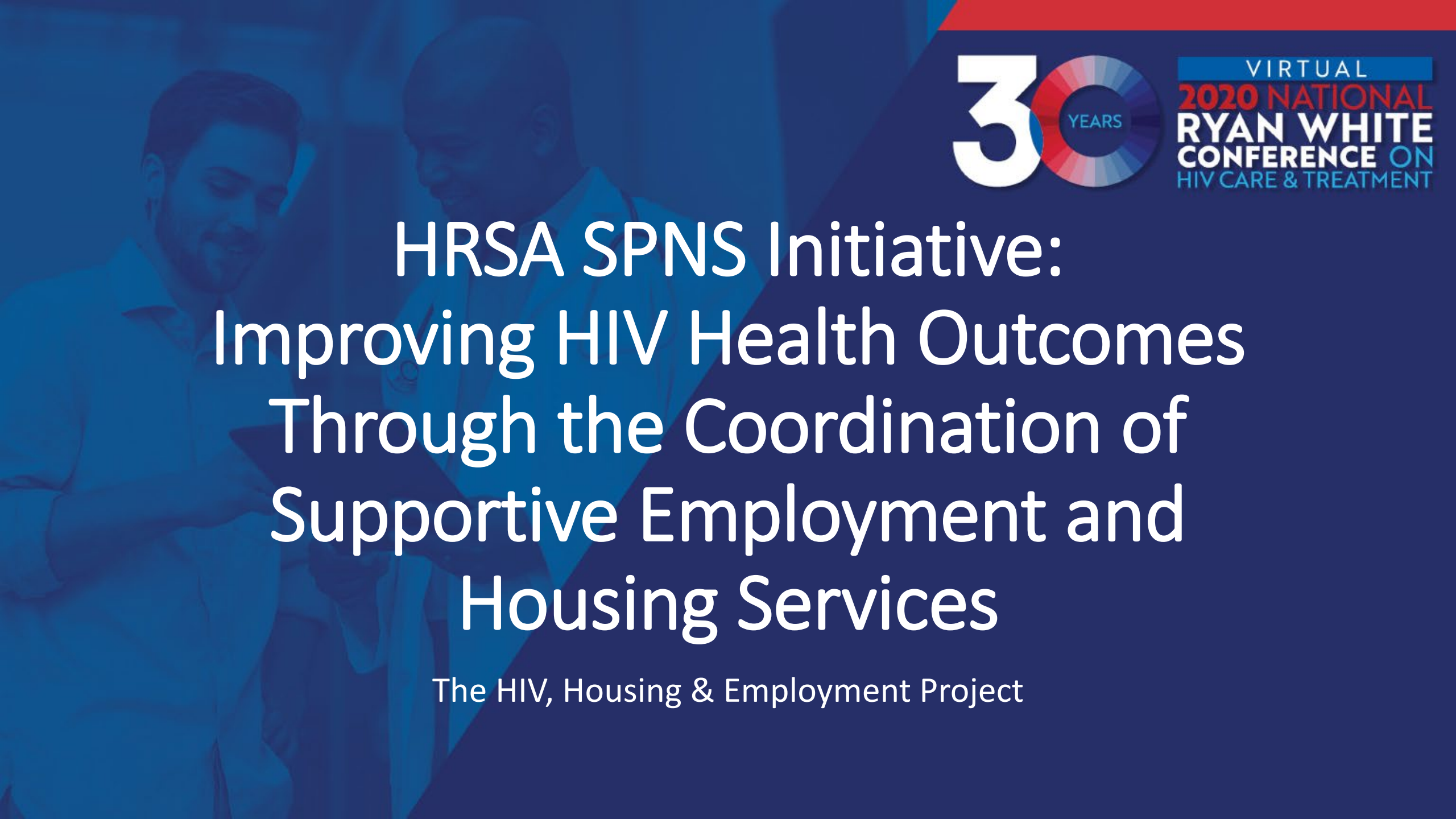


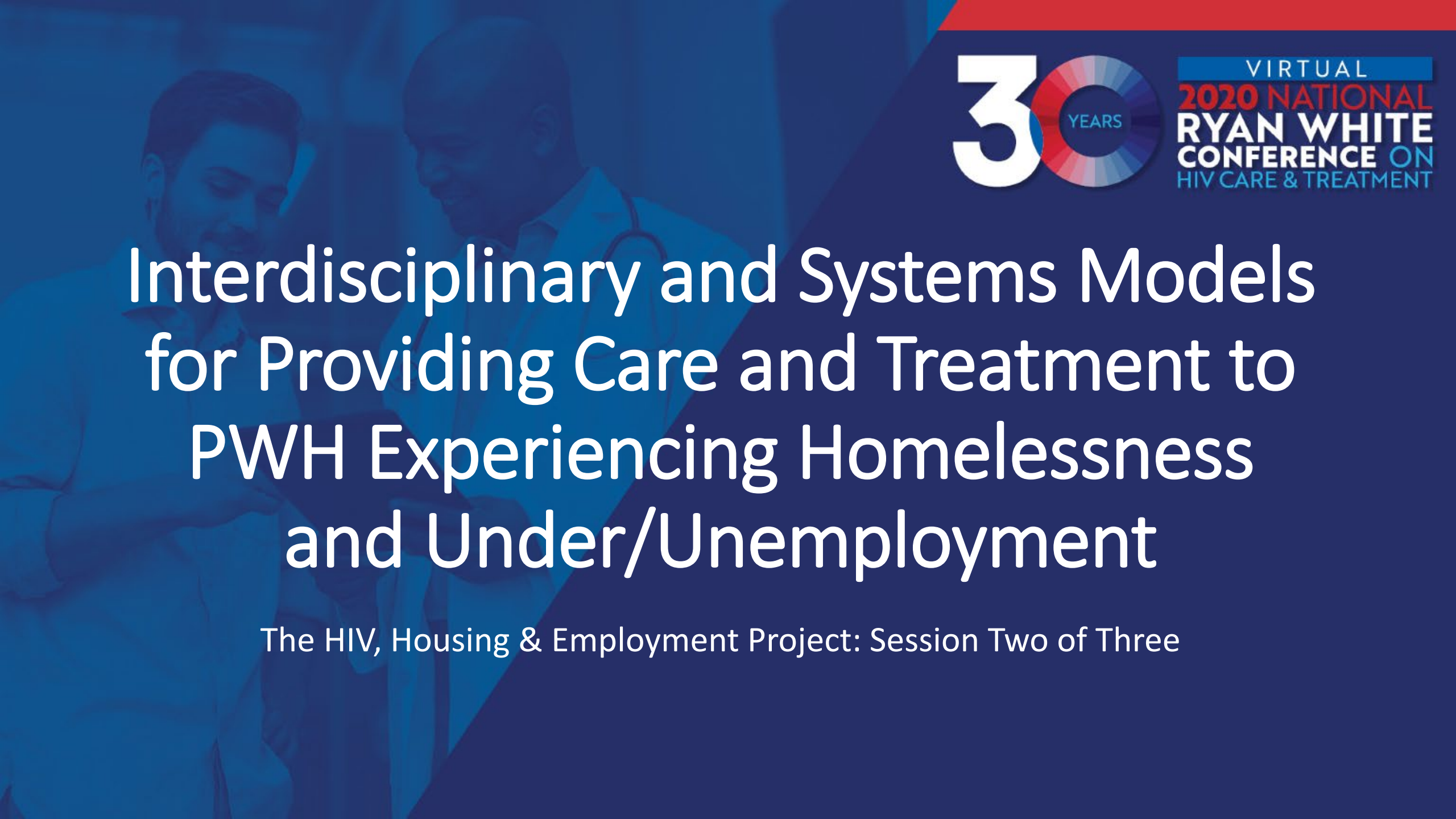
VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

HRSA SPNS Initiative: Improving HIV Health Outcomes Through the Coordination of Supportive Employment and Housing Services

The HIV, Housing & Employment Project

Institute Objectives

- Describe the complex needs of people with HIV who experience homelessness/ housing instability and unemployment/underemployment.
- Develop strategies to build staff skills and create external partnerships to facilitate care and services.
- Share strategies, resources, and tools to provide integrated care to people with HIV who are out of care, homeless/unstably housed, and unemployed/underemployed.
- Describe opportunities to leverage partnerships with federally funded housing (HUD), employment (DOL), and other community agencies, to serve people with HIV who are homeless/unstably housed and unemployed/underemployed.



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Interdisciplinary and Systems Models for Providing Care and Treatment to PWH Experiencing Homelessness and Under/Unemployment

The HIV, Housing & Employment Project: Session Two of Three

Presenters

Jessica Flaherty, Project Director
The Evaluation and Technical Assistance Provider, Boston, MA

Positive Impact Health Centers, Atlanta, GA
- Alphonso Mills, B.A., Study Enrollment Coordinator

Gay Men's Health Crisis, New York City, NY
- Laverne Hayes, M.S., Project Director

AIDS Foundation Houston, Houston, TX
- LaNikka Green-Sofola, M.S., M.Ed., Data Specialist

Disclosures

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Session Two Objectives

