POSITIVE IMPACT HEALTH CENTERS

Housing Opportunities Medical Employment Services (HOMES) Program

THE HIV, HOUSING, & EMPLOYMENT PROJECT

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Introduction

The Purpose of the Implementation Manual

This manual is a step-by-step guide to create and implement an HIV-based housing and employment intervention entitled "Housing Opportunities Medical Employment Services (HOMES)."

HOMES integrates health care into client case management. The intervention is guided by the following:

- Housing and employment are forms of health care
- When housing and employment goals are met, people living with HIV (PLWH) are able to achieve social stability and become virally suppressed.

Audience

Target audiences for this manual include:

- Social service organizations
- AIDS Service Organizations (ASOs), and
- County, city, and state agencies seeking to integrate housing and employment into service delivery structures.

Improving Health Outcomes

Over the course of the HOMES intervention, client HIV and social determinants of health improved dramatically including:

- Housing from 0% to 80%
- Employment from 50% to 85%
- Viral suppression from 51% to 65%

*Data includes both stable and

Overview of the SPNS Initiative

The HOMES intervention is part of the "Improving HIV Health Outcomes through the Coordination of Supportive Employment and Housing Services" Initiative (otherwise known as the "HIV, Housing, and Employment" Project). This Special Projects of National Significance (SPNS) Initiative is funded through the U.S. Department of Health and Human Services (HHS) Secretary's Minority AIDS Initiative Fund.

This Initiative supports the 1) design, 2) implementation, and 3) evaluation of innovative interventions—like HOMES—that coordinate HIV care and treatment, housing, and employment services in order to improve HIV health outcomes for low-income, uninsured, and underserved people living with HIV.

> ***"This is a high-need population, but this work—and the outcomes that follow—are possible." –Erik Moore, Program Manager***

Why is this important? These are issues faced by many ASOs who struggle to house vulnerable populations, particularly PLWH in tight housing markets. These service providers are in need of effective strategies and associated resources that are studied, available, and proven effective. The SPNS Initiative and resources like this manual seek to help fill that void.

Background and Intervention Overview

Description of the Demonstration Site

Positive Impact Health Centers (PIHC) is an HIV clinic, with three site locations, that improves health outcomes through coordinated HIV care, housing, and employment services to some of the most impacted communities in Atlanta, Georgia.
Services include but are not limited to:

- HIV care
- medical case management
- Housing Opportunities for People with AIDS (HOPWA) housing assistance,
- employment counseling
- pre-exposure prophylaxis (PrEP) access
- risk reduction,
- dental and vision referrals
- on-site pharmacy
- nutritional counseling
- Sexually transmitted infections (STI) testing
- individual/group counseling, and
- behavioral Health services and substance use counseling, including group treatment with access to supportive services.

PIHC is one of 12 participating sites in the SPNS Initiative. Boston University's Center for Innovation in Social Work in Health serves as the Evaluation and Technical Assistance Provider on this multisite study, assessing HOMES and other evidence-informed interventions that come out of the project. (To learn more about the project, visit https://www.targethiv.org/housing)

Description of Relevant Partners

HOMES leveraged an array of local Atlanta partners to bolster the intervention's capacity. These partners included 1) employment service providers, 2) housing partners, and 3) outside health care provider organizations.

Employment service providers: included Goodwill of N. Georgia, Jewish, Family & Career Services, NOVO Health Services, First Step staffing, GA Works, and the Atlanta Center for Self Sufficiency (ACSS).

Housing partners: included local HOPWA providers, HOPE Atlanta, Open Doors, the Department of Community Affairs (DCA), Hope Through Divine Intervention, Project Community Connections, Inc.

(PCCI), United Way of Greater Atlanta, A Vision for Hope, Matthews Place, Making A Way, county Housing Authorities, Senior Housing Programs, and LA Properties.

External health care providers included Grady Hospital, Emory University, Absolute Care (HIV Clinic), and the Grady Infectious Disease program, AID Atlanta, Aniz, Inc. Thrive SS, Someone Cares, Georgia Equality, and Here's to Life. These organizations acted as health care resources as well as community partners, strong advocates, and sources for referrals.

Description of Need

Lack of region-wide planning. The Atlanta metro region does not currently have a HIV specific housing strategy or master plan. The area also lacks any HIV-specific employment plan.

Undercounting of need. The Atlanta Continuum of Care (COC), who is responsible for assessing local homeless statistics, often overlooks PLWH. Why? Because this population is often stuck in cyclical patterns of unstable or transient housing, such as patterns of "couch surfing" or "crashing with friends." This lack of accurate data collection prohibits the comprehensive picture of area housing needs and minimizes the ability to fully address PLWH health and the ways that stable housing is linked. In addition, the Point in Time Count (PIT Count) only accounts for: 1) those individuals living in shelters who can be accounted for or 2) unsheltered individuals living on the streets who can be contacted. There is no mechanism in place to document homeless PLWH outside of shelters or street homelessness.

Rising homelessness. The reduction in affordable housing, ongoing citywide gentrification and ever-increasing rental prices have displaced many Georgia residents from neighborhoods where they were once accommodated. These factors, combined with the closing of Atlanta's only shelter of last resort, has led to an increase in the number of homeless and unstably housed residents living in the city and surrounding areas.

Lack of cultural competency around HIV and LGBTQ needs and employment. Employment agencies and employers are often not culturally aware of the needs of PLWH and the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community in general. Many PLWH also rely on disability payments, which makes obtaining housing and medications difficult given the subsistence level of financial benefits they receive.

Lack of employment re-entry support. Helping PLWH re-enter the workforce is an unmet need within the Atlanta ASOs community and a service that no other agency provides for their clients.

Description of the Intervention

Goals and objectives for the intervention included the following:

Goal I: Addressing Housing and Vocational Needs

The main goal of the intervention is to show the direct correlation and impact of housing and employment on PLWH. The HOMES intervention was designed to evaluate and improve health outcomes for unstably housed or homeless PLWH who are low-income or unemployed. Health, housing, and employment service systems are coordinated to address social determinants of health disparities, such as poverty and homelessness.

Goal 2: Dedicated Staff

The addition of employment services is an in-house innovation. The agency has never offered or focused on vocational services. As such, an important goal of this intervention is designating and funding staff specifically for employment and non-HOPWA related housing services.

The HOMES intervention staff complements existing Ryan White Medical Case Managers (MCMs) in assisting with adherence and medical needs, as well as working collaboratively with housing services staff currently funded through HOPWA.

Goal 3: Community Capacity Building

Siloed service provision is an obstacle for many PLWH. Many believe they can only access resources offered by agencies serving the LGBTQ community.

PIHC is building strong relationships with community partners to support employment and housing needs, including those outside of typical ASO services previously accessed by clients. Meeting with and training, employment and housing providers about what to expect from our referrals will further promote and enhance resource capacity and access to services for our clients.

Goal 4: Knowledge of Benefits

Provide education for PIHC staff and clients to improve their understanding of the impact of earned income on benefits, such as supplemental security income (SSI) and social security disability income (SSDI); health insurance through Medicaid and/or Medicare; and improving client motivation while diminishing sentiments/myths regarding negative consequences of employment.

In addition, PIHC assists and supports clients as they navigate and apply for SSI/SSDI benefits.

Logic Model: HOMES Intervention

Inputs	Activities	Outputs	Outcomes
• Funding by HRSA supplemented by Ryan White HIV/AIDS Program and HOPWA for coordinated services • Hire key staff: Program Manager and Non-Medical Staff • Project staff collaborate with Client Services team including Community Health Workers • Focus groups, interviews, surveys, with stakeholders • Technical assistance provided by ETAP • Partnerships with vocational service agencies	• Evaluation of the innovative intervention and project-related data • Hire project staff that train to become qualified benefits practitioners and utilize learning opportunities by ETAP • Integrate stakeholder feedback into programming • Formalize collaborations with service providers to maximize reach, increase coordination and collaboration, and decrease gaps in needed services	• Peer-reviewed journal articles and • Increased knowledge and competencies among staff • 80-110 clients receiving non-medical case management • 30-90 days of housing support during early substance use recovery • A toolkit consisting of up-to-date resources for PLWH and service providers	**Short-term** • Clients participate in quality programming of coordinated services • Clients gain abilities and strategies for employment and securing housing • Improves retention in substance use treatment • Clients will be more apt to engage services when resources are readily available **Long-term** • ASOs can incorporate the intervention to decrease gaps in care coordination • Clients maintain stable employment, housing, and HIV care adherence and retention • Positive impact on HIV health outcomes, including beginning or re-starting antiretroviral therapy (ART) and achieving viral suppression • Coordinated services are standardized and integrated into all services for PLWH

Priority Populations

HOMES' intervention participants needed to meet the following criteria:

- 18 years or older
- Reside in the greater Atlanta, Georgia metropolitan area
- English speaking
- HIV positive and /or
    - not in care[1]
    - in danger of falling out of care[2]
    - non-virally suppressed[3]
    - medically fragile[4]
- Homeless, meeting one of the following criteria
    - Literally homeless[5]
    - Transitionally housed[6]
    - Unstably housed[7]
    - Fleeing/attempting to flee domestic violence[8]
    - Imminent risk of homelessness[9]
- Unemployed or Underemployed[10]

Race/ethnicity was not a requirement nor was sex/gender; however, priority was given to:

- African American/Black men who have sex with men
- Transgender women

[1] Defined as one or more gaps in HIV primary care visits which lasted six months or more in the previous two years' prior [HRSA Retention in Care Core Measure].
[2] Defined as persons who missed their last two appointments in the last 12 months or missed their last appointment in the last six months.
[3] Defined as a most recent *viral load >=200 copies/mL*.
[4] Defined as a chronic physical condition which results in a prolonged dependency on medical care.
[5] Defined as lacking a fixed, regular, and adequate nighttime residence.
[6] Defined as being in a place for less than 24 months (i.e., participating in subsidized housing program such as rapid re-housing program; half way housing; sober housing); OR 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 (i.e., including a car, park, abandoned building, bus or train station, airport, or camping ground); OR living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (e.g., 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
[7] Defined as not having 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 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 is facing imminent eviction (received a Notice to Quit from the court system).
[8] Defined as fleeing, or attempting to flee, domestic violence; and has no other residence; and lacks the resources or support networks to obtain other permanent housing.
[9] Defined as an 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.
[10] Defined as (a) does not have a job, actively looking for work in the prior four weeks, and currently available for work. This may include people who are currently receiving unemployment benefits; OR b) 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 c) part-time employment or temporary work but would like to earn additional income; OR d) working on a cash basis for per diem work; OR e) does not have enough paid work.

Theoretical & Evidence-Informed Frameworks

The HOMES intervention stems from the HOPWA *Getting to Work Employment Initiative* supported by the Department of Housing and Urban Development (HUD).[11]

> ***PIHC uses a multi-goal approach, reflecting both employment assistance for PLHW and access to stable housing and modifies as necessary to best serve clients.***

[11] To learn more about HOPWA's Getting to Work Initaitive, visit: www.hudexchange.info/trainings/dol-hud-getting-to-work-curriculum-for-hiv-aids-providers/

Pre-Implementation Activities

Asset Assessment

Agency
Ideally, agencies replicating the HOMES intervention have clinic services on site and provide clients a "one-stop-shop" experience akin to PIHC. The availability of behavioral health and substance use services are additional value-adds, particularly given the intervention's target population.

A co-located pharmacy, like the one at PIHC, allows clients to pick up medications before exiting the building and eliminates having to make an additional stop. A specialized, co-located pharmacy also supports an ever-expanding PrEP clinic.

PIHC serves as a LGBTQ community -friendly gathering space. It holds multiple client-focused groups and events as well as community gatherings. Replicating organizations should similarly assess their involvement with targeting audience members, including the LGBTQ community.

Funding
An organization's sources of funding will significantly influence the design of direct service interventions for clients.

PIHC currently offers an array of medical, behavioral health, prevention, and psychosocial services to address client needs. These include:

- Medical: HIV medical care
- Behavioral health: counseling, psychiatry, and outpatient substance use services
- Prevention services: HIV testing, STI testing and treatment, and PrEP services,
- Psychosocial services: transportation, food support, housing, and interpretation services.

These services are funded with a blend of federal, state, and community foundation grants, including HRSA's Ryan White HIV/AIDS Program Parts A, B, and C; HOPWA; Substance Abuse and Mental Health Administration (SAMSHA); the U.S. Centers for Disease Control (CDC); the United Way of Greater Atlanta; KFF; and the Community Foundation of Greater Atlanta. The agency also participates in the 340B Drug Pricing Program and utilizes the revenue from this program to provide additional services for clients.

