%**
15.0 – 19.9 months	**13**	**11.6%**
20.0 – 24.9 months	**14**	**12.5%**
25.0 – 29.9 months	**11**	**9.8%**

Structural Level Outputs

Table 8. Outputs for Select Structural Changes

Output	Status
HOPWA and Employment Directory	The HOPWA and Employment Directory was completed September 2018, and is updated regularly (see Resource Manual in Attachments).
Information Technology System Updates	Housing and employment referral information is now included in the information technology system.
	RWHAP case management records are now entered into the EHR system, allowing for better tracking of referrals and better coordination between medical and case management services.
	A new dashboard for HIV services, funded by RWHAP Part C, has been created to view data related to people with HIV served at FHCSD.

Staff adjusted the intervention operations based on various barriers and challenges that presented themselves during the intervention implementation and process evaluation. A summary of these adjustments are presented in the table that follows.

Table 9. Barriers, Challenges and Resulting Implementation Adjustments

Category	Barriers and Challenges ⇨	Implementation Adjustments
Communication	The monthly meetings did not provide enough time for the linkage coordinator and housing navigator to coordinate client care effectively.	The linkage coordinator and housing navigator met three times per week to share information needed to track and house clients.
	Townspeople's leasing agent misplaced client paperwork and refused to approve housing for persons with no credit history or a criminal background.	The linkage coordinator and housing navigator advocated with the leasing agent and Housing Authority of San Diego until the rules were relaxed.
	The linkage coordinator and intervention manager had different intervention service delivery expectations (i.e., role of the linkage coordinator, frequency of meetings with clients, focus on employment).	Roles were clarified during intervention staff meetings.

Table 9. Barriers, Challenges and Resulting Implementation Adjustments, Continued

Category	Barriers and Challenges ⇨	Implementation Adjustments
Employment	The linkage coordinator was unable to prioritize employment with some clients who were not housed. Being unhoused created many barriers to searching for employment (e.g., hygiene, transportation, lack of telephone and address, and lack of sleep).	The linkage coordinator continued to meet with the clients emphasizing the importance of preparing for employment and offering encouragement. Alternatives to employment while waiting for housing included training, skill development, and other preparatory activities. The coordinator was also able to use this time to help some clients build self-esteem and belief in their ability to become employed.
Substance Use	Some clients with active substance use disorder needed to address the disorder in order to have the capacity to complete the steps requisite for obtaining housing.	The linkage coordinator linked clients needing extra treatment or support to in-house substance use counselors. Some clients needed to reduce their use before they were ready to complete the needed intervention activities related to housing and employment.
Transportation	Some clients could not attend meetings with the linkage coordinator or complete activities (e.g., obtaining paperwork or attending to other needs) due to lack of transportation.	Bus passes were secured and provided to clients using RWHAP funding.
Housing	Permanent housing earmarked for this intervention was not available in the expected time frame.	Clients were placed in emergency housing with CSI funding after other temporary options were exhausted (i.e., HOPWA, etc.).
Meetings with Linkage Coordinator	Some clients did not fully engage in the intervention; others had transportation or time issues.	As FHCSD was the healthcare provider for many clients, the proximity of the offices to the clinic allowed for the linkage coordinator to successfully meet clients at their medical appointments.

Some intervention facilitators were not preceded by a barrier or challenge. Three main facilitators are noted below.

- CSI staff successfully recruited and served families, due to their strong partnership with the UCSD Mother, Child and Adolescent HIV Program.
- FHCSD received a grant from the Elizabeth Taylor AIDS Foundation, which provided move-in welcome kits, school supplies for children and essential garments. CSI clients reported feeling cared for when receiving these supplies.
- Because FHCSD offered medical services, CSI staff were able to ensure clients were receiving HIV medical care by reviewing appointment lists.

Intervention Outcomes

Intervention Objectives

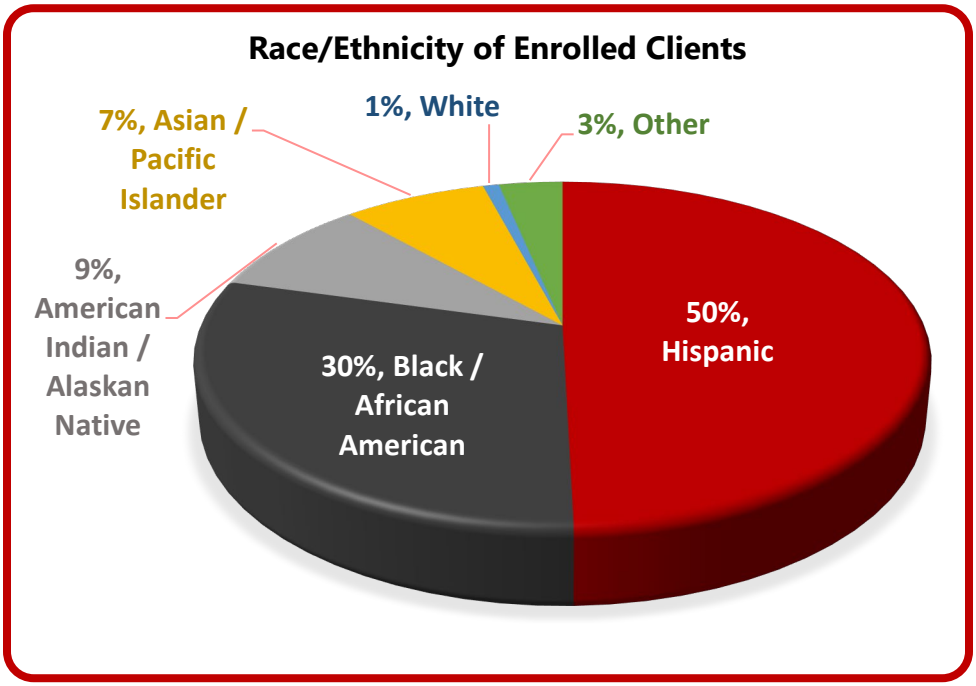
These intervention objectives, as delineated in the proposal for funding, guided intervention staff throughout the intervention implementation. Only objectives pertaining to CSI clients are included on the pages that follow.

Goal 1: *Improve HIV retention in medical care and antiretroviral therapy among clients in HIV medical care as well as viral suppression among clients in HIV medical care among racial and ethnic minority clients with HIV/AIDS in San Diego.*

Objective 1.1. Ninety (90) racial and ethnic minority people with HIV who have fallen out of care and who lack stable housing and employment will be recruited, screened, and enrolled into the intervention.

Staff enrolled a total of 121 persons into CSI in the first two intervention years. Most, 120, belonged to racial and ethnic minority groups.

Chart 1. Race and Ethnicity of CSI Clients (n=121 clients) [1]

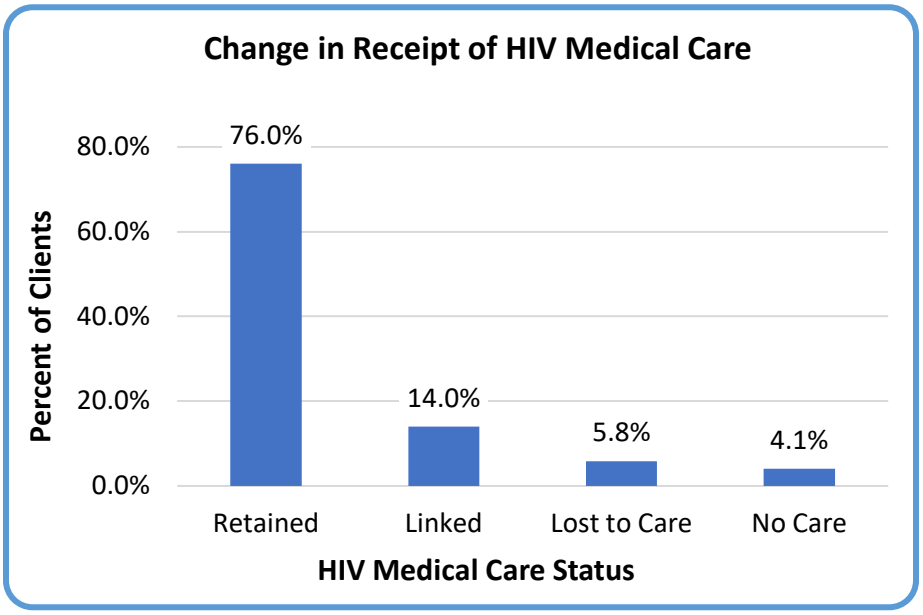


[1] All racial/ethnic categories other than 'Hispanic' are non-Hispanic.

Objective 1.2. The percentage of CSI clients receiving HIV medical care will increase.

The percent of CSI clients receiving HIV medical care increased with 14.0% (17/121) being successfully linked to medical care. Another 76.0% (92/121) were retained in care. Standard activities for patients at FHCSD includes an automated call for missed appointments, automated reminders prior to the appointment, follow-up to determine medication adherence, and re-engagement in care activities (i.e., telephone calls, prompts on the electronic health record system) aimed at persons who needed medication refills or were due for a viral load test. CSI clients were additionally contacted by CSI staff to promote linkage and retention in HIV medical care.

Chart 2. Receipt of HIV Medical Care Before and During the Intervention, CSI Clients (n=121 clients) [1,2]



[1] *Receipt of HIV medical care* defined as completing an HIV medical care visit.
Retained in care defined as having an HIV medical care visit within the six months prior to enrollment and at least one HIV medical care visit after enrollment.
Linked to care defined as not having an HIV medical care visit within the six months prior to enrolment and at least one HIV medical care visit after enrollment.
Lost to care defined as having an HIV medical care visit within the six months prior to enrollment but no HIV medical care visit after enrollment.
No care defined as not having an HIV medical care visit within the six months prior to enrolment and not having an HIV medical care visit after enrollment.

[2] Based on electronic health records or records from outside agencies (n=110) or self-report (n=11).

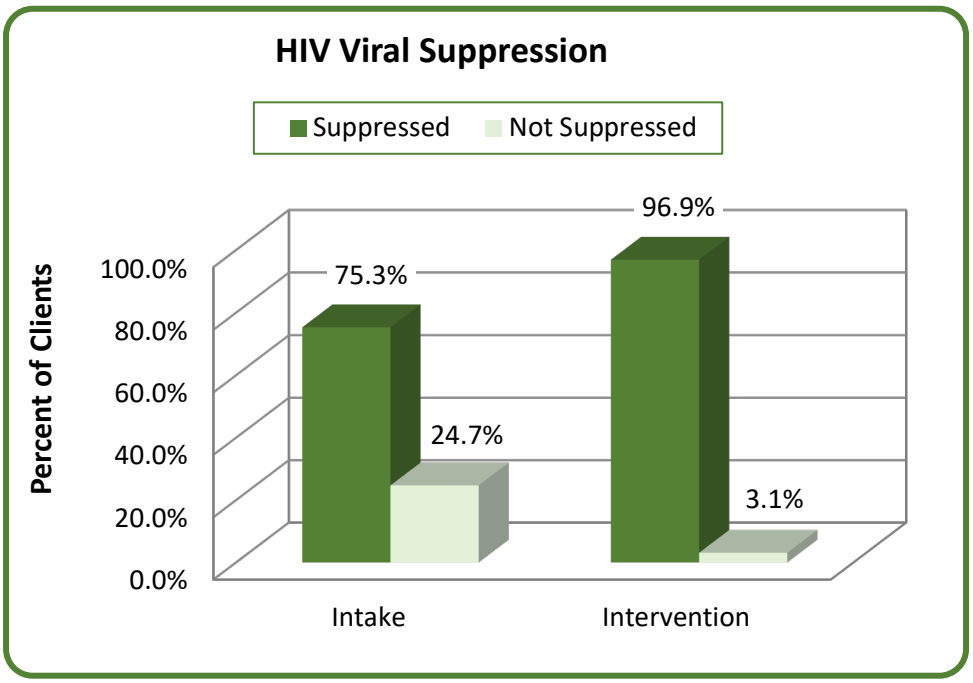
90.1%

Linked to or retained in HIV medical care (109/121)

Objective 1.4. The percentage of CSI clients with a suppressed HIV viral load (less than 200 copies per mL) will increase.

The HIV viral suppression rate among CSI clients with viral load information available increased from 75.3% (73/97) at intake to **96.9%** (94/97) at least once during the intervention period.

Chart 3. HIV Viral Suppression by Intake versus Intervention Period, CSI Clients (n=97 clients with HIV viral load information available for both time periods) [1,2]



[1] Suppression defined as a viral load less than 200 copies per mL.
[2] Values obtained from laboratory results (n=90) or self-report (n=7).
Note: Viral load information was not available for 24 persons (20% of the 121 clients).

Specifically, among those with HIV viral load information available:

- 75.3% (73/97) started the program HIV virally suppressed and remained suppressed during the intervention.
- 21.6% (21/97) changed from *not* HIV virally suppressed at intake to suppressed during the intervention.
- 3.1% (3/97) started the program *not* suppressed and remained *not* suppressed.

96.9%

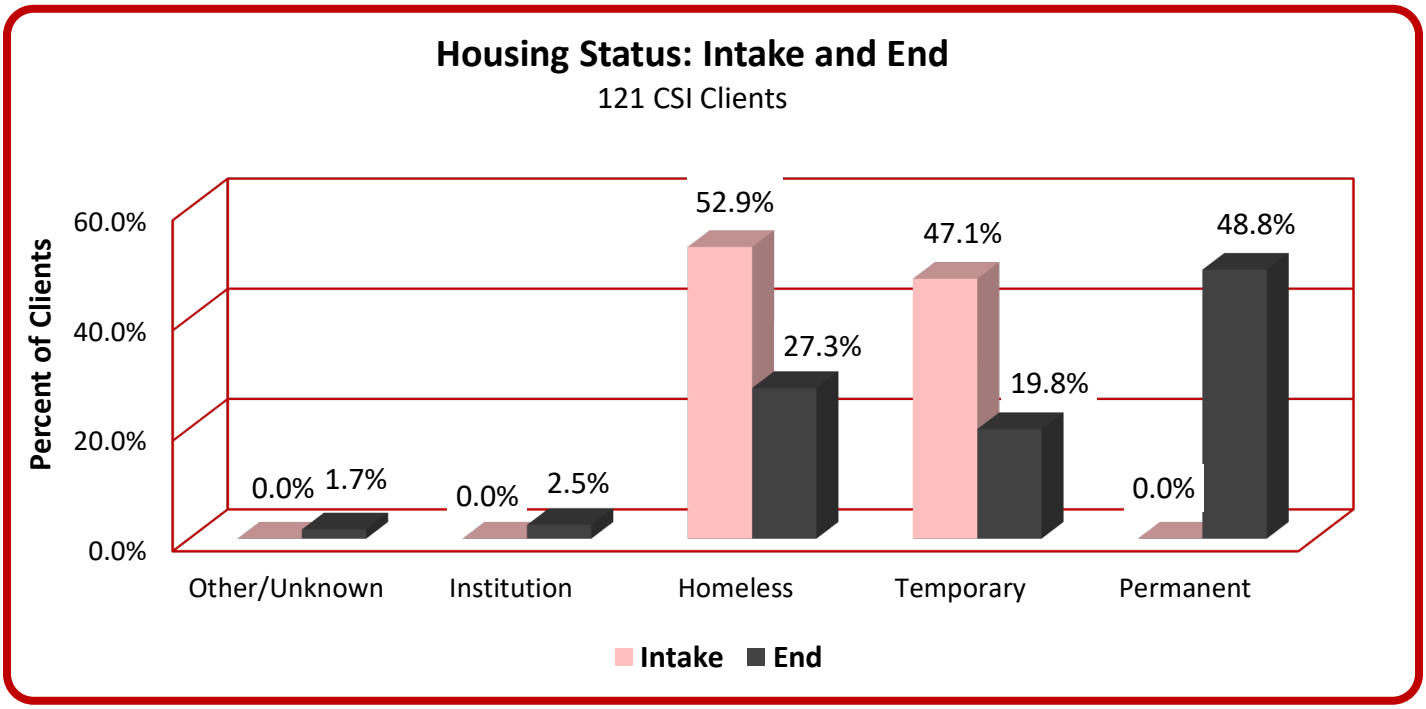
CSI clients with suppressed HIV viral load (94/97)
(at least once during the intervention period)

Goal 2: *Improve housing outcomes for people with HIV in San Diego.*

Objective 2.1. Decrease the percentage of persons with an HIV diagnosis who were homeless or unstably housed.

