FENWAY HEALTH HOUSING & EMPLOYMENT PROJECT

THE HIV, HOUSING, & EMPLOYMENT PROJECT

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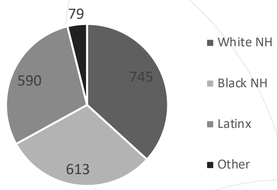
Introduction

Geographic Landscape

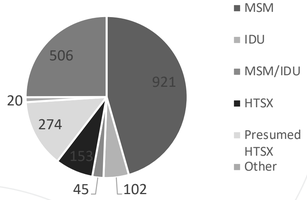
Brief description of local HIV epidemic

Of all PLWH in Massachusetts, 75% are engaged in care, 59% are retained in care, and 65% are virally suppressed. Health outcomes are lower among Black PLWH: 60% are retained in care and 63% are virally suppressed. Similarly for Hispanic/Latinx PLWH: 57% are retained in care and 60% are virally suppressed.

HIV Prevalence by Race/Ethnicity



HIV Prevalence by Risk



65% Viral suppression

34% homeless or unstably housed

16% unemployed or underemployed

The Challenge

Care: In Massachusetts, racial and ethnic minority communities experience lower rates of retention in care and viral suppression, compared to the entire population of PLWH in the state.

Housing: Boston is the third most expensive rental market in the country.

Coordination: Greater Boston has providers specializing in HIV medical care, affordable housing, and workforce development, and lacks intentional, systemic coordination between these providers.

Key Partnerships

Department of Housing and Urban Development- housing services supported by HOPWA

Department of Labor - employment services provided by MassHire

Ryan White HIV/AIDS Program- Part A

Focus population

Individuals who are receiving or are eligible for Ryan White Medical Case Management at Fenway Health and other clinical sites in Greater Boston.

The Program Model

Fenway patients who are out of care, newly diagnosed, or new to care at Fenway:

Medical Case Management Team identifies eligible clients from current caseloads, newly diagnosed list, and out of care list. Submits SPNS referrals through TFI REDCap to program coordinator.

Patients not receiving care at Fenway, referred to housing services:

AAC Housing Programs receive referrals from partner agencies and submit SPNS referrals for eligible clients through TFI REDCap to program coordinator.

Patients not receiving care at Fenway, whose providers have been trained through outreach :

External Clinical Providers that have been trained regarding program eligibility, services provided, and referral process submit SPNS referrals for eligible clients through TFI REDCap to program coordinator.

Program Coordinator

- Reviews referrals from case managers or partner agencies
- Verifies eligibility with referring provider
- Along with Evaluation Assistant, meets with clients, informs of services involved in the program, and follows up regarding appropriate referrals

Coordination with various providers:

Clinical Providers:
- Program coordinator facilitates housing referral completion, provides updates, and follows up on client matters around housing and employment with medical case managers, HIV social workers, and other clinical providers.

Housing Advocates:
- Program coordinator works with housing teams to stay updated regarding clients' housing status, provide updates around employment services, and to ensure all eligible clients are referred to SPNS program

Employment Services Provider:
- Program coordinator submits referrals to career navigator
- Coordinator and navigator collaborate around client engagement, updates, and follow-ups

Continued case coordination in these areas:

Clinical Care:
- Providers work with clients around engagement in HIV care, medication adherence, connecting to mental health and substance use services, etc.

Housing Services:
- **Housing Search & Advocacy:** staff work with clients to obtain safe, affordable housing
- **Rental Assistance:** delivers financial assistance to clients who face eviction, need assistance with move-in costs, high utility bills, or shutoff notices
- **Supportive Housing:** provides subsidies and supportive services to clients exiting homelessness

Employment Services:
- Career navigator works with clients on an individual level to provide comprehensive adult education, training, and employment services
- Clients are connected to job search services, training programs, higher education, and daily workshops and events

Lessons Learned

Investing the time and effort to orient all referral staff to the services and staff of the partner agency promotes enthusiasm and trust that referred participants will be well served.

Approaching clients holistically, providing a warm hand-off, and connecting them with a variety of wrap-around services promotes positive outcomes.

The strength of the relationship and level of trust between client and referring provider impacts client buy-in for the program as well as successful follow-through in engagement in services.

Key Innovation

New/Strengthened Partnerships

The relationship between Fenway Health's Medical Case Management team and AIDS Action Committee's Housing teams has strengthened through this project. The coordination of services has allowed for more communication and collaboration between teams. The new partnership with MassHire has introduced additional services to help clients address social determinants of health.

Preliminary Outcomes

Individual level

- Employment: 15% obtained jobs or connected to training programs
- Housing: 25% found new housing or received assistance to avoid homelessness

System level

- 70 case managers both internally and from various clinical sites throughout the Greater Boston area have been trained in project services, eligibility criteria, and referral process
- Internal changes around data sharing and communication among departments

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