- Describe interdisciplinary team models for providing care, treatment, housing, and employment services for people with HIV who are homeless/unstably housed and unemployed/underemployed
- Obtain skills, resources and tools for providing HIV medical care, housing, and employment services for people with HIV
- Learn to set up systems to make and complete referrals and share information across health, housing, and employment programs

A One-Stop Shopping Model HRSA/H.O.M.E.S. (Housing Opportunities Medical & Employment Services) Intervention

Alphonso Mills, Positive Impact Health Centers
Atlanta, GA

POSITIVE IMPACT HEALTH CENTERS

Positive Impact Health Centers

Site Overview

- Serving PWH at three unique locations, across a 25-County geographical region
- Positive Impact Health Centers (PIHC) is a Ryan White Part A, B and C Recipient *and* a HOPWA Grantee (serving 29 metro Atlanta counties)
- Serving approximately 4,900 Ryan White clients annually
- The HOPWA Housing Program provides services for approximately 600 clients per year
- Intensive efforts to expand the internal PrEP Program over the past 2 years, serving over 1,000 PWH on a yearly basis

PIHC SPNS Intervention Client Demographics

Demographics – 104 Total Clients Enrolled	
Mean Age (years)	36.59
Cisgender Men (%)	89
Cisgender Women (%)	9
Transgender Women (%)	6
African American (%)	85
Caucasian (%)	16
Other (%)	3

PIHC: One Stop Shop (Wrap Around Services)

POSITIVE IMPACT HEALTH CENTERS

The Social Work Perspective

PIHC was well positioned to address client needs from a wide variety of perspective

As a "one stop shop" for HIV care, PIHC offers care from a multi-disciplinary perspective, ensuring that the *micro, mezzo and macro* aspects of client needs are met.

