Gay Men's Health Crisis (GMHC): Project HEALTH – Housing and Employment Access Lead to Health

THE HIV, HOUSING, & EMPLOYMENT PROJECT

project health

a program at GMHC

Authors

Special thanks to everyone who contributed to the success of the intervention and this manual. The following is a list of authors of this manual; however, this does not reflect everyone who provided invaluable insight and wisdom into program activities that ultimately made their way into this document.

Lynnette Ford, MSW, MA
Angelo Trinidad
LeMarr Leggins, LCSW
John Guidry, PhD
Laverne Hayes, MS
Michael Gates
Alexa Kreisberg, MPH
Shivang Shah, MPH

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Executive Summary

An important strength of public health research is that the field relies on collaborative thinking, without which innovative ideas would never prosper and successful programs would never be implemented in more than one instance. The HIV/AIDS epidemic has historically posed a significant threat to society, however due to inherently collaborative work of many who espouse the public health credo, the threat has become much smaller and more manageable. Though there are many collaborative tools utilized in the field, the following is a very important tool known as an implementation manual. The purpose of the intervention manual is to provide a detailed description of the design and implementation of an intervention for the HRSA/SPNS Initiative "Improving HIV Health Outcomes through the Coordination of Supportive Employment and Housing Services." The specific intervention was carried out at an HIV Care Organization in New York City called Gay Men's Health Crisis, Inc. (GMHC). This manual serves to document the intervention methodology, implementation, outcomes and lessons learned from the demonstration project at GMHC under this initiative. Furthermore, the specific purpose of the manual is to help others replicate the general model of Project HEALTH at GMHC. The information in this manual will be disseminated to the wider Ryan White community, Department of Housing and Urban Development (HUD) programs, Department of Labor (DOL) programs, and other key stakeholders.

GMHC is committed to the development and implementation of innovative strategies in hopes that the HIV/AIDS epidemic is one day defeated. Founded in the earliest days of the epidemic, GMHC has 38 years' experience delivering a continuum of care services to marginalized PLWH, particularly African American and Hispanic community members, who comprise the vast majority of the 12,600 clients we serve each year. The agency is dedicated to remaining agile in the face of the evolving AIDS epidemic; to this end, GMHC continually expands its program portfolio and service models to address the myriad social determinants of health that contribute to unsuppressed viral loads among PLWH in NYC.

Critical to the effort to end the AIDS epidemic is a broad commitment to meeting clients' employment and housing needs in support of individual stability and improved rates of viral load suppression. GMHC is a national leader in this effort: for over 25 years, the agency has "vocationalized" its services, embedding employment-related activities into a variety of its care programs in order to promote improved health via job stability. In 2013, GMHC was invited to create the first-ever employment services program specifically geared towards PLWH receiving benefits from NYC's HIV and AIDS Services Administration (HASA); this program revolutionized HIV care in NYC by incorporating holistic employment services in GMHC's continuum of HIV care. Similarly, GMHC operates under the framework that housing is healthcare and that failures to maintain stable housing (e.g., rent nonpayment, landlord disputes) are often indicators of clinical issues that require a social work-informed response. Lastly, GMHC is grounded in the communities it serves; the agency is guided by a client-centered approach to care. Consistent with the findings of the HOPWA Getting to Work Employment Initiative evaluation, GMHC concentrates on meeting clients where they are, addressing challenges presented by their lived experiences, and offering services that guide clients through each stage of readiness to change.

GMHC identified several key areas of unmet need throughout the HIV care continuum which were areas of focus in the intervention and solidified the need for GMHC to house Project HEALTH: (1) Upon HIV diagnosis or initial linkage to care, clients may not be connected to the full suite of services that meet their needs. For instance, 76% of GMHC clients were previously enrolled in one service program at a time; Project HEALTH augmented existing internal and external care coordination infrastructure to increase the number of clients receiving multiple services. (2) Clients engaged in care may struggle to benefit from services provided; while 68% of people with HIV in New York State had received HIV care in 2016, only 55% were virally suppressed. Project HEALTH's social work approach to case management helped provide individualized and evidence-based support to help clients identify and mitigate barriers to achieving viral load suppression, including intermediate barriers to housing and employment stability.

In NYC's particularly grueling economic and healthcare landscape, GMHC's implementation of Project HEALTH aimed to help mitigate structural, clinical, and individual level-level factors that prevent deep engagement in care, participation in the workforce, housing stability, and viral load suppression. The program staff also recognized a need for a model of change-based care management to focus on engaging clients with varying levels of readiness. By using social work centered care management practices such as peer support, motivational interviewing, and counseling, the program was also able to work with clients to reduce fear and improve self-efficacy. Furthermore, Project HEALTH's aim was to target African American and Hispanic people with HIV, however the program was also able to serve clients outside of these demographics with positive outcomes.

The theoretical model underpinning the approach of Project HEALTH is the Transtheoretical Model developed by Prochaska and DiClemente. This is a widely used model in the context of behavior-change-based interventions and works because of the structured approach it offers intervention staff to capture and track client progress. The model relies on a client-centered approach that focuses on helping to change underlying, intrinsic motivations that dictate change behavior. It is the basis of motivational interviewing and enhancement interventions. Program staff identified a client's stage of change at enrollment and transposed this to one of two program specific tracks: Action Track and Readiness Track. Staff then identified a service plan for the client, tracking the client's progress along the stages of change and transposed track along a few timepoints throughout the intervention to update service plans and monitor progress overall.

Utilizing in-agency assets and several external assets available to the program through formal and information partnerships, Project HEALTH was successfully implemented and saw many positive outcomes and success stories for many of its participants. The program was also able to identify key lessons learned and facilitators to success despite encountering several barriers throughout the implementation of the intervention.

The goal of the implementation manual is to help others learn from implementation of Project HEALTH at GMHC and provide a template to successfully design and implement their own intervention. Though the program did encounter relative success, the hope is that replication of Project HEALTH at other sites will be more refined and increasingly successful as a function of anticipating future barriers and challenges through the lessons identified in this manual.

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Introduction

Intervention Context/Purpose

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

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

The intervention manual serves to document the intervention methodology, implementation, outcomes and lessons learned from the demonstration project at GMHC under this initiative. Furthermore, the specific purpose of the manual is to help others replicate the general model of Project HEALTH at GMHC. The Project HEALTH intervention was implemented by GMHC, a RWHAP Part F recipient, based in New York City, NY. The information in this manual will be disseminated to the wider Ryan White community, Department of Housing and Urban Development (HUD) programs, Department of Labor (DOL) programs, and other key stakeholders.

Audience

This manual specifically targets service providers, county, city and state agencies who are interested in improving the access and quality of care and services to people with HIV who are homeless or unstably housed and unemployed/underemployed.

Background and Intervention

Agency and Intervention Background

Gay Men's Health Crisis, Inc. (GMHC) has implemented an innovative care coordination program with the aim to foster improved health outcomes by addressing barriers to full engagement in housing, employment, and Ryan White HIV/AIDS Program (RWHAP) services among African American and Hispanic people with HIV in New York City (NYC). The program, Project Housing and Employment Access Lead to Health (Project HEALTH),
(1) Hired an interdisciplinary team of dedicated staff (see 'Staffing Plan' on page 12) to coordinate HIV care, employment, and housing services for PLWH with unsuppressed viral loads and/or at risk of falling out of care or out of care, (2) Expanded GMHC's technology infrastructure to support data sharing and service coordination, and (3) Augmented the agency's existing service programs with a suite of social work-informed support services to address emotional, practical, and clinical factors that impact clients' readiness to make changes in their lives. In contrast to standalone case management programs, Project HEALTH uses therapeutic techniques and evidence-based social work modalities to address social determinants of health and facilitate access to and engagement in needed care (see Intervention Implementation and Service Delivery' on page 19).

Founded in the earliest days of the AIDS epidemic, GMHC has 35 years' experience delivering continuum of care-focused services to marginalized PLWH, particularly African American and Hispanic community members, who comprise the vast majority of the 12,600 clients we serve each year. The agency is dedicated to remaining agile in the face of the evolving AIDS epidemic; to this end, GMHC continually expands its program portfolio and service models to address the myriad social determinants of health that contribute to unsuppressed viral loads among people with HIV in NYC. Critical to the effort to end the AIDS epidemic is a broad commitment to meeting clients' employment and housing needs in support of individual stability and improved rates of viral load suppression. GMHC is a national leader in this effort: for over 25 years, the agency has "vocationalized" its services, embedding employment-related activities into a variety of its care programs in order to promote improved health via job stability. In 2013, GMHC was invited to create the first-ever employment services program specifically geared towards PLWH receiving benefits from NYC's HIV and AIDS Services Administration (HASA); this program revolutionized HIV care in NYC by incorporating holistic employment services in GMHC's continuum of HIV care. Similarly, GMHC operates under the framework that housing is healthcare and that failures to maintain stable housing (e.g., rent nonpayment, landlord disputes) are often indicators of clinical issues that require a social work-informed response. Lastly, GMHC is grounded in the communities it serves; the agency is guided by a client-centered approach to care. Consistent with the findings of the HOPWA Getting to Work Employment Initiative evaluation, GMHC concentrates on meeting clients where they are, addressing challenges presented by their lived experiences, and offering services that guide clients through each stage of the readiness to change model.

Partners

GMHC has a variety of external partners and contacts that result in a mutualistic relationship; benefitting both GMHC and the partner organizations, while providing the utmost benefit to the clients. The specific partnerships identified for this initiative with signed memoranda of understanding were:

Callen-Lorde Community Health Center – Is a medical facility for the lesbian, gay, bisexual, and transgender community as well as people living with HIV and AIDS. Callen-Lorde offers a comprehensive, integrated program of quality medical and mental health services, including RWHAP services. It seeks to engage its patients in an ongoing relationship that focuses on prevention and wellness, rather than solely the treatment of illness. Callen-Lorde provides comprehensive and state-of-the-art HIV/AIDS care and support, including the following services: primary medical care; mental health; medication adherence support; care coordination; and assistance and referrals regarding benefits and entitlements, including insurance, housing, and referrals to other supportive services.

Fedcap – Develops innovative, creative, and sustainable solutions that help people surmount barriers, work toward economic independence, and effect change in their families and communities.

BOOM!Health – Is an innovative community-based nonprofit organization in the Bronx, New York deeply committed to a vision of health, wellness, and safety for all, particularly the needs of marginalized and stigmatized communities at highest risk. BOOM!Health's mission is to transform lives through health and wellness providing HIV/HCV prevention, Health Home/Health Coordination, Harm Reduction, Wellness, Legal Services, and Advocacy for individuals with HIV, lesbian, gay, bisexual, and transgender people, active and former substance users, women, and youth.

The Fortune Society, Inc. – Vision is to foster a world where all who are incarcerated or formerly incarcerated will thrive as positive, contributing members of society. They do this through a holistic, one-stop model of service provision that includes housing, employment services, education, family services, mental health and substance use treatment, health services, benefits referral, and food and nutrition services. Fortune serves over 6,000 individuals annually via three New York City locations. Its program models are recognized both nationally and internationally for their quality and innovation.

Mount Sinai Medical Center – Is a provider of Ryan White HIV/AIDS Program Services, and one of the nation's oldest, largest, and most respected voluntary hospitals. Mount Sinai's patient population represents the entire spectrum of ethnic and racial groups living in New York City, with success providing care to young men who have sex with men (YMSM), undocumented immigrants, and individuals from the African American/Hispanic communities. Racial and ethnic minority communities comprise over 82% of its current patient population.

GMHC's Partnerships

In addition to the partners listed to the left, GMHC has numerous formal and informal partnerships throughout the greater New York City area and beyond. The agency regularly engages in strategic partnerships to aid in effective and efficient service delivery for all clients. This is an important part of GMHC's success and is a component that can be added to any organization to improve outcome measures.