By the end of the intervention, **68.6%** (83/121) of the CSI clients were housed (59 in permanent housing and 24 in temporary housing) compared to **47.1**% at intake (57 in temporary housing). The difference between intake and the intervention end is shown below.

Chart 4. Housing Status Over Time, CSI Clients (n=121) [1]



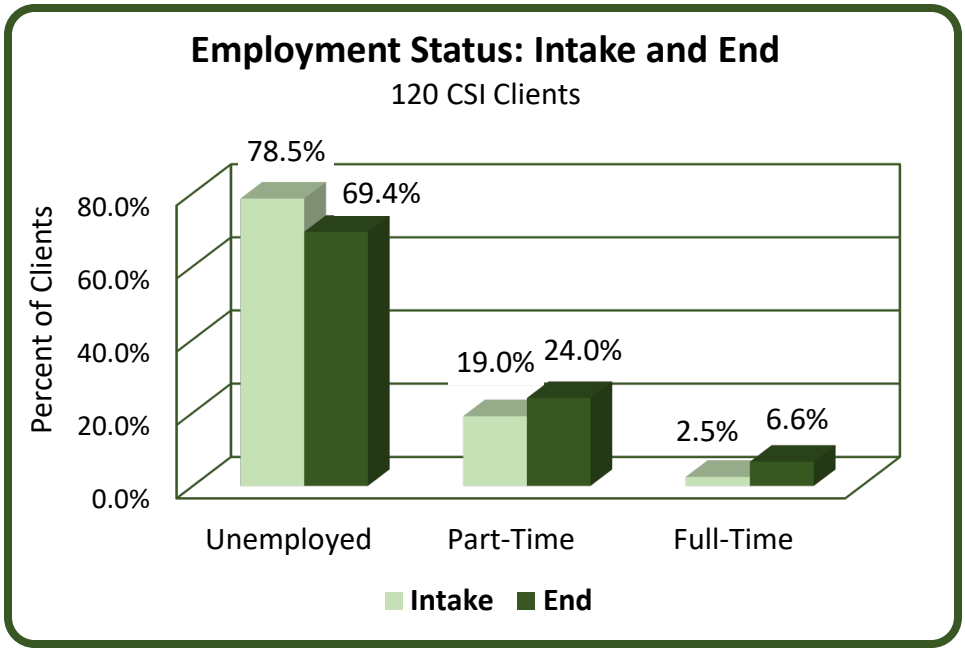
[1] If housing status was not available for the July-September 2020 time frame, information from April-June 2020 was used.

Goal 3: *Improve employment outcomes for people with HIV in San Diego.*

Objective 3.2.1. By the end the intervention, 30 people with HIV will enter or re-enter the workforce and 24 people with HIV will retain employment.

By the intervention end, **30.6%** (37/121) of the CSI clients were employed (8 full-time, 28 part-time and one part-time 'under the table') compared to **21.5**% (26/121) at intake. The difference between intake and intervention is shown below.

Chart 5. Employment Status Over Time, CSI Clients (n=120) [1]



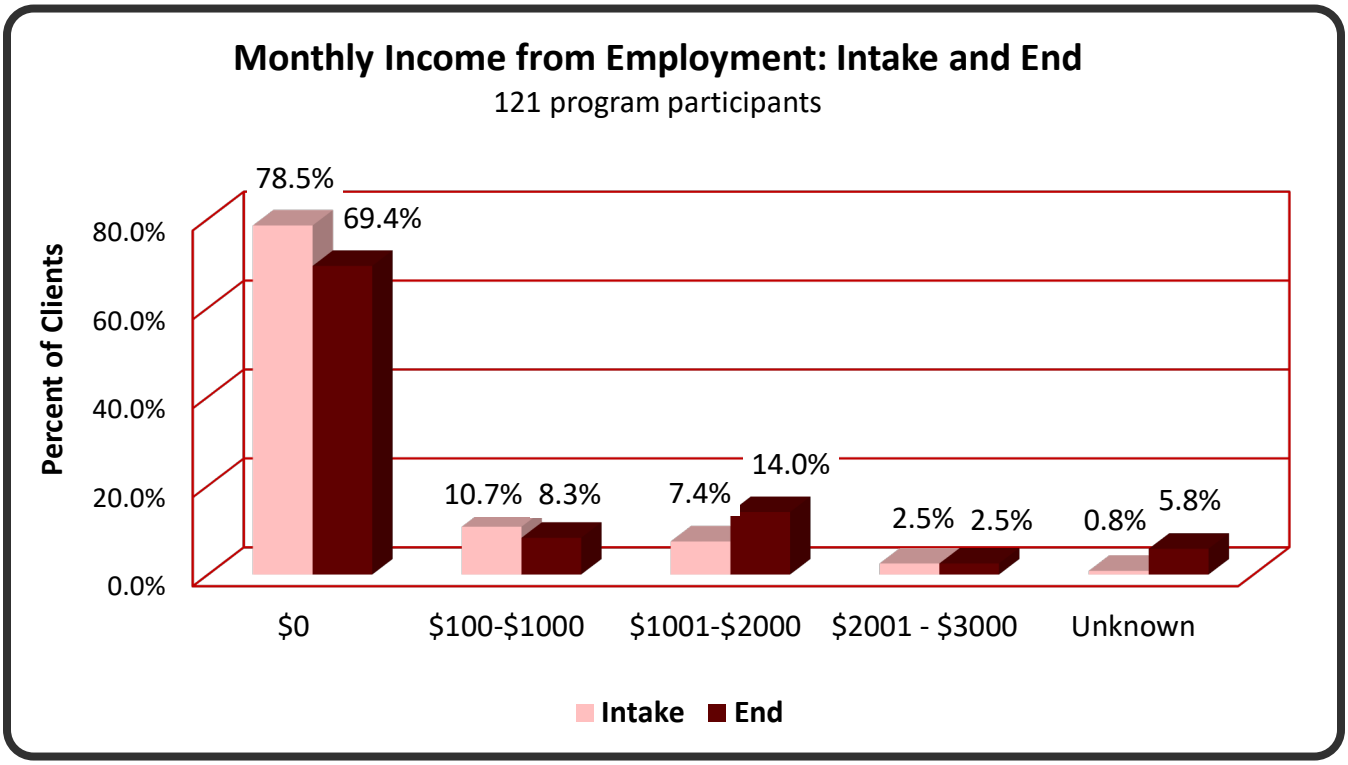
[1] If employment status was not available for the July-September 2020 time frame, information from April-June 2020 was used.

This objective was not quite met by the end of the intervention: 19 CSI clients entered the workforce and 18 CSI clients retained employment.

Objective 3.2.2. FHCSD will track and report average earnings for intervention clients.

All intervention clients report earnings at enrollment, and at specified follow-up time intervals (quarterly in intervention years two and three). The difference between income levels at intake and the intervention end is shown in the chart that follows.

Chart 6. Income from Employment Over Time, CSI Clients (n=121) [1]



[1] If employment income was not available for the July-September 2020 time frame, information from April-June 2020 was used.

A total of **16.5**% (20/121) of the CSI clients reported increased income from employment between intake and intervention end.

Outcomes Related to Sustainability

Sustained Institutionalized Changes

Processes and Relationships. FHCSD and partners established processes, procedures and systems to ensure that HIV care services, HOPWA, and DOL services met all intervention expectations, as well as treatment and service delivery guidelines put forth by HRSA, HUD, and DOL.

- CSI staff promoted long-term health and stability by incorporating and building upon HUD's Office of HIV/AIDS Housing (**OHH**) and DOL's Getting to Work initiative.
- FHCSD intervention staff were trained in human subjects research protections, cultural competency, and HUD's OHH and DOL's Getting to Work curriculum. FHCSD ensured that intervention and direct services staff from partner agencies also received these trainings.
- Care plans and RWHAP case management paperwork were modified to include housing and employment assessment and referrals.
- RWHAP case managers have been cross trained during regular staff meeting to more effectively work with HOPWA and other housing providers.

Data Management. As discussed previously, significant changes were implemented within the EHR system and will be maintained with minimal expense. These changes are underway and will have a lasting impact on FHCSD's processes and quality of care. Changes include:

- The tracking of housing and employment needs and services.
- Including RWHAP case management and CSI activities in the agency-wide EHR system.
- Notices for overdue HIV medical procedures or processes.
- The sharing of referral information real-time between service sites and staff.
- An HIV data dashboard to create, standardize and improve data reporting quality.

> ***Institutional capacity to manage system-wide referral tracking was increased through a RWHAP Part C Capacity Building grant.***

Integration

By the intervention end, FHCSD successfully integrated CSI activities into standard operating practices for racial/ethnic minority people with HIV impacted by employment and housing instability.

- FHCSD will continue to foster the relationship with Townspeople, NAMI, San Diego Workforce Partnership, and other community partners to promote sustainability beyond the three-year intervention period.
  - NAMI and Townspeople will continue to aid clients with emergency housing.
  - Townspeople will continue to utilize programs to aid renters such as those paying for security deposits and move-in supplies.

- FHCSD will provide RWHAP case management to clients in place of linkage coordination, fulfilling many of the same duties.
  - RWHAP case managers create goals related to housing, medical care, and employment, and follow-up with clients monthly.
  - Case manager will continue to link clients to the CSI employment partners (SDES and SDWP) and housing partners.

- The enhancements to EHR will ensure the timely identification of, and prompt follow-up with, patients who are not treatment adherent, whose viral load is not suppressed, or for whom employment and housing intervention/supports are needed.
  - HIV services staff will continue to use data reports to follow-up with patients who are at-risk of falling out of care.

Services Not Continuing or Reduced

- Unfortunately, RWHAP case managers will not have as much time as the dedicated linkage coordinator had to aid clients with housing and employment needs. RWHAP case managers touch on housing and employment but are not able to provide the same level of aid as the intervention linkage coordinator due to time constraints. A manual with employment and housing information was created with resources for the RWHAP case managers to help serve clients' housing and employment needs.
- CSI funding was used to fill gaps in housing needs by providing emergency housing, back rents owed, rent aid, and security deposits. This funding source will no longer be available. While other programs can provide these services, they often do not have sufficient funds or restrictions in what they can pay for.

Outcomes Related to Policy/Systems Changes

Within the system of RWHAP case managers at FHCSD, CSI provided the blueprint for improved pathways to housing, employment, and other resources for people with HIV. The lessons learned have been and will continue to be shared with RWHAP and other case managers in the organization during regular staff meetings. The lessons learned will also be shared at the quarterly People of Color meeting and at San Diego HIV Planning Group meetings.

Improved Path to Housing for People with HIV

Using CSI funds, staff streamlined housing intake and assessment forms across programs within FHCSD. FHCSD is now better able to identify unmet housing needs and create person-centered coordinated services for clients seeking housing. During the process, close collaboration with the housing and financial partners allowed for shelter stays to be extended until permanent housing became possible. These collaborations will continue.

Client Examples

One non-English speaking family received housing and employment assistance from the intervention. The linkage coordinator referred the client to Townspeople, who placed the family on the waitlist for their Vista Del Puente housing site. The linkage coordinator and housing navigator at Townspeople worked together, along with the family ,to ensure that all application forms were completed. In this case, the application forms and paperwork needed to be completed more than once, but as a result of the continued collaboration of all involved, the family was approved for housing.

Another client, a registered sex offender not eligible for HUD, was living in a halfway house. CSI staff aided this client by using intervention funds to pay for rent while he looked for a job.

Improved Path to Employment for People with HIV

CSI allowed staff to create uniform employment intake and assessment forms at FHCSD, improving the identification of unmet employment needs. Through staff training and improved referral relationships with employment partners, the linkage coordinator and RWHAP case managers are better able to assess and refer persons needing employment services.

Client Example

One non-English speaking client started the intervention without a job. This client had skills and a license to work as a manicurist. Staff encouraged the client to search for employment and supported the client by offering positive reinforcement and discussing potential agencies to approach. The client located a nail shop, approached the staff, and obtained employment at this shop despite her language barriers.

Improved Referral Pathways for People with HIV

As a result of the structural technology changes, referral pathways are now integrated throughout FHCSD's network of clinics and services, which include HIV medical care and numerous support programs. The new referral pathways allow primary care-based staff and HIV services providers, including health educators, medical assistants, patient service representatives, mental health staff, case managers, and others to work together to provide the highest quality care. Referrals and referral outcomes can be monitored by various staff positions, which ensures clients are receiving services.

Client Examples

One client fleeing domestic violence was referred by a case manager from another program after the client's EARP funding, which provided three weeks of housing, had expired. Collaboration allowed the referring agency to link the client to CSI, which guided her in finding a job in a taco shop and provided funding for her continued housing.

One RWHAP client commented that because of the new linkage of services within the FHCSD network, he was able to attend his dentist appointment without also having to bring HIV paperwork and medication lists with him. The information was obtained in the electronic system and could be accessed by staff at the dentist office.

Clients were connected to additional medical and support services to improve health outcomes.

The project revealed important insights in helping individuals with HIV find stable housing.

Lessons Learned

Barriers and Challenges

Client Barriers

Self-Esteem

The linkage and intervention coordinators noted certain characteristics among those who were difficult to engage fully in the intervention. Substance use and self-esteem was two of the main barriers inhibiting clients. Positive self-esteem and resiliency were critical factors in ensuring clients were able to move forward in the intervention. Staff worked with clients by offering guidance, positive reinforcement, and emotional support to increase self-esteem. Staff sought to help those who felt unemployable see themselves as valuable and worthy of employment.

Coordinators worked with clients to support their self-esteem development through compassionate and supportive advice during ongoing, regular communication.

As shown previously:

Linkage Coordination: Increasing Self Esteem

- Trauma-informed practices
- Strengths-based case management
- Setting realistic goals
- Praising small steps towards success
- Accompanying, helping, and encouraging clients to address their internal barriers and persevere against bureaucratic challenges

The case study that follows highlights how one client's perseverance and readiness to change led to her success in the intervention.

Case Study: Charity

Charity (not her real name) was a 38 year old Black woman with HIV. She learned of her infection in 2013, and believes she contracted HIV from her partner of three years.

Charity was born into a dysfunctional family. She lived with her mother and her mother's boyfriend Bill (not his real name). Charity witnessed several accounts of domestic violence in her home. When Charity reached the age of five, she was kidnapped and raped. She was raped on several other occasions until the age of 13. At the age of eight, Charity's five year old sister's died in a car accident. Charity's stepfather overdosed and died in Charity's arms three months later. A year later, Charity's mother fell into a coma from substance use, although she eventually recovered. Once Charity reached the age of 14, she told her mother about the numerous times she was raped. She hoped to gain love and support, but instead was ignored. In order to numb her trauma, Charity began using methamphetamine.