Micro

- Medical & Non-Medical Case Management
- Clinical Care, Provider Access, On-Site Lab

Mezzo

- Community Partnerships and Referral Programs
- Peer Support through Grassroots Organizations

Macro

- Advocating for PWH to Local Elected Officials
- Ensuring client's needs are heard on community level

Working in Care Teams at a One Stop Shop

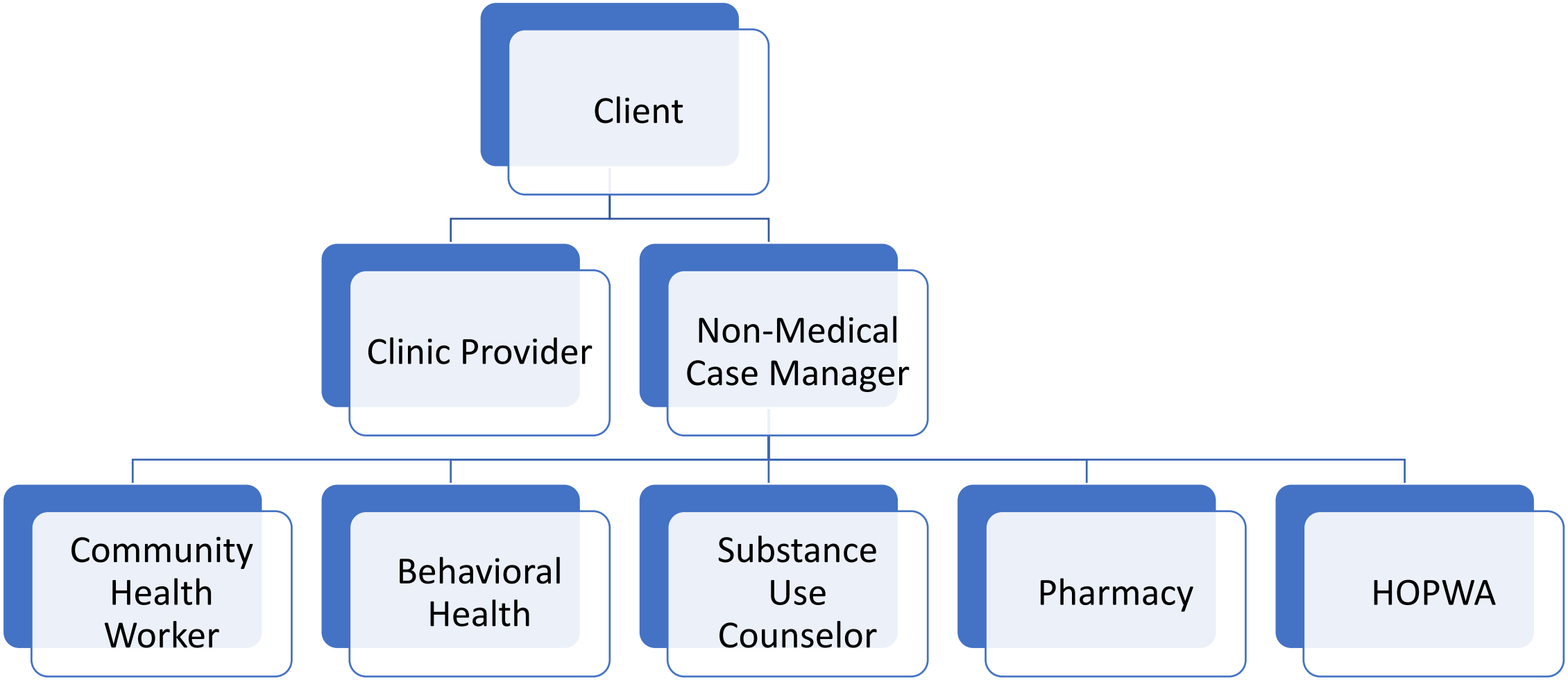
Agency for Healthcare Research and Quality defines Care Teams as:

Groups of primary care staff members who collectively take responsibility for a set of patients. Teams blend multidisciplinary skills, focusing several people's insights rather than a single physician.

At PIHC, Care Teams are…

Groups of staff members from different departments within the agency, collaborating their expertise to best assist a specific client to achieve their best health, ensuring all parties stay aware of client's progress.

PIHC Care Team Model



Care Teams: Lessons Learned

Pros

- Gives the client multiple points of entry into the agency to maintain engagement and retention.
- Creates ease of access to multiple forms of healthcare for a more holistic approach.
- Client has more support to achieve health and life goals.
- Creative techniques for providing care can be produced with multidisciplinary backgrounds.

Cons

- Each provider must stay within their own expertise, and every encounter must be documented.
- If the team does not communicate, the client's care suffers.
- Potential for client to share different pieces of narrative with each provider.

Lights, Camera, Care Teams!

Client 1

- Black Cis-Gender Male
- Referred by Behavioral Health: Homeless; Unemployed
- History of Alcoholism, Depression, and Substance Use
- Maintains undetectable Viral Load

Care Team 1

- Non-Medical Case Manager
- Weekly Therapy
- Community Health Worker
- Harm Reduction Class

Client 2

- Black Women of Trans Experience
- Referred by Community Health Worker: Homeless; Unemployed
- Living under a Bridge, Sex Work and Part Time Work
- Struggle with Adherence, Fluctuating Viral Load

Care Team 2

- Non-Medical Case Manager
- Together Learning Choices (TLC) Intervention
- Community Health Worker
- Chris 180 Housing Program

PIHC Moving Forward

- Implementing Care Teams and intensive Case Management for clients with layered needs.
- Adding Employment services into Case Management practice.
- Leveraging intensive Case Management services for clients with advanced needs to other departments in the agency.
- Stronger interdepartmental collaborations to build systems for better continuity of care for PWH.