Overview of the Intervention

The theoretical model underpinning the approach of Project HEALTH is the Transtheoretical Model developed by Prochaska and DiClemente [1]. This is a widely used model in the context of behavior-change-based interventions and works because of the structured approach it offers intervention staff to capture and track client progress. The model relies on a client-centered approach that focuses on helping to change underlying, intrinsic motivations that dictate change behavior. It is the basis of motivational interviewing and enhancement interventions. Program staff identified a client's stage of change at enrollment and transposed this to one of two program specific tracks. Staff then identified a service plan for the client, tracking the client's progress along the stages of change and transposed track along a few timepoints throughout the intervention to update service plans and monitor progress overall.

Description of Need

GMHC has identified several key areas of unmet need throughout the HIV care continuum which were areas of focus in the intervention: (1) Upon HIV diagnosis or initial linkage to care, clients may not be connected to the full suite of services that meet their needs. For instance, 76% of GMHC clients were previously enrolled in one service program at a time; Project HEALTH augmented existing internal and external care coordination infrastructure to increase the number of clients receiving multiple services. (2) Clients engaged in care may struggle to benefit from services provided; while 68% of people with HIV in New York State had received HIV care in 2016, only 55% were virally suppressed. Project HEALTH's social work approach to case management helped provide individualized and evidence-based support to help clients identify and mitigate barriers to achieving viral load suppression, including intermediate barriers to housing and employment stability.

In NYC's particularly grueling economic and healthcare landscape, GMHC's implementation of Project HEALTH aimed to help mitigate structural, clinical, and individual level-level factors that prevent deep engagement in care, participation in the workforce, housing stability, and viral load suppression. The program staff also recognized a need for a model of change-based care management to focus on engaging clients with varying levels of readiness. By using social work centered care management practices such as peer support, motivational interviewing, and counseling, the program was also able to work with clients to reduce fear and improve self-efficacy. Furthermore, Project HEALTH's aim was to target African American and Hispanic people with HIV, however the program was also able to serve clients outside of these demographics with positive outcomes.

Goals

- **Goal 1:** Help clients identify and articulate their goals with regards to housing, employment, and HIV care
- **Goal 2:** Identify and address clients' practical, clinical, and structural barriers to deep and consistent engagement in care
- **Goal 3:** Connect clients with the full suite of programs for which they are eligible and help them maximally benefit from housing and employment services, RWHAP care, and other resources
- **Goal 4:** Build GMHC's capacity to collaborate with partner agencies to improve client health through a social determinant-based approach

[1] Boston University School of Public Health, 2019. "The Transtheoretical Model (Stages of Change)". https://sphweb.bumc.bu.edu/otlt/MPHModules/SB/BehavioralChangeTheories/BehavioralChangeTheories6.html

Intervention Logic Model

Target Population	Goals and Objectives	Assumptions
• African American and Hispanic PLWH living in New York City who are not virally suppressed or are out of care, and who are either homeless or unstably housed, unemployed or underemployed, or a combination of these factors.	• Reduce the effects of social determinants of health on HIV outcomes for PLWH in NYC • Improve GMHC's ability to identify and address clients' unmet housing, employment, and Ryan White service needs • Decrease disparities in health, housing, and employment outcomes for African American and Hispanic PLWH • Improve access to systems of care for African American and Hispanic PLWH • Improve care coordination across GMHC programs and with partner agencies across New York City • Augment existing services to improve retention and maximize benefits of care	• Unmet needs for housing, employment, legal services, and other structural factors limit clients' ability to achieve viral load suppression • Individual readiness to change impacts PLWH's self-efficacy and ability to enter and engage in care • Clients' service needs evolve as they move from one stage of readiness to the next

Inputs	Activities	Outputs	Outcomes
Partnerships • Mount Sinai Hospital • Callen-Lorde Community Health Center • BOOM!Health • Fedcap • The Fortune Society, Inc. **Staff** • Vice President of Programs and Clinical Services • Senior Managing Director, Coordinated Care • Social Work Case Manager • Transitional Benefits Counselor • Senior Managing Director, Analytics and Evaluation • Community-Based Participatory Researcher • Peer Support Navigator **Programs Leveraged** • Employment Services (Workforce Development Programs) Financial Management • HOPWA Housing and Housing Assistance • Mental Health and Substance Use Services • Legal Assistance • Wellness (complementary therapies, arts, education, and entertainment) • Psychosocial support groups • Hunger Relief Services and Nutrition Counseling	**Staff** • Establish MOU's describing linkage to care procedures • Link PLWA to medical care if unlinked, housing services, and employment services as indicated. • Track client's service, outcome, and activity data across programs, share data with partners, discuss client progress and identify emerging needs. • Leverage existing outreach and in-reach mechanisms • Assess client needs, barriers, and stage of change • Identify opportunities for brief intervention • Develop a service plan • Provide metro-cards for client travel, engagement, and retention • Provide peer mentorship to clients • Build data collection tools/data modules • Collect and share data with technical assistance providers at Boston University for all 12 sites of the initiative known as Evaluation and Technical Assistance Providers (ETAP), and with partners • Collaborate with ETAP, partners, and GMHC staff to integrate program components into agency practices • Develop and disseminate intervention manual **Client** • Attend program orientation **Readiness Track:** • Attend readiness counseling and case management • Attend support groups • Attend medical, legal, and social services appointments **Action Track:** • Attend Transitional Benefits Counseling sessions • Attend psychoeducation and support groups • Attend housing, employment, RWHAP, and/or other support services.	**Staff** • Conduct outreach to over 2,000 clients annually • Hold 12 orientation sessions annually • Enroll 100 clients into the program • Conduct weekly trainings/group sessions • Maintain at least 70% retention in the program. **Client** • Attend weekly group sessions	• Improve data and care coordination systems within GMHC and with partners • Improve GMHC's ability to mitigate the effects of social determinants of health on health outcomes **Short Term** • Increase the number of clients receiving HIV care, housing, and, employment services • Increase the number of clients with permanent housing and enrolled in appropriate benefit programs • Increase the number of clients retained in HIV care and adherent to ART • Increase the number of clients hired • Improve client knowledge, self-efficacy, and ability to retain housing, maintain employment, and stay engaged in medical care • Reduce attrition from care programs **Long Term** • Increase medication adherence • Decrease homelessness/housing instability • Decrease unemployment **Impact** • Increase viral load suppression • Improve longevity, quality of life, and health/social outcomes for PLWH

Pre-Implementation Activities

Leveraging Assets

GMHC has a plethora of assets to leverage and use as complementary services to the basic services provided in the intervention. The leveraged assets include: HOPWA services, vocational services, computer labs, power suited career clothing closet, RWHAP behavioral health, mental health, and psychiatric services, substance use services, legal services, case management, hot meals and food pantry, benefits and health insurance advocacy, complementary therapies which include reiki, massage, acupuncture, wellness programs such as health homes and transitional care coordination, and transportation support which include 2-trip MTA cards for travel to/from medical appointments, apartment viewings, support group attendance, and counseling appointments with project staff. By leveraging the full complement of available GMHC and NYC-based services, GMHC has been able to help clients address barriers to stable employment, permanent housing, and viral load suppression. Particularly for "Action Track" (see page 19 for additional information on "Action Track" versus "Readiness Track") participants who had articulated their motivation to gain jobs and stable housing, structural and clinical factors like inconsistent HIV care, unaddressed mental illness or substance use issues, and domestic violence histories prevented successful transition into the workforce. At Project HEALTH program intake and as needs arose through the program, the social work case manager referred clients to support services that mitigated the impact of these barriers on health.

Project HEALTH was integrated into GMHC's care coordination department and leveraged the agency's well-established infrastructure for sharing client data, making referrals, and ensuring clients benefitted from care offered. A comprehensive housing and social services provider, GMHC has been able to provide intersectional and integrated care. This comprehensive approach encouraged clients to deeply embed in GMHC's service landscape which in turn fostered program retention and client resiliency. Furthermore, the social work case manager case-conferenced by telephone or in-person with both internal and external supportive service providers, benefits advocates, and other clinicians to ensure integrated care delivery.

Agency Services/Assets

TREAT Local EHR – GMHC's local electronic health record, TREAT, is integral to the functioning of programmatic activity across the agency. TREAT stores all client level service data and encounters for various programs. The EHR was critical in identifying clients in need who would benefit from the Project HEALTH intervention. Furthermore, special widgets were created in TREAT to track clients' progress in the program and helped determine additional support needed for clients to be successfully housed, employed, and in care.
Legal Services – GMHC's legal services department directly responds to clients' presenting needs. Legal staff aid with housing matters, including source of income discrimination for HASA beneficiaries, holdover cases, and eviction prevention.
Immigration Services – Particularly among Hispanic people with HIV, immigration issues present a significant barrier to gaining sustainable employment, accessing housing, or enrolling in medical care.

HOPWA Housing Services – GMHC's on-site (separately-funded) HOPWA housing services including housing placement assistance, short-term rental, mortgage, and utilities payments (STRMU), and permanent supportive housing through congregate and scatter-site programs. GMHC housing placement staff receive regular updates on housing vacancies across NYC from the Center for Urban Community Service's Residential Placement Management System. These updates advertise vacancies at Congregate Support-Level II, Congregate Treatment-Level II, Scattered Site Community Housing, Supported SRO-Community Care, and Support Housing-Single Site-Community Care facilities. GMHC staff regularly accompany clients on site visits to ensure that housing meets program goals; help clients gather appropriate application materials and negotiate with landlords/housing administrators, and follow-up on housing applications and advocate for client needs with respect to housing quality, arrears, and apartment maintenance.

Mental Health and Substance Use Services – GMHC has provided culturally-competent RWHAP-funded mental health and substance use services since 2005. Through targeted counseling groups and evidence-based interventions, GMHC offers support for depression, anxiety, substance use issues, grief, and management of HIV. GMHC mental health practitioners deliver over 1,800 counseling sessions each year and offer services in Spanish and English. The agency has also expanded its services to include psychiatric and insurance-billable care through two new, New York State-licensed on-site clinics.

Transitional Care Coordination (TCC) – Provides housing placement and case management to HIV-positive unstably-housed clients. The program assists clients throughout their transition to stable housing through comprehensive and trauma-informed needs assessments, assistance locating and selecting housing, and connection to Medicaid, Health Homes, HRA rental assistance, and other benefit programs.

Food and Nutrition Services – Funded by RWHAP and NYS Hunger Prevention and Nutrition Assistance Program dollars, GMHC serves nearly 81,000 hot meals annually and provides groceries to generate an additional 30,000 meals each year. GMHC also offers full-service nutrition counseling to help clients work towards self-sufficiency and build healthy living skills.

Workforce (Vocational Services) – GMHC currently operates an NYC-funded program specifically designed for recipients of HASA benefits. Through GMHC's significant experience serving HASA beneficiaries, staff have worked closely with PLWHA clients, HRA, and employers in a range of industries to mitigate these challenges and facilitate successful transitions into employment including the following programs:

RISE – Partnering with HRA, a targeted employment training, placement, and retention program for HASA beneficiaries.

MATCH – Offers an interdisciplinary case management model specifically targeted to PLWH.

Career Advance – Provides job training, internships, career assessments, and counseling, and financial management education specifically tailored to transgender/gender non-conforming people, and lesbian, gay, and bisexual identifying clients.

Vocational Training – Through a partnership with State University of New York's SUNY Advanced Technology Training, and Information Networking computer labs, GMHC's SUNY ATTAIN lab offers sector-specific trainings to provide vocational foundations in areas including carpentry, electrician skills, plumbing, and health care/home health as well as academic and English-language-learning support.