The existence of varied funding sources provides an excellent opportunity to offer a strong continuum of care for individuals living with HIV. Clients who present for enrollment into PIHC's medical clinic, for example, are assessed for other needs, such as mental health support, housing, food, and transportation. Unmet needs are acknowledged—especially as related to their contribution to poor care retention and poor health outcomes—and are addressed via co-located programs at PIHC.

An ideal example of how an agency may leverage its funding resources is illustrated by the use of HOPWA resources for HOMES intervention clients. PIHC has a long history of receiving HOPWA funding for housing services, such as emergency lodging, short-term rental/mortgage/utility assistance, and rental subsidy. There are instances, however, when the HOPWA program regulations can present significant barriers in specific situations. This is especially observable for clients who may not be able to move seamlessly from 60 days of emergency lodging into a rental subsidy situation via Tenant Based Rental Assistance (TBRA). PIHC provides a "housing first" model. Housing plans for both HOPWA and HOMES clients often include a leveraged blend of HOPWA and HRSA funding to obtain and maintain permanent housing.

Funders to Leverage

The organizations listed below include those leveraged by PIHC. Sites replicating the HOMES intervention may wish to consider similar funders.

Replicating site may want to explore the following potential funders:

- **HOPWA**: Internal and external HOPWA providers (Tenant Based Rental Assistance - TBRA, Short Term Rent Mortgage Utility Assistance - STRMU, Emergency Hotel Lodging and Permanent Housing Placement - PHP). Homeless Services providers in the Metro region (United Way, Project Community Connections, Inc., Decatur Cooperative Ministries, HOPE Atlanta, Salvation Army, Action Ministries, Central Outreach, Partnership for Community Action).
- **340b Drug Pricing Program Funding** – Does the agency have access to such funding or unrestricted dollars from fund raising, donations or agency endowments?
- **Emergency Solutions Grant (ESG) recipients** and other Housing and Urban Development (HUD) funding.
- **Federal, State, County and City entities:** HUD (Federal), State (Georgia) housing authorities and the Department of Community Affairs (DCA), County (Fulton & DeKalb) and the City (Atlanta).
- Senior Income-Based housing.
- **Veterans Administration (VA)** housing programs Supportive Services for Veterans Families (SSVF) and VA affiliates (Veterans Empowerment Organization VEO), HUD VASH housing vouchers and the Community Resource and Referral Center located at Fort McPherson (CRRC).
- **Religious Affiliated Charities** (First Presbyterian, HOPE Through Divine Intervention, MUST Ministries, Crossroads Community Ministries, Norcross Cooperative Ministries, Basilica of the Sacred Heart Atlanta).

Survey Available Benefits

When developing or replicating an intervention, it's important to survey available resources and benefits. In metro Atlanta, where PIHC is located, there are a range of provider organizations that may interface with HOMES intervention clients and to which the intervention may be able to liaison. These include

1) Housing providers
2) Housing search/locator services
3) Employment providers
4) Medical care clinic services
5) Pharmacies,
6) Ryan White HIV/AIDS Program AIDS Drug Assistance (ADAP)/Georgia Health Insurance Continuation Program (HICP) and Health Insurance/Affordable Care Act (ACA) navigation, advocates, and shelters.

Setting – Integration and Expansion

HOMES is a new service that was integrated into the existing PIHC agency structure. The intervention was created from scratch using a template common to homeless service providers in Atlanta. Building the intervention from the ground up allowed us to incorporate new ideas and services without the confines of a more structured, federally funded housing program—yet with the perks of federal SPNS innovation funding.

"The intervention in combination with our existing HOPWA services allowed us to serve a greater number of clients in a more flexible way than traditional housing services."

Consumer Involvement/Consumer Advisory Board

In advance of implementation, the HOMES team sought the input of internal and external consumers as well as the Consumer Advisory Board (CAB) in the Decatur and Duluth locations of PIHC. Additionally, a questionnaire was distributed through the agency to clients to obtain their input and to inquire about their housing and employment needs. The case managers met with focus groups in the substance abuse program to gauge interest in the program and to assess needs of the attendees.

Gaining Internal Organization and Partner Buy-in

The HOMES team met with each department within the PIHC structure, at both locations, to pitch the program and to start a dialogue about program specifics and how clients will benefit from the services offered. The referral process and eligibility requirements were stressed as the intent of the program is to assist clients with both a history of poor health outcomes and those in need of housing and employment. A survey was conducted to assess PIHC employee's impressions of what types of services they felt their clients would benefit most from through a housing and employment program. A list of services offered was developed based on both client and employee input.

Presentations were made to various HIV and LGBTQ advocacy groups and to housing and employment agencies to test the waters on forming partnerships and a referral pipeline. Program expectations, eligibility and the referral process were discussed with the advocacy groups as we viewed them a great resource for client referrals. The housing and employment partners were briefed

and educated on "what to expect" when receiving a referral from PIHC to engage in their services as our clients often present unique qualifications and needs. Educating the agencies was an important piece, as most housing and employment providers do not cater to PLWH specifically or the LGBTQ community in general.

PIHC's Board of Directors (BOD) was also approached to gain buy-in on promoting and supporting the HOMES intervention. A presentation was given at a monthly BOD meeting to present the findings of client and employee surveys and to explain how clients will benefit from growing and sustaining the program in the future. The CEO of PIHC arranged for the team to speak at the monthly BOD meeting and acknowledged the importance of the program to PIHC clients and the PLWH community in Atlanta.

Planning for Sustainability

Program and organizational sustainability is a much more complex and dynamic process than simply reducing dependency of a project, program or grant on a singular funding source. Practitioners wishing to implement a similar intervention should plan for and strategize a sustainability plan at the onset of program design. Key tenants of a sustainability plan should include:

- **What has worked?** *Highlight key elements that have improved outcomes.*
- **What do you plan to discontinue and why?** *Identify key elements that did not improve outcomes. Identify key activities no longer needed.*
- **What do you plan to support and why?** *What services and interventions do you wish to sustain?*
- **How do you plan to continue supporting these services and interventions?** *Describe with specificity how each continued service or activity will be integrated into the organization.*
- **Describe funding sources**

Promoting the Intervention

Early success related to program enrollment, referrals, community response and coordinated care can be credited to specific and strategic efforts to promote the HOMES intervention launch. Attention should be paid to promoting the intervention to providers while discussing the referral process and while discussing program requirements and services with potential clients.

A one-page program brief was created to distribute to local ASOs and HIV service providers to explain how the program functioned, how clients could be referred, and how potential clients should expect to receive services.
One-page Program Brief Document (See Appendix A)

Marketing and Communications Plan
The marketing plan for this program was heavily dependent on grassroots and community outreach to spread the word about the work that we were going to be engaging in with program enrollees. Combined with presentations to the Atlanta Ryan White Planning Council, the HOPWA Housing Committee, and

Community Advisory Boards the team advertised and promoted the HOMES Program throughout the City of Atlanta for three months leading up to the beginning of client enrollment into the program.

PIHC provided a large-scale roll out of the HOMES Intervention, three months prior to accepting referrals. A considerable amount of time, planning and discussion went into the program roll out. Activities included:

Early March 2018 – Enrolling the first client into the HOMES Intervention (May 2018)
PIHC staff met with Atlanta metro area ASOs that we determined would be a key source of making referrals on behalf of clients. The team also met with and introduced the program resources to housing and employment providers. The presentations included:

1) General overview of the project and goals
2) An introduction to the newly established staff
3) Details on what clients could expect during the first meeting and subsequent interactions
4) Step-by-step details for the electronic referral process
5) Review of eligibility requirements; and
6) An introduction of evaluation components, outcomes and goals.

Communications and community visibility were two major factors that drove our marketing and outreach endeavors.

Communications
The Study Enrollment Coordinator played a major role in engaging with stakeholders in the HIV field around Atlanta including Ryan White Planning Council Members, Community Advisory Boards, Executive Directors, Grassroots Organizers, as well as HIV Advocates to gain insight about how to best engage community and establish a connection for potential referrals. Stakeholders gave insight to other housing opportunities that could support the HOMES program, sober living options, social support clubs, connections to local employment agencies, and community groups. We presented PowerPoint presentations, sat on panels, and facilitated focus groups to explain our plan for the project and to gain feedback on how to assist people living with HIV navigate housing and employment services in Atlanta.

The HOMES Team also engaged with the community outside of the HIV arena. Participating in events at: Men's Health Fairs, Atlanta Criminal Record Store Day, and Local Faith Organizations normalizes the conversation around HIV and getting tested and opens the door to talk about the services that we offer and ask simple screening questions to triage people throughout the agency.

Visibility
Each member of the HRSA Team was very involved in Outreach opportunities for the agency. This provided multiple opportunities for engagement with the community. Consistent feedback we received from the community was during outreach. We determined that people don't want to be talked at, so our approach to engaging community was very affirming in respect to all sexual orientations, gender identities, and presentations. "People don't care about how much you know, until they know how much you care." –Theodore Roosevelt.

Mini Case Study: A client was recruited during Positive Impact Health Center's Atlanta Black Pride testing and outreach event. A HOMES case manager engaged an individual that was living in the park where the event was being held. The case manager that worked with this client sat in the park with the

client for two hours and engaged in natural conversation that built trust to establish care, and eventually establish housing. Over time, the client was able to achieve undetectable status for the first time since his initial diagnoses.

Following inception of the program, the HOMES team continued to meet with new service providers throughout the duration of the program to market and promote the intervention. The team established and maintained relationships with service providers across the spectrum of housing, employment, HIV care providers, and local ASOs. HOMES conducted community outreach, distributed brochures, participated in AIDS Walk, and presented to the local Planning Council.

Planning Costs

- **Grocery Cards –** Used as incentives to encourage clients to engage in services. Also used in emergency situations when clients lose income or have reduced income and run into trouble paying for food and hygiene supplies. Budgeted $4,000-$5,000/year.

- **Transportation –** Used as an incentive for clients to make and keep clinic appointments and meetings with case managers. Uber and Lyft have been utilized to access providers and resources when public transportation will not work. Also distributed to clients to aid in their housing search and to travel to interviews and employment. Budgeted $3,500-$4,500/year.

- **Client Supplies –** Includes food and beverages (mainly snacks like granola bars or fruit that can be quickly consumed), hygiene products, notebooks or daily planners or any other supplies that case managers might need strengthen their work with clients. Budgeted $1,500-$2,500/year.

- **Employment Related Supplies –** Used to assist in paying for licenses related to employment or clothing needed for work (such as work boots or a chef uniform). Budgeted $1,000-$2,000/year.

- **Moving Services –** Clients often need help moving into housing if they have possessions in storage. Often a moving truck or a moving service needs to be engaged to ensure a smooth transition into housing. Budgeted $1,500-$2,000/year.

- **Office Supplies –** New office supplies can include tablets for mobile intakes, recording equipment for in-depth interviews or cell phones for the case management team. Budgeted $2,500-$3,000/year.

IRB Costs – Fees associated with conducting a research program mainly focus on the initial IRB approval and yearly renewals as well as any amendments or additions made to the original proposal of the project. Budgeted $3,000-$4,000/year.

Trainings – Training includes the free HUD and Human Research Subjects courses mentioned below in the "staff onboarding and training section" as well as SOAR training and Trauma/PTSD seminars. Budget may include $2,000/year for additional fees associated with staff trainings.
At a minimum, staff should also attend the bi-annual National Ryan White Conference on HIV Care and Treatment. Other suggested conferences: National Conference on Social Work and HIV/AIDS, United States Conference on AIDS (USCA) and the Annual Rural HIV Research and Training Conference (GA specific). Budgeted $1,500/attendee, per conference ($6,000 for a staff of 4 to attend – includes travel, hotel, per diem and registration fees)

Staffing Plan

Recruitment and Hiring
The minimum number of employees needed to serve up to 100 clients per year would stand at four full-time employees.

- **1 Study Enrollment/Intake coordinator** to schedule intake appointments, collect data, perform the 6 and 12 and month follow up sessions and the 6, 12, and 18-month chart reviews.
- **2 Non-Medical Case Managers** to assist clients with housing, employment, medical needs and referrals.
- **1 Program Manager** to oversee daily functions of the program including but not limited to budgeting, staff and client needs and accounting and tracking functions of the program.