PIHC Moving Forward

Dissemination!

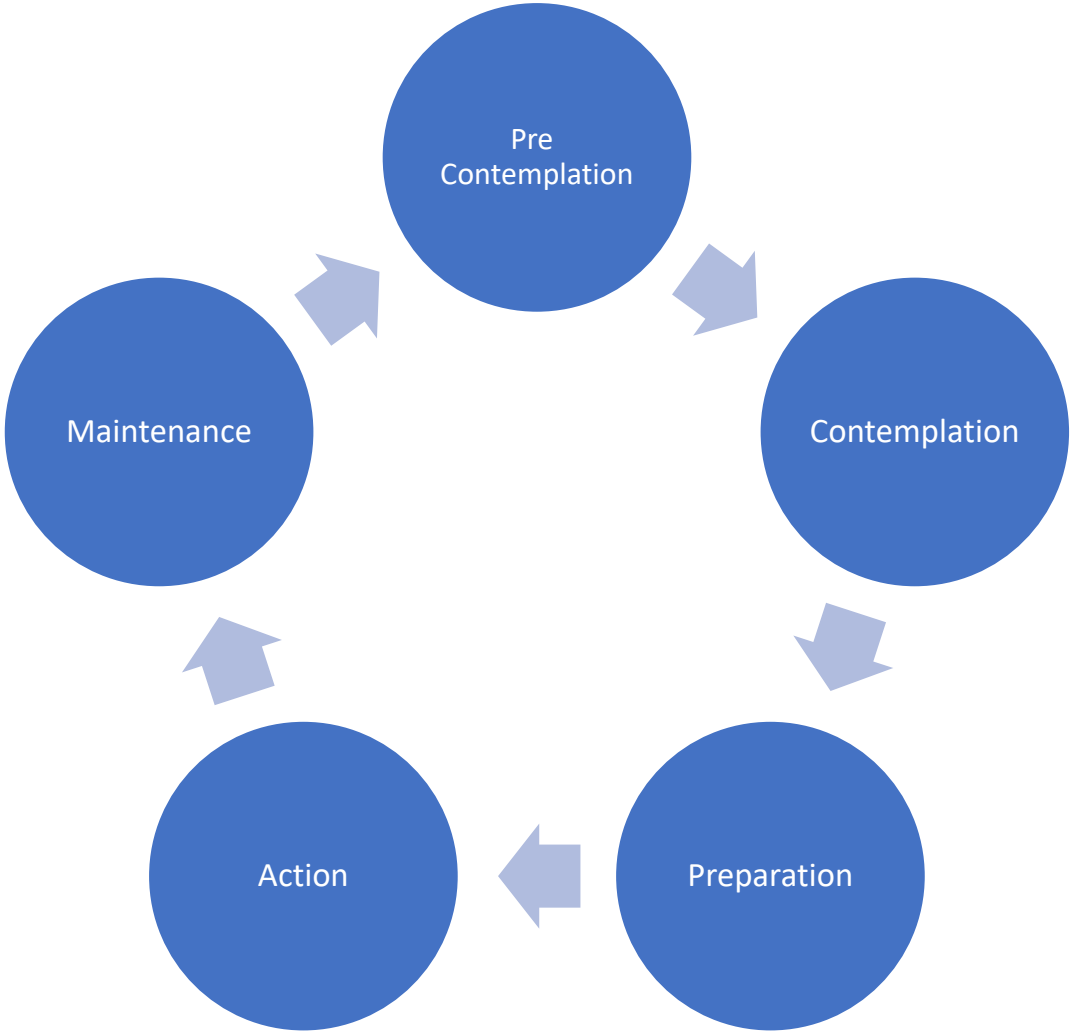
Utilizing the Stages of Change Model Project Health

Laverne Hayes, Program Manager
Gay Men's Health Crisis, New York City, NY

Services Offered

- Geffen Testing Center
- Workforce Development
- SUNY Computer Lab
- Legal Services
- Nutrition & Wellness
- Duane Reade Pharmacy Onsite
- Financial Management
- Youth Services
- Long Term Survivors/Buddy Program
- HOPWA Housing
- STRAP/After Hours
- Safety in Housing
- Mental Health
- Substance Abuse
- Women's Services
- TGNC Services
- Support Groups
- Case Management