Real Estate Certification (NYU) – Clients will have access to New York University's real estate certification program. Upon successful completion of coursework, clients are eligible to take the New York State Real Estate Salesperson Qualifying Exam free of charge.

Financial Literacy – The agency's workforce development department offers bi-monthly classes on household budgeting, credit, savings accounts, and navigating public benefits systems. The programs particularly focus on helping clients manage the transition from public benefit supports to earned income and address clients' concerns about maintaining healthcare coverage and adequate income as their benefits eligibility shifts.

Benefits Advocacy – GMHC's Benefits Advocacy Unit, helps clients access over $4 million annually in public benefits. The Unit excels at enrolling clients in comprehensive health insurance plans and connecting them with supplemental benefit programs such as Medicare Part D, Medicare Advantage Plans, HASA, ADAP, and ADAP Plus. Benefits advocacy staff also connect clients with public food, housing, and income supports including SSI/SSDI, LINC, SEPS, SNAP, and WIC. These programs are funded in part through NYS AIDS Institute under the RWHAP Minority AIDS Initiative.

Representative Payee Program – GMHC operates the GMHC Financial Management (GFM) Program that serves as the representative payee for individuals living with HIV who are referred through the New York City HIV/AIDS Services Administration. GFM collects clients' federal and state income benefits (e.g. Social Security Disability Insurance, State Supplement Program), directly pays for clients' rent and utility expenses, and disburses the balance of the funds to clients. Through GFM, GMHC directly manages clients' social security and other public benefit monies, offers financial literacy and housing retention services, and connects clients with income, housing, and food subsidies.

External Services/Assets

GMHC has numerous partnerships both formal and informal across the greater New York City area and used all influence across these partnerships to ensure optimal service delivery to Project HEALTH clients. In addition, Project HEALTH strengthened active partnerships with HOPWA housing providers across New York City including Boom!Health, Housing Works, and Bailey House. GMHC was also able to strengthen partnerships with programs at partner agencies such as The Fortune Society for employment-related services (in addition to existing services on-site.)

Setting

The agency is was designed and planned to incorporate all program and department activity. The layout of all floors is such that new programs can become a part of the organization seamlessly. Groups were conducted in large meeting/conference rooms that were reserved for multiple sessions, and the agency has a hallway of private meeting rooms to discuss private client matters with the clients or with staff.

Promoting the Intervention

Promoting and marketing a new intervention is critical in the framework of pre-implementation activities. By reaching out to partners, gaining buy-in from both internal and external stakeholders and garnering interest from potential clients sets a solid foundation to any intervention and allows for program staff to build on the foundation thoughtfully. This also allows those who have bought-in to the program from the beginning to ensure and celebrate its success. To promote Project HEALTH to potential clients, referrals were received by internal stake holders and

external organizations. Internal stakeholders included case managers from programs within Coordinated Care (Health Homes Care Management and Transitional Care Coordination.) External partners providing client referrals included Callen-Lorde, Mount Sinai, Fortune society, and FedCap. As a new addition to the programs under Coordinated Care, Project HEALTH was introduced to other departments within GMHC to establish criteria and contacts for referral.

Meeting and Presentations with Program Staff – Meetings with other GMHC program staff, within other programs, occurred once and then as needed throughout the active recruitment period. The meetings with the staff from a variety of modalities, enabled the recruitment coordinator to inform GMHC staff about the program, including:

1. Goals of the program
2. Target population and eligibility
3. Core phases of the program
4. Mechanisms for referring to the program

Meeting with other staff also created buy-in from the staff, which increased the likelihood that the program staff would refer other potential recruiters to Project HEALTH. Program staff also had the opportunity to ask questions and seek clarification. Staff were provided with a referral form and program literature.

Consumer Involvement/Consumer Advisory Board (CAB) – The recruitment coordinator presented quarterly during the first year and semi-annually the next two years, and then as needed to promote the intervention and gain additional perspective from the board, at the GMHC consumer advisory board. The consumer advisory board consists of GMHC clients, both HIV positive, HIV negative, and at-risk who provide feedback on GMHC programs, as well as advocate on behalf of the client population. The presentation mirrored the presentation conducted for GMHC staff and included:

1. Goals of the program
2. Target population and eligibility
3. Core phases of the program
4. How to become a client of Project HEALTH

During the presentation, CAB members were encouraged to become a part of Project HEALTH if they met the eligibility requirements, and to provide insight and perspective on the services provided. Those CAB members who expressed an interest in becoming a client were provided with an appointment, within one week of the presentation, to meet with the program staff for eligibility screening and learn more about the program. Additionally, the recruitment coordinator distributed business cards and palm cards (See Appendix B) to the CAB members, so they can contact the recruitment coordinator at a late date if they become interested in being a part of Project HEALTH or had any further insight to provide. CAB members also had the opportunity to ask questions and seek clarification.

Outreach – The recruitment coordinator was responsible for identifying and conducting outreach and recruitment activities in the community and community-based organizations where the target population may congregate, live, or receive services. Outreach locations were determined based on the New York City Department of Homeless Services listing of shelters and SROs. Outreach was conducted in those facilities:

1. With the representation of the target population
2. With a communal area to host a meeting

To identify suitable street-based outreach locations, the recruitment coordinator worked with members of the program including the Principal Investigator and Program Supervisor, as the off-site supervisor is responsible for developing a monthly off-site/outreach calendar of recruitment locations that offered the best opportunity to engage with potential program enrollees. The street outreach team included a minimum of two people, with one person bilingual. At the outreach facilities, and street-based outreach, staff provided information on the program, along with contact information to set an appointment for agency intake and screening for the program, followed subsequently by program intake if they were deemed eligible through the program screening. The outreach also included presentations with supplementary palm cards to the partner organizations previously mentioned to ensure quality referrals and to enforce the buy-in that the organizations engaged in through the memoranda of understanding. (See Appendix A for sample memorandum of understanding, and Appendix B for palm card)

Sustainability

Project HEALTH staff and GMHC management continues to work with partner agencies (e.g. Mount Sinai Hospital, Callen-Lorde Community Health Center, FedCap, Boom!Health, and the Fortune Society) to incorporate successful program elements into agency practices even after the project period has ended. This is an informal but iterative process that allows agency programs to work more effectively and efficiently with other programs within the agency and external partners through learned experience from Project HEALTH. Program elements included ensuring agency staffs, as part of the clients' intake processes, assess client identified service gaps for employment and housing and make the necessary referrals to our partner agencies. We identified potential partners through service provision analysis, e.g. what services did potential partners provide. After this analysis, we connected with each partner, via phone and then scheduled in-person meetings to provide an overview of services as well as the service gaps. A linkage agreement was signed with each partner that outlined the specific program services each organization would offer to clients in need of services. GMHC is incorporating the best practices and frameworks refined throughout Project HEALTH into practices and programs agency wide, beginning with GMHC's other care coordination programs, and expanding to the agency's employment, housing and other RWHAP services. The core elements of the program fostered improved collaboration systems across partners and within GMHC, built the infrastructure for increasingly-coordinated care, and used evidence-based social work principles to guide clients through the HIV care continuum and mitigate the impact of social determinants of health as described in the Intervention Implementation and Service delivery section on page 19. Each of these elements is directly transferrable to GMHC's service environment after the end of the project period. Lessons learned and skills obtained through implementation of the program are actively being embedded into other program areas to ensure sustainability of program areas to ensure clients continue to have positive housing, employment, and HIV outcomes. Once the program period is over, any clients remaining without fully positive outcomes are subsequently referred to internal programs that may provide needed services to the client, and/or external partners and other organizations.

Funding

Planning for a program to provide services at a non-profit organization such as GMHC comes with its challenges. Specifically, there are numerous planning costs to consider. Project HEALTH uses a program model that needs some resources to be able to provide services to its clients. Because of this, a development staff member/grant writer, in addition to a finance specialist are critical to understanding the true cost of implementation, and potential funders to approach.

GMHC currently manages 30 public contracts totaling $14 million annually, administers $1 million in private foundation grants and major gifts, and operates large-scale representative payee and rental assistance programs for over 530 clients annually. As such, GMHC has developed a robust infrastructure for administrating line item and performance-based contracts, monitoring program implementation, meeting specified performance benchmarks, and submitting timely and accurate program and fiscal reports. Program administration and grants management activities are supported by GMHC's Finance and Analytics & Evaluation Departments, which implement rigorous internal review and reporting procedures to ensure appropriate fund disbursement, compliance with grant requirements, and highest-quality program implementation.

GMHC's deep experience providing responsive wraparound social services exceptionally positions the agency to improve outcomes for housing insecure and unemployed people with HIV. In planning for the intervention, GMHC understood the nature of funding and its sources, and the necessity to consider sustainability after the program funding period. Because the agency relies on a model of wrap-around services, there are some sources of funding that clients in the program can benefit from. Furthermore, the program also considered private funders to leverage. These potential funders should focus on health equity to support the two phases of the program (See page 20 for more information on Action and Readiness Tracks), if the agency does not have funding to support the program. As with all programming, funding is based on the release of RFP's by city, state, and federal funders, as well as private funding. To this end, GMHC's development routinely seeks out funding to support programming and sustainability. In the final year of the demonstration project, donations and extra funds were difficult to procure due to the global COVID-19 pandemic that placed all of New York City and many parts of the world in a lockdown situation. This presented numerous challenges obtaining the necessary funds to fully sustain the program after the end of the program period. The pandemic continued through the remainder of the program and through the remainder of 2020. The team continues to implement lessons learned from the demonstration project into normal programmatic activity across the agency to ensure these key lessons are not lost.

Staffing Plan

The Intervention staffing plan included the following positions with brief descriptions and full-time equivalent percentage:

- Vice President, Programs & Clinical Services (5% FTE)

Provided management oversight and worked with clinical staff agency-wide to facilitate the provision of evidence-based coordinated care for the program

- Director, Coordinated Care & Intake (40%)
  Ensured high-quality clinical interactions, collaborating with partner agencies and GMHC's other care coordination programs, and ensuring that all project activities were carried out faithfully and in support of improved health outcomes for clients
- Social Work Case Manager (100% FTE)
  Responsible for delivering evidence-based care coordination, case management, and psychosocial support services to Project HEALTH clients
- Transitional Benefits Counselor (100% FTE)
  Provided logistical and psychosocial support to help clients navigate medication payment, cash assistance, food, and other benefit programs as they transitioned into the workforce and stable housing
- Senior Director, Analytics & Evaluation (15% FTE)
  Provided oversight and technical monitoring for the evaluation components of this program; supervised Lead Evaluator, Monitoring & Evaluation Specialist, and two part-time research assistants
- Monitoring & Evaluation Specialist (45% FTE)
  Supported program in identifying key quality and management indicators and created monitoring processes onsite.
- Peer Support Navigator (57% FTE)
  Provided one-on-one and group support, practical assistance linking clients to care, assistance with data collection and sharing (in support of intervention process evaluation/client experience), and peer mentorship

Job Descriptions

Each position had its own unique job description. The staffing plan included the following job descriptions:

Vice President, Programs & Clinical Services | Reports to: Chief Executive Officer

The Vice President of Programs and Clinical Services provides vision and leadership to the agency's clinical services and a significant part of its programs. This Senior Management Position oversees the administrative, fiscal, and clinical aspects of a significant portion of the agency's programs and services, currently including Coordinated Care (e.g., Health Homes), Mental Health Services (e.g., Article 31 Clinic), Substance Use Treatment (e.g., Article 32 Clinic), and Women's Care and Prevention.

Essential Job Functions Related to Project HEALTH

- Significantly contribute to and actively participate in a senior management capacity, especially relating Project HEALTH to agency goals, fiscal integrity, efficient systems, policies & procedures, strategic initiatives, triad management, and the implementation of agency vision, mission and values.
- Motivate large and diverse staff to infuse all services with the organization's mission and values, and to deliver the highest quality of care with the utmost clinical, ethical, and fiscal integrity.