A 6-month period of preprogram implementation is suggested to design the structure of the program, to conduct internal and external surveys and to form base partnerships.
In this case, the onboarding of all four employees is not necessarily required from day one. Staffing can be tiered with the Program Manager and Study Enrollment/Intake coordinator hired to start and build the program and onboarding of the case manager's 2-3 months after the initial start of the program. Case managers will lack for work if the program is not yet engaging clients. Two to three months into the start of the project, Case Managers could assist with information gathering and promoting partnerships in the community.

Recruitment of staff should focus on identifying potential candidates with a MSW degree and experience in the world of housing and/or homelessness and/or employment services. Experience working with PLWH is also preferred.

Minimum Qualifications
Minimum qualifications for staff, such as the Program Manager, Study Enrollment/Intake Coordinator, and Case Managers for the HOMES intervention, included the following:

Program Manager:
Master's in Social Work (MSW) or related field
2+ years' experience managing a team
4+ years in the housing and/or employment field(s)
Experience with capacity building and program implementation
Knowledge of HIV, HIPAA and social work ethics
Experience with data collection and reporting

Knowledge of accounting basics

Study Enrollment/Intake Coordinator

Bachelor of Science (BS)/Bachelor of Arts (BA) in Psychology, Counseling, Social Work, or related fields
Knowledge of HIV, HIPAA rules and social work ethics
The ability to ask difficult questions and process client sensitive information
Experience with data collection and reporting
Experience working with EMR databases
Experience with partnership and capacity building

Case Managers

Master's in Social Work (MSW) or related field
2+ years in the housing and/or employment field(s)
Knowledge of HIV, HIPAA rules and social work ethics
Ability to provide support services to 50+ clients
Experience working with EMR databases or related housing databases

Job Descriptions and Postings
PIHC Employee Job Descriptions (See Appendix B)

Staff Onboarding, Training, and Continuing Education
The onboarding process for new PIHC employees includes universal HIPAA training as well as EMR training, HIV 101, the basics of client confidentiality and a review of PIHC values and standards for client care. Training and development of key staff began by utilizing HUD's *Getting to Work* online modules as a basic orientation to the concepts of integrating HIV care, housing, and employment. For purposes of evaluation and the ability to validate and disseminate project findings on a larger scale, all project staff completed Human Subjects Research (HSR) Trainings. These two training models became the foundation of staff on boarding to address the intersection of HIV care, housing, and employment.

Getting to Work
Team members were also required to complete the three modules of the HUD Exchange *Getting to Work: A Training Curriculum for HIV/AIDS Service Providers and Housing Providers*. The Getting to Work training curriculum assists service providers in understanding HIV/AIDS in the context of employment and the different approaches to helping clients who are ready to work identify and achieve their related goals.
www.hudexchange.info/trainings/dol-hud-getting-to-work-curriculum-for-hiv-aids-providers/

Human Subjects Research Training
Each employee on the HOMES team has completed HSR training via the National Institutes of Health (NIH). To find out if your research requires Human Subjects Research Training:
https://grants.nih.gov/policy/humansubjects.htm

Human Subjects Infographic NIH (See Appendix C)

Trauma Informed Care/PTSD Exposure Training
Trauma training also plays a role in the daily work of all HOMES team members and has been fully

integrated into the everyday culture of PIHC as an agency. Emory University provided a mandatory agency wide training focused on Trauma Informed Care while internal behavioral health staff have provided ongoing in-house trauma care and PTSD related seminars and lunch and learn trainings. http://gradytraumaproject.com/

In addition, all new PIHC clients are screened for Trauma/PTSD and referred for behavioral health services.
Trauma/PTSD Screening Tool (Appendix D) – we also have a great PowerPoint presentation but I'm not sure how to link to it in this document

SSI/SSDI Training
Case managers are recommended to attend a SOAR training called "Stepping Stones for Recovery" on how to assist clients with applying for SSI/SSDI. SOAR trained case workers serve as appointed representatives for the purpose of applying for SSI/SSDI for applicants.

The SOAR effort in Georgia is an initiative designed to increase access to SSI/SSDI for eligible adults who are experiencing or at risk of homelessness and have a mental illness, medical impairment and/or a co-occurring substance use disorder.
https://soarworks.prainc.com/states/georgia

Referral Mapping
The referral process mainly focused on internal clients that already were active in services at a PIHC location. PIHC did accept referrals from outside agencies, that we had previously presented the outline of the program to, that encountered eligible clients. The program was widely promoted within the agency and all departments were encouraged to send referrals to the Study Enrollment Coordinator. A copy of the referral form used for the program can be found in Appendix D**.**

Staff Training

Trauma-Informed Practice
Trauma informed care is an essential element that has been integrated into services at PIHC. Training and having an understanding of the practice is extremely important to the HOMES intervention, as many of the intake questions center on issues that can reveal past traumatic experiences. In addition, many of the clients experiencing homelessness are also currently living in traumatic situations where they may trade sex for shelter, perform sex work for money, are in and out of jail or prison or they are in abusive and unstable relationships.

Trauma-informed care looks at the widespread effects of trauma, hope for recovery, signs and symptoms of trauma, and incorporating knowledge about trauma into policies and procedures. Through this lens, staff seeks to prevent re-traumatization of clients. Trauma-informed care is typically implemented through universal screening for trauma symptoms, training for all staff and the use of a trauma liaison in order to keep awareness about the issues related to trauma alive.

Trauma/PTSD Screening Tool (Appendix C)

Stigma/Discrimination and Anti-Racism
All PIHC newly hired staff receive training on Stigma and Discrimination as required by the agency

onboarding process. Anti-Racism issues are regularly addressed agency wide and we have an ongoing, open door discussion with regards to topics of racism and inequality. Training is also provided for Transphobia and HIV stigma related concerns.

Competency Assessment and Development Plans
The staff complete 60-day work plans upon first hire and receive yearly evaluations with supervisors, including setting yearly goals and reviewing performance plans.

Mentorship Plans
The clinic and Behavioral Health staffs meet once per week with the case management team to discuss clients in case conference. The differing perspectives from each discipline lend case managers a chance to discuss clients in a space where issues other than case management needs are addressed. Case conference is an interdisciplinary meeting which includes agency colleagues from case management, clinic, behavioral health, substance abuse, ADAP, housing, and prevention departments.

Supervision Structure

Clinical Supervision
The Director of Client Services, who is a LCSW with 30+ years working in the HIV field, provides weekly clinical supervision to the case managers. The whole team meets once per week to discuss clients and program specifics. The Program Manager provides daily support and supervision regarding housing and employment resources and referrals to community partners. The whole team also meets once per month with the Department Director and PI for the program to review program related issues and provide updates.

Management Approaches
The Management team has provided outlets and opportunities to address stress, secondary trauma, and burnout for the case managers in the program and agency wide. The Client Service team has attended seminars to equip the team with strategies and skills to handle stress and burnout.

During weekly supervision, issues around burnout and compassion fatigue often come up and the team talks through ways to manage the stress of working with difficult client situations. Advice was sought from social workers within the agency who have been in the field for years to inquire how they have dealt with stress, burn out, compassion fatigue, and secondary trauma.

Partner Organizations

Partner organizations of the HOMES intervention included the following:

Partner Organizations	
Housing Providers	
Jerusalem House	The oldest and largest provider of permanent housing for low-income and homeless individuals and families affected by HIV/AIDS.
HOPE Atlanta	Provides HOPWA, housing and homeless based services including programs for veterans, those fleeing domestic violence, shelter + care, transitional placements and relocation services via Greyhound.
Project Community Connections, Inc. (PCCI), Open Doors, United Way, Hope Through Devine Intervention, A Vision for Hope, Matthews Place, Making A Way, County Housing Authorities, Senior Housing Programs, LA Properties, AID Atlanta, Decatur Cooperative Ministries	Provides homeless and housing services ranging from housing locator services and housing advocacy to transitional and permanent housing placements and temporary financial aid (TFA) to obtain and maintain housing.
Housing Search/Locator Services	
Open Doors	Connects nonprofit organizations, serving low-income populations to real estate operators. Open Doors leverages real estate and business relationships to recruit affordable housing options. Offers quick housing placements to approximately 1,000 clients per year. Participating nonprofits must sign a memorandum of understanding (MOU) to refer clients. To learn more, visit: https://opendoorsatl.org/about-us/
Georgia Housing Search	Their mission: to ensure that homes will always be available to people exiting homelessness. Sponsored by the Georgia Department of Community Affairs, GeorgiaHousingSearch.org provides detailed information about rental properties and helps people find housing to best fit their needs. The service also provides links to housing resources and helpful tools for renters such as an affordability calculator, rental checklist, and information about renter rights and responsibilities. To learn more, visit: www.georgiahousingsearch.org
PadSplit	An online roommate search service that provides users with local listings of available rooms to rent in their search area. Their mission: to solve the affordable housing crisis one room at a time. To learn more, visit: www.padsplit.com

Roomies	An online profile and rental search service that connects users to open up discussions between the parties to potentially become roommates. Offers a free "roommate agreement" to record the general terms of a room rental. To learn more, visit: www.roomies.com/atlanta-ga
Open Doors	Connects nonprofit organizations, serving low-income populations to real estate operators. Open Doors leverages real estate and business relationships to recruit affordable housing options. Offers quick housing placements to approximately 1,000 clients per year. Participating nonprofits must sign a memorandum of understanding (MOU) to refer clients. To learn more, visit: https://opendoorsatl.org/about-us/
Georgia Housing Search	Their mission: to ensure that homes will always be available to people exiting homelessness. Sponsored by the Georgia Department of Community Affairs, GeorgiaHousingSearch.org provides detailed information about rental properties and helps people find housing to best fit their needs. The service also provides links to housing resources and helpful tools for renters such as an affordability calculator, rental checklist, and information about renter rights and responsibilities. To learn more, visit: www.georgiahousingsearch.org
Employment Providers	
Jewish Family and Career Services (JFCS)	Provides employment services, job referrals and vocational training on top of offering community food assistance, clinical services, transportation and TFA for individuals and families in need.
NOVO Health Services	NOVO operates four regional healthcare linen facilities that provide stable employment to job seekers.
Goodwill of N. Georgia	Located in multiple locations across the state of Georgia, they offer a variety of employment related services such as job training, coaching and placement to resume writing and access to job boards and job fairs.
First Step Staffing	Offers same day and on the spot employment opportunities at multiple metro area employers and transportation to the placements.
Jewish Family and Career Services (JFCS)	Provides employment services, job referrals and vocational training on top of offering community food assistance, clinical services, transportation and TFA for individuals and families in need.
NOVO Health Services	NOVO operates four regional healthcare linen facilities that provide stable employment to job seekers.
Medical Care Clinic Services	
AID Atlanta, AID Athens, Absolute Care, Grady Infectious Disease Program (Grady IDP), Emory University and Midtown Clinic and the Fulton County Health Department	Serves as metro area providers that assist clients with HIV related health services and resources.
Food Assistance	

Open Hands, Atlanta Community Food Bank, Toco Hills Community Alliance, Hosea Feed the Hungry, First Presbyterian Church, Free Food Commune, Butler Street CME, Malachi's Storehouse, Essence of Hope, Buckhead Christian Ministries	Serve as food resources for individuals in need of assistance.
ADAP/HICP Services	
Statewide Locations	ADAP is a state administered program that provides HIV/AIDS medications to low-income individuals living with HIV disease who have little or no coverage from private or third-party insurance. Georgia ADAP services are available to all eligible residents of Georgia. There are 28 enrollment sites located throughout the state, inclusive of five (5) approved sites located in metro Atlanta. Enrollment sites may be located using this link the GA Department of Health: https://dph.georgia.gov/hiv-care/aids-drug-assistance-program-adap
Pharmacies	
Community Walgreens, Longs, Norcross Pharmacy	These pharmacies are the main entities that we use to service clients, including our own in-house pharmacy. Each location is ADAP-certified and familiar with our client population and their unique medical needs. They will also courier medications to our locations and ship to client homes under certain circumstances.
ACA Navigation and Community Advocacy	
The Health Initiative	The Health Initiative's mission is to advance fairness, safety and opportunity for lesbian, gay, bisexual and transgender communities and our allies throughout the state of GA. They provided ACA navigation during open enrollment as well as voter registration and educational activities meant to organize and mobilize LGBT residents and allies. The Health Initiative closed June 2020.
Aniz, Inc.	Serves as a community advocacy group that offers mobile testing, behavioral health services, clean needle access and exchange, harm reduction programs, peer support groups and Ryan White HIV/AIDS Program primary care.
Thrive SS	Functions as a community advocacy agency that offers peer support and linkage to assist clients with healthcare needs to lower the community HIV viral load founded by and primarily serving black gay men with HIV.
NAESM	The mission of NAESM is to provide national and local leadership to address the myriad of health and wellness issues confronted by Black gay men through services such as advocacy, PrEP access, and mental and behavioral health counseling.
Shelters and Homeless Services	

Gateway 24/7 Center, Salvation Army, the Atlanta Union Mission	These are the three main shelters located in the City of Atlanta.
City of Refuge, Mary Hall Freedom House	City of Refuge is the only “women only” shelter in Atlanta and Mary Hall Freedom House supports women fleeing domestic violence.
Central Outreach and Advocacy, Crossroads Ministries, Midtown Assistance Center, the Furniture Bank of Metro Atlanta	These groups provide homeless services ranging from helping individuals obtain their GA State ID or birth certificate to providing clothing, food, transportation, furniture, and job training.