Charity reported that her substance use disorder seemed out of control. She recalled the last time she got high; she was up for five consecutive days. On the fifth day, she observed her mother being physically and verbally abused by her boyfriend Bill. Charity, outraged by the mistreatment, said she "snapped" and began hitting Bill but could not stop him. She began to break the television and her belongings before the police arrived with the psychiatric team although Bill refused to let the psychiatric team into the house. Charity told an officer, "I need help, I am on drugs and I am having a breakdown."

The police told her to, "Put out your cigarette, you nigger bitch!" The police proceeded to tase her "16 times on her genital area."

She later went to jail in 2018, where she discovered she was pregnant with twins. The babies' biological father was incarcerated and could not be reached for support.

After her release, Charity took the initiative to enter a 90-day residential treatment program for women and mothers, from March to June 2018. Once Charity completed the treatment program, she faced homelessness and was living alone under a bridge.

Charity was referred to UCSD's Mother, Child and Adolescent HIV Program, who then referred Charity to CSI. The CSI linkage coordinator linked Charity to Townspeople, but she was deemed ineligible for their Vista Del Puente site due to her felony arrest charge. **Townspeople was, however, able to move Charity into one of their other housing properties (51st Street).**

Charity is currently stable on her medications and attending all her medical appointments. She is actively engaged in anger management classes, therapy, and parenting classes in order to continue a healthy and sustainable lifestyle.

Substance Use

Staff noted that some clients used substances, which impacted their ability to complete meetings, paperwork, or employment searches. If clients exhibited such problems or setbacks, staff referred them to on-site RWHAP substance use counselors for support and treatment and continued to work with the clients.

Housing

Timing and Availability of Housing Units

This intervention was planned with the idea that Townspeople was about to have abundant housing available earmarked for this intervention. However, due to problems with the leasing agency approval process, most placements were delayed well into 2019, and an insufficient number of units was available for this intervention. This created a cascade of difficulties for clients.

- The application paperwork expired for many clients prior to being housed.
- Some of the paperwork required additional client travel and time in order to visit a doctor (with appointments a month or more away) to obtain a certificate of disability.
- Some clients did not obtain permanent housing, and for others, the intervention needed to exhaust funds from other programs to stabilize persons in emergency housing situations prior to housing availability.

Additional Delays to Housing

Leasing and approval processes created delays to housing clients who had been approved for permanent housing through Townspeople.

- After clients obtained the housing approval from the leasing agency, the housing or apartment needed to be inspected by the Housing Authority of the County of San Diego, who offered these services on a very limited schedule. This delayed move-in dates.
- Many clients had been rejected by Townspeople's leasing agency for former felony convictions, although a felony conviction was not a disqualifier for HUD housing. As per their contract with the San Diego County Housing Commission, Townspeople could not change their leasing agency. Townspeople and FHCSD therefore spent a great deal of time trying to improve this system.
    - Due to this barrier, many intervention clients waited over six months for permanent housing.
    - FHCSD and Townspeople advocated for the clients and connected them to resources to appeal the denials.
    - Some individuals who were denied ended up receiving housing through Townspeople's other properties, sometimes being placed in transitional housing until permanent units became available.

An upgrade to the homeless navigation software utilized by all programs in San Diego County created a bottleneck of service delivery. Not all housing navigators had access to the new software and screening process, without which one cannot place clients on the formal housing list with the County of San Diego. Placing clients on the formal housing list is a necessary first step for the housing process in San Diego County, which is handled through the central Homeless Management Information System.

Lack of Housing Services for Persons Lacking Documentation

As stated previously, persons lacking legal documentation (or persons with visas not qualified for HUD) could not access HUD housing, which created an insurmountable obstacle to permanent housing for some clients, even those with children who were citizens. As a result, many individuals could not be served by this intervention to meet their permanent housing needs. Instead, the intervention helped persons who lacked documentation by attempting to:

- Place them in HOPWA programs that did not require legal residency documentation.
- Place them in rapid re-housing programs through the County of San Diego if they had enough income to pay for rent after being employed.
- Link them to the employment partner, SDWP, who was able to assist persons lacking documentation with searching for employment.
- Connect clients to the Landlord Engagement and Assistance Program (LEAP), funded by the San Diego Housing Commission, to aid in searches for permanent housing units. LEAP provides incentives for landlords with rental housing units in the City of San Diego who rent to San Diegans experiencing homelessness.

Facilitators of Success

1. **Client Characteristics**
2. **Intervention Partners**
3. **Availably of Linkage Coordinator**
4. **Funding**
5. **Coordination of Services**
6. **Existing Intervention Colocation**
7. **Trust in the Community**
8. **Client Recruitment**
9. **Agency Attributes**
10. **Additional Funding**

Townspeople, Inc.: Vista Del Puente housing

Client Characteristics

Client characteristics needed for success included self-esteem, motivation, and the ability to reduce substance use enough to participate in the process. Some clients exhibited very high levels of motivation and perseverance despite difficulties. About 25% were already employed part-time at enrollment. Clients who would remain in contact with the team and attend meetings experienced higher levels of success and reported increased self-esteem.

Recommendation 1: Focus on increasing client self-esteem and motivation through (1) addressing substance use issues and (2) utilizing staff who are trained in these topics or a curriculum/intervention that addresses these topics.

Recommendation 2: Continue checking in and offering support for clients who do not have sufficient motivation or control of their substance use until they are in a place to more easily access services. Refer clients and offer warm handoff to programs that can help them.

Intervention Partners

The housing partner and employment partners were able to serve persons who lacked documentation, which greatly aided the intervention process. NAMI's short-term housing solutions funds helped house some clients while waiting for permanent housing.

Ideal housing partner: An ideal housing partner would know, or be willing to be educated, about homeless individuals with multiple barriers to becoming stably housed, including felonies and citizenship status. The partner would also have empty units needing to be filled.

Recommendation 3: Work with an agency that has experience and can help manage existing programs and funds to temporarily house individuals. By utilizing multiple funding sources, partners were able to house persons for longer.

Recommendation 4: Have a robust employment intervention such as one, or all, of the following:

1. Sufficient staff time available to accompany clients to the employment partner sites.
2. Employment training services (resumes writing, etc.), presentations, and mini-job fairs hosted at the intervention site.
3. Employment curricula intervention taught by knowledgeable on-site staff.
4. Services targeted specifically for undocumented individuals.

Availability of Linkage Coordinator

The linkage coordinator for this intervention worked diligently, often seeing clients after regular business hours. This additional availability coupled with her non-judgmental nature helped clients to trust her. She attained these skills through her training in social work and substance use disorder treatment.

***Recommendation 5*:** Utilize staff who are compassionate, have training in social work and substance use disorders when possible, and are culturally competent.

Funding

Intervention funding has been very important in facilitating success. Several programs provided funding to keep clients temporarily housed (i.e., HOPWA, EARP, CSI) while there were delays in obtaining permanent housing. Additionally, some clients who were initially rejected for permanent housing by the leasing agent were able to find other housing through Townspeople programs while waiting.

Key Idea: CSI funds allowed the intervention to offer emergency housing and to address unexpected delays and barriers to housing.

Coordination of Services

The intervention coordinator convened meetings and ensured coordination of services among employment and housing partners, as well as among other partnerships and supports. Moreover, CSI was strongly supported by the County of San Diego Health and Human Services Agency, San Diego's Local Health Jurisdiction, who disseminated knowledge of the intervention throughout the county's RWHAP, employment, and housing providers.

Recommendation 6. Include time for start-up activities such as reviewing and streamlining intake and assessment forms, forming partnerships, and determining how data will be shared across agencies so that services can be coordinated.

Existing Intervention Colocation

The FHCSD site where CSI was located was also home to other HIV services, such as RWHAP Medical Case Management and Targeted Services for People of Color programs, both of which worked hand-in-hand with the CSI staff. The co-location of these services allowed CSI staff to learn from more experienced staff and allowed clients to benefit from a variety of services in one location. Clients reported feeling 'cared for' by the various sympathetic staff and programs available at this location.

Key Idea: Co-located services allow for knowledge sharing among staff and helps clients more easily obtain a variety of services.

Trust in the Community

Because FHCSD has been the largest provider of HIV medical care and supportive services in San Diego County for many years, there is a high level of trust and awareness about the agency in the HIV community. This pre-existing trust and awareness helped clients feel safe when seeking services, aided recruitment efforts, and fostered relationship building with new partners such as SDWP. Agencies such as UCSD and Neighborhood House Association also referred potential clients to this intervention and trusted that FHCSD would serve clients well.

Recommendation 7. Operate within a trusted community organization or partner with an agency that has a positive reputation in the community, both among clients and professionals.

Client Recruitment

Prior to intervention implementation, staff promoted the intervention to other programs and agencies that served people with HIV through presentations and flyers. Because of this planning, and the acute need for housing in San Diego County, it was not difficult to find potential clients. Staff maintained a wait list prior to the intervention implementation, which allowed them to both pre-screen for motivation (i.e., clients willing to remain in contact while on the wait list), and to begin enrolling clients immediately when services were available.

Recommendation 8. During the planning phase, be sure that there are enough potential clients available and willing to engage in services. If not, determine the reasons and update the intervention plan accordingly.

Agency Attributes

Because of the large patient base (over 1,000 people with HIV seen per year) and numerous pre-existing HIV service programs at FHCSD, the process of recruiting clients for this intervention and integrating the intervention into existing programs was easier than would be expected in a smaller organization. Experienced staff from other programs at FHCSD eliminated many training needs and likely contributed to client success.

Recommendation 9. Find experienced staff to ensure intervention success; utilizing current agency staff may simplify intervention integration.

Additional Funding

Because existing services and programs were insufficient to meet clients' housing needs, FHCSD actively applied for more funding during the operation of this intervention. The new funding described below will enable RWHAP case managers to refer potential clients to this intervention as CSI wanes.

The New Start Project will provide ongoing psychosocial support, peer navigation, and one-time material needs assistance, including household supplies, non-perishable food pantry items, school supplies, and clothing to formerly homeless families and children/youth affected by HIV who are transitioning into stable housing. By addressing the psychosocial and material needs of these vulnerable families, the program will promote retention in stable housing and HIV medical care, as well as overall quality of life.

FHCSD received funding from the Elizabeth Taylor AIDS Foundation (New Start Project) to improve the quality of life of families and children affected by HIV and experiencing homelessness and/or housing instability in San Diego County, California.

Dissemination Activities

Intervention Presentations

- People of Color Case Management Meeting, November 11, 2018
- Mother Child Adolescent Program, November 11, 2018
- Transitional Case Management Program, September 28, 2018
- San Diego County HIV Planning Group, Strategies Committee
- Joint City-County HIV Housing Committee, July 18, 2018
- California Department of Correction, Division of Adult Parole Operations, February 6, 2019

Dissemination Activities to Area Ryan White HIV/AIDS Programs

FHCSD plans to disseminate the intervention findings to the FHCSD medical leadership team, HIV Planning Group, and to other pertinent RWHAP organizations as deemed necessary. In addition, FHCSD will continue to foster partnerships with community members and organizations by providing quarterly and bi-annual in-services and/or presentations focused on increasing referrals and resources for racial and ethnic minority people with HIV who have fallen out of care and who lack stable housing and employment.

AIDS Education and Training Centers Outreach

FHCSD will provide the manual to the local AIDS Education and Training Center and discuss with them the intervention findings and lessons learned.

TargetHIV

The manual will be uploaded to the TargetHIV site, which is the HRSA HIV/AIDS Bureau website for resources (https://targethiv.org/).

Appendix

Appendix

Goals and Objectives

Goal 1: *Improve HIV retention in medical care and antiretroviral therapy among clients in HIV medical care, as well as viral suppression among clients in HIV medical care among racial and ethnic minority clients with HIV/AIDS in San Diego.*

Objective 1.1. By September 30, 2018, begin enrolling clients into the intervention. By the end of each intervention year, a minimum of 30 racial and ethnic minority people with HIV who have fallen out of care and lack stable housing and employment will be recruited, screened and enrolled into the intervention.

Objective 1.2. The percentage of patients with an HIV medical care visit in the first half of the year that had a second HIV medical care visit at least 90 days after the first will increase by the end of each intervention year.

Objective 1.3. The percentage of HIV patients who are *prescribed ART* in the last 12-month measurement period will increase each intervention year.

Objective 1.4. The percentage of HIV patients with a *viral load less than 200 copies per mL* at last test in the 12-month measurement period will increase each intervention year.

Goal 2: *Improve housing outcomes for people with HIV in San Diego.*

Objective 2.1. Increase the percentage of persons with an HIV diagnosis receiving housing services who were homeless or unstably housed in the 12-month measurement period by the end of each intervention year.

Objective 2.2.1. By the end of each intervention year, 10 people with HIV will be assisted in obtaining tenant-based housing.

Objective 2.2.2. By the end of each intervention year, 30 people with HIV will be assisted in obtaining transitional housing.

Objective 2.2.3. By the end of each intervention year, 10 people with HIV will be assisted in obtaining permanent housing.

Goal 3: *Improve employment outcomes for people with HIV in San Diego.*

Objective 3.1. Increase the percentage of people with HIV with unmet employment needs receiving employment services in the 12-month measurement period.

Objective 3.2. Increase performance on Employment and Training Administration (ETA) Common Performance Measures.

Objective 3.2.1. By the end the intervention, 30 people with HIV will enter or re-enter the workforce and 24 people with HIV will retain employment.

Objective 3.2.2. FHCSD will track and report average earnings for intervention clients.

Objective 4.1. By the end of year 3, sustain and integrate CSI functions into agency operations.

Objective 5.1. By the end of year 3, disseminate intervention findings to facilitate replication.