- Participate in the procurement and budgeting of funds and assist in the writing of RFPs and the sustainability of programs to help support a full range of services based on clients' needs.

Education and Certification
Master's degree in a professional helping profession (e.g., psychologist, social worker, etc.), public administration, or public health is required. Professional licensure in Mental Health is desired, and advanced clinical and/or systems management experience or training is a plus.
Special Skills and Knowledge

- Minimum of five years of management and supervisory experience of a large and diverse staff and client-base
- Significant proven successful experience managing a multi-million-dollar budget, and proven experience in program design, implementation and evaluations
- Experience working with managed care and/or health insurance markets with familiarity and sensitivity to HIV-related needs and issues, including care coordination, and the medical and psychosocial needs of people with and affected by HIV is highly desired

Director, Coordinated Care & Intake | Reports to VP, Programs & Clinical Services
Provides overall management, oversight and supervision of GMHC's intake Unit, Gender Empowerment Network, Project Health and agency initiatives targeting viral suppression. Partners with other Health Homes supervisors in the clinical and administrative supervision of Health Homes Care Navigators.

Essential Job Functions Related to Project HEALTH

- Provide clinical, administrative and programmatic supervision to staff to ensure the highest level of staff functioning and the greatest level of client satisfaction.
- Manage the program such that the policies, procedures, processes, work flow, and client flow are as efficient, streamlined, comprehensive and integrated as possible.
- Ensure all related funding and contractual expectations (e.g., deliverables, reports, expenditures, etc.) and agency expectations (e.g., Triad management, data management, fiscal management, policy adherence, etc.) are met.
- Ensure the delivery of services are of the highest caliber, meeting expected outcomes, and that documentation of services, retention of records, recording of data, and analysis of data are accurate, timely and all within legal, ethical and contractual expectations.
- Ensure Care Managers under supervision are effective in the delivery of their services, and meeting client GMHC and expectations

Education and Certification
Master's degree in mental health, social services, psychology, or other clinical professions is required

Special Skills and Knowledge

- Supervisory and managerial experience in social services.
- Care Management and/or Health Homes experience.

- Experience working with the mentally ill, substance users, and those infected with HIV.
- Proficiency in Microsoft systems, especially Excel.
- Excellent interpersonal, communication and problem-solving skills.

Social Work Case manager | Reports to: Director, Coordinated Care & Intake

The Social Work Case Manager has the overall responsibility for the day-to-day coordination and delivery of case management, health promotion, individual and group support, and community referrals to clients.

Essential Job Functions Related to Project HEALTH

- Orients and educates clients by explaining the role of the social work are manager; initiating the care plan; and providing educational information in conjunction with direct care providers related to treatments, procedures, medications, employment and continuing care requirements
- Develops interdisciplinary care plan and other case management tools by participating in meetings; coordinating information and care requirements with other care providers; resolving issues that could affect smooth care progression; fostering peer support; providing education to others regarding the case management process
- Works closely with the interdisciplinary care team including PCP, psychiatrist, therapist, residential services, substance abuse treatment program, ACT Team
- Monitors delivery of care by completing patient rounds; documenting care; identifying progress toward desired care outcomes; intervening to overcome deviations in the expected plan of care; reviewing the care plan with clients in conjunction with the direct care providers; interacting with involved departments to negotiate and expedite scheduling and completion of tests, procedures, and consults.
- Conducts home visits and participates in client appointments and case conferences in the community with other providers including HIV primary health care and treatment providers.
- Researches community resources and government benefit programs to determine eligibility criteria, provide appropriate referrals, and perform follow up activities for referrals.
- Proactively identifies or forecasts barriers clients will face in meeting goals and strategies to minimize or eliminate the barrier.
- Outreaches to clients to facilitate keeping scheduled appointments; arranges for metabolic and periodic preventive screening, per evidence-based guideline standards
- Ensures that clients and care givers are aware of test results by facilitating a discussion between the client and physician as necessary
- Coordinates services between clients and extended care team providers to ensure that integrated care plan is fully implemented
- Assigns daily tasks to Transitional Benefits counselor to meet the needs of the caseload and the program. Advises supervisors of tasks which are not completed on time.
- Teaches clients through behavior modeling the necessary skills to promote self-sufficiency, medical adherence, and the ability to access community resources on their own.

Education and Certification
Master's Degree in social work/psychology or another related human services field.

Transitional Benefits Counselor | Reports to: Social Work Case Manager
Provides education, counseling, advocacy and assistance to HIV+ individuals on the transition from public/government benefits, including cash assistance, SSI/SSD and public health benefits, to salary-based income and health care access and insurance. Assists individuals who need help in accessing or maintaining health care benefits, or governmental entitlements to ensure uninterrupted health care access and income management. The Specialist identifies presenting issues, researches and gathers information, strategically plans to resolve issues, and performs direct contact and negotiation with relevant providers, agencies and organizations to achieve issues resolution. Working with each client, the Specialist develops a personal budget analysis and an individualized Personal Benefit Transition Plan (PBTP) that clearly projects how the participant's income and expenses will change upon employment.

Essential Job Functions Related to Project HEALTH

- Works with participants to help them understand what to expect once employment begins and benefits change.
- Develops a personal budget analysis and an individualized Personal Benefit Transition Plan for each client.
- Provides benefits counseling to participants, including personalized budget counseling
- Advocates to HASA and other government agencies on behalf of participants as needed.
- Provides eligibility screening and application support for the AIDS Drug Assistance Program (ADAP) and other work supports.
- Offers Financial Literacy Training workshops for participants.
- Provides technical assistance to other departments in the organization on benefit and income transition issues.

Education and Certification
Bachelor's degree preferred. Related experience can be substituted for academic requirements

Special Skills and Knowledge
Knowledge of government policies and procedures, including Social Security Administration and health insurance regulations. Bilingual English/Spanish preferred

Peer Support Navigator | Reports to: Social Work Case Manager
The Peer Navigator will perform various duties to support the Social Work case manages, Transitional Benefits Counselor and their respective clients with similar conditions by providing on-going health education, emotional support, and encouragement. They act as role models, sharing personal strengths and skills and promoting hope and recovery. The Peer Navigator must be knowledgeable about community resources, including educational, social and emotional support services, available to clients. The Peer Navigator will assess needs and connect patients with these resources, either directly with the patient or through collaboration with the treatment team. Duties may also include recruiting patients, administering questionnaires, data gathering, maintaining patient databases, assisting with event organizing, and performing various administrative tasks.

Essential Job Functions Related to Project Health:

- Health promotion, health education, and risk reduction counseling.
- Appointment reminder phone calls.
- Accompaniment to appointments.
- Follow-up on missed appointments, and scheduling and rescheduling appointments.
- Address barriers to appointment adherence by arranging for mental health, Substance use, childcare, transportation, and translation services.
- Home visits.
- Assistance with entitlements/insurance applications.
- Motivational interviewing and goal setting.
- Routine communication with all members of the care team.
- Participate in clinic-based case conferences.
- Provide treatment education and adherence support
- Routine communication with all members of the care team.
- Complete and submit documentation of services provided in a timely and efficient manner (e.g., within two business days past the provision of service).
- Maintain all documentation of services provided.
- Attend other meetings as deemed appropriate and related to the scope of service.
- Adhere to workplace policies and procedures, including confidentiality, documentation, channels of communication, workplace culture, dress code, and conflict resolution.

Education and Certification
HS Diploma or GED required

Special Skills and Knowledge
Ability to make data entries into computer database. Knowledge of resources for PWAs and their support networks. Good verbal, written, computer, communication, and interpersonal skills. Use of computer software --Microsoft Office Suite including Word and Outlook calendaring, and Excel. Bilingual in Spanish/English helpful.

Senior Director, Analytics & Evaluation | Reports to: Chief Operating Officer
The Managing Director of Analytics & Evaluation provides vision and leadership to the A&E Department as well as to the entire agency using data to monitor program performance, improve the quality of services provided and spearhead new initiatives. This position manages the programmatic and administrative aspects of agency grants and contracts, analyzing data and preparing and submitting reports to monitor agency progress toward annual contractual goals including deliverables as well as billable services. This role manages the development of Quality Assurance and Continuous Quality Improvement (CQI) systems and oversees the evaluation of programs through quantitative and qualitative means. The Managing Director makes recommendations for improving program efficiency, reaching targeted deliverables, quality and integrity. The Managing Director provides technical support

and training in these areas to program staff; serves as a liaison to other departments and facilitates interdepartmental coordination on grant- and program-related matters.
Essential Job Functions Related to Project HEALTH

- Oversees, provides guidance on, and supports the Project HEALTH Evaluation.
- Analyzes processes to minimize data collection redundancies and enhance reports
- Holds departmental responsibility for the implementation and use of GMHC's Electronic Health Records system (HiNext's TREAT);
- Works together with IS to develop new data systems and processes as needs arise.
- Serves as a liaison between staff in Information Systems, Human Resources, Development and Finance as related to agency reporting needs.
- Trains and supports staff on data collection and analysis systems;
- Oversees the submission of contract interim and progress reports to funders.
- Maintains a system of health records that meets industry standards for logical/ efficient organization and revises as necessary. Ensures that standards for HIPAA and Article 27F compliance are maintained and regulatory requirements are met.

Education and Certification
Master's Degree in related field (e.g., MPH, MPA, MBA) or equivalent experience in this field

Monitoring & Evaluation Specialist | Reports to: Senior Director, Analytics & Evaluation
The Monitoring and Evaluation Specialist provide strategic leadership and capacity for supporting agency-wide data-driven management processes, research activities, and quality improvement initiatives. The Director will support programs in identifying key quality and management indicators and creating monitoring processes. This individual will evaluate these programmatic efforts, collecting and analyzing agency data in order to produce research that will contribute to the knowledge base of effective program management, quality improvement, and HIV care.
Essential Job Functions Related to Project HEALTH

- Evaluates program outcomes and quality improvement initiatives and produces presentations and written reports, such as white papers and academic articles, on findings and the effectiveness of the Project HEALTH initiative.
- Effectively communicates with the program team to fulfill data requests and to deliver analysis results.
- Assist the implementation of an electronic health record and to integrate the EHR into continuous quality improvement efforts
- Contributes summarized and standardized reports that will be part of GMHC's performance management documentation control and distribution.
- Assists the program team in utilizing tools and monitoring systems to track contract deliverables, program outcomes, and quality improvement projects.

Education and Certification

Bachelor's degree in social work, health informatics, public health or a related discipline required, Master's degree preferred.

Staff Onboarding

Staff were to be trained on internal record keeping system and electronic medical records system (EMR) for two weeks. Intervention staff attended 2-day Motivational Interviewing training. Intervention staff are also to be trained on referral mapping to internal and external organizations for various services, initial service plans, and service plan updates. As part of the onboarding training, all staff are to attend the following trainings, which were offered by the New York City Department of Health and Mental Health (NYCDOMHM), Training Institute, Cicatelli Associates, an organization funded by the NYCDOHMH. Both the NYCDOHMH and Cicatelli Associates used NYCDOHMH developed curricula.

- HIV Confidentiality
- Cultural Competency
- Trauma Informed Care
- Trans-Awareness Training
- Anti-racism

Supervision Structure

Supervision is an inherent process at the organizational level and there is a method that has been standardized and that is used across the agency known as the triad method. In the triad method, the supervision structure includes what is known as data driven administrative supervision (DDAS) in addition to the clinical supervision, which entails skills building, and other identified areas for improvement. The staff are to meet with their supervisor once per week to discuss an individual dashboard of items that are to be tracked as key performance indicators, which guide the conversation of the clinical supervision.