Intervention Implementation/Service Delivery Model

Core Components of the intervention/Services Provided

Individual level
Consent and Enrollment
Once a client is determined to be eligible, the client meets with the Study Enrollment Coordinator (SEC) for consent into the evaluation. Once consented, the individual completes a baseline interview and is provided a $20 incentive gift card for their time and participation. The baseline interview takes anywhere from 90 – 120 minutes to complete. From there, a face to face warm "hand-off" to the assigned case manager takes place and an appointment is set up for the client to return for a housing and employment needs assessment. If the client does not consent, there is no baseline interview and no incentive is provided, rather an informal discussion of their housing and employment needs takes place with the SEC.

Initial Appointment
At the initial meeting between the client and the case manager, they jointly create a plan to begin working towards stated goals and to eliminate defined barriers.

The three main goals that are covered with every initial appointment are:

1) ***Adherence,***
2) ***Employment****, and*
3) ***Housing needs***.

The initial appointment can consume anywhere from 60 – 90 minutes. A discussion of what the client hopes to achieve concerning each goal forms the basis for actions taken by both the client and case manager moving forward. Some clients desire their own apartment, some desire to move back with family and some are seeking a rooming house or a roommate – each client has a unique path so the case manager needs to be mindful of the fact that the most effective plans are created in conjunction with plenty of client input.

Barriers are also discussed in detail as the path to the client achieving their goals is often littered with multiple roadblocks. What does the client need to achieve success in each area? Barriers have included evictions, lack of work history, lack of identification documentation (e.g. social security card, driver's license, birth certificate), unpaid utility bills, transportation, felony convictions or charges, child-care needs, mental health and/or substance use concerns and more. From there, an action plan is developed to minimize the present barriers and to agree upon roles and responsibilities for each party involved.

Moving Forward
Case managers are expected to meet with clients, at a minimum, on a weekly basis. Each client presents with unique needs and challenges, therefore daily check-ins or frequent phone contact is not uncommon. The case managers work in conjunction with PIHC clinic staff to monitor the clients' viral load and adherence to medications. Adjustments along the way are often needed as barriers to care such as lack

of transportation, losing meds, job or housing loss, domestic violence and relocation often arise unexpectedly. Helping clients maintain their clinic care and get to an undetectable status takes time however, as client barriers are removed and employment is obtained, contact becomes less frequent and less critical. As a stopgap measure, all of the clients enrolled in the study remain in case management, regardless of the level of their success with obtaining housing and employment, as a means to ensure that they also remain engaged in medical care and retained within other agency programs.

Services Provided and How
Services provided included a range of navigation, behavioral health medical care, case management. This includes the following:

- **Housing and Employment** related case management advisement is provided on an as needed basis or by appointment, depending on the client needs and urgency.

- **Transitional Lodging** is provided for clients that have started the process of securing housing but are not yet able to move into their unit (e.g. a client that has been awarded a section 8 voucher but is still searching for a property to accept the voucher or a client that has been accepted at a complex but they have not completed the entire TBRA process with HOPWA). This housing option provides the client with a safe place to stay while they are transitioning from instability to stability. Each client placed into transitional lodging is required to abide by the rules and regulations of the program as well as the rules of the hotel.

- **Transitional Lodging Client Rules & Regulations (**Appendix H**)**

- **Behavioral Health** appointments are set up by the client's therapist and are most regularly on a weekly basis.

- **Medical Clinic Care** appointments are set by RNs and occur daily from 9 AM – 7 PM and from 10 AM – 2 PM every other Saturday.

- **Peer Support** groups are held daily at both locations and cater to diverse populations (e.g., long-term survivors, Trans Women – TWILLOW, Cis-Gendered Women – WILLOW).

- **Substance Abuse** counseling appointments are set by the client's therapist and group therapy is help daily. Part of the group therapy sessions center on life skills and the case managers present quarterly on housing readiness and renters rights: www.vhda.com/Renters/Documents/RenterHandbook.pdf

- **Prevention services and testing** are available on a daily, walk in basis—including hours on Saturday mornings.

- **Tangible reinforcements:** food, clothing, hygiene, kits.

- **Transportation:** The H.O.M.E.S case managers can arrange transportation assistance such as providing public transportation cards as well as access to private transportation providers. MARTA cards are provided for clients accessing public transportation. MARTA also offers a

reduced fare card for riders with a disability that entitles them to purchase rides for one dollar. The case managers sign up every program eligible client for a card during their initial intake and a provider signs off on the application.

- Reduced Fare Application (available here: www.itsmarta.com/uploadedFiles/Fares_and_Refills/Fare_Programs/RF%20Health%20Care%20Provider%20Cert%20Form%209.18.2018.pdf)
- The private transportation providers that are utilized for PIHC service areas are UberHealth, Lyft, J&J Transportation and if applicable, Medicaid Transportation. Case managers can also leverage agency wide Ryan White transportation funds by making sure that clients that are coming for housing or employment appointments, that require transportation assistance, also have a medical appointment set up as Ryan White will pay for transportation to and from provider visits.

Food assistance: Provided for Ryan White eligible clients in the form of Kroger grocery cards. Each client is capped at receiving a maximum of $300.00 per calendar year in food assistance. Extensions of this allowance is done on a case by case basis and clients are encouraged to enroll for food stamps and to seek out food banks, soup kitchens and churches as alternatives to accessing Kroger cards. The most common food banks/soup kitchens in Atlanta are listed in a previous section of the manual. Clients are often referred to churches for food assistance as they provide a host of services such as support with obtaining an ID, homeless services, hygiene kits, clothing closets and limited financial assistance.

- **Clothing:** Occasionally, PIHC will offer hygiene kits and clothing to clients. Community grants cover the cost of the items or they are donated by companies or foundations. We access the United Way to obtain hygiene kits during the Winter Holidays and back to school items during the school year. We also do spot fundraising on Facebook if we need specific items for clients that are starting back to work, asking for such items as work clothes and shoes or gift cards to help purchase uniforms. Many of our clients also received a winter coat from donations provided by Burlington Coat Factory.
  www.burlington.com/coat-drive

Individual Service Plan

Individual Service Plans (ISP) are completed by the HOMES Case Managers during the initial visit and every six months thereafter. The ISP is a tool for the case managers to use in conjunction with previous case notes located in the PIHC EMR. The intent is to provide a framework for documenting important assessment elements and standardizing the key questions that should be asked as part of an intake. Breaking down responsibilities and roles is an important part of the plan to ensure that there are no grey areas with regards to which party is going to perform the task at hand (who is responsible for contacting housing providers, who is responsible for following up with the provider or how is transportation being provided and who is arranging it?). The ISP also translates the assessment into a level of programmatic support designed to provide the client with assistance, appropriate to their assessed needs and levels of functioning.

Individual Service Plan Chart and Client Narrative (Appendix G**)**

Communication

System level
Partnerships created and how maintained:
An internal needs assessment was coordinated to determine the type of new partnerships that would need to be formed to assist PIHC with starting up a housing and employment services program. The main HOPWA providers in the City of Atlanta were referred to our own internal program and services located at HOPE Atlanta and AID Atlanta. Partnerships with these organizations previously existed and the HOMES team met with the providers to promote and explain the interworking of our new program.

The team also met pre-program implementation with agencies that provide homeless services as well as private property owners in the community and housing advocates. These partnerships were also in place before the program began providing services and were strengthened through previous collective experience and personal relationships held by team members.

The agency has never offered a concrete employment program on site. The vocalization of PIHC, however, has become increasingly necessary as clients are living longer and able to work and as less of them are filing for—or eligible for—disability benefits. Another factor compounding the need for employment services is the lack of affordable housing available in the metro area. It is no longer realistic to believe that one can afford stable housing in the City of Atlanta and surrounding area without earning a living wage.

The HOMES team collaborated with two main employment providers to begin the program and expanded access to providers over time. We began by approaching the Goodwill of North Georgia and the Jewish Family and Career Services. Both agencies offer a menu of career and employment services tailored to clients from low-income backgrounds that lack the job skills needed to transform their employability. The case managers and Program Manager met with representatives from both sites and set up an agreement to vet and refer clients to them based on the demographics that they serve and the programs that were available. Once the agreements were in place, the case managers began to filter clients to the appropriate corresponding agency on a weekly basis, checking in with their agency contacts regularly.

Organizational Staff Meetings
A tiered meeting structure supports PIHC to ensure shared vision, communication channels are on-going, services are not duplicated, client case conferencing takes place, gaps are identified, challenges or barriers are addressed, and capacity building takes place. The below table outlines the various organization staff meetings, memberships, purpose and outcomes.

Meeting Structures and Communications		
Meeting	**Frequency and Format**	**Attendees**
HOMES Team Huddles *Purpose*: Team oriented dialogue, resource planning, program client case conferencing and housing and employment updates	Daily, short interval (30-60 minutes or less), in-person	HOMES team staff and Client Services Director (as needed and available)
Housing and Employment Meetings *Purpose*: Review outcomes and discuss client needs, offer support, check-ins on client progress and sharing resources and information	Daily, short interval (15-30 minutes or less), via email or phone	HOMES team case management staff
Transitional Lodging Check-Ins *Purpose*: Coordinate with the Inn Town Suites Regional Manager to check-in on client activity, renew clients into lodging and exit those moving into other housing options	Daily, short interval (15-30 minutes or less) via email or phone	HOMES Program Manager and Inn Town Suites Regional Manager
Clinic Case Conference *Purpose:* Coordinate services for clinic clients to improve adherence and retention, highlight important clinic updates and a platform for providers to share client updates	Weekly, 60-90 minutes, in-person	Client Services staff, Clinic Staff (including providers) and Mental Health and Substance Abuse staff
Decatur Client Services Team Meetings *Purpose*: Update team on Client Services programs, recent accomplishments, share information amongst team members, detail upcoming deadlines and future needs	Monthly, 60-90 minutes, in-person	All client services staff located at the Decatur location
HOPWA Team Meetings *Purpose:* Coordinate HOPWA services for mutual clients, resource planning, HOPWA program updates	Monthly, 60-90 minutes	All HOPWA staff and select HOMES team members
All Client Services Staff Meetings *Purpose:* Update team on Client Services programs, presenting guest speakers and client focused trainings, plan for future Client Services needs	Quarterly, 2-3 hours, in-person, large group setting	All Client Services staff, agency wide
All Decatur PIHC Staff Meetings *Purpose:* Provide agency and site-specific updates, platform for Directors and Program Managers to provide program updates and employee presentations	Monthly, 60 minutes, in-person, large group setting	All PIHC staff located at the Decatur location
All PIHC Staff Meetings *Purpose:* Team building exercises, provide agency updates, platform for Directors and Program Managers to provide Agency and program updates	Quarterly, 6-7 hours, in-person, large group setting	All PIHC staff, agency wide

Use of EMR-for Documentation and Reporting
Cerner is the electronic medical records system (EMR) used by PIHC for documentation and reporting purposes. Within Cerner, the two main programs utilized are Powerchart and SPM. These two programs contain various features and ways of documenting client interactions:

- **Powerchart** is mainly used to document client interactions whether it may be face-to-face or non-face-to-face. Case managers are expected to enter documentation within 24 hours of client interaction. Powerchart also allows case managers to track a client's medical history, review medical labs, view provider interactions and notes and it allows the user to see who has worked with the client in the past or who is currently working with the individual presently. One unique tool used in Powerchart allows case managers to log the amount of Kroger cards that are provided to a client to track the amount given to a client within a calendar year.
- **SPM** is mainly used as a scheduling tool to set client appointments, track client demographics, and check clients in/out of the clinic.