Attachments

Attachments

Job Descriptions

Title	Role, Responsibilities & Rationale for Time Requested	Education, Experience & Qualifications
Director of Special Populations	Responsible for successful implementation of the project and for integration of best practices into ongoing services; assists with formalizing key partnerships, finalizing Vocationalizing Plan, and establishing baseline measures and goals; participates in program meetings; ensures client enrollment and service provision begin according to timeline; leverages services across programs and partners to maximize available services; oversees the Associate Director.	Bachelor's degree in a relevant field with 5-7 years in senior healthcare management or a master's degree with 3-5 years' experience. Knowledge of the service needs of the HIV/AIDS community with at least three years' experience serving the patient population. Action-oriented with negotiation skills necessary to achieve position expectations. Demonstrated programmatic and fiscal management abilities.
Associate Director of Special Populations	Oversees HIV Services and Special Populations programs; formalizes key partnerships and subcontracts; works with leadership to establish baseline measures and goals; finalizes Vocationalizing Assessment and Plan; participates in monthly and quarterly meetings; provides input into Resource Directory; reviews data reports with project manager; leads the identification of out-of-care racial/ethnic minority people with HIV; supports staff in client screening and enrollment; supports the integration of intake and assessment forms into RWHAP programs.	Bachelor's degree in a relevant field with 5-7 years' experience in senior healthcare management, or a master's degree with 3-5 years' experience. Knowledge of the service needs of the HIV/AIDS community with at least 3 years' experience serving the patient population. Demonstrated programmatic and fiscal management abilities, including budget and report preparation. Demonstrated experience overseeing a diverse workforce, including effective leadership and supervisory skills.
Program Manager	Oversees day-to-day operations of the program; coordinates CAB meetings and integration of consumer feedback; participates in development of Vocationalizing Assessment, Plan, and the Resource Directory; participates in all meetings; supervises the program coordinator; ensures streamlining of intake and assessment forms; coordinates identification of potential clients; establishes baseline measures and goals; leads quality improvement projects; ensures integration of assessment forms into programs for people with HIV; ensures staff is trained to conduct	Bachelor's degree in relevant field with 5-7 years' experience in senior healthcare management; or a master's degree in a relevant field with 3-5 years' experience in program management. Knowledge of the service needs of the HIV/AIDS community with at least three years' experience working with organizations serving people with HIV. Demonstrated ability with programmatic and fiscal management.

	employment assessments; presents outcomes and shares findings with other providers.	
Data Manager	Oversees program data management and reporting; program manager in streamlining of client intake and assessment forms; develops schedule for standardized data reports in collaboration with information technology staff; uses knowledge of EHR to pull reports of people with HIV of color who are out-of-care; generates daily reports of missed appointments and patients who have not been seen in the last 90 days; generates monthly reports of client enrollment and HIV clinical indicators (e.g., fallen out of care, ART adherence, viral suppression); assists leadership in review of data reports and use of data for quality improvement.	Master's degree in Public Health, Social Work, or related field. Two years' experience working with specific data systems and evaluators. Three years' experience in research, data analysis, and data management. Strong skills in computer applications. Knowledge of all screening, assessment, treatment tools, and reporting requirements; and processes, procedures, and best practices relating to data collection, analysis, and evaluation.
Linkage Coordinator	Conducts client screening, intake, assessment and enrollment into the program; documents assessment results in electronic health records and other databases as appropriate; works with information technology to set-up automated appointment reminders; coordinates directly with data manager to address client barriers; follows-up with clients who miss appointments or who have fallen out of care to identify and address barriers; works with data manager and care team to develop standardized report schedule; provides housing referrals and assistance; conducts monthly case conferencing with CSI subcontractors and quarterly CSI partnership meetings; provides employment referrals and linkages to services.	Bachelor's degree in Public Health, Social Sciences, Business Administration, Health Care Administration, Nursing, or closely related field; or, current enrollment in bachelor's program. One year experience in program management in health care field, including experience working with LGBT, homeless and/or HIV-positive patients. Bilingual English/Spanish and demonstrated cultural sensitivity.
Program Coordinator	Coordinates with staff and partners to streamline intake and assessment forms; ensures client enrollment and data collection processes begins within specified time frame; works with data manager to identify potential clients using electronic health records; works with information technology staff to ensure prescription order decision-aids are in place; participates in monthly case conferencing among CSI contractors and quarterly CSI partnership meetings. Supervises the linkage coordinator.	Bachelor's degree in Public Health, Social Sciences, Business Admin., Health Care Admin., Nursing, or closely related field; one year experience in program management, including experience working with Lesbian, Gay, Bisexual, Transgender (LGBT), homeless and/or HIV patients. Demonstrated cultural sensitivity.
Information Technology	Completes updates to electronic health records related to the collection of housing and employment status, and secure sharing of client data across	Bachelor's degree in Computer Science, Information Systems, or related field. Two years' experience in computer application

Software Engineer III	partners; works with the linkage coordinator to set-up automated appointment reminder system for participants; works with the program coordinator to ensure prescription order decision-aids are in place; coordinates with the data manager to develop a schedule for standardized data reports of missed appointments and HIV clinical indicators.	system design, implementation or comparable skills. Experience using MS SQL Management with expert level knowledge of writing queries to perform basic function, creating Stored Procedures, Function, and Views required.
Evaluator	Design and oversee participant services and outcome tracking; develop a program database; assist in updating client assessment forms and other data collection forms; participate in monthly and quarterly CSI partnership meetings; monitor data quality; prepare evaluation reports required by funders.	Master's Degree or higher in Public Health and/or other health science field. Specialized training and a minimum of five years' experience evaluating community-based health and public health projects and programs.

Screening Form

SPNS Coordinated Services Intervention: Screening Eligibility Checklist

1. **Are you 18 years or older?**
   - ☐ No (Is not eligible for the study-refer to other services/programs)
   - ☐ Yes

- Are you of Hispanic, Latino/a, or Spanish origin? A person of Cuban, Dominican, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race? ☐ No ☐ Yes
- Are you: *(Please indicate all that apply)*
  ☐ White/Caucasian ☐ American Indian/Native Americans ☐ Pacific Islander
  ☐ Black/African American ☐ Alaska Native ☐ Asian

AND Staff Only: Qualifies as racial or ethnic minority? ☐ No (*not eligible - refer to other services/programs)*
☐ Yes

AND

2. **Are you HIV–positive?**
   - ☐ No (Is not eligible for the study-refer to other services/programs)
   - ☐ Yes

   If yes, you must identify within the one or more of the following parameters:

   2a. Newly diagnosed within the past 12 months prior to enrollment into the SPNS Program?
   - ☐ No
   - ☐ Yes

   2b. Have one or more gaps in HIV primary care visits which lasted six months or more in the previous two years prior to the date of enrollment?
   - ☐ No
   - ☐ Yes

2c. At risk of falling out of care? (Instructions: Select one option. Options are in order of priority. For missed appointments, select the option based on information available from the client or chart records.)

- ☐ No, not at risk of falling out of care
- ☐ Yes, exiting incarceration (jail or prison)
- ☐ Yes, missed their last two appointments in the last 12 months
- ☐ Yes, missed their last appointment in the last six months

2d. Not virally suppressed (has a viral load ≥ 200 copies/mL)?

- ☐ No, client is virally suppressed
- ☐ Yes, client is NOT virally suppressed

AND

3. Are you currently homeless or unstably housed? (Select one)

- ☐ No (Is not eligible for the study-refer to other services/programs)
- ☐ Yes, literally homeless; lacks a fixed, regular, and adequate nighttime residence, or transitionally housed[8]:
  - Transitionally housed is defined as being in a place for less than 24 months; this can be a person participating in subsidized housing program such as rapid re-housing program; halfway housing; sober housing; **OR**
  - An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; **OR**
  - An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low income individuals); **OR**
  - An individual who is exiting an institution where he or she resided for less than 90 days and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution; **OR**
- ☐ Yes, unstably housed:
  - Has not had a lease, ownership interest, or occupancy agreement in permanent and stable housing with appropriate utilities (e.g. running water, electricity) in the last 60 days; **OR**
  - Are in permanent supportive housing and received a shut off notice in the last 60 days; **OR**
  - Has experienced persistent housing instability as measured by two moves or more during the preceding 60 days; **OR**
  - Can be expected to continue in such status for an extended period of time; **OR**
  - Imminent eviction (Received a Notice to Quit from the court system); **OR**
- ☐ Yes, client is an individual fleeing, or attempting to flee, domestic violence who:
  - Has no other residence; and
  - Lacks the resources or support networks to obtain other permanent housing; **OR**

[8] The Homeless Definition and Eligibility for SHP, SPC, and ESG. U.S. Department of Housing and Urban Development

☐ Yes, client is in imminent risk of homelessness[9], defined as:
Individual or family who will imminently lose their primary nighttime residence, provided that:
- Residence will be lost within 14 days of the date of application for homeless assistance;
- No subsequent residence has been identified; and
- The individual or family lacks the resources or support networks needed to obtain other permanent housing.

AND

4. Are you unemployed or underemployed? (Select one)
- ☐ No (Is not eligible for the study-refer to other services/programs)
- ☐ Yes, does not have a job, actively looking for work in the prior 4 weeks, and currently available for work. This may include people who are currently receiving unemployment benefits; **OR**
- ☐ Yes, is on SSI/SSDI but demonstrates an interest in earning additional income via a type of paid employment (up until the threshold allowed so as to not jeopardize benefits); **OR**
- ☐ Yes, has a part time employment or temporary work but would like to earn additional income; **OR**
- ☐ Yes, is working on a cash basis for per diem work; **OR**
- ☐ Yes, does not have enough paid work or is not doing work that makes full use of skills and abilities to meet their essential needs.

Eligible: ALL questions must be YES (#1 both parts, #2, #2a-d, #3, #4 – all must have at least one "YES").

Exclusion Criteria:
- Persons engaged in care AND virally suppressed at time of enrollment
- Existing clients who demonstrate consistent attendance at HIV primary medical appointments in the previous two years prior to enrollment

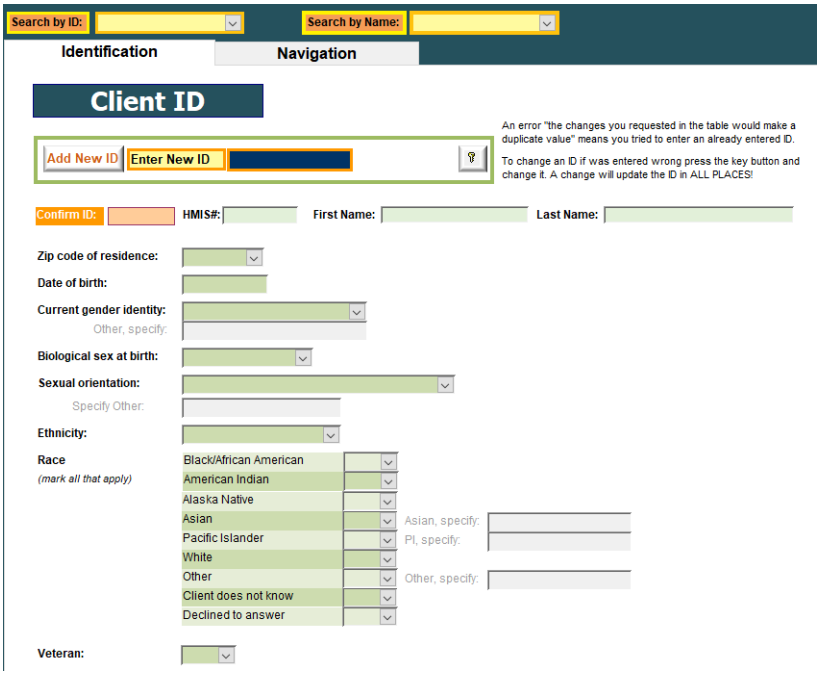
[9] HUD Category 2 of Homeless definition. https://www.hudexchange.info/resources/documents/HomelessDefinition_RecordkeepingRequirementsandCriteria.pdf

Evaluation

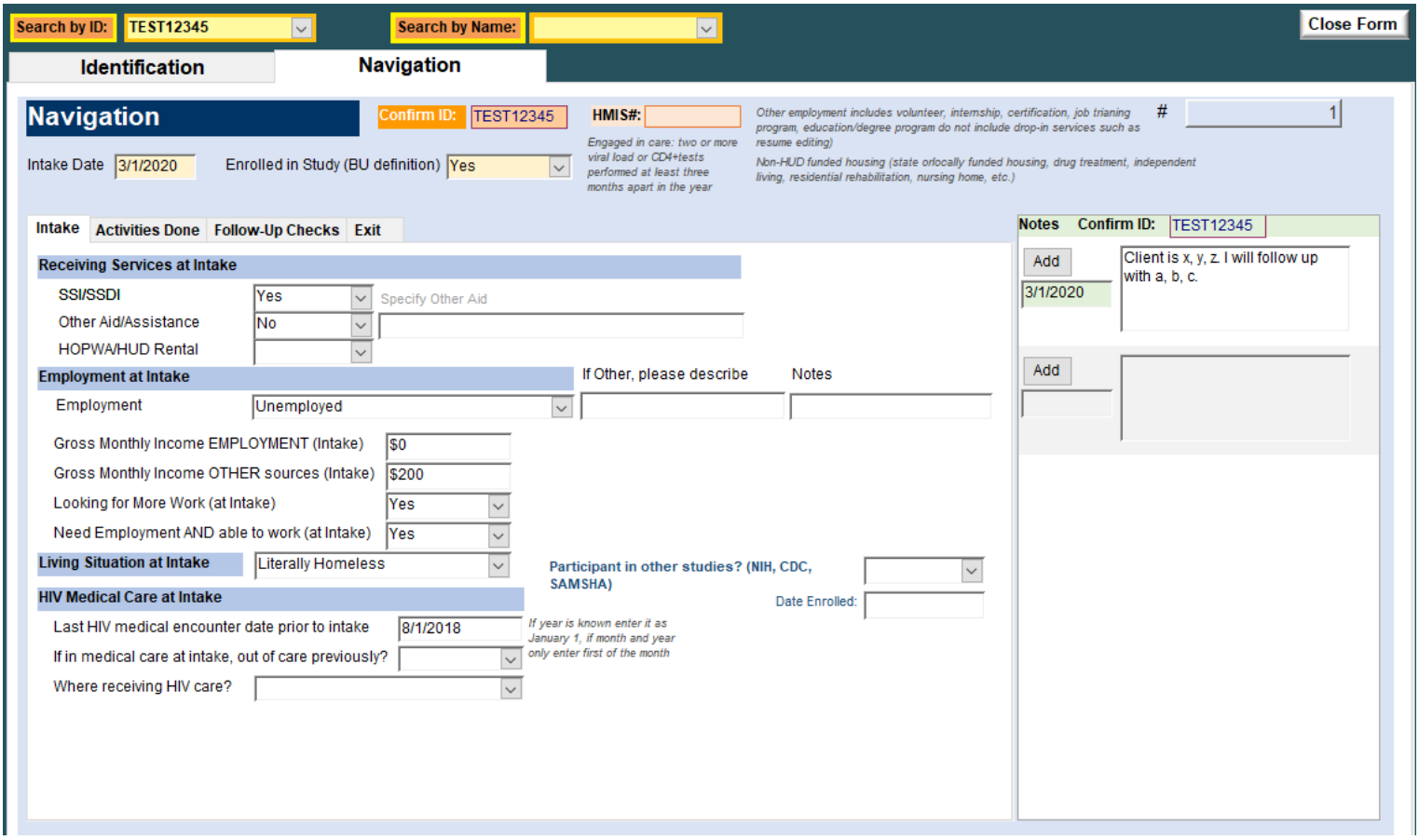
Participant Services and Outcome Tracking Database

The screen shots below portray the different elements of the tracking database.