The DDAS is followed by the clinical supervision which allows for the staff and supervisor to discuss items such as secondary trauma, stress, and burnout, in addition to areas of improvement as outlined by the individual dashboard, and specific skills or trainings necessitated by particular events or general skills building. If staff anecdotally discusses items such as secondary trauma, stress, and burnout, the supervisor will use the toolkit necessary for supervisors at the agency to aid in these situations. Due to the nature of the organization, social work practices are inherent in the organization and are essential in these discussions.

Furthermore, GMHC offers over 5 weeks of general PTO (includes sick leave and vacation time), a comprehensive health insurance plan which includes access to numerous behavioral health professionals, an active culture of self-care and associated practices, occasional staff health fairs, and some wellness classes that are available to clients and staff.

Intervention Implementation and Service Delivery

Core Components

Clients that were referred from external partners or were new clients entering GMHC were formally referred to Project HEALTH from the intake process for enrollment eligibility, if they were deemed eligible from initial conversations at intake. Some were in-reached clients, meaning they were clients of the agency that could benefit from this program. To in-reach clients, the evaluator pulled a list from the TREAT, the local EHR, of clients who matched the eligibility criteria, and who consented to being contacted via phone during the intake process. These clients were subsequently contacted by the program team to gauge interest in the program.

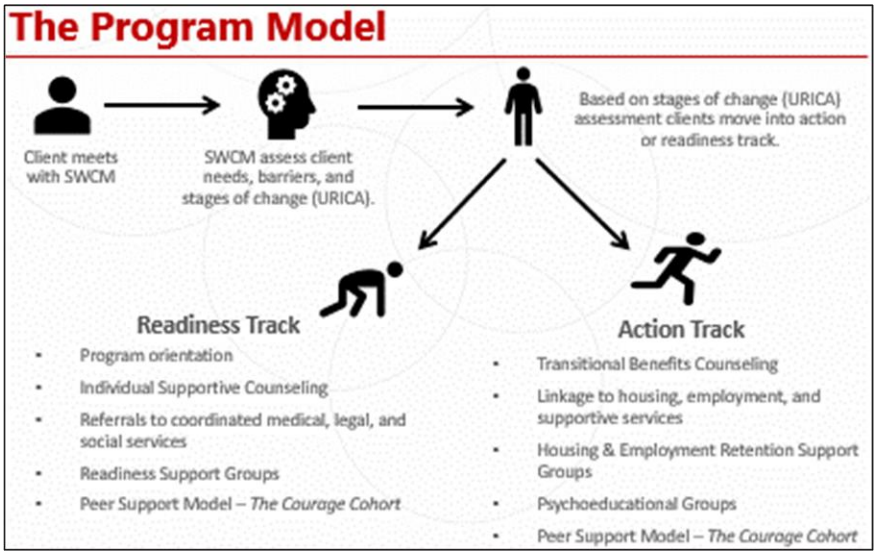
Individual Level

After referral to Project HEALTH, the intervention staff (transitional benefits counselor or peer support navigator) that was available to see the client provided them with an eligibility screener which determined whether they were truly eligible for the specific program. The screener included questions about age, HIV status, housing and employment status, and engagement in HIV care. For this demonstration project, specific eligibility criteria dictated that the client had to be aged 18 years or older, newly HIV positive in the last year, or HIV positive and out of care, at risk of falling out of care, or not virally suppressed, homeless or unstably housed, and unemployed or underemployed. It is important to note that the eligibility criteria were specific to the demonstration project, are not necessarily requirements for those looking to replicate the Project HEALTH intervention. However, the program was designed specifically to help those who were unstably housed or homeless and underemployed or unemployed to become motivated to change those contexts and as a result, maintain HIV care. Being newly diagnosed or out of care is not a recommended requirement for program participants in replication, because the nature of housing and employment issues dictates that there will be increased risk of falling out of care. Once the client was deemed eligible, the client was provided with a modified and adapted version of the University of Rhode Island Change Assessment (URICA, see Appendix C). This assessment, originally created for use in determining stage of change for those in tobacco cessation, and other substance use behavior change programs, was adapted for use with this program. The 12-item URICA that was used in this program was to determine whether a newly enrolled client was in the pre-contemplation, contemplation, action, or maintenance stage of change in the transtheoretical model. The scores of the assessment were then transposed to place clients into one of two tracks developed by the intervention team for targeted service delivery. These tracks were the Readiness and the Action tracks. Once the client completed the URICA, they were scheduled to meet with the transitional benefits counselor and peer support navigator for a more in-depth conversation. The client would also meet with the social work case manager to complete a comprehensive bio-psycho-social assessment to determine initial/ongoing service needs and a treatment plan. After

completion of eligibility screenings, assessments, and HIPAA forms, the client would then be placed into the Readiness or Action track for targeted interventions.

The Transtheoretical Model and Action vs Readiness

As part of the Project HEALTH enrollment eligibility screening, all clients completed an initial URICA scale to assess their levels of motivation in seeking Housing and Employment. During enrollment, clients were asked to complete a modified, 10-item version of the URICA questionnaire which was used as an acuity scale for the intervention and administered by program staff. The URICA scale utilized by Project HEALTH was adapted from the original tool which has been used to assess stages of change as outlined in the Transtheoretical Model developed by Prochaska and DiClimente[1].



The screening tool establishes a client's stage of change (Pre-contemplation, Contemplation, Action, and Maintenance) in reference to seeking Housing and Employment. This scale would also indicate which clients would be placed in the "Readiness" and "Action" tracks.

The Transtheoretical Model (Also known as the Stages of Change Model), focuses on the decision-making of the individual and how motivation relates to behavior. As one's motivation increases, they progress within the levels of change in a cyclical. Different intervention strategies are implemented at specific levels of change to assist a client in progressing to the next stage. There are multiple processes associated with specific stages of change (including consciousness raising, self-reevaluation, environment reevaluation, helping relationships, and reinforcement management.)

The URICA scales are meant to assess where a client's motivation to change is located within the stages of change so appropriate interventions can be completed. It is also important to note that a client may relapse into prior behaviors exhibited in former stages of change. The purpose of the stages of change model is to continue using motivational enhancement interventions to maintain change from previous behavior.

The stages of change include Pre-contemplation, Contemplation, Preparation, Action, Maintenance, and Recurrence. In the pre-contemplation phase, a client may be reluctant to change or may not be fully aware of their behavior's conscious impact. They exhibit resistance to change, feeling resigned to their current behavior, and rationalize their behavior. The contemplation phase is characterized by client's thinking about changing their behavior and expressing ambivalence toward change. They may exhibit procrastination or be resistant. In the preparation phase,

[1] Boston University School of Public Health, 2019. "The Transtheoretical Model (Stages of Change)". https://sphweb.bumc.bu.edu/otlt/MPHModules/SB/BehavioralChangeTheories/BehavioralChangeTheories6.html

clients are ready and committed to changing their behavior. The have decided to stop their problematic behaviors which prevent them from attaining progress toward their goals. The action phase is where a client is actively engaging in change and modifying their behavior. They are seeking support from others to facilitate their success and sticking to the plan created in the preparation stage. The maintenance stage focuses on maintaining new behaviors and having continued support to maintain success. It is important to note that clients may experience a relapse or re-occurrence of past problematic behaviors which will result in returning to a previous stage of change. Project HEALTH interventions were developed to work with patients at these different levels.

Staff Activities

Project HEALTH intervention team members (Social Work Case Manager, Transitional Benefits Counselor, and Peer Support Navigator) individually provided services for all program participants, however each team member had their own caseload as well. Caseloads were divided to place those who scored highest on the URICA acuity scale on the Social Work Case Manager's caseload, followed by those who scored somewhere in the middle on the Transitional Benefits Counselor's caseload, and those who scored low on the acuity scale were placed on the Peer Support Navigator's caseload as this was a part-time position.

Staff would meet with clients bi-weekly at a minimum to provide ongoing psychosocial support, motivation-based interventions, internal and external referrals, and ongoing outreach. The team would also make ongoing attempts to re-engage clients who are difficult to maintain contact with, by using phone, mailing letters, and home visitation.

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

Because clients were placed in the action or readiness tracks, they also received ongoing companion services that enhanced their ability to benefit from care in accordance with their level of readiness to change. Readiness track services targeted clients who were in the pre-contemplation or contemplation stages of change who may have exhibited apprehension with entering the workforce or living independently. Action track services targeted clients who were in the planning and action stages of change and were prepared to seek employment, permanent housing, and stay engaged in care. As a part of engaging the clients in the tracks, the social work case manager developed group curriculum in collaboration with the transitional benefits counselor and peer support navigator to address specific needs of the clients. (See Appendix B)

Referrals and Tangible Reinforcements

Referrals for ancillary services, and access to tangible reinforcements through Project HEALTH such as snacks as a majority of the clients were food insecure, and 2-trip Metro-Cards for transportation as clients were underemployed and unemployed and did not have the monetary resources to purchase the Metro-Cards for travel to appointments, were regularly provided for clients depending on need. Project HEALTH clients were provided with multiple referrals to internal services and programs which included: Health Homes Care Management, Transitional Care Coordination, Client Advocacy, Legal Service, Behavioral Health and Substance Use Counseling Services, Nutritional Counseling and Education, Prevention Services, HOPWA, RWHAP, and Workforce Development Programs. In addition to the ancillary benefits these services provide, they also provide tangible resources such as lunch and dinner services, 2-trip Metro-Cards for transportation, barrier protection, and access to a computer lab for resume writing, or computer training. The team also assisted clients in the completion of the HRA 2010E supportive housing applications, and any other housing and employment aid they could provide clients in addition to providing them with a push in their motivation to change. Finally, external referrals were made to a variety of organizations, namely: HASA, ACCESS-VR, External HOPWA Providers, and Breaking Ground.

System Level

Important Partnerships and the Referral Process

As mentioned previously, GMHC has engaged in memoranda of understanding (MOU) (See Sample MOU in Appendix A) with Callen-Lorde Community Health Center, Fedcap, BOOM!Health, The Fortune Society, Inc., and Mount Sinai Medical Center. These organizations were instrumental in many early referrals for new clients to enroll into the program through organizations such as Fedcap, BOOM!Health, and the Fortune Society, Inc., and referrals from the program to medical services provided at organizations such as Callen-Lorde Community Health Center and Mount Sinai Medical Center. The referral process is as follows:

1. A GMHC representative will acquire the required confidentiality release as obligated by New York State HIV Confidentiality Law Article 27F.
2. A GMHC representative will call to notify the organization of any referral and to schedule an appointment, ideally within 24 hours of an HIV positive result on a preliminary test or realized need for a referral. And, whenever possible, notification will be provided at least a day prior to the referral.
3. A GMHC representative will contact the organization to confirm if the client kept their appointment.
4. GMHC will maintain regular contact with the organization to share data as required for service planning and/or by the ETAP and to discuss ongoing data needs.

Note: If the organization had a client to refer to GMHC services, specifically for housing and employment services, GMHC will remain in contact with the client and organization until there is a confirmed attendance to an appointment with Project HEALTH staff or if there is a recorded declination from the client.

