SPNS Housing/Employment Date2Care Initiative Improves Access for People with HIV in Paterson & Puerto Rico

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Milagros Izquierdo, *City of Paterson, NJ*Alison O. Jordan, *ACOJA Consulting LLC*Carmen Cosme, *One Stop Career Center*Jesse Thomas, *RDE Systems, LLC*



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Introduction

The Special Projects of National Significance (SPNS) aim to enhance access to care for vulnerable populations by demonstrating innovative approaches that build workforce capacity, expand housing and employment service collaboration, and utilize Health Information Technology (HIT) solutions. Highlighted by two case studies, these projects demonstrate how HIT-mediated data exchange and quality improvement efforts can effectively increase client access to care by addressing housing and employment needs. Interventions at various levels have resulted in process efficiencies and quality improvements in federal reporting and transitional care coordination, exemplified by initiatives at the One Stop Career Center of Puerto Rico and in Paterson, New Jersey.



One Stop Career Center of Puerto Rico, Inc. (OSCCPR) is a private nonprofit organization incorporated in November 2000, with state and federal tax exemption. Offering services to young people and adults across the island with a commitment to develop and help strengthen community structures. Believing in the importance of collaborations between organizations, with the aim of bringing more and better services to the participants.

The City of Paterson, Division of Health is the lead public health institution in the City of Paterson and is tasked with the delivery of Public Health services, care and treatment to the residents of Paterson and some surrounding towns. Paterson Division of Health, very often referred to as the "Board of Health" can be traced back to its creation on November 13, 1882, by ordinance. Today the Division of Health continues to provide core public health services in areas including communicable disease investigation, environmental health, sexually transmitted diseases, immunizations, vital statistics, childhood lead poisoning, health education, tuberculosis, HIV/AIDS/PrEP, well baby clinic, emergency disaster preparedness, podiatry, Ryan White dental care etc.

RDE has long served the HIV/AIDS community, and has chosen to support those who prevent, care for, treat, serve, and house people living with HIV through charitable giving, whether in-kind, discounts, voluntarism, community service, financial support, or free resources.

As global citizens, we believe in supporting valuable and noble causes that help lift up humanity as we are able to through the patronage of long-term partners who benefit from our work and who believe in our vision and approach of using data and technology to make a significant, lasting positive impact on the world.

Case Study #1:

One Stop Career Center of Puerto Rico, Inc. /NYC

Case Study #2: Paterson

I. Methodology

Transitional Care Coordination: NYC/PR

- Build on SPNS Congressional Hispanic Leadership Institute (CHLI) & Latino Initiatives to enhance collaboration and coordination among providers
- Train employment and housing specialists in Transitional Care Coordination
 - HIV education and risk reduction
 - Outreach & engagement
 - Transitional care planning
 - Coordination with service providers
- Patient navigation after incarceration
- Conduct SPNS local evaluation
- Secure reliable transportation for clients
 Sustain collaborative and service delivery
- Linkages to primary care, substance use, and mental health treatment upon release

Steps to Implementation: NYC/PR

- Identify Staff
 - Train staff in TCC
 - State certified HIV counselors
- Transportation
 - Transportation Service
 - · Identify sustainable funding
- Coordinate with Corrections
 - Access to correctional facilities
 Patient health records
- Engage Key Stakeholders
 - Establish linage agreements and a consortium
 - Sustain using resource guide

II. <u>Results</u>

- Fewer visits to the emergency department, from 0.60 per person in the 6 months prior to baseline to .20 visits at follow-up
- Housing instability and food insecurity decreased from over 20% at baseline to less than 5% at follow-up.
- Individuals also self-reported feeling in better general health.
- Prevention education/risk reduction sessions provided at jail orientations to identify potential clients (n=360)
- 69 enrolled and completed baseline
 - All received transitional care coordination
 - 10 additional served as part of pilot
 - 58 returned to community after incarceration
 - 54 of 58 eligible (93%) linked to HIV primary care and other services after incarceration
 - All 10 (100%) pilot participants linked to care
- 94% of people returning home with a transitional care plan linked to care after incarceration (n=80)

I. Methodology

Project Goals

- Develop standardized procedures for referrals for employment services.
- Develop the eCOMPAS Employment Referrals and Outcomes Module
- Develop the eCOMPAS Housing Status Enhancements
 Develop the eCOMPAS CAPER Module
- Develop the eCOMPAS linkage to e2MyHealth

Smart Care Management

- Leverage evidence-informed models of coordinated care in which HIV primary care is linked with case
 management, housing assistance, substance use and mental health treatment, as well as legal,
 employment and social services
- Use technology, resources and coordinated network of care to address changing needs and number who know their COVID-19 status
- Engagement in healthcare services and treatment
- Facilitate access to social determinant of health including housing and employment