The Stages of Change

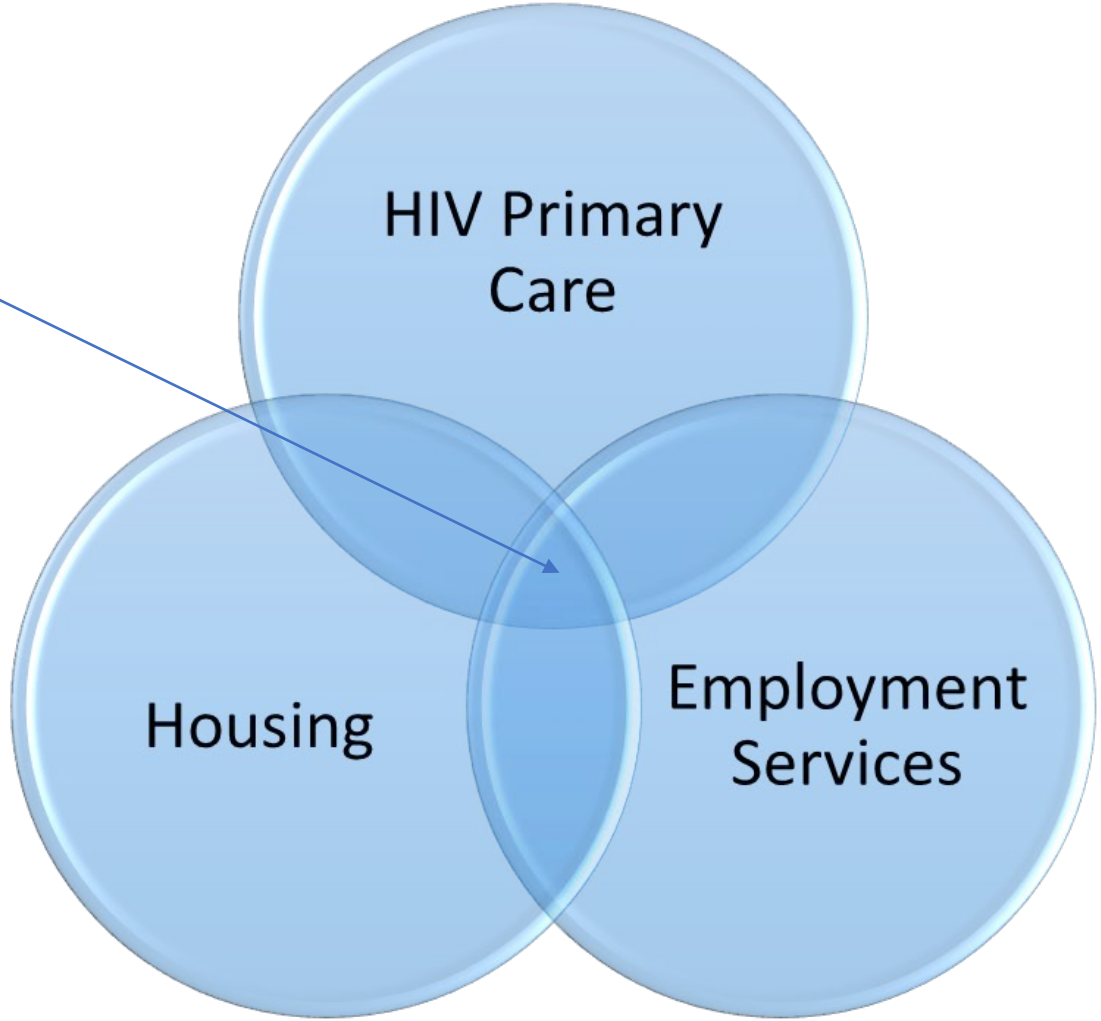


Service Menu

Change-Readiness Responsive Intervention Tracks: approx. 90 days each	
Readiness Track	Action Track
Individual Supportive counseling	Transitional Benefits Counseling
Referrals to coordinated medical, legal, and social services	Linkage to housing, employment, RWHAP, and supportive services
Readiness Support Groups	Psychoeducational Groups
Orientation	Housing & Employment Retention Support Group
Peer Support Model – "The Courage Cohort"	
Peer support group	Peer support group
1:1 contact with Action Track peer	1:1 contact with Readiness Track peer

Interdisciplinary Care Coordination

Project HEALTH



Team Structure

Social Work Case Manager

Partners

Transitional Benefits Counselor

Peer Counselor

Social Work Case Manager

Comprehensive Assessment Includes:

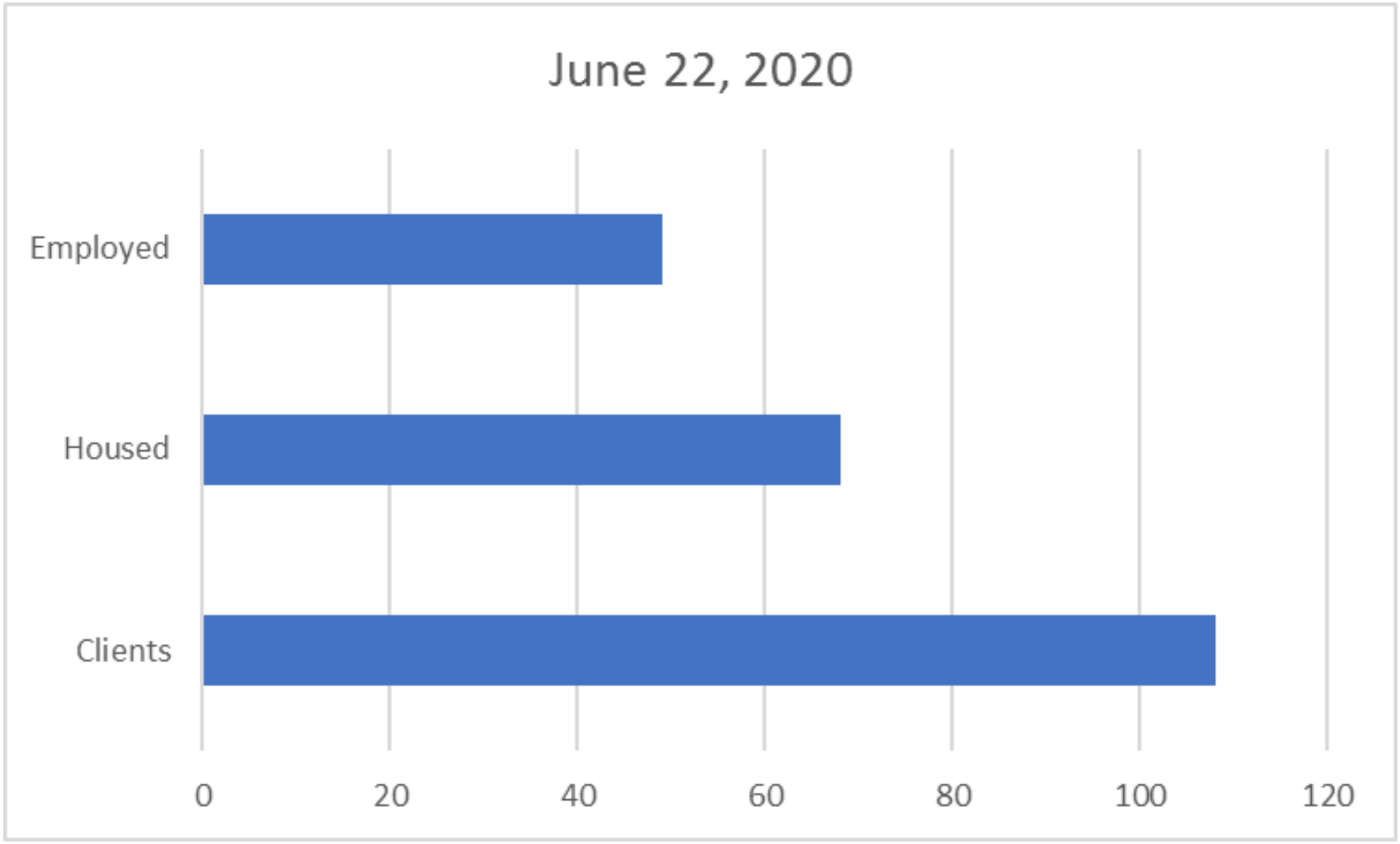
- Demographic Data
- Family Composition (and Social Supports)
- Psychosocial/Housing History
- Legal History
- Medical History
- Mental Health and Substance Use History
- Risk Assessment (Trauma, DV, SI/HI)
- Education and Employment History
- Present Situation (Strengths, Challenges, Goals)
- Summary and Recommendations