Documentation

Documentation is an important part of the intervention, particularly because proper documentation allows staff to keep track of clients and their progress in the intervention, and also enables staff to reach clients in a timely and seamless fashion with information being updated as it comes along. The following items were used in the documentation process:

Client assessment, service planning, and reassessment: Upon referral to Project HEALTH, the program staff conducted a program intake to fully identify clients' needs and barriers to care. The social work case manager used evidence-based motivational interviewing techniques to determine client needs in the following areas:

University of Rhode Island Change Assessment (URICA) Scale: Project HEALTH improved clients' ability to deeply engage in care, maintain connection to care, and otherwise maximally benefit from services. In order to achieve this objective, all service planning and delivery activities were grounded in the Transtheoretical Model (TTM) or Stages of Change. As previously mentioned, TTM articulates behavior change (i.e. entry into services, treatment adherence, engagement in employment) as a continuum of emotional stages, each with unique intervention and support needs. TTM (Stages of Change) include pre-contemplation (no intention to change), contemplation (intention to change), preparation (planning to take action), action (practicing new behaviors and actions), and maintenance (adjusting to new practices). At program intake and throughout the service delivery process, program staff used this stage of change assessment, a validated assessment tool, to evaluate clients' stage of change. URICA enabled Project HEALTH to respond to client's needs based upon their level of readiness, thereby improving the likelihood that clients would engage in planned services. This model, original applied to smoking cessation practices, has been demonstrated to contribute to positive outcomes with regards to HIV prevention. (Appendix C)

The Health Assessment: This assessment was used to gather information about the clients' recent medical care and hospitalization history, viral load, food security (food choices, kitchen access), diagnoses of any heart, lung, or blood disorders, neurological disorders, cancer sexually transmitted diseases or other medical conditions, current prescription medications, and adherence to anti-retroviral treatment regimens.

The Transitional Benefits Plan: This included a review clients' housing status, income sources, expenses, debt, benefits, and insurance coverage.

The Psychosocial Assessment: This assessment gathered details about clients' recent substance use history and mental health conditions such as anxiety and depression. It also captured information about clients' criminal and incarceration history, household members, and personal support networks. In addition, it gathered information about clients' readiness to change across a series of behaviors, including readiness to live independently, readiness to move to new housing, readiness to work a part-time or full-time schedule, or readiness to begin and complete a training certificate program. This informed, comprehensive, and collaborative assessment process is a critical first step in ensuring clients receive a responsive care plan. GMHC has found this approach to be particularly effective in determining clients' readiness to begin work and enter stable housing. Project HEALTH's target population may be unwilling or uncertain about making major changes like regularly reporting to work, complying with supportive housing requirements, and adjusting to financial independence; unlike traditional case management models, the

readiness-based Program Intake provides a forum for identifying and addressing these issues. Six months after completion of the initial Project HEALTH Assessment, GMHC completes a Re-assessment with participants to identify any emerging needs, discuss progress towards goals, and reassess clients' stage of change. At this point, GMHC also gather data about client needs, program engagement, and outcomes to inform our understanding of how Project HEALTH services influence client health.

The Chart Review Checklist: This document and protocol was created due to a need by the evaluation team. As part of any SPNS intervention, or any program in an HIV/AIDS organization, there are important clinical outcomes measures that need to be tracked to measure client success. Measures such as HIV viral load, CD4 cell count, engagement in care, adherence to HIV retroviral medication, and a variety of other clinical outcomes are needed to understand the nature of client success. Because GMHC does not have a clinical service component to its organizational structure, and due to strict HIPAA guidelines to follow for client safety, it was difficult for the evaluation and program team to obtain the clinical outcomes. The protocol (see Appendix D) was developed to use in the intervention to ensure success in obtaining the data and details a step-by-step process. Furthermore, the checklist part of the protocol helps track the data due to the large size of the files obtained through the clients' clinical providers.

Tracking Systems: Once any assessment is complete or data is obtained, it was placed into document libraries, and tracking systems to ensure staff had the most up-to-date information.

Electronic Medical Records (EMR): All assessments completed were entered into the EMR system used by GMHC called TREAT. This is where all program activity was housed including agency intake, program intake and assessments, chart data, and paper copies including assessments, HIPAA consent for release of medical records, and chart data. Program staff also used the EMR to document progress notes any time they contacted the client, spoke with the client, or met with the client for any reason. Though progress notes range in their verbiage and style depending on the reason for the note, below is a sample progress note:

Interaction Start Date: DD-MM-YYYY HH:MM
Interaction End Date: DD-MM-YYYY HH:MM
Created: DD-MM-YYYY HH:MM EST by [FirstName LastName]
Last Modified: DD-MM-YYYY HH:MM by [FirstName LastName]

Service	Encounter #	Admit Date	Patient Type
Ind/Fam Support	##########	DD-MM-YYYY HH:MM	Outpatient

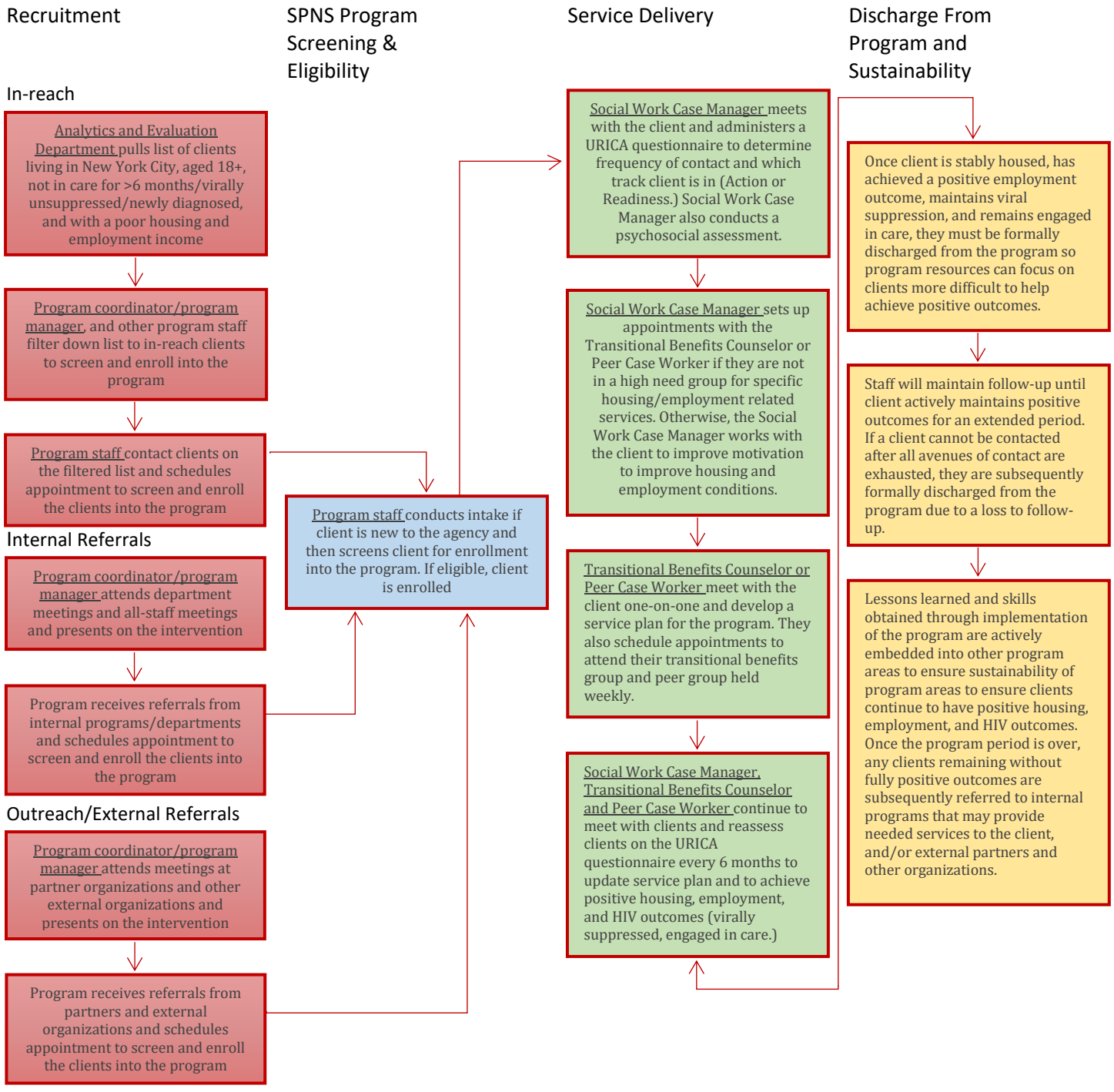
[FirstName LastName] (Signed DD-MM-YYYY HH:MM EST)

Program Activities
GMHC ClientID
MM/DD/YY
HHMM-HHMM
PH Enroll

Client attended Project HEALTH Enrollment appt. 12/11/18
Client provided proof of age [age] years old and HIV status: HIV+, moved to NYC recently from [State]. Client was out of medical care. Client reported having inadequate housing and employment…

Tracking Evaluation Activity: The evaluation believes in seamless evaluation, which is the use of warm handoffs from program staff when clients are immediately available for evaluation activity, and constant communication between clients, evaluation staff, program staff to mitigate the risk for program or evaluation attrition. Evaluation activity was tracked using Excel tracking spreadsheets to track clinical data request submission to a variety of medical providers throughout the greater New York City area and even in other parts of the country.

Implementation Flow Chart



Changes in Implementation

Though the intervention produced many positive outcomes, there were many barriers to success (see Lessons Learned below), and as a result, some changes in implementation. Halfway into the intervention, the Social Work Case Manager left the agency, and replacing the role proved to be difficult, therefore the Readiness Track and Action Track groups, which were scheduled for Mondays and Wednesdays with the Social Work Case Manager, were canceled and removed from the intervention in August 2019. Additionally, after tracking group attendance, and making the attempts to increase attendance to the Transitional Benefits Counseling Group, which was scheduled Tuesdays with the Transitional Benefits Counselor, was canceled and removed from the intervention in December 2019. The conclusion and reason for removing the Transitional Benefits Counseling Group is that clients felt there were too many programmatic activities including evaluation activities, and one-on-one conversations with either the Transitional Benefits Counselor or the Peer Case Worker and did not attend the groups. The clients instead opted for the one-on-one conversations which clients enjoyed and benefitted from. Finally, the Peer Group which was scheduled Thursdays with the Peer Case Worker was well attended every week, however due to an unforeseen and unprecedented issue in the COVID-19 pandemic, the group was canceled in March 2020.

Transitioning to Standard of Care

Project HEALTH leveraged internal and external resources in order to support client's psychosocial needs in their pursuit of stable housing and employment. Because this was inherent in program service delivery, it was a template to the transition into a standard of care, which allowed for seamless discharge planning into existing programs at the agency that were able to learn from challenges and barriers encountered by Project HEALTH staff (see 'Barriers and Challenges' and 'Facilitators of Success' in the 'Lessons Learned' section below). The areas that helped the move to transition to a standard of care were:

Continuous client engagement and client adherence strategies – As clients transitioned through the continuum of care, Project HEALTH provided sustained support services to prevent later-stage attrition and addressed new challenges as they emerged.

Peer support and mentorship – Project HEALTH implemented a peer mentorship model that fosters continuous and goal-orientated engagement in care. Action Track clients were matched with clients from the Readiness Track and encouraged to meet regularly, discuss challenges, and form habits of mutual, recovery-based, support.

Identifying and re-engaging clients – Project HEALTH team members used TREAT's IPCC module to track clients' engagement in care, attendance at appointments, and follow-through on referrals. Clients who missed appointments or otherwise failed to adhere to service plans were contacted by the Peer Support Navigator (PSN) for re-engagement in care. The Social Work Case Manager (SWCM) met individually with hard-to-engage clients to discuss their motivations, goals, and any emotional or practical challenges to staying in care or attending services. As part of GMHC's organizational effort to decrease client attrition, the agency's Analytics and Evaluation Department produced reports to help program staff identify clients who haven't received appropriate assessments or achieved viral load suppression; these clients will be proactively targeted for re-engagement as necessary.

Transportation support – GMHC provided clients with MetroCards to facilitate travel to appointments.