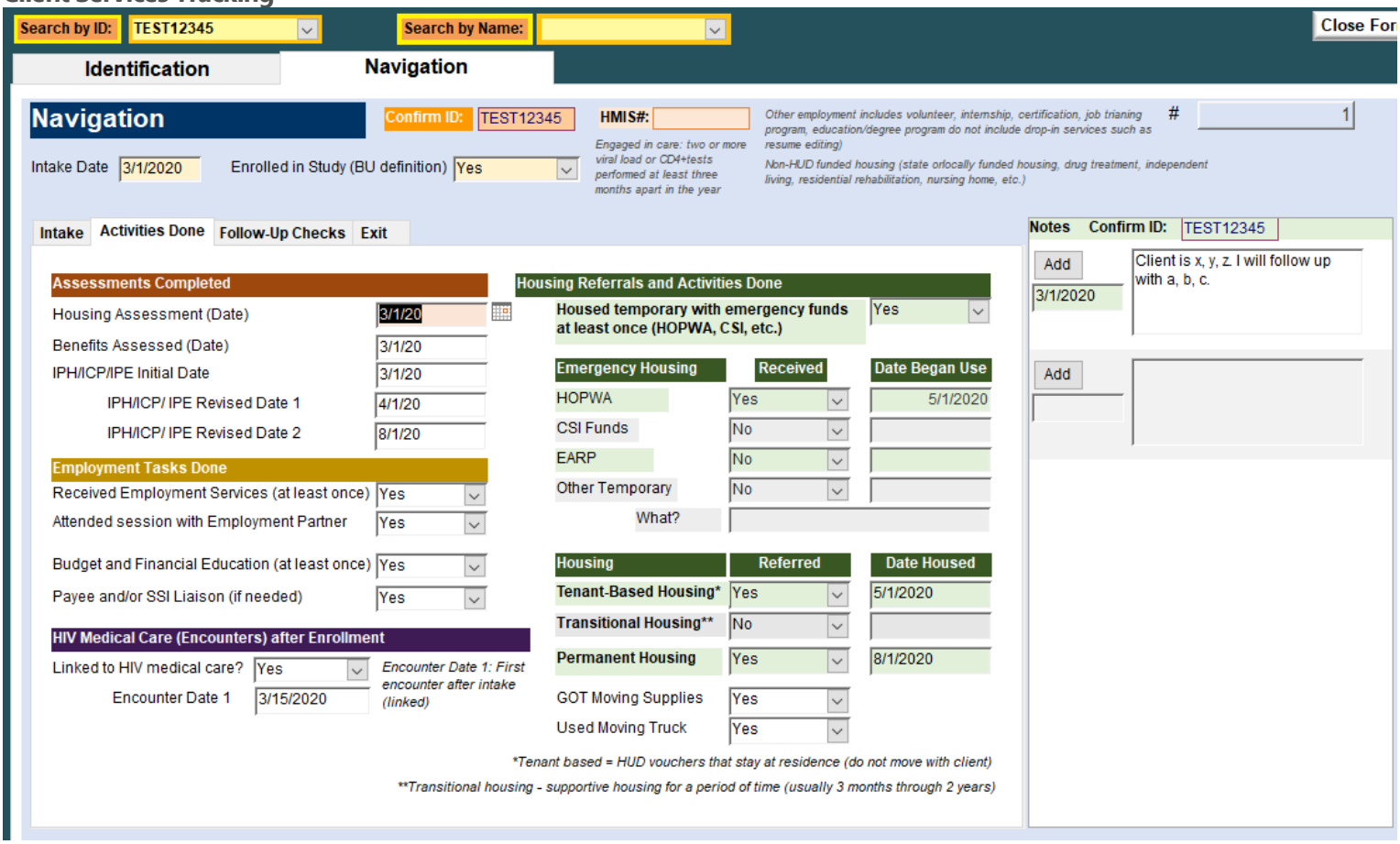
Client Identification



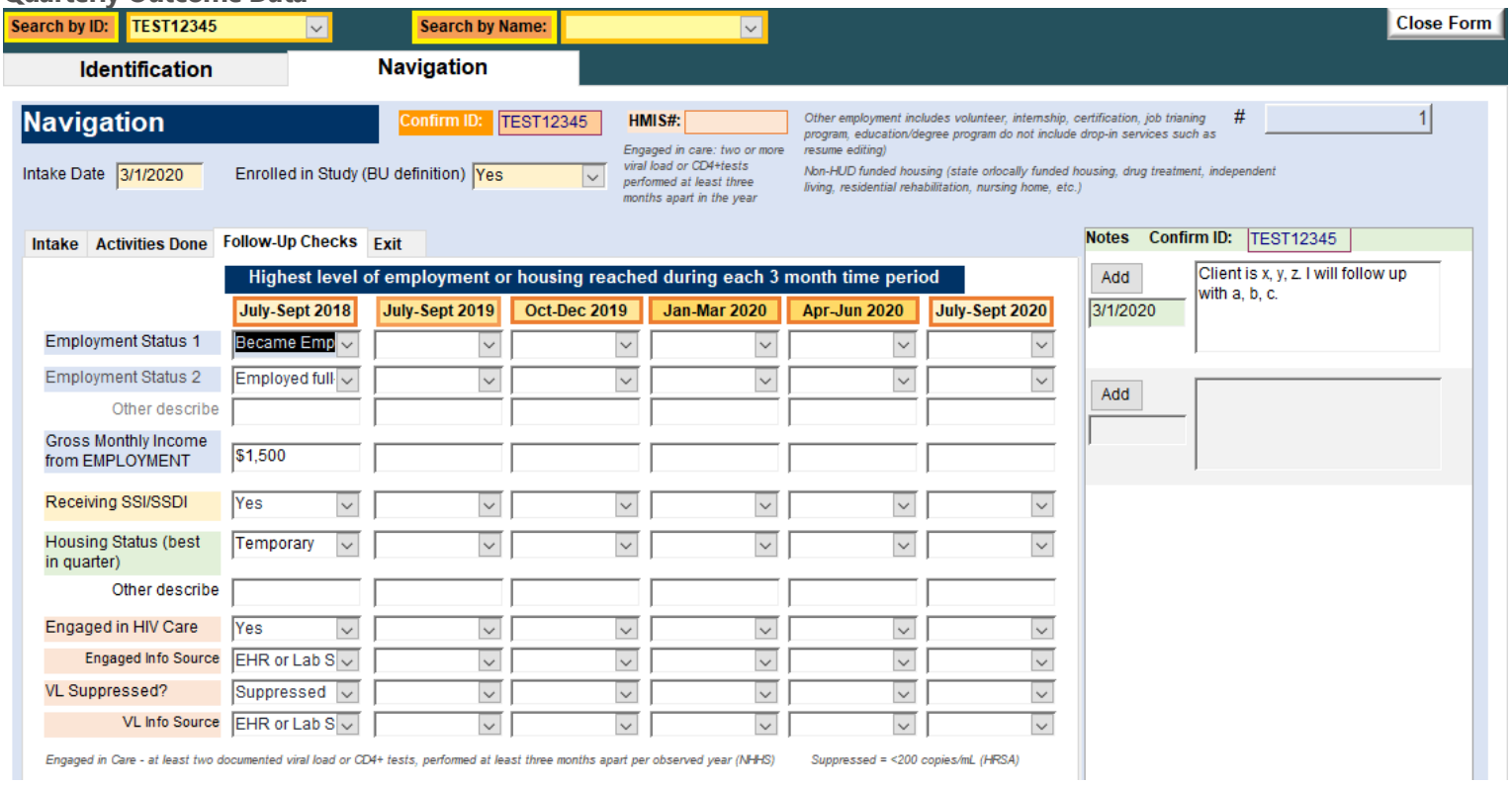
Client Intake Information



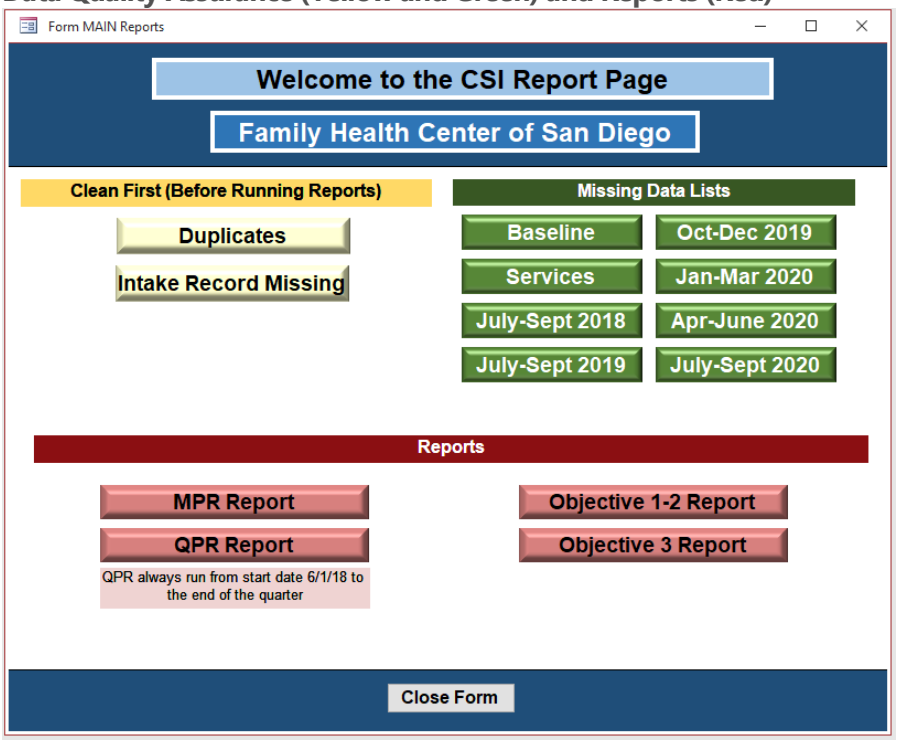
Client Services Tracking



Quarterly Outcome Data



Data Quality Assurance (Yellow and Green) and Reports (Red)



Quarterly Database Report - Partial Page 1

Quarterly Aggregate Service Form [Run from 6/1/18 through end of quarter]

Site ID: 4 (Family Health Centers of San Diego)

Period Beginning (mm/dd/yyyy): 6/1/2018 *Run report from 6/1/18 - end of each quarter [intake done between these dates]

Period Ending (mm/dd/yyyy): 12/31/2020

Total SPNS Clients served to date:	1

Total number of SPNS clients employed or maintinaed employing during this reporting period	Intake	July-Sept 2018	July-Sept 2019	Oct-Dec 2019	Jan-Mar 2020	Apr-June 2020	July-Dec 2020	Intake -Sept 2019
Of these clients, describe the highest level of employment status achieved this quarter								
a. Full time employment	0	1						1
b. Part-time employment looking for additional work	0	0						0
c. Per diem work	0	0						0
d. Under the table work	0	0						0
e. Other, Specify	0	0						0
Unemployed	1	0						0
Not Recorded	0	0	1	1	1	1	1	0
Please indicate how many of your total SPNS clients received SSI/SSDI during the reporting period								
SSI	1	1						1

Monthly Database Report - Partial Page 1

SPNS Coordinated Services Intervention: Aggregate Service Form

Site ID: 4 (Family Health Centers of San Diego)

All persons with an intake between

Period Beginning (mm/dd/yyyy): 6/1/2018

Period Ending (mm/dd/yyyy): 12/31/2020

Total NEW clients provided services	1

Of these persons, please indicate how many were:

a. Literally homeless (currently staying in shelter, living on the street, other public place, other emergency housing (hotel/motel paid by a program)	1
b. Unstably housed (in a temporary/transitional housing setting (up to 6-24 months), staying with friends/family, hotel motel paid by self)	0
c. Fleeding domestic violence	0
d. In imminent risk of homelessness	0
Stably housed	0
Missing	0

EARP Budget Worksheet

Client Name: **Date:**

1	2	3	4	5
TOTAL INCOME	**MONTHLY EXPENSE ITEMS** Check each item client spends money on each month	**AMOUNT USUALLY SPENT EACH MONTH** This is client's portion only	**TOTAL AMOUNT OWED THIS MONTH** Only complete for items that are different than column 3	**SUBTRACT COL 3 AMTS FROM COL 4 AMTS** This shows how much extra is owed outside normal budget
	Rent			$0
	Utilities			$0
	Phone			$0
	Food			$0
	Household Items			$0
	Personal Hygiene			$0
	Clothing/Laundry			$0
	Medications			$0
	Co-pay			$0
	Car/Transportation			$0
	Entertainment			$0
	Cable TV			$0
Other (specify)				$0
				$0
				$0
				$0
	TOTALS	**$0**	**$0**	**$0**

This amount should be equal to or more than the amount you are requesting

1. Explain Column 5: Why does client have extra expense? OR, if this request is made due to a drop in come, why has income dropped, is this drop permanent or temporary, and how much has it dropped?

(the amount you are requesting must be less than or equal to this drop in income amount)

2. What is the plan, SPECIFICALLY, to get this client to live within his or her budget?

Monthly Progress Report Format for Subcontractors

Monthly Progress Report Template

Organization Name:
Primary Contact:
Telephone Number:
Email Address:
Grant Name: CSI
Reporting Period:

1. **Progress toward achieving Scope of Work activities**

2. **Share 3-5 key achievements during the reporting period**

3. **What challenges have you encountered in executing your Scope of Work? Describe the actions you have taken to address these challenges.**

4. **Please describe your plans for the upcoming reporting period and when you anticipate the activity to take place.**

Data Collection Tools: Care Plan

SPNS Coordinated Services Intervention Care Plan

Include Goals for Housing, Employment and Medical Care

Client ID ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ **MR#**_____ **CM**_____

Date	Attainable Specific Goal	Date Attained
___/___/___	1._____	___/___/___
___/___/___	2._____	___/___/___
___/___/___	3._____	___/___/___
___/___/___	4._____	___/___/___
___/___/___	5._____	___/___/___
___/___/___	6._____	___/___/___
___/___/___	7._____	___/___/___
___/___/___	8._____	___/___/___
___/___/___	9._____	___/___/___
___/___/___	10._____	___/___/___

Last HIV medical visit: ☐Within the last 6 months ☐7-11 months ago ☐12 or more months ago ☐Never

Did you miss your last HIV medical care appointment? ☐Yes ☐No If yes, Why?_____

_____

Is your next HIV medical care appointment scheduled? ☐Yes ☐No If yes, when? ____/____/_____

Need mental health services? ☐Yes ☐No Currently receiving MH services? ☐Yes ☐No Referred MH? ☐

Need subst. abuse services? ☐Yes ☐No Currently receiving SA services? ☐Yes ☐No Referred SA? ☐

Date Enroll SA Services____/____/____ Date Completed SA Services____/____/____

Notes (cite goal number if applicable):_____

_____

_____

_____ _____

Client Signature Case Manager Signature **☐Copy given to client**

Data Collection Tools: CSI and Ryan White Case Management Intake Form

CMIS MR#: _____ ARIES ID: _____ Date: _____

Name: First Middle Last	Date of Birth
Current Address	**Telephone Msg.**
Lease Y-N How Long?	Home: Y-N Cel: Y-N Msg: Y-N
Social Security Number	**Gender**
	☐ Male ☐ Female ☐ Transgender(M⇒F F⇒M)
Ethnic Origin/Language	**Veteran**
	☐ Yes ☐ No
Marital Status	**Number of Children**
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Significant Other	Male _____ Female _____
Emergency Contact	**Power of Attorney**
Name: Address: _____ Phone: Msg. Y-N	☐ Yes ☐ No **Mother's Maiden Name**
Medical Coverage	**Income**
☐ CMS ☐ MediCare ☐ Medi-Cal ☐ Other : _____	$ _____ /month Source: GR____ SSI____ SDI____ SSA____ VA____ EMP___ Other ____

Health Providers	Address	Telephone
Physician/Group		
Mental Health		
Pharmacy		
Other (i.e. Dentist)		
Registered sex offender	Convicted of Arson	PCRS:

HIV Diagnosis	Date of Diagnosis
☐ HIV ☐ HIV Comp. ☐ AIDS	HIV AIDS
Psychiatric Diagnosis	**Date of Diagnosis**

Symptoms

☐ SOB ☐ Skin ☐ Night Sweats ☐ Dyspnea on Exertion
☐ Cough ☐ Affect ☐ Bowels/Bladder ☐ Orientation/Safety
☐ Fatigue ☐ Fever ☐ Gait/Balance ☐ Memory Loss
☐ Weight ☐ Appetite ☐ Nausea/Vomiting ☐ Thrush

Living Arrangements At Time of Entry	Sexual Orientation
☐ Unstable, No permanent address ☐ Living w/Partner/Spouse ☐ Living w/blood relative ☐ Living w/friends ☐ Living Alone ☐ Living in Residential Care ☐ Other _____ ☐ Transitional _____	☐ Homosexual ☐ Heterosexual ☐ Bisexual ☐ Unknown ☐ Other _____

Education	Transmission Category
☐ Postgraduate ☐ College Graduate ☐ Some College ☐ Trade/Vocational School ☐ High School Diploma ☐ Some High School ☐ Elementary ☐ No Schooling ☐ Unknown	☐ MSM or MSM/W ☐ IV Drug Use (IDU) ☐ MSM & IDU ☐ Hemophilia/Coagulation Disorder ☐ Transfusion/Blood Component ☐ Heterosexual Contact ☐ Parent at Risk ☐ Multiple Factors ☐ Unknown

Employment Status	Usual Occupation	Support System
☐ Unknown ☐ Never Employed ☐ Unemployed ☐ Employed FT-PT ☐ Active Military ☐ Retired Military ☐ Pre-Retirement ☐ Retired ☐ Pension ☐ No Pension Last Employed:	☐ Unknown ☐ Professional ☐ Technical ☐ Non-Technical ☐ Military ☐ Education ☐ Entertainment/Media ☐ Clerical ☐ Artistic-Design ☐ Other _____	☐ Family/Friends ☐ Spiritual ☐ Work ☐ Financial ☐ Clubs/Groups ☐ Other _____

Life Stressors	Medications
Children/Adolescents in Home (Names/Ages)	
Previous	
Other Losses/Changes	
Problems/Needs	

Coping Strategies

Alcohol and Drug Use History	Age At First Use:
☐ Alcohol ☐ Marijuana ☐ Tranquilizers ☐ Barbiturates ☐ Heroin ☐ Methamphetamine ☐ Crack ☐ Cocaine	☐ GHB ☐ Special K ☐ Nitrates/Nitrites ☐ Hallucinogens (LSD, Mescaline, Mushrooms) ☐ Ecstasy ☐ PCP ☐ Sherm (cigarettes/marijuana dipped in PCP) ☐ Other, specify:_____
Ingested: ☐ Smoke ☐ Snort ☐ IDU ☐ Oral ☐ Anal	Drug of choice?_____

Consequences to AOD Use.