Additional Team Members

- **Transitional Benefits Counselor**
  - Budget counseling
  - Individual psychosocial support
  - Personal Benefits Transition Plan
  - Employment related supports
  - TBC group

- **Peer Care Navigator**
  - Supportive counseling
  - PSN Group
  - Assistance with Housing, Realtors, Outreach

Outcomes

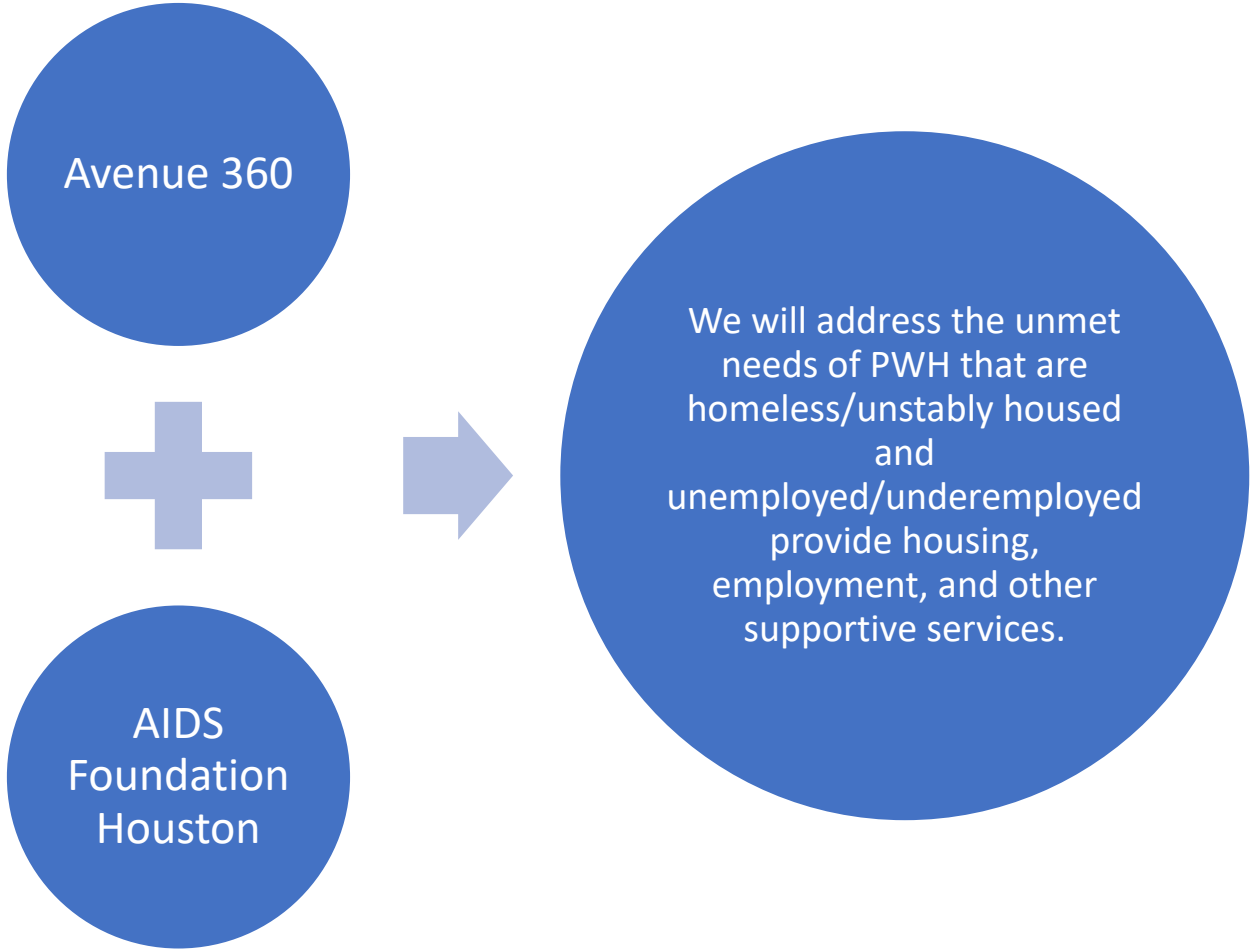


Client Story

Partnering with the Department of Labor
Avenue 360 Health and Wellness & AIDS Foundation of Houston