Continued access to supportive services and computer labs – Employed participants that enroll GMHC's meals program, care coordination, treatment adherence, mental health and substance abuse programs, and computer labs have continued access to these onsite services for as long as they are needed.

Continued benefits counseling and application assistance – Following their Personal Benefits Transition Plan, employed participants were invited to return to the Transition Benefits Counselor after beginning a job or increasing wage or hours, to assess eligibility for work supports and complete any new applications. The Transition Benefits Counselor was also available to answer questions about benefits changes and to advocate with government agencies as needed.

Support groups for the newly employed and newly housed – Individuals transitioning into employment or housing developed a new set of concerns, questions, and frustrations, and support groups are an optimal forum for sharing, venting, mentoring, and advising one another. Participants were strongly encouraged to attend support groups for their first three months of employment or housing placement.

Collaboration with partner agencies – An active and leading member of NYC's social service community, GMHC supplements its onsite services with partnerships with dozens of agencies, enabling clients to receive specialized care where it helps them most. GMHC is a member of multiple service consortia and regularly shares referrals with agencies across NYC. Linkages with partner service organizations enhance GMHC's onsite offerings in three key ways:

1. Expand the scope of services offered – Through linkage agreements, GMHC can offer clients credentialing programs not available onsite. For example, through our partnership with Fedcap Rehabilitation Services, clients were able to earn OSHA and Fireguard Certifications to improve their employment prospects.

2. Increase accessibility to services – GMHC is committed to partnering with organizations from across NYC in order to reduce transportation barriers to work and care. While GMHC's Chelsea-based headquarters are easily accessible, GMHC's established linkages with providers throughout NYC's five boroughs enable us to increase convenience for clients, thereby improving chances of program and client success.

3. Improve ability to meet special needs – Clients come to GMHC with a wide range of barriers to employment and service needs. Project HEALTH included formalized partnerships with specialized service organizations that bring specific experience serving special populations. For example, GMHC has executed a linkage agreement with The Fortune Society, who operates programs specifically for formerly incarcerated job seekers. A significant number of GMHC's clients have histories of criminal justice involvement. African American and Hispanic PLWH are overrepresented in the justice system; criminal justice histories are a significant barrier to accessing stable employment and housing for the Project HEALTH target population. Similarly, GMHC has a strong relationship with Good Temps staffing agency, who specializes in hiring and placing individuals with disabilities (including PLWH). GMHC also has a strong partnership with the William Ryan Community Health Center, a full-service health and community center with specific training and internship resources for women and those with families.

Selected organizations with whom GMHC has formal linkage agreements:

1. Vocational Training: Fedcap, Harlem United, Fortune Society, AIDS Service Center of NYC, Henry Street Settlement, LGBT Center
2. Secondary and Post-Secondary Education: City University of New York, New York University, State University of New York, Education Development Center, Hunter College
3. HIV Medical Care: Mount Sinai Health System, Callen-Lorde Community Health Center, Community Healthcare Network, Ryan/Chelsea-Clinton Health Center, Elmhurst Hospital Center
4. Immigration Services: Elmhurst Hospital Center, New York Immigration Coalition
5. Substance Use Treatment: Housing Works, Addiction Institute of NY
6. Food and Nutrition Support: Food Bank NYC, Coalition for the Homeless, Gods Love We Deliver
7. Legal Assistance: New York Legal Action Group, Legal Action Center
8. Housing: Bailey House, Lantern Community Services, Harlem United, Boom!Health, West End Integration Residence
9. Violence Prevention and Response: NYC Anti-Violence Project
10. Linkage Process: GMHC has refined a streamlined and effective processes for linkage

Through the intake assessment or ongoing discussions of client need, staff continued to identify opportunities for clients to receive services with a partner institution and other programs and services offered at the agency. GMHC contacted the partner organization to set up a client appointment. Staff at both agencies held regular case conferences to ensure clients were receiving adequate service levels.

Coordination with Medical Care: During Project HEALTH intake, GMHC confirmed whether each participant was connected to an HIV primary care provider and has attended an appointment within the past 3 to 6 months. Participants who did not currently see an HIV care provider were immediately referred to Mount Sinai, Callen-Lorde, or another provider of their choice to obtain appointments within 48 hours. In addition, the SWCN contacted providers to regularly collect clients' primary care status measure (PCSM) data and other data to assess engagement in care.

GMHC has strong relationships with both Mount Sinai and Callen-Lorde and has established smooth processes for sharing clinical data and collaborating to improve client outcomes. The SWCM met regularly with staff from Mount Sinai and Callen-Lorde to address procedural and client-specific issues, and their combined efforts have proven successful in attempts to reach and re-engage clients who otherwise may have dropped out of care.

Discharge Planning

A discharge plan has been in place since the start of the intervention; however, clients were discharged at various times throughout the program. Some clients were lost to follow-up or refused to participate in program activity at a point and were subsequently discharged without any further action. For all other clients, in addition to regularly maintaining the client chart, in the last 3 months of the program period, intervention staff took a comprehensive look at the clients' cases and enacted a discharge plan to ensure ample time to continue services for the client if needed. Some clients who achieved housing, employment, and positive HIV outcomes (viral suppression, engagement in care, and adherence to antiretroviral medication) did not have any indication in their chart located in a locked file cabinet near the program manager or in the TREAT EHR (see page 21 for information on documentation and tracking systems) for continued services that were provided in Project HEALTH, and were discharged with no further program specific intervention services required, so that program resources could be focused on clients more difficult to help achieve positive housing, employment, viral suppression, engagement in care, and adherence to antiretroviral medication. Program staff followed up with clients that achieved the previously mentioned positive outcomes until they were deemed to have actively maintained the positive outcomes. The clients were only discharged once program staff felt that the clients were at a decreased risk of falling back into poor housing, employment, and HIV outcomes. In the final months of the program funding period, those clients with an indicated need for continued service either for housing, employment, or engagement in care, were subsequently referred to other programs and services offered at GMHC, or at external partner organizations. The clients' cases were followed until there was a verified linkage.

Implementation Costs

The program did not change much in its initial cost planning. Though there was staff turnover, and some positions remained vacant, the program was able to achieve positive outcomes for many clients with: VP or Prevention and Clinical Services (PI), Program Manager, Transitional Benefits Counselor, Peer Case Worker, and the full evaluation staff and some finance staff as support for the program. In recreating the intervention, the team has identified some critical areas that program funding is necessary. Though items such as overhead costs, and some adjacent personnel costs can be managed by leveraging other areas of the agency budget, some key costs must be specifically handled. The transitional benefits counselor, and peer worker provided the necessary one-on-one conversations with the clients to help guide them through the stages of change in the model of care, and through various processes of obtaining positive housing, employment, and HIV related outcomes. Though the social work case manager was not part of the program for too long, the initial psychosocial assessment they provided for all newly enrolled clients was important in creating a meaningful service plan that functioned as a roadmap to helping the client achieve positive outcomes. Furthermore, items such as snacks and metro cards were important to the program as most clients began the program financially unstable, food insecure, and unable to pay for much of their travel expenses.

For programs seeking to replicate this intervention, program staff should consider and factor into their budgets the following implementation costs that are vital to the program's success

- Staffing Costs: Staffing under this funding should be offered a competitive wage and is commensurate with their level of experience. Given the nature of the program, it is recommended that full – time staff have experience. While GMHC was able to allocate most staffing cost across multiple contracts to equal 1 full – time equivalent (FTE), this may not be doable for other agencies. As such, when deciding on implementation

cost, the agency should seek to cover the cost of personnel at 100% for each FTE, as noted below (cost take into consideration the cost of living for living for NYC and may be lower or higher depending on your location, in addition to fringe benefits, if offered. GMHC offers its employee health insurance).

- Director of Program - $65,000 annually
- Transitional Benefits Counselor - $45,000 annually
- Social Work Case Manager - $60,000 annually
- Evaluator - $60,000 annually
- Peer Support Navigator - $15,566 annually ($15 per hour x 20 per week). Note: GMHC pays all its peer support staff a minimum of $15 per hour.
- Research Consultant - $15,000 annually
- Fiscal Analyst - $40,000 annually

- Client Incentives: Incentives should be distributed to clients for reaching milestones and should be graduated starting lower and increasing with each milestone completed. This aids in client motivation, engagement, and retention. A minimum of $10,000 should be budgeted for this ($25, $50, and $100 for completion).

- Program Supplies: Program supplies are needed to support the provision of services and should be included in the implementation cost and range from $2,000 - $5,000 annually based on the number of clients the agency proposes to serve.

- Administrative and Overhead: Administrative and overhead should be included in the implementation cost; however, depending on how each agency allocates these costs across funding sources or unrestricted dollars will dictate the final dollar amount needed to house the program.

- Outreach and Promotional Materials: Outreach and promotional materials should be developed and planned for and this includes utilizing paid ads via social media to widen reach. Agencies should allocate a minimum of $3,000 annually for outreach and promotional materials.

  The cost discussed above are essential to successful program implementation; however, the final figures will be individualized and based on each agency's need, clients served, and existing funding sources, both restricted an unrestricted. GMHC does not believe there are cost that are negligible.

Local Evaluation Plan

URICA Evaluation

As described previously, the URICA questionnaire was developed as an acuity scale, allowing for the program staff to make service plan updates as the clients went along from baseline to the 6 and 12-month follow-ups. The URICA scale was also meant to be used in an evaluation context to understand the needs presented by clients at baseline, 6, and 12-month follow-ups, and the subsequent services provided. (See Appendix C)

Qualitative Evaluation

The qualitative evaluation is an important component of the local evaluation. It allows for a mixed-methods approach to research and allows for the evaluation team to make meaningful conclusions from the conversations and subsequent themes derived from them. The qualitative interviews were conducted on 30 clients at baseline, and on 23 clients at the 12-month follow up. The clients were asked questions about their experience before enrollment into the program, including their experiences in all stages of life relating to family and other relationships, housing, employment, HIV care, mental health history, and substance use history. The follow-up questionnaire posed questions in the same topics but in the context of program experience. (See Appendix C)

Stigma Evaluation

Though the stigma survey questions were made available to all sites on the multi-site survey platform, they were added as optional questions due to the ongoing nature of GMHC's stigma research on SPNS-funded programs. The stigma questions relate to HIV-stigma, Race/Ethnicity-stigma, Transphobia-stigma, and Homophobia-stigma. Using a mixed-methods approach, the evaluation plan is to understand stigma-based themes in the qualitative interviews and the measures presented in the stigma questionnaires.