Current Status ☐ N/A ☐ No longer use ☐ Harm Reduction ☐ In Recovery ☐ In AOD Tx.
Current/Prior AOD Treatment Episodes

Shared Needles:	Hepatitis and STD History	
☐ Never ☐ Sometimes ☐ Always	☐ No STDs/Hepatitis ☐ Syphilis ☐ Gonorrhea ☐ Trichomoniasis ☐ Hep B	☐ Chlamydia ☐ HPV (genital warts) ☐ HSV (genital herpes) ☐ Hep C ☐ Other _____
Current CD4 Count	Current Viral Load	
Date	Date	

Lowest CD4 Count		Highest Viral Load
Date		Date
Current Weight	Normal Weight	Last TB Test Results and Date
		Hepatitis B vaccine
		1st 2nd 3rd

Hospitalizations

Data Collection Tools: Ryan White Case Management Comprehensive Assessment

CLIENT NAME: _____ **DATE:** _____ **CASE MANAGER:** _____

Need Area	Assessment
1. Support System • Client's relationship with family, friends, significant others ☐Very helpful ☐Somewhat helpful ☐Not very helpful • How many friends/family members are consistently available? ____ • How does client feel about his or her support system? ☐Very helpful ☐Somewhat helpful ☐Not very helpful • Is client a victim of physical or verbal abuse? ☐Yes ☐No • Does client need professional or volunteer support ☐Yes ☐No • Among those in the support system, are there any unmet needs that impact the client? ☐Yes ☐No If yes, what?	Description: _____ _____ _____ _____ _____ Recommendations: _____ _____ _____ _____ _____
2. Living Situation • Client's housing history (check all that apply) ☐Rent ☐Own ☐Homeless _____ • Current residence (check one) ☐Rent ☐Own ☐Homeless _____ Is client primary renter, who else lives at residence? _____ • Is the client satisfied with living arrangement? ☐Yes ☐No • Can client afford living situation? ☐Yes ☐No • Are utilities affordable and functioning? ☐Yes ☐No • Is dwelling unit clean and physically accessible? ☐Yes ☐No	Description: _____ _____ _____ _____ _____ Recommendations: _____ _____ _____ _____

3. Basic Needs
• Client needs
  ○ Food_____
  ○ Clothing_____
  ○ Items for house_____
  ○ Other_____
• Does client receive food stamps, WIC, food pantry, home delivered meals?
  ☐Yes ☐No If yes, which_____
• Can client cook for self, shop, manage household? ☐Yes ☐No
• Does client need assistance with cooking, cleaning, etc. ☐Yes ☐No
  If yes, with what? _____
	Description: _____
	_____
	_____
	_____
	_____
	Recommendations: _____
	_____
	_____
	_____

4. Benefits/Income
• Client's sources of income
  ☐Employment_____
  ☐Public Assistance _____
  ☐Friends/Family_____
  ☐Other _____
• Stability of monthly income
  ☐Very stable ☐Somewhat stable ☐Not very stable
• Has client's standard of living changed significantly? ☐Yes ☐No
  If yes, how?_____
• Does client need to apply for public benefits? ☐Yes ☐No
	Description: _____
	_____
	_____
	_____
	_____
	Recommendations: _____
	_____
	_____
	_____

5. Transportation
• Client's current means of transportation
  ☐Own car _____
  ☐Public transportation _____
  ☐Friends/family_____
  ☐Other_____
• Does client utilize, bus pass, van program, taxi vouchers? ☐Yes ☐No
• Does client have any transportation needs? ☐Yes ☐No
	Description: _____
	_____
	_____
	_____
	_____
	Recommendations: _____
	_____
	_____

	_____
6. Vocational • Education: ☐<HS diploma ☐HS diploma ☐AA ☐BA/BS ☐Master/PhD ☐Vocational_____ ☐Other_____ • Recent Work History: ☐Full-time ☐Part-time ☐Seasonal ☐Occasional ☐Volunteer ☐Disability • Current Employment: ☐Full-time ☐Part-time ☐Seasonal ☐Occasional Is current employment temporary or ending soon: ☐Yes ☐No • Has the client served in the military? ☐Yes ☐No • Does the client volunteer? ☐Yes ☐No If yes, where/when?_____ • Does the client have any physical obstacles that make it difficult to work/go to school? ☐Yes ☐No If yes, what?_____	Description: _____ _____ _____ _____ _____ Recommendations: _____ _____ _____ _____
7. Legal • Does client have history of civil/criminal legal involvement? ☐Yes ☐No If yes when/what?_____ • Has client ever been incarcerated, on parole/probation? ☐Yes ☐No • On parole/probation currently? ☐Yes ☐No • Does client have any outstanding warrants? ☐Yes ☐No • Does client need assistance with divorce, custody, INS, etc.? ☐Yes ☐No • Does client have a legal guardian ☐Yes ☐No If yes, _____ • Any involvement with CPS/APS? ☐Yes ☐No If yes, explain?_____	Description: _____ _____ _____ _____ _____ Recommendations: _____ _____ _____ _____

8. Mental Health • Does client have a confirmed psychiatric diagnosis? ☐Yes ☐No If yes, what?_____ • Client's history of mental health treatment (tx) ☐Mostly in tx ☐Sometimes in tx ☐Mostly out of tx • Client's current status of mental health treatment ☐Fully treated ☐Partially treated ☐Not receiving treatment • Does client take any psychotropic meds? ☐Yes ☐No What?_____ • Is client currently in therapy/treatment? ☐Yes ☐No Where/what type?_____	Description: _____ _____ _____ _____ _____ Recommendations: _____ _____ _____ _____
9. Chemical Dependency • Client's history of chemical dependency and current status ☐No History ☐Yes History If yes, explain:_____ • Is client currently in treatment program? ☐Yes ☐No If yes, where?_____ • Does chemical use impact client's compliance with HIV treatment? ☐Yes ☐No • Is client interested in a recovery program? ☐Yes ☐No If yes, type:_____	Description: _____ _____ _____ _____ _____ Recommendations: _____ _____ _____ _____

10. Access to Health Care and Medications

- How many months has it been since your last HIV medical care visit?
  ☐Within the last 6 months ☐7-11 months ago ☐12 or more months ☐Never
  Date of last visit: ___/___/_____ *(If >12 months skip to *)*
- Do you know what your CD4 cell count is? ☐Yes ☐No
- Do you know what your viral load is? ☐Yes ☐No What_____
  If yes, is your viral load undetectable? ☐Yes ☐No
- Are you taking HIV medications? ☐Yes ☐No
  If no – why not? ☐Not prescribed ☐Choose not ☐Other
  Explain:_____

  If yes - in the last week, how many days did you **miss taking any** of your HIV medications? _____ days ☐None
  If yes, what medications do you take?_____
- *Is your next HIV medical care appointment scheduled? ☐Yes ☐No
  If yes, when is it scheduled? ____/____/_____
- Is it difficult for you to make or keep HIV care appointments? ☐Yes ☐No If yes, Why?_____
- Client's insurance/health care coverage: _____
- What OI has client had and when?_____
- Does client receive IHSS or other in-home nursing care? ☐Yes ☐No
- Does client see any specialists?☐☐Yes ☐No Who?_____

Description: _____

_____

_____

_____

_____

Recommendations: _____

_____

_____

_____

11. Physical Condition/Mobility • Is client ambulatory? ☐Yes ☐No • Does client require any medical equipment? ☐Yes ☐No • To what extent can client perform ADL's? *(I=Independent, NH=Need Help, D=Dependent, ND=Not Do)* ____Bathing (personal hygiene and grooming) ____Dressing/undressing ____Transferring (movement and mobility) ____Toileting (continence-related tasks, control, hygiene) ____Eating (preparing food and feeding) • Has the client's physical condition changed or weakened as a result of HIV infection? ☐Yes ☐No • Is client's physical condition currently stable? ☐Yes ☐No • Has client lost a significant amount of weight? ☐Yes ☐No	Description: _____ _____ _____ _____ Recommendations: _____ _____ _____ _____
12. Secondary Medical Needs • Does client need to access any of the following services: Non-HIV-specific medical services ☐Yes ☐No Dental care ☐Yes ☐No Optical or auditory care ☐Yes ☐No Nutritional counseling ☐Yes ☐No Physical or occupational therapy ☐Yes ☐No Other_____ ☐Yes	Description: _____ _____ _____ Recommendations: _____ _____ _____
13. Clients' Strengths/Weaknesses Strengths / Weaknesses _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	Description: _____ _____ _____ Recommendations: _____ _____ _____ _____

14. Prevention Needs – Partner Services

- Does client have sexual partner(s)? ☐Yes Number:_____
  ☐No *(no, skip to screening question #1)*
- Is client able to practice safe sex (use condoms, or sex with no fluid contact) with partner(s)? ☐Yes ☐No
  If yes, how often (within the last 3 months)?
  ☐All the time ☐Most of the time ☐About half the time ☐Less than half
- Is client interested in HIV or STD testing? ☐Yes ☐No

Screening (first assessment)

1. Do all of your current sex or injection partners know your HIV status? ☐Yes ☐No* ☐No partners
2. Do you have any past partners that may need to be informed? ☐Yes* ☐No
3. Is there anyone that could have infected you who may not be aware of their HIV status? ☐Yes* ☐No
4. Have you been diagnosed with a sexually transmitted disease (STD) in the past year? ☐Yes* ☐No

*If any responses are * then offer PS, otherwise skip to*

Screening (re-assessments)

1. Who else (in general) do you need to tell about your status? Are any of these sex or injection partners? ☐Yes* ☐No
2. How many of your partners that we talked about last time did you self-disclose to?____ *(completed disclosure)*

Description: _____

_____

_____

_____

Recommendations: _____

_____

_____

_____

Provided PS education: ☐About PS ☐On how to disclose to future partners

PS Offer:

***Dual/Third:* Would you like help from me or a Health Advisor to notify your partners?**

☐Yes, offered - accepted # dual___ # third____
☐No, offered - refused
☐Not offered **Why not?**
☐DV Threat ☐*refer to DV service*
☐Mental Health Concerns ☐*refer MH*
☐Other_____

PS Offer:

***Self-Disclosure Assistance*: Would you like to work with me on how to disclose to your partners?**

☐Yes, offered - accepted # self ____ *(plan to disclose to)*
☐No, offered - refused
☐Not offered **Why not?**
☐DV Threat ☐*refer to DV service*
☐Mental Health Concerns ☐*refer MH*
☐Other_____

Plan to get HIV negative/unaware partners tested: *(reflect, ask questions and provide guidance/ suggestions/more education as needed)*_____	**Plan to get HIV negative/unaware partners tested; Plan for dual/third acceptance if self-partners not disclosed to:** *(reflect, ask questions and provide guidance/suggestion /more education as needed)*_____
15. Prevention Needs – Support Groups • Does client attend any support groups? ☐Yes ☐No If yes, which?_____ • Is client interested in any prevention programs ☐Yes ☐No If yes, which?_____	Description: _____ Recommendations: _____

Transition Tool

Medical Case Management Screening and Transition Tool

Client Eligibility Screening Tool

For Ryan White HIV/AIDS Treatment Extension Act Medical Case Management

This tool is required as a guide to determine need for medical case management.

Check one: ☐ Initial Assessment ☐ Reassessment

Client Name:_____

Date of Birth: ____/____/_____ Gender: _____ Race/Ethnicity: _____ Zip Code: _____

Date:_____

Screening Completed By:_____

Agency:_____

Start

1. Is the client able to access and stay in HIV medical care?

Check "yes" or "no" for each of the following:

a. Enrolled in HIV medical care	☐ Yes	☐ No	
b. Following her/his medical plan*	☐ Yes	☐ No	
c. Keeping medical appointments	☐ Yes	☐ No	
d. Taking medication as prescribed	☐ Yes	☐ No	☐ N/A

If all boxes checked "Yes" or "N/A"

Not eligible for Medical Case Management; create "Client Transition Plan"

*NOTE: The medical plan may include other health-related issues (for example, mental health, substance abuse, smoking, hypertension, gynecological, etc.)