Module Adaptation for Target Populations
During outreach and recruitment, the team focused on two priority populations: 1) African American MSM and 2) those identifying as transgender. Team members attended meetings and conventions specifically catering to these populations to recruit new clients and to present the program guidelines and eligibility requirements. Throughout the enrollment period, the team continued to attend targeted meetings to recruit and present to the two main target populations.

Transitioning to Standard Care

When considering transitioning a participant to standard care, assess the participant, their progress towards reaching stated goals and their overall needs. Once a participant is enrolled in the program, case managers initially follow up with the client on a daily or weekly basis. As clients progress through the program and meet their goals, encounters and check-ins become less frequent, based on individual needs. Case managers continue to monitor the participant's progress to determine if the participant is on target with achieving their goals or if modifications are needed. Overall, the gauge of a participant's success is based on three main factors; obtaining and maintaining employment, obtaining housing and becoming viral suppressed and medically adherent. Once a client has met these goals, case managers work on other life skills types of goals such as securing food resources, assisting with Furniture Bank referrals, connecting individuals with mental health counseling (if needed) and helping clients become more independent in general. Participants are eligible to receive assistance, resources and referrals at any time while enrolled in the program.

Documentation

Electronic Medical Records
PIHC provides formal Health Insurance Portability and Accountability Act (HIPAA) training for all new staff members and offers multiple trainings throughout the year on sensitive health subjects. PIHC also

has an internal electronic medical records (EMR) system where sensitive client information can be shared and communicated within the agency as opposed to using an unsecured form of communication such as email. Program-specific employees have access to the EMR system to maintain information integrity and client confidentiality. Each employee, working with the study, who engages in direct client contact, has completed human subject's research training.

Case Notes

Documentation is also made via case notes. Every client encounter is detailed within 24 hours of client interaction.

Case Note Template (Appendix H**)**

Other Data Management Systems
Excel spreadsheets were used to track transitional hotel lodging stays. Every client who accessed this type of transitional lodging was tracked by length of stay and cost of the room. This was to ensure that their period of homelessness was brief and that it resulted in a permanent housing placement. For this project, 70% of clients exited their transitional lodging and into a permanent housing placement.

Invoices paid for the lodging were also tracked for financial reporting purposes.

Documented Technical Assistance Needs and Requests

- Monthly all-sites advisement calls
- Recruitment strategies
- Dissemination Strategies
- Working with homeless clients
- Tracking systems

Partner Activities

PIHC's approach was to introduce and integrate social determinant support services, namely housing and employment, into our care portfolio. Key partners included staff across all disciplines and locations. PIHC has been expanding services and locations for the past 5 years to holistically meet community needs for quality care. This includes advancing primary care services, testing, mental health, substance use, and pharmacy services. The addition of housing and employment services enhanced these efforts and was the next natural progression for PIHC.

The HOMES case managers had the unique advantage of having a wealth of partners co-located in the same building. The Decatur and Duluth locations each offer behavioral health, substance use, medical, and pharmacy services within the same building. The Cobb County PIHC location has case managers, housing, and clinical services as well.

Although these services co-exist in one building, they are not always coordinated and "on the same page" with each other due to competing needs and interests, and disparate disciplines. The HOMES team saw an opportunity to fully integrate the intervention activities into the organization. We were able to partner with our internal clinic staff to provide them with a resource to address social determinants of client health (e.g. housing, income, food, transportation) that are not related to their client's physical health or HIV medical care. We presented our program as an additional way for clinicians to provide a higher level of service over and above direct client health care needs.

PIHC Innovative Practice Model: Integration of Housing & Employment

Coordinated	Co-Located	Integrated	Self-Sufficient
Case management screening for housing and employment needs	Medical, behavioral health, pharmacy, housing & employment located in the same location	Housing and employment services provided across multiple locations	Creating a comprehensive internal care network
Referral Relationship ***across all*** departments	Referral process streamlined	Coordinated treatment plans	Offsetting greater Atlanta infrastructure challenges
Routine exchange of information	One-stop shop for clients; combats barriers to care (e.g., transportation)	Shared EMR; shared documentation across provider types	Responding to community need through sustained services
	More client-entered	Team approach vs provider silos	
	Enhanced informal communication		

Fully integrating housing and employment services into the agency, through internal PIHC partnerships invariably led to improved health outcomes for our clinic clients. We based the integration of these services on the notion that "housing is health care" and the notion that client who achieve stability are more likely to remain medically adherent and in turn, they are more likely to seek out and maintain ancillary services such as behavioral health and substance use counseling.

Disparate programs and a myriad of services can be difficult to coordinate within an agency and across multiple sites. Establishing and strengthening referral mechanisms within PIHC was a primary focus. Changing the way our teams and services operate – to protect against working in silos – was essential. Local challenges and fragmentation of housing, employment, and care services has long troubled the Atlanta Metro region. With high HIV incidence and prevalence, the need to circumvent area challenges in funding, leadership, infrastructure, and service delivery was viewed as paramount to ending the HIV Epidemic.

Modifications Made During Implementation

Originally, the main client referral base was to come from our in-house substance abuse team and outpatient rehabilitation groups. This was altered because there were not enough eligible clients in the program to constitute referrals coming only from a single source. The modification was made to broaden the base of eligible clients by accepting referrals from all PIHC departments and outside providers in addition to clients coming through our substance abuse programs.

Intervention Implementation Costs

- **Transitional Lodging** - $120,000 covers an expense of $10,000/month for 1 year. That amount covers approximately seven clients per month in lodging at a rate of $350/week for a single room. The amount of administration to maintain seven clients in lodging can be overwhelming thus 4-6 clients is recommended with a cost savings providing longer stays for clients enrolled in the program. There tends to be a more intense need for transitional lodging during the winter months due to the cold weather, depending on locality.

- **Client Incentives** - at program enrollment/intake, clients are provided with a $20 Kroger card incentive for their time and participation (we have also used Walmart and Amazon cards as incentives for clients that may not have access to a Kroger Grocery Store). They are also provided a $20 incentive for completing the 6 and 12 follow up appointments. The cost for enrolling 100 clients in the program and providing them with the above noted incentives would be $6,000. Some clients do fall out of care, move away from the area, or elect to no longer participate in the program so the $6,000 allotment for incentives may vary.

- **Transportation** - One of the main challenges that the program faces is the lack of reliable public transportation and clients without access to vehicles. The City of Atlanta is a very car heavy environment where movement is difficult if you do not have the means to afford a vehicle or if you are not located near public transit. Therefore, providing transportation incentives is crucial to ensure ongoing client participation. The budget allowed for $7,000 - $8,000 per year for transportation expenditures. The budget allows for purchasing round trip and weekly MARTA cards as well as accessing ride share programs such as Uber and Lyft. Again, this value may vary as the number of clients enrolled and receiving services will fluctuate from the time of inception of the program through the 3-year period of the grant.

- **Snacks for Clients** - The enrollment/intake appointment takes approximately 2 hours to complete and can be emotionally and mentally draining due to the content of the study questionnaire. Given this time frame and the nature of the questionnaire, we have attempted to provide clients with a small snack and beverage to accommodate any adverse reactions to the process of enrollment/intake. We budgeted $1,500 - $2,000 per year client supplies to cover the expense.

Intervention Outputs and Outcomes

Employee Trainings

In addition to previously mentioned in-services, the HOMES team completed the following trainings:

- Blood-borne Pathogen Training
- CPR Certification
- 340b Employee Training
- GA HIV Program Security and Confidentiality
- Cybersecurity Awareness
- Motivational Interviewing
- Trauma-informed Care
- HIV 101
- Effective Communication
- Cultural Competency (via https://thinkculturalhealth.hhs.gov/education/behavioral-health)
- PIHC Emergency Procedure Training
- Lorem ipsum dolor sit
- Lorem ipsum dolor sit

Intervention Outputs

Employee Trainings
The entire client facing PIHC staff, at all three locations, were present for at least one training/presentation on how the HOMES intervention functions within the agency. More in-depth training and discussions have occurred on a one on one basis with employees who interact frequently with the team and see mutual clients (e.g., HOPWA staff, behavioral health staff that share mutual clients, etc.).

Intervention Outcomes

The HOMES Intervention addressed myriad social determinants of health and advanced project efforts achieving the following intervention outcomes and target populations:

Demographics

Client Profiles: Intervention Participant Demographics (*N*=108)	Mean	Percent
Age	37	100%
Race		
Black	90	83%
White	16	15%
Other	2	2%
Sex		
Male	92	85%
Female	10	9%
Transgender	6	6%
HIV Status		
Virally Suppressed	69	73%
Undetectable	53	56%

HIV Care Continuum Stages

44% → 77%

Engagement in Care at Enrollment vs. May 2020

51% → 65%

Viral Load Suppression at Enrollment vs. May 2020

Policies and Systems Change
PIHC established a "first-of-its-kind" program that is open to all PLWH in need of housing and employment resources in the Atlanta Metro Region. This included creating and maintaining a pipeline for employment services and changing the mindset of program participants seeking employment or experiencing homelessness and getting PLWH "back to work."

The HOMES Intervention helped decrease the overall number of people in the Atlanta Metro Region experiencing homelessness. The intervention positively impacted housing, employment, and clinic services for PLWH in the City of Atlanta and highlighted the social determinants of health that are impacting underserved populations in the state of Georgia.

Sustainability Planning
PIHC has applied for alternative funding sources to maintain the case manager position. PIHC has also applied for and received another SPNS intervention grant. Buy-in from senior leadership has continued to be a priority in order to maintain funds for the program and ensure that employment services are integrated within the agency.

Integration into the System of Care
HOMES intervention staff have worked to secure buy-in from senior leadership as well as an overall agency commitment to ensure that housing and employment remain integrated within the agency and that lessons learned through the intervention are shared throughout the organization.

PIHC established a transitional/supportive housing program with guidelines as standard operating procedures, which can be found within Appendix I. Housing and employment services are fully integrated in to every case management and clinic intake, found in Appendix G. Every department (from all three locations) is aware of how to refer clients in need of housing and/or employment to the HOMES team for advisement.

Lessons Learned

Barriers and Challenges

Transportation
The Decatur PIHC site is conveniently located one block from our Metropolitan Atlanta Rapid Transit Authority (MARTA) public transportation system. Being close to public transportation allows us to serve clients that do not own a vehicle; however, commutes on public transportation are often long and discouraging for an individual with multiple appointments or stops along the way. While we do offer incentives to assist clients with transportation, often times getting the clients to the office to access the incentives can be challenge as their resources are already limited. MARTA itself has its own limitations as the train routes do not serve many areas of the City and just getting to a train station can often involve a few miles walking or taking busses that meander through the city. The expense of transportation is also a concern as many of the clients in the program are zero income status or very low/low-income earners. To offset the expense, we have each client in the intervention apply for a MARTA half-fare disability card. This entitles them to $1/one-way rides as opposed to the $2.50/one-way rides that most riders pay for.

Communication
Encountering clients who are often homeless or unstably housed and with minimal or no employment makes maintaining a mode of communication a barrier to keeping consistent contact. Whether the client's phone number has changed, or clients have periods of having no service, this can be difficult when trying to pass on new information, setting up future appointments and follow ups and when connecting them to referring agencies and programs.

Lack of Affordable Housing
The housing market in Atlanta is unforgiving to our clients who have previous evictions, felonies, or lack of a livable wage. Affordable units are often in areas that have high rates of crime and/or drug use. A high proportion of clients have experienced or are experiencing drug recovery; being placed in high drug use environments does not aid the recovery process and is often not advised by substance abuse counselors on the Care Teams.

Due to Atlanta's economic development, affordable housing is no longer accessible as property owners and apartment complexes are increasing their rates. The Fair Market Rate (FMR) is not increasing at the same percentage. This creates an issue when clients search for apartments, finding limited options and the compounding of existing barriers.

Facilitators of Success
The biggest factors leading to successful outcomes occurred when case mangers worked collaboratively with clients to create action plans based on their needs (not a "one size fits all" approach) along with the leveraging of available community resources.

- ***Educate, Educate, Educate your providers!*** Let them know about the population you serve and what to expect when referrals are made for services.

- ***Employment and Housing resources are fluid.*** Be flexible and cultivate as many partners as possible.