LaNikka Green-Sofola, AIDS Foundation Houston
Houston, TX

FQHC & ASO Partnership



FQHC & ASO Partnership

Avenue 360 Case Manger identify clients with unmet needs

AFH Outreach Specialist pre-screen potential clients

AFH Network Navigator provides the clients with Non-Medical Case Management and other supportive services.

Forming the Partnership with the Department of Labor

Who/What?

- Employment Specialist
- Provide employment services and resources to Project CORE Clients

When/Where?

- September 2018
- While attending a Community Resource Fair

How/Why?

- Attended a workshop and made a connection with the Workforce Solutions Regional Facilitator
- Clients will be able to receive weekly employment resources and services

Provide workforce development services to employers and job seekers by promoting and supporting a workforce system that creates value and offers employers, individuals, and communities the opportunity to achieve and sustain economic prosperity.

Services provided:

- Job readiness workshops
- Career counseling
- Computer training
- Job search assistance
- Vocational/trade training referrals
- Free assistance for certifications leading to employment

Program

Clients are able to attend workshops at the AFH Corporate Office once a week

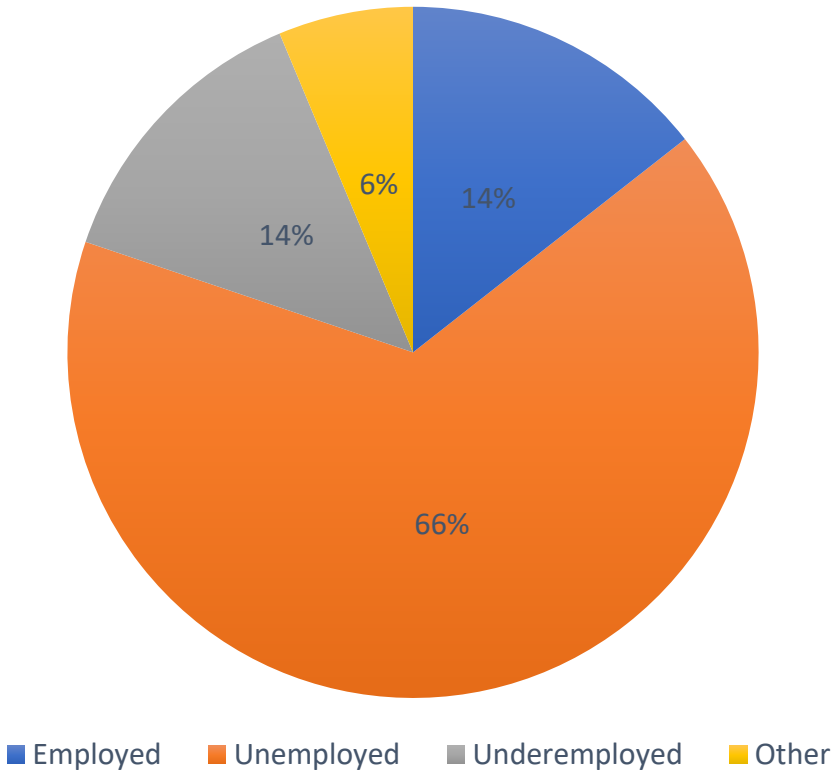
One on one training provided by a Workforce Solutions Regional Facilitator

Job search assistance

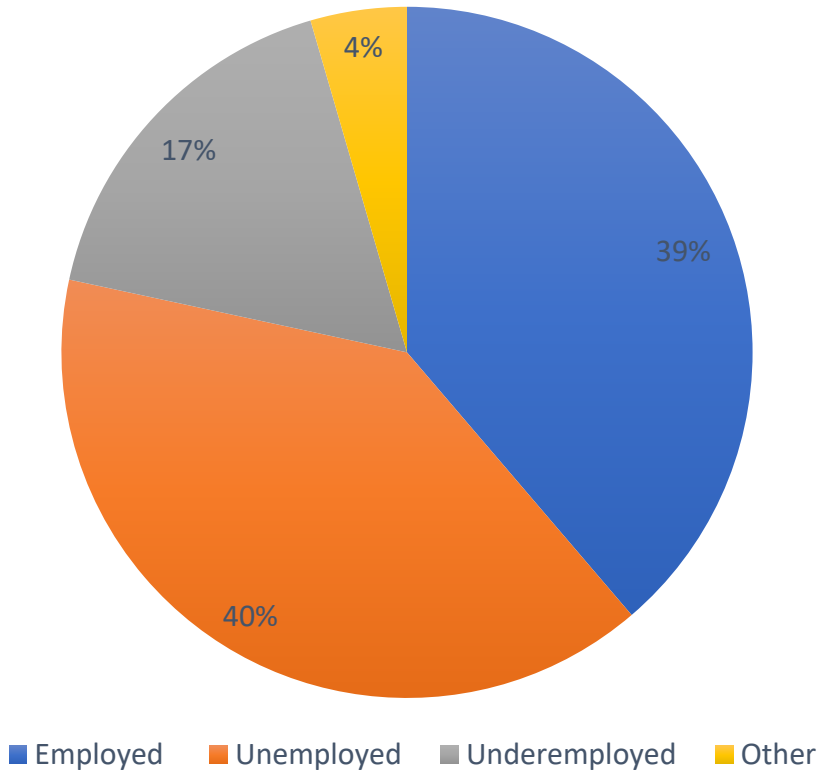
Smaller class sizes

Outcomes

Employment status at baseline



Employment status as of April 2020



Client Success Story: “Barry”