Smart Care Management Steps to Implementation:

- Referrals
 - Increase efficiency of referral process through development and implementation of standard operating procedures for housing and employment service referrals
- Train Staff
 - Provide staff training to enhance coordination and service integration of housing, health care, and employment
- Smart Care Management
 - Support coordination of HIV care and services through housing and employment service reporting integration
- Enhanced Data
 - Enhance data collection and utilization management tools to identify, quantify, track, and evaluate
 the impact of homelessness, housing instability, under and unemployment on linkage to and
 retention in care as well as HIV clinical indicators
- Meaningful Use
 - Improved information sharing helps identify barriers and risk factors that lead to comprehensive, targeted interventions with needed support services to improve engagement in HIV care and treatment

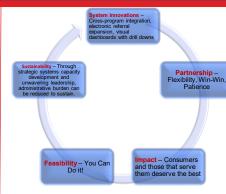
II. Results

- 15,800 + Electronic Referrals made in eCOMPAS
- 13,800+ Times users accessed the Alerts Module in eCOMPAS
- As of August 2023, 190 successful consumers have registered and have accessed e2MyHealth over 450 times.

Jesse Thomas

- 15,700+ Lab Data Points
- 2,100+ Prescription Data Points
- · 92 Active Patients





- A paradigm of health information and data exchange can free up time better spent on client care and quality improvement through interactive use of mobile audience engagement tools
- Adopt and adapt innovative strategies and approaches, implement web-based resources to achieve federal compliance and improve quality management, and increase access to care for vulnerable populations including people unstably housed with history of increast inn.
- identify key collaborative partners in developing innovative approaches to coordinated care including housing, employment, community reentry, corrections, transportation and healthcare systems
- Automated methods developed will foster sustainability and reduce administrative burden.
 - Reduced Administrative Burdens include:
 - Manual data entry for medical and case management services for hundreds of participants every year.
 - Paper forms eliminated
 - Approximately 270 hours a year spent on double data entry

Downstream Benefits from SPNS Initiatives

- Referrals serve local mission while achieving national objectives
 In-grant SPNS Replication results from SPNS-inspired partnership and technical capacity development including:
 - Homelessness Prevention: More than 10 families stably housed
 - Employment Services: 10 employed and over 80% of
 - Skills enhanced: At least half reported ancillary benefits from education, skills development, and job training as a result of the initiative.
 - Interviewing skills and more increased community awareness and connection between government services and community for the City of Paterson

Milagros Izquierdo
City of Paterson, DHS mizquierdo@patersonnj.gov
(973) 321 1336

ACOJA Consulting LLC, ali@acojaconsulting.com

Carmen Cosme

(xxx) xxx xxxx

One Stop Career Center, $\underline{\mathsf{ccarmen.admin@onestop} \mathsf{careerpr.org}}$

ONE STOP Career Center of Puerto Rico, Inc. RDE Systems, <u>Jesse@rdesystems.com</u> (973) 773 0244

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Introduction



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€COMPAS

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Division Director of the Ryan White Grants for the City of Paterson Health and Human Services Department, to manage a regional service delivery system of HIV Care and manages various federal public health grants and funds. Secured and distributed over ten million dollars in delivery of HIV care. Over the past few years, taking part in integrating other HIV Care resources to expand the network of care through grant funded projects under HUD-HOPWA (Housing Opportunity for People with HIV/AIDS). Involvement with the Ryan White program for more than a decade. Working closely with the City's administration, accounting department, corporate counsel, and governing body to execute contracts and process payments in a timely fashion.

RDE has long served the HIV/AIDS community, and has chosen to support those who prevent, care for, treat, serve, and house people living with HIV through charitable giving, whether in-kind, discounts, voluntarism, community service, financial support, or free resources.

2024 National Ryan White Conference on HIV Care & Treatment

Belief in supporting valuable and noble causes that help lift up humanity as we are able to through the patronage of long-term partners who benefit from our work and who believe in our vision and approach of using data and technology to make a significant, lasting positive impact on the world.