- ***Transitional Housing options are vital*** (e.g., sobriety focused group living, hotel lodging, Padsplit.com, roomies.com).
- ***Leverage ALL housing resources*** (e.g., ESG, HOPWA, CoC, RW Funds, Private Donors). Remember that not everyone living with HIV needs to access HIV-specific housing.
- When addressing employment, ***aim for a livable wage at all times***.
- ***Consider the clients' transportation needs*** and feasibility of their commute.
- ***Persistence*** in searching for resources is vital.
- ***Work Skills and Life Skills are not always common sense***. Spend time talking with clients about the "what if's" (what if I lose my transportation, what if I get sick, what if I relapse).
- ***There is always a solution***. Don't let setbacks derail major goals.

Dissemination Activities

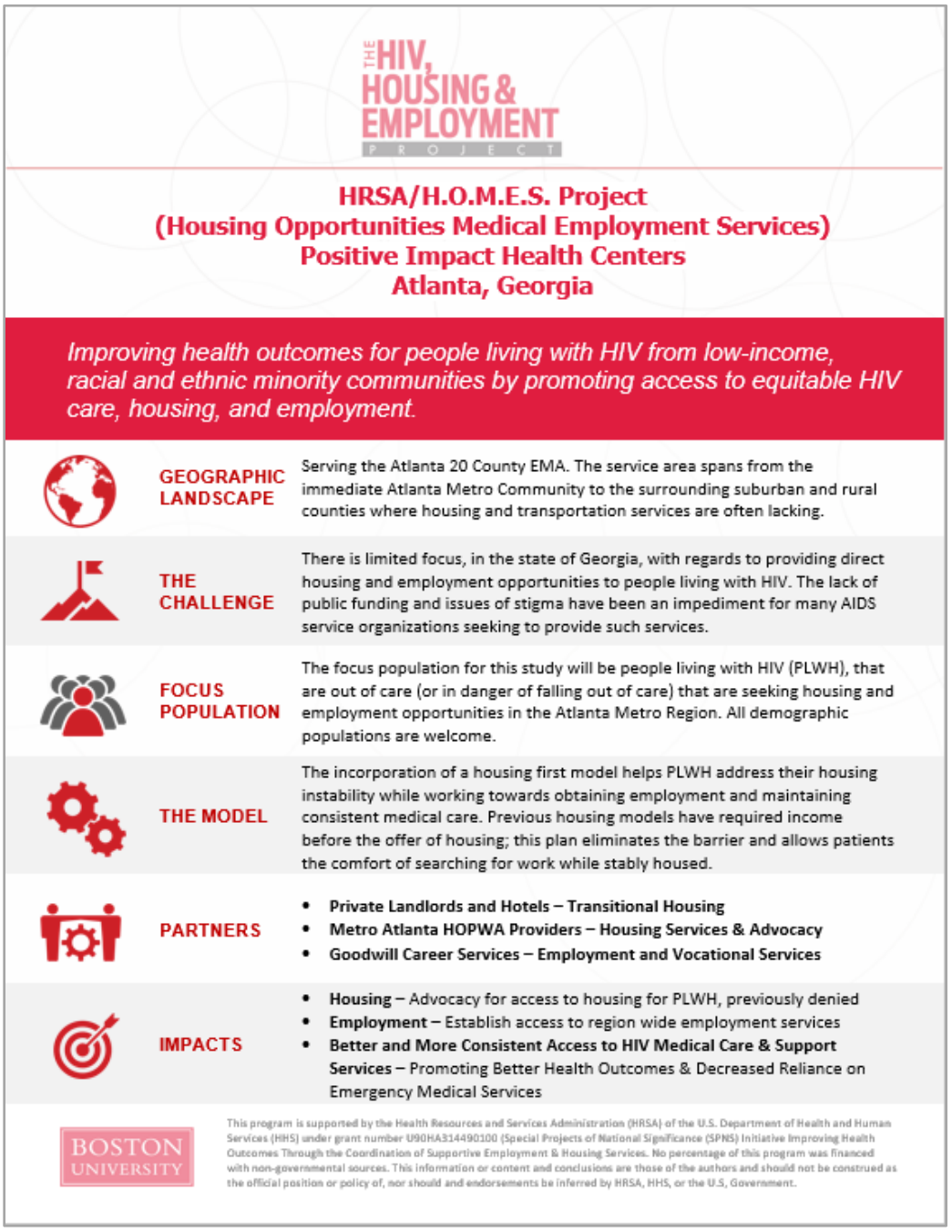
PIHC conducted a number of dissemination activities over the course of the project. This included outreach across the greater Atlanta metro region to make community members and stakeholders aware of the intervention and to develop partnerships to strengthen the intervention's reach. PIHC shared lessons learned throughout the intervention's lifecycle with other SPNS grant recipients at meetings, technical assistance calls, and through presentations.

PIHC conducted a poster presentation at the 2019 SPNS all-site conference and at the 2020 National HIV/AIDS Social Workers conference. The team also presented during a housing seminar at the 2018 Ryan White Conference and is slated to speak at the Ryan White 2020 conference on the intersection of housing and health outcomes.

The final production of this manual will be available for download and posted at TargetHIV and AETC National Coordinating Resource Center (NCRC) websites, and at the regional AIDS Education and Training Centers (AETCs).

Appendix

Appendix A:
(Intervention Overview)



THE HIV, HOUSING & EMPLOYMENT PROJECT

HRSA/H.O.M.E.S. Project
(Housing Opportunities Medical Employment Services)
Positive Impact Health Centers
Atlanta, Georgia

Improving health outcomes for people living with HIV from low-income, racial and ethnic minority communities by promoting access to equitable HIV care, housing, and employment.

GEOGRAPHIC LANDSCAPE	Serving the Atlanta 20 County EMA. The service area spans from the immediate Atlanta Metro Community to the surrounding suburban and rural counties where housing and transportation services are often lacking.
THE CHALLENGE	There is limited focus, in the state of Georgia, with regards to providing direct housing and employment opportunities to people living with HIV. The lack of public funding and issues of stigma have been an impediment for many AIDS service organizations seeking to provide such services.
FOCUS POPULATION	The focus population for this study will be people living with HIV (PLWH), that are out of care (or in danger of falling out of care) that are seeking housing and employment opportunities in the Atlanta Metro Region. All demographic populations are welcome.
THE MODEL	The incorporation of a housing first model helps PLWH address their housing instability while working towards obtaining employment and maintaining consistent medical care. Previous housing models have required income before the offer of housing; this plan eliminates the barrier and allows patients the comfort of searching for work while stably housed.
PARTNERS	• **Private Landlords and Hotels – Transitional Housing** • **Metro Atlanta HOPWA Providers – Housing Services & Advocacy** • **Goodwill Career Services – Employment and Vocational Services**
IMPACTS	• **Housing** – Advocacy for access to housing for PLWH, previously denied • **Employment** – Establish access to region wide employment services • **Better and More Consistent Access to HIV Medical Care & Support Services** – Promoting Better Health Outcomes & Decreased Reliance on Emergency Medical Services

BOSTON UNIVERSITY

This program is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U90HA31449010O (Special Projects of National Significance (SPNS) Initiative Improving Health Outcomes Through the Coordination of Supportive Employment & Housing Services. No percentage of this program was financed with non-governmental sources. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should and endorsements be inferred by HRSA, HHS, or the U.S. Government.

Appendix B:

(Employee Job Descriptions)

Positive Impact Health Centers
JOB DESCRIPTION: Program Manager

Position: Program Manager for OMES Demonstration Project
Department: Client Services
Date: October 30, 2017; revised April 2018, April 2019
Status: 1.0 FTE, Exempt (salaried)
Reports to: Director of Client Services

Positive Impact Health Centers (PIHC) is a community leader in providing HIV prevention, care and treatment services. The PIHC model of care assures that persons with HIV have access to medical, pharmacy, dental, behavioral health and social services, providing the best opportunity for clients to achieve high-quality health outcomes. PIHC also provides aggressive HIV prevention services to men who have sex with men (MSM), injection drug users, and others at the highest risk for HIV infection. Centers are currently located in Duluth and Decatur. Service area includes the 20-county eligible metropolitan area surrounding Atlanta.

POSITION DESCRIPTION SUMMARY:
This position involves the program management and direct supervision of staff for a 3-year SPNS Demonstration Project at an outpatient center that offers medical, mental health and social services to adults living with HIV. The Program Manager for the HOMES Demonstration Project will provide general and day-to-day supervision of the Study Enrollment Coordinator and non-Medical Case Managers (nMCM), ensuring that project services provided comply with grant requirements.

ESSENTIAL JOB FUNCTIONS

• Assign clients/patients to each non-MCM based on service needs and in an effort to maintain a balanced workload for department staff.
• Provide instruction and supervision to nMCMs regarding Federal, State local, and agency standards, procedures and policies.
• Ensure that nMCMs are performing day-to-day operations, including but not limited to the staffing of the Client Resource Line.
• Coordinate nMCM orientation and training with the Director of Client Services.
• Assist the Director of Client Services with quarterly client chart audits for project and agency documentation compliance.
• Provide instruction and supervision to the Study Enrollment Coordinator to ensure execution of project duties and responsibilities.
• Assist in identifying new resources for clients and ensure that staff has access to resource information.
• Disseminate information to nMCMs on trainings, workshops and conferences.
• Participate in weekly interdisciplinary Case Conference meetings.
• Participate in monthly project conference calls as scheduled, preparing programmatic updates as directed by ETAP.
• Participate in program webinars and ensure participation by PIHC project staff.
• Manage the reporting and special projects related to the HOMES Demonstration Project, ensuring accuracy and timely completion of all reporting and projects.
• Provide oversight to the community outreach efforts of nMCMs to ensure that clients are referred to community services.
• Provide input to the Director of Client Services on performance evaluations of staff.
• Assist the Director of Client Services with preparations for site visits and chart audits by funders.
• Submit updates regarding non-medical case management and programmatic guidelines to Director of Client Services as needed.
• Attend CEU workshops and applicable trainings to ensure knowledge of current HIV-related service trends and to maintain State of Georgia licensure.
• Abide by all state and federal policies regarding confidentiality of client information.
• Perform other duties as assigned.

Required Knowledge, Skills and Personal Qualifications:
• Knowledge of and the ability to interpret local, state, federal and agency standards, procedures, and policies. Ability to interpret, explain, and enforce established policies and procedures.
• Knowledge of HIV treatment goals and specific needs of the target population.
• Must possess excellent interpersonal and communication (writing, spelling, listening, speaking) skills, and the ability to communicate effectively in a multi-cultural setting including target populations, volunteers, agency staff, and program advisors.
• Ability to be a self-starter and to multi-task.
• Ability to demonstrate good-to-excellent facilitation skills. Ability to work cooperatively as a team member.

• Ability to resolve problems and make decisions. Ability to work without close supervision.
• Ability to utilize good management techniques.
• Ability to follow through to completion of assigned tasks.
• Ability to abide by all policies and procedures concerning personnel including conflict of interest policy.
• Computer skills required. Skills in word processing, proficiency in spreadsheet database and presentation software.
• Ability to apply independent judgment in making decisions and resolving problems with limited supervision.
• Ability to plan and coordinate programs, meetings, and special events related to the program.
• Ability to build and maintain effective and professional working relationships with employees, clients, and professionals in the community.
• Ability to read, write, and communicate the English language.
• Ability to use/operate various general office equipment.

Education & Experience: Required and Preferred Training and Experience:
• Minimum two years' experience in a healthcare or social service setting required.
• Master's degree in Social Work, counseling or other helping profession strongly preferred. Licensure preferred if applicable.
• Professional experience with HIV/AIDS population preferred.
• Administrative and supervisory experience preferred.

Physical Demands:
• Ability to travel between agency's two centers.
• Work duties are usually performed while seated. Sitting may be relieved by brief or occasional periods of standing or walking.
• Limited amount of physical effort required associated with walking, standing, lifting and carrying light objects (less than 25 lbs.) 5-10% of work time.
• Work is performed in a normal office environment where there are little or no physical discomforts associated with changes in weather or discomforts associated with noise, dust, dirt, and the like.

I have read and understood the Job Description. A copy of the same has been provided to me.

_____ _____
Employee Signature Date

_____ _____
Supervisor's Signature Date

NOTES:
1. Positive Impact Health Centers, Inc., is an equal opportunity employer and does not discriminate against any employee or applicant for employment because of race, creed, color, religion, gender, sexual orientation, gender identity/expression, national origin, disability, age, or covered veteran status.
2. Recreational drugs, weapons, and violence are not permitted on agency property or at any agency events or programs
3. This position is an at-will employment position. No contract for employment is implied at any time. Drugs, weapons, domestic violence are not permitted on clinic property or at any clinic events or programs.