If at least one box is checked "No"

2. Check all that apply to this client:

- ☐ Newly diagnosed with no services
- ☐ Unstable living situation (for example, homeless on the streets, episodically homeless in past 12 months, etc.)
- ☐ Insufficient source of income
- ☐ Physical limitations that impede ability to care for self *(NOTE: check for referral to AWP, High Acuity Medical CMP, Hospice)*
- ☐ Domestic violence
- ☐ Released from prison or jail in past 12 months
- ☐ Impairment due to acute or long term mental illness (for example, suicidal, self-harming, bipolar, etc.)
- ☐ Major impairment due to active substance abuse
- ☐ HIV+ youth/child under 18
- ☐ HIV+ parent of youth/child
- ☐ Newly settled immigrant within past 12 months, monolingual (non-English speaking), difficulty acculturating into mainstream community
- ☐ Unable to read / low literacy

Enroll/Continue into Medical Case Management

CLIENT TRANSITION PLAN – for internal use or for referral to other programs as needed
__ Provided copy to client _ Forwarded copy to Case Worker / Peer Advocate __ Placed original in agency file

Client Name: _____ Date Completed: _____

Date of Birth: _____/_____/_____Gender: _____ Race/Ethnicity: _____ Zip Code: _____

Transition Plan Developed by: _____ Agency: _____

Check One: ☐ Initial Assessment ☐ Reassessment

Outcome of Medical Case Management (MCM) Client Eligibility Screening (check all that apply)

___ Client eligible for MCM, referred to another MCM Program (special population focus or higher medical acuity (i.e., CMP, AWP, Hospice)
___ Client eligible for MCM, but declined service at this time – client was provided with information
___ Client not eligible for MCM, referred to Case Worker or Peer Advocate
___ Client not eligible for MCM, declined referral to Case Worker or Peer Advocate
___ Client need(s) resolved in this visit
___ Other: _____

Comments: _____

Current Benefits and Services (check all that apply)

Health Care Funding	*Income Benefits*	*Support Services*	*Housing*
___ CMS	___ Employed FT/PT	___ IHSS	___ Stable
___ ADAP	___ General Relief	___ ICM Client	___ Homeless
___ Medi-Cal	___ SSI	___ Case Managed in the past	___ EARP
___ Medi-Care	___ SDI	___ Laundry	___ PARS
___ QMB/SLMB	___ Soc. Security Disability	___ Legal Clinic	___ HOPWA/TBRA
___ CARE HIPP	___ Private LTD	___ Food Vouchers	___ Housing Information & Referral
___ Medi-Cal HIPP	___ Unemployment Ins.	___ Food Stamps	___ Marisol/Wilson St.Apts
___ Private Insurance	___ CalWorks (TANF)	___ Home Delivered Meals	___ Section 8
___ Other:_____	___ Other	___ Bus Pass	___ RAS (Josue Homes)
___ No insurance		___ Van	___ Other
		___ Other	

Referrals

Date	Program	APPT. Date/Time	Contact Person

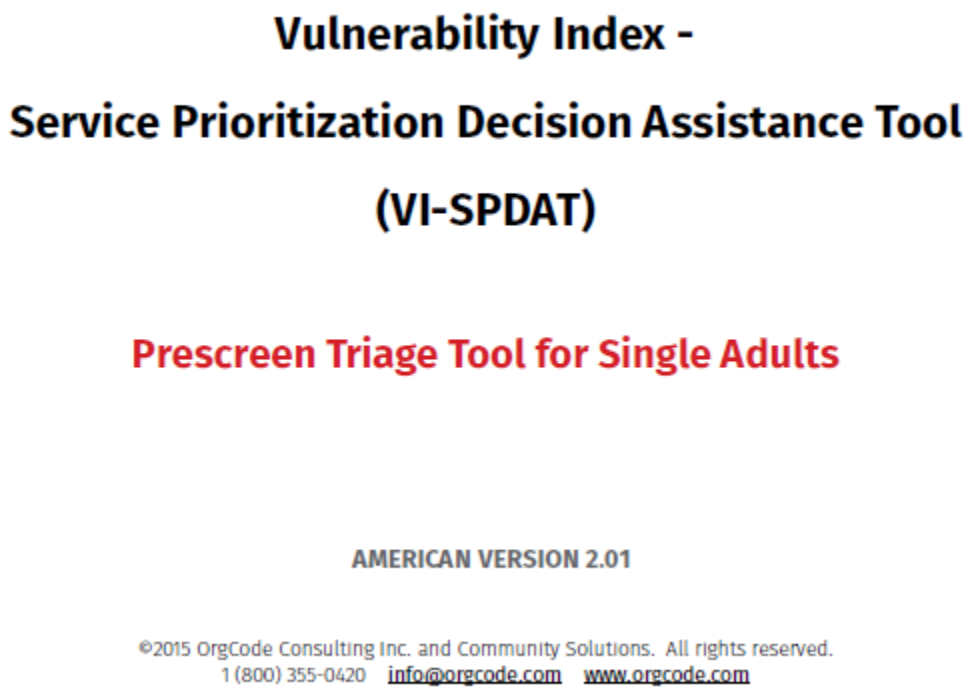
The Client Eligibility Screening Tool has been explained to me and I understand my options regarding medical case management services. I have been informed in detail about the referrals provided on this "Client Transition Plan."

_____ _____
Client's Signature Date

_____ _____
Medical Case Manager Signature Date

Housing Acuity Tool

The Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) is used by the coordinated housing services entry system in San Diego County. The VI-SPDAT as well as a host of other useful tools are located here: https://www.orgcode.com/products



Collaborative Meeting Agenda Example

Agenda

Special Projects of National Significance (SPNS) Employment and Housing Coordinated Services Intervention (CSI)
Partners Meeting
September 11, 2018, 1:30pm – 3:00pm
NAMI
5095 Murphy Canyon Rd, Suite 320,
San Diego, CA. 92123
Agenda

I. Introductions

II. Partners
   a.) National Alliance on Mental Illness (NAMI)
   b.) San Diego Workforce Partnership
   c.) Townspeople, HOPWA Provider

III. Reporting
   a.) Monthly

IV. Check-In & updates

V. September ETAP TA Webinar: **The Intersection of Housing & Employment for Clients with Incarceration Histories 9/18/18 10:00-11:30AM PST**

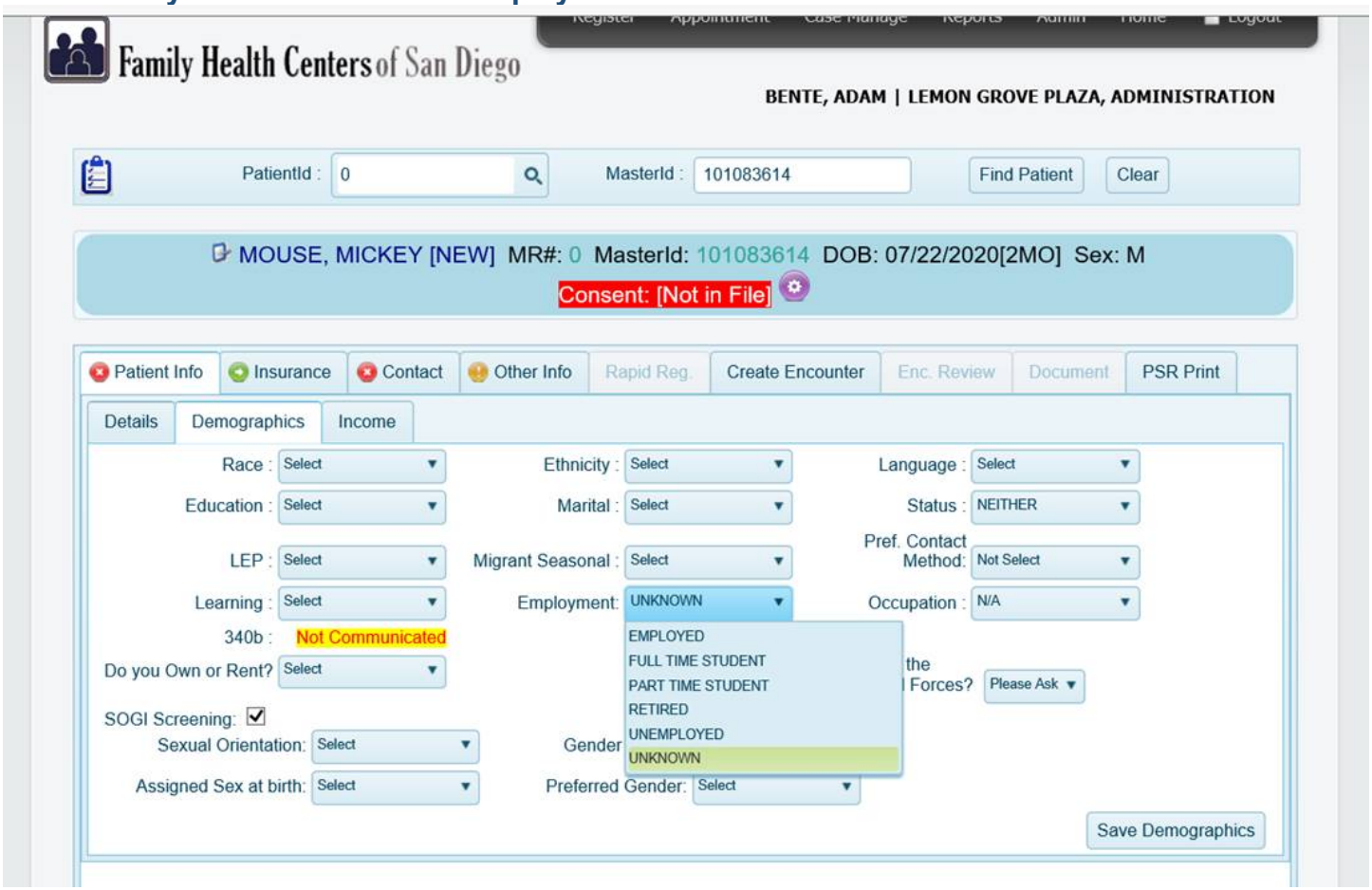
Call in with the following info OR use computer audio when you enter the webinar (do not call in if you are using computer audio/microphone)
Dial US: +1 669 900 6833
Webinar ID: 582 254 513

VI. Next Meeting (TBD)

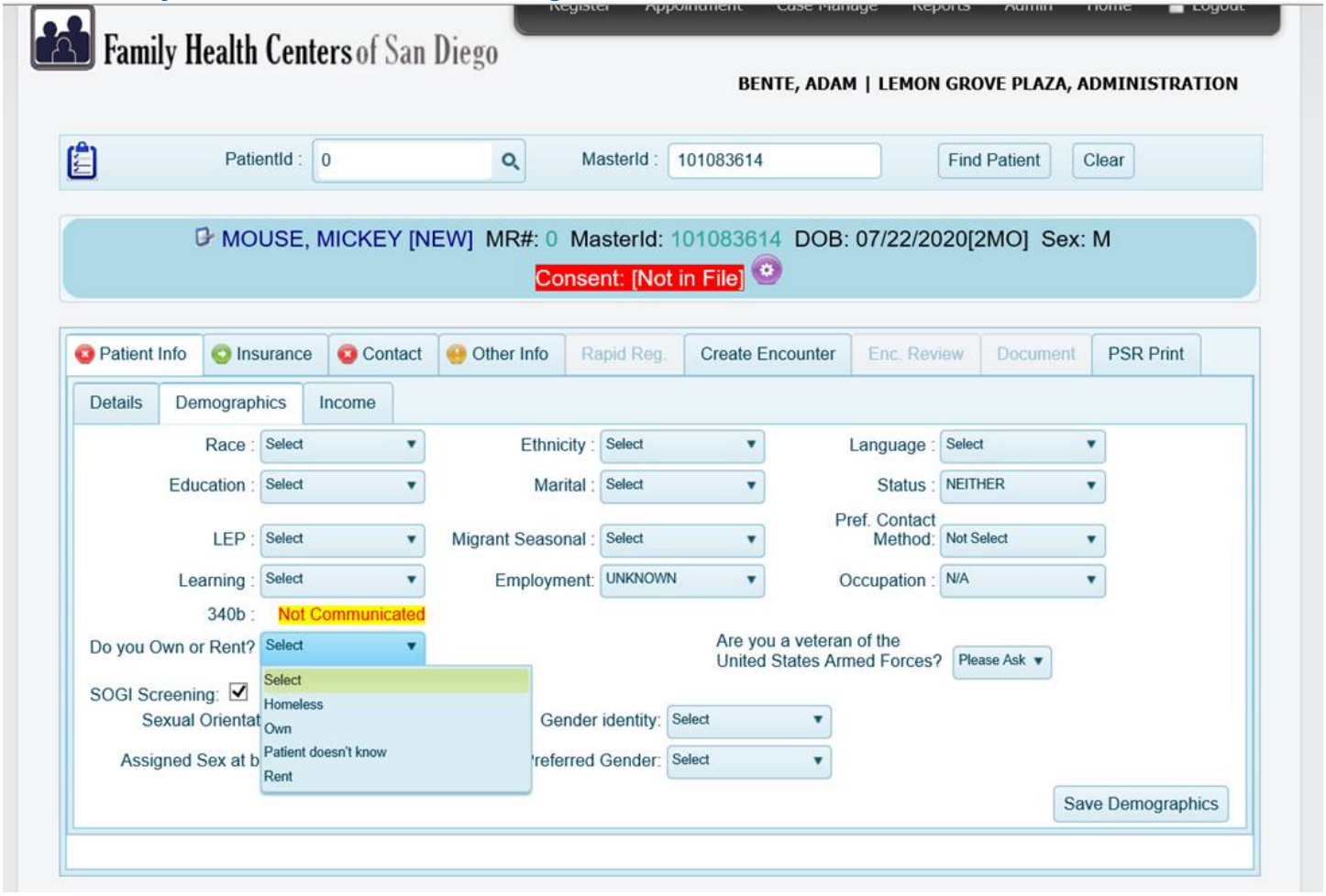
VII. Adjournment

New EHR Modules

Patient Entry Screen: Addition of Employment Status



Patient Entry Screen: Addition of Housing Status



Resource Manual

The following are screen shots of a few of the pages from the housing and employment resource manual assembled by CSI staff. All Ryan White case managers can use this manual, which is centrally housed at FHCSD.

Housing

HOPWA

HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS (HOPWA) PROGRAM
Administered by the County of San Diego, Housing and Community Development Services

HOPWA Program Analyst: **Robin Ramirez –** (858) 694-4810
Robin.Ramirez@sdcounty.ca.gov

HOUSING SERVICES
HOPWA Programs: Please contact provider for eligibility requirements and restrictions.

Emergency Housing:	**Townspeople- (619) 295-8802** **www.townspeople.org** Provides 60 households per year with emergency beds in the form of hotel/motel vouchers for up to 30 nights.
Licensed Residential Care Home:	**Fraternity House, Inc.- (760) 736-0292** Provides 18 beds through Fraternity House (8) and Michaelle House (10) for consumers who need 24-hour comprehensive care.
Transitional Group Homes:	**St. Vincent de Paul Village, Inc.- (619) 667-2610** Provides 38 beds in transitional housing for consumers who are ambulatory, self-sufficient and recovering substance abusers.
ermanent Housing:	**Community Housing Works- Marisol Apartments** **(760) 432-6878 ext 5506** **www.chworks.org** 10 units in Oceanside for consumers and their families. Support services are provided.

Tenant Based Rental Assistance (TBRA):	**County of San Diego, Housing and Community Development Services- 780 Bay Blvd., Suite 200, Chula Vista, CA 91910** **Toll free (877) 478-5478 or (858) 694-4885 www.sdhcd.org** Program provides rent subsidies/vouchers for up to 80 consumers. Applicants are placed on a waiting list and preference is given to extremely low income households with at least one family member having an AIDS diagnosis. Medical and income eligibility are verified when applicants are pulled from the waiting list.

SUPPORT SERVICES

HOPWA Programs: Please contact provider directly for eligibility requirements and restrictions.

Moving Services:	**Being Alive San Diego- (619) 291-1400 www.beingalive.org** **4070 Centre Street, San Diego, CA 92103** Provides consumers with moving services.
Case Management:	**County of San Diego AIDS Case Management- (619) 293-4700** Provides Inpatient Substance Abuse Treatment along with Intensive Case Management for consumers who are homeless or at risk of homelessness. Features immediate placement for qualified consumers and detoxification services when needed.
Information and Referral:	**2-1-1 San Diego** **www.211sandiego.org** Provides Housing Information and Referral services
HOPWA Nutrition Project:	**Mama's Kitchen- (619) 233-6262 www.mamaskitchen.org** Provides meal packages through a home meal delivery service to people who are HIV symptomatic or living with AIDS and who are not eligible to receive meals under any other program/project

LOW-COST APARTMENT LISTING

1ST CONGREGATIONAL MEM TOWER SAN DIEGO, CA 92103 Phone: 844-803-3482

BAY VISTA METHODIST HEIGHTS 4888 LOGAN AVE SAN DIEGO, CA 92113 619-527-0741

BIG SISTER LEAGUE RESIDENCY 3360 4th Avenue SAN DIEGO, CA 92103 Phone: 619-692-1485

CANYON RIM APARTMENTS 10845 Via Los Narcisos San Diego, CA 92129 Phone: 858.672.2001

CASA COLINA DEL SOL 5207 52nd Place SAN DIEGO, CA 92105 Phone: 844-721-8068

CATHEDRAL ARMS 3911 PARK BLVD SAN DIEGO, CA 92103 Phone: 619-291-3883

CERRO PUEBLO 2835 CLAIRMONT DR. SAN DIEGO, CA 92117 619-275-5361

COLUMBIA TOWER 904 State St SAN DIEGO, CA 92101 Phone: 619-696-0201

CORONADO TERRACE I 1183 25TH ST SAN DIEGO, CA 92154 619-423-5804

Employment

COUNTY OF SAN DIEGO
AGENCY

HEALTH AND HUMAN SERVICES

DIRECTORY OF EMPLOYMENT RESOURCES

DO YOU NEED A JOB OR TRAINING? Call one of these agencies in your area. Many of these agencies offer training for new job opportunities. This directory is provided as a courtesy by the Health and Human Services Agency and offers no endorsement of listed resources by the County of San Diego. Participants of these programs must still cooperate with all GR program requirements.