Before Project CORE	After enrollment	Client update
• Homeless • Unemployed • Viral load >100,000 copies/ml (off medication for 5 months) • Suffers from depression and anxiety • No transportation • No income • Limited job skills	• Client completed a Housing Assessment and was referred to a housing program • Client was referred to LCDC for Mental Health Evaluation • Client attended weekly Workforce Solutions Job Readiness Workshops • Client enrolled in a Welding vocational class	• Stably housed in a HOPWA funded Program • Full time employed • Virally suppressed • Attending bi-weekly therapy sessions • Volunteer at homeless a local homeless shelter in the food pantry • Client has reliable transportation

Sustainability

- Continue to promote Project CORE and the available resources
- Continue to provide Job Readiness Workshops
- Encourage clients to obtain additional job readiness skills
- Encourage clients to attend vocational and certification training
- Provide clients with incentives
- Promote job fairs and job openings
- Create opportunities for community and client engagement
- Provide evaluations to see where there is a need for improvement

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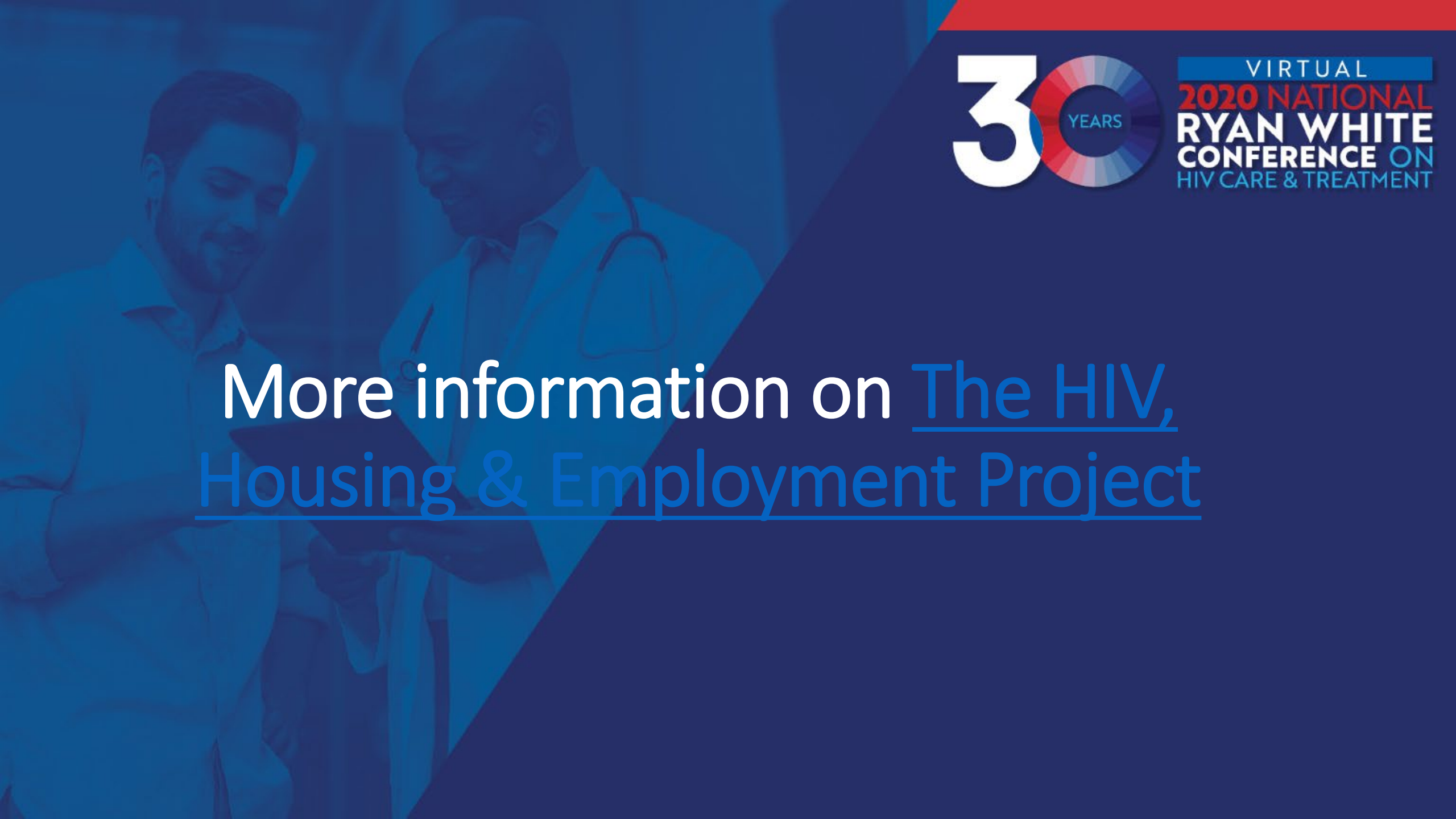
30 YEARS

Questions?



More information on The HIV, Housing & Employment Project

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Thank you

The HIV, Housing & Employment Project: Session Two of Three