Methodology:



Case Study #1: One Stop Career Center of Puerto Rico, Inc. & NYC

Transitional Care Coordination: NYC/PR

 Build on SPNS Congressional Hispanic Leadership Institute (CHLI) & Latino Initiatives to enhance collaboration and coordination among providers

Train employment and housing specialists in Transitional Care

Coordination

- HIV education and risk reduction
- Outreach & engagement
- Transitional care planning
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Transitional Care



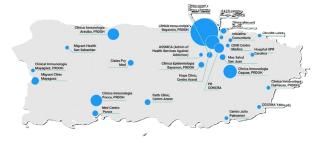


Results:



Case Study #1: One Stop Career Center of Puerto Rico, Inc. & NYC

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Methodology:

RYANDWHITE CONFERENCE ON HIV CARE & TREATMENT

Case Study #2: Paterson

Project Goals

- Integrate employment and housing services via referrals. Develop standardized procedures for referrals for employment services.
- Improve Employment outcomes.
 Develop the eCOMPAS Employment
 Referrals and Outcomes Module
- Improve Housing Outcomes. Develop the eCOMPAS Housing Status Enhancements
- Federal Grant Compliance across HRSA & HUD. Develop the eCOMPAS CAPER Module
- Patient Empowerment. Develop the eCOMPAS linkage to e2MyHealth

ECOMPAS°

Smart Care Management

- Leverage evidence-informed models of coordinated care in which HIV primary care is linked with case management, housing assistance, substance use and mental health treatment, as well as legal, employment and social services
- Use technology, resources and coordinated network of care to address changing needs and number who know their COVID-19 status
- Engagement in healthcare services and treatment
- Facilitate access to social determinant of health including housing and employment



Smart Care Management Steps to Implementation:

Referrals

 Increase efficiency of referral process through development and implementation of standard operating procedures for housing and employment service referrals

Train Staff

 Provide staff training to enhance coordination and service integration of housing, health care, and employment

Smart Care Management

 Support coordination of HIV care and services through housing and employment service reporting integration

Enhanced Data

 Enhance data collection and utilization management tools to identify, quantify, track, and evaluate the impact of homelessness, housing instability, under and unemployment on linkage to and retention in care as well as HIV clinical indicators

Meaningful Use

 Improved information sharing helps identify barriers and risk factors that lead to comprehensive, targeted interventions with needed support services to improve engagement in HIV care and treatment



Conclusions:



Downstream
Benefits from
SPNS Initiatives

• Referrals serve local mission while achieving national objectives

In-grant SPNS
Replication
Results

- Homelessness Prevention: More than 10 families stably housed
- Employment Services: 10 employed and over 80% of retained employment, despite COVID-19 challenges
- **Skills enhanced**: At least half reported ancillary **benefits** from education, skills development, and job training **as a result of the initiative**
- Interviewing skills and more **increased community awareness and connection** between government services and community for the City of Paterson.





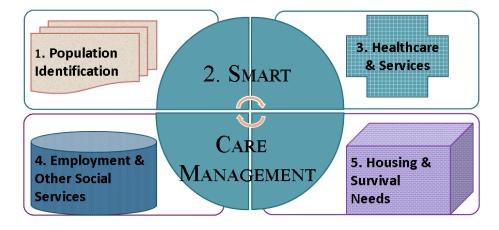


Results:

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 - 15,700+ Lab Data Points
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Results: Case Manager Experience



- Experience with the housing and employment SPNS project
 - It was enlightening finding services for clients
 - We provided job services
 - Barriers such as COVID-19 and client drug addiction was challenging
- Success Stories
 - One client was homeless and is now doing quite well
 - Got over 12 people housed
 - Had a plan for clients to be self-sufficient
 - Leveraging the City's HOPWA program was a strength and benefit
- Working with the SPNS Team (Recipient, RDE, and Partners)
 - It is a good experience
 - Team work we did the best we can
 - This will be a sustainable program



Tisa Nicole Smith Medical Case Manager CAPCO Resource Inc.





Conclusions:



System Innovations Cross program integration, electronic referral expansion, visual dashboards with drill downs Sustainability Through strategic systems capacity development Partnership Flexibility, Win and unwavering leadership, Win. Patience administrative burden can be reduced to sustain. Impact Consumers and those Feasibility You Can Do it! that serve them deserve the best

- A paradigm of health information and data exchange can free up time better spent on client care and quality improvement
- Adopt and adapt innovative strategies and approaches, implement webbased resources to achieve federal compliance and improve quality management, and increase access to care for vulnerable populations including people unstably housed with history of incarceration.
- Identify key collaborative partners in developing innovative approaches to coordinated care including housing, employment, community reentry, corrections, transportation and healthcare systems
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Thank you for your time!



Milagros Izquierdo mizquierdo@patersonnj.gov



Jesse Thomas

<u>Jesse @rdesystems.com</u>



Free and innovative resources to end the epidemic

www.RDE.org/Red



Ali@ACOJAconsulting.com



Carmen Cosme Pitre onestop.sccarmen@gmail.com