Positive Impact Health Centers
JOB DESCRIPTION: Non-Medical Case Manager

Position Title: Non-Medical Case Manager
Employee Class: Client Services – Full-time, Non-Exempt (hourly)
Department: Client Services
Supervisor: Erik Moore, Program Manager for HOMES Demonstration Project
Hours: Mondays – Fridays, 9:00 am – 5:30 pm

Positive Impact Health Centers is a non-profit agency founded in 1990 that provides HIV Prevention Education, Support Services, Medical Clinic, Housing, Volunteer Programs and Advocacy to the Atlanta Metro Area.

General Narrative Description of Position: Under the direction of the HRSA-HOMES Project Program Manager and the Director of Client Services, the Non-Medical Case Manager (n-MCM) is part of the Client Services Department and works collaboratively with the Clinic, Client Services and Behavioral Health teams to improve rates at which clients affected by HIV are retained in care and adherent to ARTs. Community-based and in-home outreach and short-term (between 3-6 months) care coordination are integral to this position. Job tasks includes providing social support, informal counseling, and intensive navigation support to help clients address psychosocial needs and remove barriers that make it challenging to stay healthy. These include, but are not limited to, transportation, housing, insurance benefits, mental health, substance use, stigma, food, and the navigation of complex healthcare and support systems.

Essential Job Duties:

- Establish trusting relationships with clients who are HIV positive, their families, friends and provide general support and encouragement.
- Provide non-medical case management services to an assigned caseload of clients. This includes ongoing contact with assigned clients through phone calls, home visits, and visits to other settings where clients can be found.
- Apply skills derived from evidence-based interventions to support clients in improving HIV-related health outcomes.
- Help clients set personal goals, and schedule and attend appointments.
- Provide referrals and help link clients to community-based services that will help clients stay healthy, with a particular emphasis on vocational services and housing stability.
- Work closely with medical providers to help ensure that clients have comprehensive and coordinated care.
- Work with other clinical, behavioral and supportive service providers assigned to the same client.
- Work closely with community agencies and services to develop housing and vocational partnerships for clients.
- Act as a client advocate and liaison between the client and community service agencies.
- Assist clients in completing applications and registration forms.
- Attend regular staff meetings, trainings and other meetings as requested.
- Promote and maintain positive relationships with the surrounding neighborhood.
- Comply with the agency's policies and procedures.
- Learn the use of the agency's Electronic Medical Record (EMR) system and maintain timely and accurate documentation of client interactions.
- Participate in quality assurance reviews as assigned.
- Other duties as assigned.

MINIMUM QUALIFICATIONS

- Bachelor's degree in a social service specialty (e.g. social work, psychology, sociology, public health).
- Possess and demonstrate a basic understanding of HIV.
- Possess a strong understanding of factors that affect a client's ability to stay in care and adhere to ARTs.
- Possess an understanding of the community served.
- Possess a knowledge of relevant community resources and methods for accessing them.
- Good communication skills, such as listening well, and using language appropriately.
- Ability to work flexible hours to address client needs.
- Interest or experience in working with clients who are difficult to engage and retain in traditional health care services.
- Ability to communicate and work effectively with clients and staff from diverse backgrounds.
- Ability and willingness to provide emotional support, encouragement and motivation to clients.
- Basic computer skills.

PREFERRED QUALIFICATIONS:

- Professional experience in HIV service delivery, housing, and/or vocational service delivery.
- Bi-cultural background/experience desired.
- Strong applicants can demonstrate the ability to be positive in their empathetic responses to all persons; understand the value of meaningful and deep client engagement; have the potential to acquire the necessary knowledge, attitudes and skills of effectively reaching clients who are HIV positive.
- Valid GA Driver's License with no violations. In absence of this, the ability to utilize alternative forms of transportation (public, UBER, LYFT, etc.) to conduct home visits with clients, visit community agencies, and attend off-site meetings and trainings

Physical Demands:
The physical demands described here are representative of those that must be met by an employee to perform the essential functions of this job successfully. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. While performing the duties of this job, the employee is frequently required to sit and talk or hear. The employee is occasionally required to walk; use hands to handle or operate computers, objects, tools, or controls; and reach with hands and arms.
The employee must occasionally lift and move up to 30 pounds. Specific vision abilities required by this job include close vision and the ability to adjust focus.

I have read and understood the Job Description. A copy of the same has been provided to me.

_____ _____
Employee Signature Date

_____ _____
Supervisor's Signature Date

NOTES:

1. ***PIHC is an equal opportunity employer. PIHC does not discriminate against any employee or applicant for employment because of race, creed, color, religion, gender, sexual orientation, gender identity/expression, national origin, disability, age, or covered veteran status.***
2. ***This position is an at-will employment position. No contract for employment is implied at any time.***
3. ***Drugs, weapons, domestic violence, are not permitted on agency property or at any agency events and programs.***

Positive Impact Health Centers
JOB DESCRIPTION: Study Enrollment Coordinator

Position Title: Study Enrollment Coordinator
Employee Class: Client Services – Full-time
FLSA Non-Exempt
Department: Client Services
Supervisor: Program Manager, HOMES Demonstration Project
Revised April 16, 2018

Positive Impact Health Centers is a non-profit agency founded in 1990 that provides HIV Prevention Education, Support Services, Medical Clinic, Housing, Volunteer Programs and Advocacy to the Atlanta Metro Area.

General Narrative Description of Position:

Under the direction of the HRSA-HOMES Demonstration Project Program Manager and the Director of Client Services, the Study Enrollment Coordinator is part of the Client Services Department and works collaboratively with the Clinic, Client Services and Behavioral Health teams to improve rates at which clients affected by HIV are retained in care and adherent to ARTs. Responsible for Data collection, data analysis and care coordination. Will assist with the local IRB proposal, coordinating with the ETAP on the development of multi-site data components, and coordinating technical assistance. Will support and assist the Program Manager with investigating funding sources for unmet needs and will assist in the writing of a paper for publication which details the methods and results of the intervention for replication by other ASOs.

Essential Job Duties:

- Establish trusting relationships with clients who are HIV positive and provide general support and encouragement.
- Complete screening and eligibility forms and obtain client consent to participate in the program.
- Conduct program enrollment interviews and 6- and 12-month interviews to track client progress.
- Submit monthly health data tracking forms and maintaining confidential client information and data.
- Record, monitor and analyze data in preparation for project reviews and progress reports.
- Monitor and evaluate data quality and integrity.
- Apply skills derived from evidence-based interventions to support clients in improving HIV-related health outcomes.
- Act as a client advocate and liaison between the client and PIHC staff. Make appropriate referrals to staff on an as needed basis.
- Learn the use of the agency's Electronic Medical Record (EMR) system and maintain timely and accurate documentation of client interactions.
- Monitor appointments and client documentation in the agency's Electronic Medical Record (EMR) to help ensure that clients are maintaining comprehensive and coordinated care.
- Complete monthly data reports and maintain ETAP relationships, requesting technical assistance as needed.
- Assist clients in completing applications and registration forms.
- Attend regular staff meetings, trainings and other meetings as requested.
- Promote and maintain positive relationships with the surrounding neighborhood.
- Comply with the agency's policies and procedures.
- Participate in quality assurance reviews as assigned.

Perform other duties as assigned.

MINIMUM QUALIFICATIONS:

- Bachelor's degree in a social service specialty (e.g. social work, psychology, sociology, public health); Master's degree preferred.

And

- One year's experience in data collection and/or Human Subjects research preferred.

Certifications:

- Valid GA Driver's License with no violations.

Knowledge, Skills, Abilities

- Must possess a basic knowledge of HIV treatment guidelines and psychosocial factors unique to the population being served.
- Must possess a strong understanding of factors that affect a client's ability to stay in care and adhere to ARTs.
- Must possess an understanding of the community served.
- Must possess a knowledge of data collection and human subject research.
- Must possess good verbal and written communication skills, with an emphasis on listening well and using language appropriately.
- Ability to work flexible hours to address client needs.
- Ability to work with clients who are difficult to engage and retain in traditional health care services.
- Ability to communicate and work effectively with clients and staff from diverse backgrounds.
- Ability and willingness to provide emotional support, encouragement and motivation to clients.
- Basic computer skills and technical experience.

PREFERRED QUALIFICATIONS:

- Professional experience in HIV service delivery, data management and interview skills.
- Bi-cultural background/experience is helpful.

- Ability to be positive in their empathetic responses to all persons; understand the value of meaningful and deep client engagement; have the potential to acquire the necessary knowledge, attitudes and skills of effectively reaching clients who are living with HIV.

Physical Demands:
The physical demands described here are representative of those that must be met by an employee to perform the essential functions of this job successfully. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. While performing the duties of this job, the employee is frequently required to sit and talk or hear. The employee is occasionally required to walk; use hands to handle or operate computers, objects, tools, or controls; and reach with hands and arms.
The employee must occasionally lift and move up to 30 pounds. Specific vision abilities required by this job include close vision and the ability to adjust focus.

I have read and understood the Job Description. A copy of the same has been provided to me.

_____ _____
Employee Signature Date

_____ _____
Supervisor's Signature Date

NOTES:
1. ***PIHC is an equal opportunity employer. PIHC does not discriminate against any employee or applicant for employment because of race, creed, color, religion, gender, sexual orientation, gender identity/expression, national origin, disability, age, or covered veteran status.***
2. ***This position is an at-will employment position. No contract for employment is implied at any time.***
3. ***Drugs, weapons, domestic violence, are not permitted on agency property or at any agency events and programs.***

Appendix C:

Human Subjects Research

Research involving a living individual about whom data or biospecimens are obtained/used/studied/analyzed through interaction/intervention, or identifiable, private information is used/studied/analyzed/generated

Examples of human subjects research include:

- Collecting blood
- Conducting a survey
- Changing participants' environment
- Administering medicine
- Interviewing
- Administering a psychological test
- Collecting data
- Conducting a focus group
- Testing a new educational technique

Included in the NIH application:

✓ Protection of Human Subjects attachment

If funded, grantees will need:

✓ An Institutional Federal-Wide Assurance (FWA) with OHRP

✓ IRB approval or determination of exemption

✓ Human Subjects education* even for exemptions

If research meets the criteria for one of the eight categories of activities that are **exempt** from the federal regulations, not all of the above may apply. Some of the exemptions require a limited IRB review (7 and 8, and some designs under 2 and 3).

Exemptions:

Exemption 1
Conducted in an educational setting involving normal education practices

Exemption 2
Use of educational tests, surveys, interviews, or observations of public behavior

Exemption 3
Use of benign behavioral interventions in adults

Exemption 4
Collection/study of data or specimens if publicly available or recorded such that subjects cannot be identified*
*May be identifiable in limited cases. See §46.104(d)(4)(iii) and (iv)

Exemption 5
Public service program research or demonstration projects

Exemption 6
Taste and food quality evaluations

Exemption 7
Storage of identifiable information or biospecimens for secondary research use. Broad consent and limited IRB review are required.

Exemption 8
Secondary research use of identifiable information or biospecimens. Broad consent and limited IRB review are required.

Questions/comments? Contact OER-HS@nih.gov

Appendix D:

(Trauma/PTSD Screening Tool - Can provide a PDF copy)

Client ID: _____ Date: _____
Evaluator: _____ Appointment: _____

Primary Care PTSD Screen (PC-PTSD)

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- a serious accident or fire
- a physical or sexual assault or abuse
- an earthquake or flood
- a war
- seeing someone be killed or seriously injured
- having a loved one die through homicide or suicide

Have you ever experienced this kind of event?
Circle one: YES NO
If no, screen total = 0. Please stop here. If yes, please answer the questions below:
in the past month, have you…
1. had nightmares about the event(s) or thought about the event(s) when you did not want to? YES NO
2. tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?
YES NO
3. been constantly on guard, watchful, or easily startled?
YES NO
4. felt numb or detached from people, activities, or your surroundings?
YES NO
5. felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?
YES NO

Total YES answers

Instructions for Intake:
1. Please continue to do the PC-PTSD screening while doing the Eligible Metropolitan Area (EMA) with clients
a. If client scores more than 2, talk to them about Behavioral Health Services and refer them to Behavioral Health using our normal procedures (we will take it from there)
2. Scan in the document as a Behavioral Health Form and title it PC-PTSD
3. Put paper copy in bin:
a. In Duluth, that bin is in the mental health area and it's marked
b. In Decatur that bin is on my desk and marked as well (well now it is J)

Appendix E:

(HOMES Referral Form)

HOMES Referral Sheet

The HOMES study is a new program at Positive Impact Health Centers, which aims to investigate the correlation of housing & employment on health outcomes. Participants in the study will receive intensive case management and support navigating housing and employment resources in Atlanta.