For County, City, State and Federal Job Information, call the following job lines for taped messages about job openings:

For Ride Share Info	(800) 266-6883
Caltrans Jobs (www.dot.ca.gov)	(916) 653-1705
City of Carlsbad Jobs (www.ci.carlsbad.ca.us)	(760) 602-2480
City of Chula Vista Jobs (www.ci.chula-vista.ca.us)	(619) 691-5095
City of El Cajon Jobs (www.ci.el-cajon.ca.us)	(619) 441-1671
City of Escondido (www.ci.escondido.ca.us)	(760) 839-4585
City of Imperial Beach Jobs (www.cityofib.com/employ.htm)	(619) 338-4331
City of National City Jobs (www.ci.national-city.ca.us)	(619) 336-4306 (619) 336-4300 Spanish (619) 336-4304 TDD
City of Oceanside (www.ci.oceanside.ca.us)	(760) 435-3505
City of Poway (www.ci.poway.ca.us)	(858) 668-4444
City of San Diego Jobs (www.sannet.gov)	(619) 682-1011
City of Vista Jobs (www.ci.vista.ca.us)	(760) 639-6147
San Diego County Jobs (www.sdcounty.ca.gov)	(619) 531-5764 (619) 531-5362 TDD 1-866-880-9374 Toll Free

Helpful Links

Housing

General

www.hud.gov

California

www.dfeh.ca.gov

San Diego

www.southbaycommunityservices.org
www.sdul.org
www.townspeople.org
www.svdpv.org
www.steppingstonesd.org
www.211sandiego.org
www.vvsd.net
www.accesstoindependence.org
www.ais-sd.com
www.servingseniors.org
www.elderhelpofsandiego.org
www.crisishouse.org

Employment

General

https://careers.walmart.com/

California

https://www.dor.ca.gov/Home/CareerCounselingInformationandReferral
https://www.edd.ca.gov/jobs.htm

San Diego

https://jobs.nassco.com/
https://linkstaffing.com/locations/san-diego-ca/?utm_source=yext&utm_medium=local
https://workforce.org/
https://www.mhsinc.org/listing-category/employment-services/
https://www.amazon.jobs/en/locations/sandiego
https://jobs.target.com/location/san-diego-jobs/1118/6252001-5332921-5391811/4
https://www.macysjobs.com/?&lat=32.7269669&lng=-117.16470939999999&distance=25&sorting=Nearest&v=963

Promotional Materials

Flyer

Improving HIV Health Outcomes through the Coordination of Supportive Employment and Housing Services – Evaluation and Technical Assistance Provider (ETAP)

Recruitment Script:
Family Health Centers of San Diego is running a study to learn the best way to get people living with HIV who have needs related to housing and employment get services, medical care and treatment they need and help them stay engaged in care. This is a three year study running from May 1, 2018 to September 29, 2020. However, your participation will last for two years.

If you decide to participate, you will have the opportunity to receive services from FHCSD i.e. access to an employment specialist, housing navigator, peer specialists and connection to medical care.

To be eligible for this study, one must be:

- 18 years or older,
- be HIV positive,
- have been diagnosed with HIV more than 6 months ago, but not fully engaged in care (missed HIV medical appointments, diagnosed within last 12 months or detectable viral load)
- homeless and unstably housed (not in permanent stable housing) or looking for work

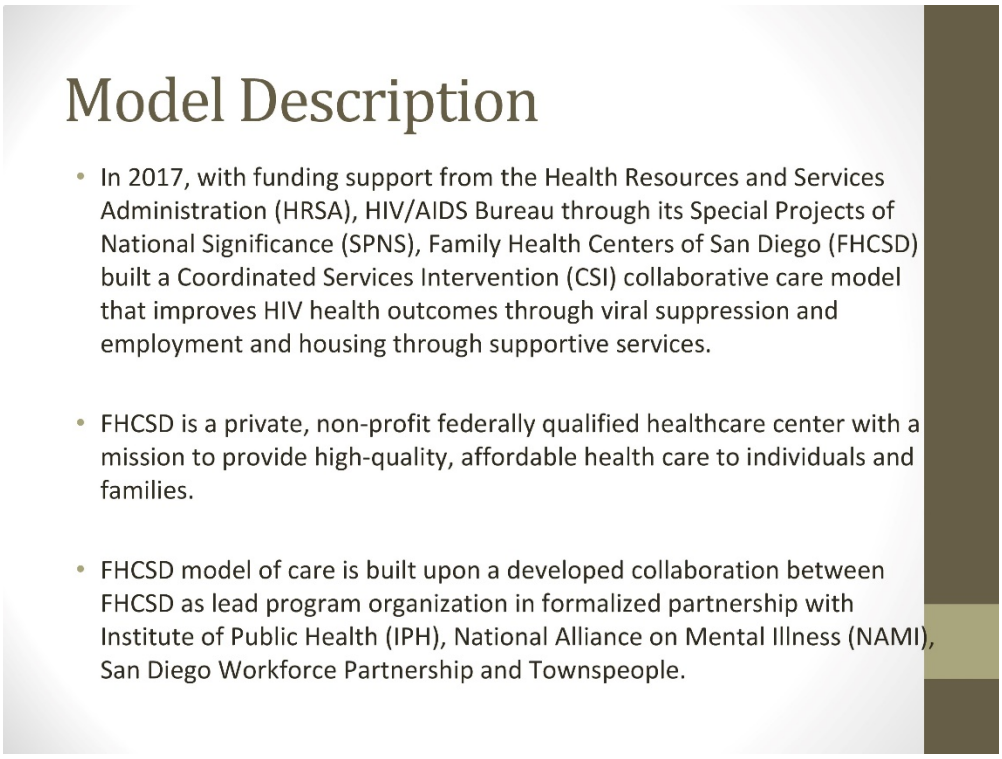
You will be asked to complete a series of three interviews. Topics covered will be on access to housing, employment and support services, ability and experiences in obtaining HIV services and medical care, social networks and support, mental health and substance abuse history and overall health and quality of life. The first interview will be conducted in person and will take approximately 60 minutes and you will receive a ($20) gift card when you finish the interview. The other two interviews can be conducted in-person or over the phone, at a place of your convenience. We will collect some information from your medical chart for a period of two years that will include lab results (such as HIV viral load and CD4 cell count), medical visits, referrals for other services, intervention staff encounters, and other health indicators from up to 12 months prior to and after your enrollment in this intervention. You will also receive a gift card of $20 for each of the other two interviews.

If you are interested in participating or have more questions, please contact xxxxx at (xxx) xxx-xxxx Xxxxx.

This study has been approved by the San Diego State University Institutional Review Board

Slides


Special Projects of National Significance
Coordinated Services Intervention (CSI)
FAMILY HEALTH CENTERS OF SAN DIEGO
NAMI San Diego
National Alliance on Mental Illness
iph
INSTITUTE for PUBLIC HEALTH
Bridging research & practice.
TOWNSPEOPLE


Model Description
• In 2017, with funding support from the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau through its Special Projects of National Significance (SPNS), Family Health Centers of San Diego (FHCSD) built a Coordinated Services Intervention (CSI) collaborative care model that improves HIV health outcomes through viral suppression and employment and housing through supportive services.
• FHCSD is a private, non-profit federally qualified healthcare center with a mission to provide high-quality, affordable health care to individuals and families.
• FHCSD model of care is built upon a developed collaboration between FHCSD as lead program organization in formalized partnership with Institute of Public Health (IPH), National Alliance on Mental Illness (NAMI), San Diego Workforce Partnership and Townspeople.

Project Goals & Objectives

Improving HIV Health Outcomes through the Coordination of Supportive Employment and Housing Services.

- Increase retention in quality HIV care
- Increase client engagement and resulting in viral load suppression
- Improve housing stability
- Improve employment status

Target Population

- Ethnic/Minority Race
- 18 Years or Older
- People Living With HIV/AIDS (PLWHA)
- Not Fully Engaged in Care
- Newly Diagnosed
- Detectable Viral Load
- Homeless or Unstably Housed
- Unemployed, Underemployed, Temporary Employed or Part-Time Employment
- Fleeing Domestic Violence

Eligibility Criteria

- 18 years or older
- Ethnic/Minority
- HIV-positive
- Recently released from jail or prison
- Diagnosed with HIV more than six months ago, but not fully engaged in care
  - One or more gaps in care, which lasted six months or more in the two years prior to date of enrollment
  - Clients at risk of falling out of care
  - Missed last two appointments without rescheduling.
  - Newly diagnosed (within 12 months at time of intake into the program)

Vision & Implementation Plan

Improve HIV long-term health outcomes of racial/ethnic minority PLWH through a Coordinated Services Intervention that implements and evaluates unmet needs

- Network navigators (aka, case manager, housing navigator, NAMI assistant manager, data manager & program coordinator)
  - Non-traditional HIV medical case managers
  - Health care team
  - Behavioral health integration & HIV primary care
  - Partner meetings
- Partnering with housing providers & landlords
- System level coordination (housing, health, mental health, substance use treatment providers)
- To improve healthcare outcome by viral load suppression

Example Meeting Agenda with Recruitment Presentation (FHCSD)

People of Color Case Management Provider's Meeting
Auditorium At The San Diego LGBT Center, 3909 Centre St, San Diego CA 92103
November 15, 2018 from 9 AM - 10:30 AM

Agenda

Presenters:
1. Call to order By Susanna Concha-García
2. Moment of Silence by Susanna Concha-García
3. Introductions by Members - Members Present
4. Thank those who brought goodies- **Octavio Vallejo, Merck & Co.**
5. **Presentations: FHCSD, South Bay Community Services, Sharon Turner of Casa de Milagros & Octavio Vallejo of Merck & Co.**
6. **Location sponsored by Ricardo Gallego, Director, Latin@ Services, at the San Diego LGBT Center**
7. Agency Announcements -

Stakeholders

For project activities the main stakeholders included FHCSD, NAMI, Townspeople, IPH, SDWP, and SDES.

Additional stakeholders for the CSI included San Diego-based organizations which addressed community health and housing needs. Aside from staff from FHCSD who served people with HIV (e.g. medical personnel, Ryan White case managers, etc.), the following stakeholders influenced, aided or benefitted from this project:

- **Affordable housing**
    - Wakeland Housing Development
    - Affirmed Housing
    - Bridge Housing
    - Community Housing Works

    FHCSD has clinics co-located at certain affordable housing sites.
- **Homeless services**
    - Ocean Beach Homeless Collaborative
    - Ocean Beach Merchants Association
    - Community Christian Service Organization
    - Salvation Army
    - Bayside Community Center
    - Local libraries (for outreach)
    - Home Start
    - San Diego Rescue Mission
    - Townspeople
    - Veterans Village of San Diego
    - People Assisting the Homeless San Diego
    - Catholic Charities
    - St. Vincent de Paul
    - Alpha Project
    - Monarch School
    - Volunteers of America

    FHCSD operates primary care clinics co-located with the San Diego Rescue Mission, People Assisting the Homeless, and Veterans Village of San Diego, as well as providing Healthcare for the Homeless Services.

- **Education**
    - San Diego City College
    - San Diego Workforce Partnership
    - Second Chance
    - Center for Employment Training
    - Career Spark
    - FHCSD's primary care clinic on the campus of San Diego City College
- **Hospitals**
    - Scripps Mercy Hospital
    - Scripps Chula Vista
    - Sharp Grossmont Hospital
    - Sharp Memorial Hospital
    - UCSD Medical Center
    - Rady Children's Hospital
- **Primary care**
    - San Diego Family Care
    - North County Health Services
    - Vista Community Clinic
    - La Maestra Community Clinic
    - Neighborhood Healthcare
    - Operation Samahan
    - Planned Parenthood
    - San Diego American Indian Health Center
    - San Ysidro Health Center
    - UCSD's Owen Clinic
    - Christie's Place
- **Behavioral health**
    - The San Diego LGBT Community Center
    - Community Research Foundation
    - Mental Health Systems
    - McAlister Institute for Treatment and Education
    - Progressive Medical Specialists
    - U.S. Department of Veterans Affairs
    - Marine Corps Community Services, Miramar
    - San Diego County Probation Department
    - Volunteers of America
    - Psychiatric Hospital of San Diego County
    - NAMI

- **LGBTQ services**
    - The San Diego LGBT Community Center
    - Stepping Stone of San Diego
- **Sober living**
    - San Diego Sober Living Coalition (a collaborative of operators of sober living services)
- **Substance use disorder detoxification**
    - Volunteers of America
    - McAlister Institute for Treatment and Education
- **Substance use disorder residential treatment**
    - Freedom Ranch
    - McAlister Institute for Treatment and Education
    - Community Resources and Self Help, Inc.
    - House of Metamorphosis
    - Stepping Stone of San Diego
    - The Way Back
    - Casa Milagros
    - Pathfinders
    - Tradition One
    - Ethridge Center
    - Salvation Army
    - Crossroads
    - Alpha Project
    - Fellowship
    - Heartland House
    - Veterans Village of San Diego
- **Domestic violence**
    - Center for Community Solutions
    - FHCSD's domestic violence counseling program
- **Youth transition**
    - San Diego Youth Services (for case management, housing, youth drop in center)
    - Social Advocates for Youth San Diego
    - Catalyst
    - Kickstart
    - Youth in Transition
    - Just in Time for Foster Youth
    - FHCSD's Teen Health Center

- **Older adult services**
    - San Diego County Older Adults Council
    - San Diego Health Literacy Task Force
    - Serving Seniors, and Wesley Community Service Center
    - Rebuilding Together San Diego (for adaptive home repairs)
    - Adult Protective Services
    - Elder Law and Advocacy
    - Family Resource Centers
    - ElderHelp of San Diego
    - Jewish Family Services
    - County of San Diego Aging and Independent Services
    - FHCSD's Older Adults Services
- **Family support**
    - Home Start
    - Social Advocates for Youth San Diego
    - Union of Pan Asian Communities
    - YMCA Child Care Services
    - Metropolitan Area Advisory Committee Project
- **Food services**
    - Mama's Kitchen
    - Meals on Wheels
    - Feeding San Diego
    - Jacobs Cushman Food Bank
    - American Red Cross Women Infants and Children
    - SDSU Women Infants and Children
    - Scripps Health Women Infants and Children
- **Legal services**
    - Legal Aid Society of San Diego
    - Consumer Center for Health Education and Advocacy
    - San Diego Volunteer Lawyer Program
    - Serving Seniors
- **Faith based organizations**
    - Episcopal Community Center
    - First Baptist Church
    - Wesley United Methodist Church
    - Dignity San Diego (organization of LGBTQ Catholics)
    - Grace San Diego
    - Metropolitan Community Church
    - Unitarian Universalist Church
    - Christ the King Church