1. Is your client 18 years old or older?

ð Yes (Continue to 2.) ð No

AND

2. Is your client living with HIV?

ð Yes …and is this person out of care or in danger of falling out of care?

AND

3. Is your client's housing status:

ð Literally Homeless (Shelter, Transitional Housing)

ð Unstably Housed (receiving housing support; couch surfing; risk of eviction)

ð Fleeing Domestic Violence/Risk of Eviction <14 Days

AND

4. Is your client's employment status:

ð Unemployed (and seeking)

ð Underemployed (looking to make more money; can't support self on current income)

ð On SSI/SSDI but would like additional income or recently lost benefits

If you were able to check one box under each number, feel free to reach out to Erik Moore for an official eligibility screen, explanation of study and if appropriate…complete consent and schedule the baseline interview.

If the client would like to reach out to us about the study directly, they may reach out to the Study Enrollment Coordinator to set up a screen:

Client Name or MRN: _____

Client Phone Number: _____

Referred by: _____

_____

Alphonso M. · Study Enrollment Coordinator
HOMES-Housing/Employment Project
Telephone: 404-977-5129 Email: alphonso.mills@pihcga.org

Appendix F:
(Individual Service Plan)

HOMES Individualized Service Plan (ISP)

Life Areas	Stable		Need(s)
	Yes	No	
Medical History / Physical Health			
Medical Treatment and Adherence			
Health Insurance			
Family/Domestic			
Housing			
Income			
Nutrition/Food			
Mental Health			
Substance Abuse / Addiction			
Personal and Community Support			
Risk Reduction			
Disclosure			
Legal			
Transportation			
Cultural Beliefs			
Employment			

Goal/Intervention

Follow-up/Re-evaluation

Date:	Client MRN#:
Client Name:	CM Name:
Client Signature:	CM Signature:

HOMES Individualized Service Plan Narrative (ISP):

Date: _____

Client (Name) is a (xx) year old, (M/F/T) who presents today for HOMES. Assessment. Referred by (Name) for (Housing, Employment, Clinical, etc.) services.

Client presents as well dressed, clean, neat, on time, A&Ox4, and willing and able provide background information about past care/facilities.

Primary concerns:
1) *Client Needs Assessment*
2) *Ongoing access to HIV medications*

***Medical/Adherence/Insurance*:**

- **HIV+ Dx**:
- **ARV History & Current Usage**:
- **Last provider visit and lab date: _**

- **Symptomatic Complaints**:
- **Co-Existing Medical Conditions**:
- **Hx of STIs**:
- **Other RXs**:
- **History of Surgeries**:
- **Insurance Status**:

***Housing/Financial/Education*:**

- **Housing**:
- **Employment**:
- **Education**:

***Mental Health / A & D Usage*:**

***Family/Social Support*:**

***Legal*:**

***Transportation*:**

***Risk Reduction/Disclosure Concerns*:**

***Services completed today**:*
HOMES expectations, services, and policies reviewed with client

Appendix G:
(Case Note Template)

Client Information
Name:

Address:
Sex:
Date of Birth:
Phone:
MRN#:
Location: Positive Impact Health Centers
Date of Service:
Attending Physician:

Client presents today for HOMES assessment.

Primary concerns:
1) Client Needs Assessment
2) ongoing access to HIV medications

H**ealthcare-Related Activities**

_ Collect, update, and/or confirm information about HIV-specific services for documentation purposes

_ Collect, update, and/or confirm information about non-HIV medical services for documentation purposes

_ Linking newly-diagnosed client to first HIV medical appointment

_ Accompany client to a medical appointment

_ Discuss medical appointments

_ Assist with making appointment for health care

_ Create or update client individualized care plans

_ Follow up or reminder about a healthcare service or referral

_ Assist client with obtaining medications (HIV or non-HIV)

Mental Health- or Substance Use-Related Activities

_ Collect, update, and/or confirm information about mental health, substance abuse treatment, or psychosocial support services for documentation purposes

_ Accompany client to a mental health appointment

_ Accompany client to a substance use treatment appointment

_ Assist with making appointment for mental health care

_ Assist with making appointment for substance abuse treatment

_ Follow-up about a mental health or substance use treatment service or referral

Housing-Related Activities

_ Collect, update, and/or confirm information about current housing

_ Provide support for maintaining housing

_ Create or update goal plan for housing services

_ Accompany client to housing service appointment or other housing-related activity

_ Assist with fair housing counseling or help with housing discrimination

_ Assist client with housing application

_ Discuss housing needs or assist with obtaining housing

_ Follow up or remind about a housing service or referral

_ Assist client with a move

Transportation and Other Social Services

_ Assist with obtaining and arranging transportation services

_ Assist with obtaining and arranging other support or social services (e.g., childcare)

Educational and Emotional Support

_ Relationship building (e.g. checking in with client; providing emotional support/counseling)

_ Talk with a client about disclosure

_ Coaching on living skills

_ Provide basic HIV treatment education, support, and/or advocacy

_ Provide harm reduction education (safer sex, substance use)

_ Mentoring/coaching on provider interactions

Employment and Other Practical & Social Support

_ Assist client with finding employment

_ Assist client with obtaining skills training or job/vocational training

_ Assist with job placement services

_ Assist with obtaining resume activities

_ Assist client with accessing resources for employment purposes (e.g. getting clothing, getting a haircut)

_ Assist client with obtaining cell phone

_ Assist client with budgeting/financial planning

_ Assist client in obtaining legal assistance or advocacy

_ Assist client with obtaining legal documents (e.g. an ID or Social Security card)

_ Assist client with obtaining benefits (medical insurance, food stamps)

_ Social networking event (lunch/meal gathering, activity)

_ Coordinate and assist with obtaining skills to prepare for interviews and employment

Case Note/Narrative:

Appendix H:

(Transitional Lodging Rules and InTown Suites Guest Agreement)

POSITIVE IMPACT HEALTH CENTERS

Program Rules - Lodging

Positive Impact Health Centers (PIHC) Housing Programs are designed to assist the participants in achieving self-sufficiency and medical compliance, by providing housing subsidies, case management and referrals to appropriate resources. It is the program participant's responsibility to adhere to the following policies and rules while enrolled in PIHC's Lodging Program:

Please initial by each statement if you understand and agree.

1._____ Lodging participants understand that Lodging cannot exceed the allotted number of days specified by your assigned Case Manager, without prior authorization from the program manager.
2._____ Lodging participants are required to meet with their assigned Case Manager weekly, or as needed and report progress, problems, concerns or issues. Failure to comply could result in immediate program termination.
3._____ Lodging participants are required to assist in the development of a housing plan to remove barriers to homelessness within the **first week** of Lodging.
4._____ Lodging participants are required to report immediately any income changes to their assigned Case Manager. Failure to notify assigned Case Manager of income changes may lead to termination from PIHC's lodging program.
5._____ Lodging participants are responsible to keep the hotel/Supportive Housing free of any damages. The participant is responsible for any damage caused by the participant's family and/or guest to the hotel/supportive housing property.
6._____ Lodging participants are encouraged to remain compliant with medical care, mental health (if necessary) and substance abuse services (if necessary) while receiving Lodging.
7._____ Lodging participants will report any changes to their living arrangement (i.e. new roommates, property damage, property management concerns, pets, move-outs, increase in fees, late payments, etc.) to their assigned Case Manager within 24 hrs.
8._____ All housing placement and hotel policies must be followed. If these rules are broken or disregarded, the housing placement provider has the right to evict you from their property. (**NO FIGHTING, NO ALCOHOL, NO DRUGS, NO SMOKING INSIDE THE HOTEL ROOM, NO SOLITITATION, NO WEAPONS, NO CHILDREN LEFT UNATTENDED**). FAILURE TO COMPLY MAY RESULT IN PIHC HOUSING PROGRAM TERMINATION.
9._____ Contact your assigned Case Manager if the housing placement is inappropriate in regards to cleanliness, safety, etc. Any emergencies (i.e. flooding) must be immediately reported to the assigned Case Management and the property manager.
10._____ All items in the hotel/supportive housing program at the time of move in are the property of the (hotel/Supportive Housing Provider). If you remove or damage these items, payment will be required for replacement from the participant.
11._____ **Only approved participants may stay in the hotel/Supportive Housing. NO EXCEPTIONS. Disregarding this rule may result in termination from the Lodging housing program.**
12._____ Pets are not allowed on the property, unless allowed by the property manager. Required pet deposit will be the participant's responsibility. Emotional Support animals are accepted with supporting documentation. The participant must provide the current immunization records for all pets.
13._____ Appropriate conduct is expected at all times while in the hotel/Supportive Housing program.
14._____ Children are the responsibility of their parent(s). Children must be supervised at all times. All school-aged children must be enrolled in and attend school. Positive Impact Health Centers is required by law to report child abuse and neglect to the proper authorities. Leaving a child 12 years old or younger alone and unsupervised is considered child neglect by Georgia Child Protective Services.
15._____ Positive Impact Health Centers is **not** responsible for any lost, trashed or stolen personal items. **ALL PERSONAL ITEMS MUST IMMIDATELY BE TAKEN OUT OF THE HOTEL WHEN YOU EXIT THE LODGING PROGRAM.**
16._____ Participants are required to keep their hotel/Supportive Housing rooms clean.

17._____ **I understand that I may stay in one of Positive Impact Health Centers rented hotel/Supportive Housing rooms as long as I am in a PIHC program. I understand that this is not my property and if asked to leave the property, I will vacate the assigned property within the time requested by my assigned Case Manager or property manager.**
18._____ Participants who own private vehicles are solely responsible for the expense of using these vehicles. Breakdown of the vehicle will not exempt participants from the requirement that they maintain housing related appointments. Participants will be expected to utilize an alternative means transportation in the event that their own vehicle is not available.
19._____ I consent to allowing my housing-related files to be viewed by HRSA, HUD, HOPWA and/or The City of Atlanta upon request, or during auditing. I understand that I will not be present or informed when my files are being viewed by authorized parties.
20._____ I understand that I may not chose where I will be placed, if provided with lodging assistance. **All changes to lodging accommodations must first be approved by the Housing Director.**
21._____ I understand that in the event that I am terminated from the Lodging program, I have the right to file a grievance with the Program Manager.
22._____ I understand that Positive Impact Health Centers will set forth all reasonable efforts to safeguard all documentation surrounding my identity.

Please read and check all that apply

I have read and understand these rules as a condition of my lodging via Positive Impact Health Centers and I agree to the program rules as stated above.

I understand that I do not have to agree to these program rules to receive services from Positive Impact Health Centers, but rather it may limit the services that are available to me at this time.

_____/_____
Participant Date Expires

_____/_____
Witness Date Expires

TERMS OF GUEST AGREEMENT **OPERATIONS**
STANDARD – 15021

Policy: InTown Suites has established rules that must be followed and enforced at every property. Doing so enables InTown Suites to provide safe, clean, comfortable accommodations at a reasonable price.

1. Room Occupants
· Primary registered guest must be at least 21 years of age.
· All room occupants over the age of 18 must be registered guests. Individuals younger than 18 cannot be registered guests and cannot be issued room keys.

2. Maximum Occupancy Per Room: As assigned by PIHC Housing Provider.

3. Rules of Conduct: A guest's violation or disregard of any of the following rules could result in removal from the property and forfeiture of security deposit.

Any illegal activity including Internet abuse
Firearm or weapon possession on property
Harassment or threats toward other guests or employees
Unsanitary living conditions
Interfering with sprinkler heads or fire suppression system
Leaving a minor child unattended
Leaving trash and other debris in common areas
Loitering or Parking utility trailers in an unauthorized area
Unregistered guests occupying room
Large parties, loud music, or disruptive behavior
Pets of any kind (excluding assistance animals) and Feeding stray animals
Operating grills or outside barbecues or creating other fire hazards
Using bicycles, skates, or skateboards on the walkways or in the parking lot
Failing to wear shoes and shirt when outside room
Consuming alcoholic beverages outside room or Smoking in unauthorized areas
Washing, repairing, or advertising the sale of vehicles
Sunbathing or Disturbing other guests or potential guests
Causing conditions or situations that result in an unfavorable impression of InTown Suites