Intervention Outputs and Outcomes

Client Enrollment

Ineligibility Reasons	Number	Percent
Younger than 18	1	2%
Not HIV+	0	0%
HIV+ but not newly diagnosed	35	83%
HIV+ but no gaps in care	38	90%
HIV+ but not at risk of falling out of care	37	88%
HIV+ but virally suppressed	38	90%
Not homeless	2	5%
Not unemployed	13	31%

Project HEALTH Eligibility Screener	**Number**	**Percent**
Clients Screened	151	100%
Clients Eligible	109	72%
Clients Ineligible	42	28%

Enrolled in Intervention Client Demographics	Number	Percent
Race	107	100%
Asian	2	2%
Black/African American	48	45%
Hispanic/Multiracial	31	29%
White	13	12%
Other	7	7%
Not Selected	6	6%
Ethnicity	107	100%
Hispanic or Latino	42	39%
Non-Hispanic or Latino	61	57%
Not Selected	4	4%
Age	107	100%
18-29	30	28%
30-39	40	37%
40-49	17	16%
50+	20	19%
Gender Identity	107	100%
Female	5	5%
Male	97	91%
Transgender - FTM	1	1%
Transgender - MTF	4	4%
Borough	107	100%
Bronx	30	28%
Brooklyn	20	19%
Manhattan	25	23%
Queens	20	19%
Staten Island	3	3%
Other	9	8%

Outputs

Intervention Outputs	Number of Groups
Peer Group	66

Staff Trainings
Human Subjects Research Certification
HIV Confidentiality
Trauma Informed Care
Motivational Interviewing
Mental Health First Aid
American Sign Language (ASL) – Class 2
Adult and Pediatric CPR/AED
Meeting Facilitation
Housing Law 101 for Caseworkers
Time Management
Stages of Change
Advanced Excel 1 (VLOOKUP Formulas)
Working as part of a Project Team
Working with Difference and Privilege in the Workplace
Trans Awareness Workshop
HIV testing and risk counseling
Patient navigation and medical case management
Adherence assessment and counseling
Alternative models for delivering HIV care (task shifting, telemedicine, emerging technologies, etc.
Cultural competency (racial/ethnic, gender, and sexual orientation)
Mandated Reporter Training

Outcome

Highest Housing-Related Outcomes	Number	Percent
Rental	72	67%
With Relations/Friends (Temporary)	16	15%
Transitional Housing	9	8%
Emergency Shelter	9	8%
Other	1	1%

Highest Employment-Related Outcomes	Number	Percent
Number Employed Full-Time	28	26%
Number Employed Part-Time	15	14%
Per Diem	4	4%
Student	3	3%
Volunteer/Intern	3	3%
Unemployed	54*	50%

Highest HIV Care Continuum-Related Outcomes	Number	Percent
Clients engaged in care	40	37%
Clients not engaged in care	8	7%
Unknown engagement in care status	59	55%
Clients virally suppressed	68	64%
Clients not virally suppressed	1	1%
Unknown viral suppression status	38	36%

*This unusually high number (compared to the goals of the intervention) is due, in part, to lessons learned as outlined on pages 40-42.

Linkage to Care and Other Services	Referred	Those Referred Linked to Care	Total in Care
Mental Health Referrals	42	9	15
Meals/Nutrition Education Referrals	90	50	62
Legal Referrals	46	25	29
Benefits Advocacy/Access to Healthcare Referrals	31	14	26
Testing Referrals	1	0	5
Employment/Workforce Referrals**	48	22	38
Case Management Referrals**	66	48	66
Substance Use Referrals	11	3	12
Prevention/Community Health Referrals	11	17	19
Wellness Referrals	95	24	28
Housing Referrals**	3	0	18

**Note: The housing/employment and case management referrals to programs are in addition to the assistance provided in the intervention, and in the discharge planning stages of the program.

Qualitative Evaluation

A preliminary look at the qualitative evaluation shows that many of the clients are in similar from an outside perspective, however they encounter a variety of intersectional stigmatizing experiences in their everyday lives. Furthermore, the qualitative interviews help corroborate the idea that the qualitative data suggests, which is that clients are increasingly motivated to change their housing situation over their employment situation. Finally, an initial look at the qualitative interviews highlights a need for simplified and standardized navigation through the HIV healthcare and social service systems in New York City, as many clients have provided anecdotes of negative experiences navigating the respective systems from moment of HIV diagnosis, and in many cases even years after the initial HIV diagnosis.

Lessons Learned

As with all programs, Project HEALTH encountered numerous barriers and challenges through the implementation of the intervention, however the program team was able to learn from the encountered barriers and challenges, and were subsequently able to make changes to facilitate program and client success (achieving positive housing and employment outcomes, and maintaining viral suppression, engagement in care, and adherence to HIV antiretroviral

medication.) Below are individual barriers followed by actions taken to facilitate success following the encountered barrier.

Barrier	Facilitator to Success
1. Staff turnover is always a potential issue for any program or organization. The program went through some turnover in staffing, which made reporting difficult, as many of the staff that left were responsible for reporting, and other higher-level administrative processes.	1. The staffing changes led to new leadership stepping into aiding the program administratively and with experience implementing programs such as these. Having this experience was integral in the success of this program.
2. The initial job description for the social work case manager proved to be too much for the single social work case manager. There were tasks that did not overlap well and made it difficult for the social work case manager to provide quality care. Furthermore, the qualifications were very stringent, making it difficult to replace the social work case manager once they left the agency.	2. Due to the leadership of the Managing Director and Program Manager, the work was divided and spread out throughout program staff. It allowed for long-term success and made for quality service delivery from all program staff.
3. Clients were not attending all groups as designed in the original intervention plan. The clients felt there were too many program activities and too many groups. They did enjoy the one-on-one counseling, and the peer mentor group because clients were able to exchange information themselves on networking, and how to be successful in going through process to getting an apartment in various social service-based settings.	3. Staff made attempts to increase group attendance, however when they were made aware of the clients' thoughts on the groups, they removed the groups from the intervention, which helped the intervention continue and flow smoothly.
4. Many clients were too specific in their criteria for a location to be housed. Specifically, most clients would request a location in Manhattan to be closer to their provider, or closer to some other organization that they are a part of.	4. Following one-on-one motivational interviewing sessions there was a change in understanding and behavior, which led to increasingly positive housing outcomes.
5. The staff ran into retention issues with some of the clients. Some clients eventually were lost to follow-up because they wanted housing more than employment and were not working on obtaining employment after a certain period after program enrollment. However, some clients were difficult to contact due to phone number changes, address changes, and other changes in contact information.	5. The program manager and staff were able to relieve retention issues by maintaining contact with other program staff at the agency where clients were obtaining services and other partner agencies, and case conferencing with other known providers and partner agencies.

6. An important part of the intervention is obtaining clinical outcomes data, including HIV viral load, primary care visits, and a variety of other information. GMHC does not have a clinical service component to the organization, and it was difficult to obtain the data even from the clinical service partners. This became increasingly difficult during the global COVID-19 pandemic which began in March 2020 and continued through the remainder of the project.	6. The staff created a protocol to obtaining clinical service outcomes to supplement data received on interventions at the agency to give program and evaluation staff a clear picture of the effectiveness of the intervention and what areas to work on. (See Appendix D)
7. Both evaluation and program staff encountered clients with past trauma that would present itself under the context of various triggers.	7. The staff created a protocol to handling a situation where a client is triggered and displaying an attitude that may lead to harmful actions either to themselves or to others. All staff were trained in Mental Health First Aid and had the protocol ready to use at a moment's notice. (See Appendix D)

Dissemination Activities

GMHC has a detailed communications strategy to disseminate critical information, engage clients and other stakeholders, and highlight GMHC's role as a leader in the field of HIV/AIDS. External communications are led GMHC's Vice President of Communications and Communications Department. This team is responsible for generating and executing responsive, compelling, and effective communications strategies across all media. It coordinates all requests for design of new materials and social marketing campaigns, press inquiries and planning for forums go through this department, so that the communications plan is integrated into all programmatic and development efforts. The agency disseminates best practices, highlights areas for inquiry, and drives scholarship through heavy participation in national and international conferences and coalitions. GMHC regularly gives presentations around the country, and over web conference, in addition to attending numerous conferences every year. The team presented items related to Project HEALTH at the 2018 and 2020 Ryan White Conference. In the evaluation of the program, it's outcomes, and its implementation, GMHC plans to develop many research papers through this HRSA-funded initiative. Specifically, GMHC plans to develop an expository paper describing how the program worked, program outcomes, and lessons learned. In addition to the expository paper, GMHC plans to develop an implementation science paper, a paper describing medical outcomes collection in an agency without clinical services, a paper on housing, a paper on employment, and through the use of the qualitative data, GMHC will develop papers regarding stigma, trauma, and immigration.

GMHC also is represented on New York City's HIV Planning Group, Governor Cuomo's Task Force to End the Epidemic, the National Minority AIDS Council, and other coalitions that enable us to shape the future of the response to HIV/AIDS. Finally, the team has contact with the regional Northeast/Caribbean AIDS Education and Training Center (AETC) and aims to disseminate program successes and lessons learned to help those in the region obtain positive outcomes with a similar population as was serviced by Project HEALTH.

Appendix

Appendix A: Program Planning

Sample Memorandum of Understanding with Medical Partner

Gay Men's Health Crisis, Inc. (GMHC) and [Name of Organization] have agreed to collaborate on a mutually cooperative and beneficial affiliation for the purpose of a proposal to the health Resources & Services Administration Special Projects of National Significance funding opportunity Improving HIV Health Outcomes through the coordination of Supportive Employment and Housing Services – Demonstration Sites (funding opportunity number HRSA-17-113).

GMHC, located at 307 West 38th St., New York, NY 10018, is a nonprofit organization with a mission to end the AIDS epidemic and uplift the lives of all affected. GMHC works to achieve this mission by providing HIV testing, counseling, and support services to over 12,600 New Yorkers each year who are at risk for, living with, or impacted by HIV/AIDS.

[Partner Organization Information]

Contact Information – [Partner Organization]

Contact Information – GMHC
[PI of Project]
[Title of PI]
307 West 38th St., New York, NY 10018
[Phone Number of PI]
[Email of PI]

[Information on history of previous partnership(s) with partner organization; formal or informal.]

Service Agreement
[Terms of Service agreement between GMHC and partner organization.]

[Partner Organization] to accept referrals for Ryan White HIV AIDS Program Services: [Partner Organization] agrees to partner by accepting referrals of all GMHC clients that are newly diagnosed with HIV or formerly diagnosed and in need of medical care. [Partner Organization] will enroll these individuals in RWHAP services, including HIV primary care, at [Partner Organization]. Additionally, GMHC and [Partner Organization] agree to provide services to eligible clients currently enrolled in [Partner Organization] or GMHC care programs. In addition, GMHC and [Partner Organization] agree to regularly share clients' clinical and exposure data. Specific data requirements to be determined upon program award.

Enrollment and Data Collection Processes: GMHC and [Partner Organization] agree to collect and report clients' clinical data to GMHC, the HRSA Evaluation and Technical Assistance Provider (ETAP), and the SPNS program to support the publication and dissemination of information about this program's activities and outcomes. Any release of patient-related information will be approved in writing by the individual patient enrolled in care. GMHC and [Partner Organization] agree to share data through the following process:

1. A GMHC representative will acquire the required confidentiality release as obligated by New York State HIV Confidentiality Law Article 27F.
2. A GMHC representative will call to notify [Partner Organization] of any referral and to schedule an appointment, ideally within 24 hours of an HIV positive result on a preliminary test and whenever possible, notification will be provided at least a day prior to the referral.
3. A GMHC representative will call [Partner Organization] to confirm if the client kept his or her appointment.
4. GMHC will maintain regular contact with [Partner Organization] to share clinical and intervention exposure data as required for service planning and/or by the ETAP and to discuss ongoing data needs.

Confidentiality: Both GMHC and [Partner Organization] agree that the confidentiality of all clients' specific information will be protected in accordance with the HIV Testing and Confidentiality Law (Article 27-F of the Public Health Law) or other applicable laws, including obtaining a signed and dated Department of Health-approved release from the enrollee prior to the release of specific information outside the care management program, and that a copy of that release be retained in the client's record; [Partner Organization] and GMHC agree to collaborate to obtain required consents from clients in order to fulfill the mutual terms within this agreement.

GMHC and [Partner Organization] acknowledge their commitment to the principles highlighted below in serving the target population:

1. We will work together to ensure coordination of referral services to facilitate and track each qualified participant for enrollment in services;
2. We are working to establish coordinated systems of comprehensive care for high-risk individuals and HIV-positive individuals who are not currently connected to care;
3. We are committed to the development and support of comprehensive care infrastructures that increase access to culturally competent, client-centered care;
4. We will provide support services to facilitate access to and encourage retention in care.

This agreement will be reviewed at least every five years and may be modified or terminated by either party at any time upon written notice.

_____	_____	_____	_____
[Name of Partner Organization Representative, Title, and Name of Partner Organization]	[Date]	[Name of GMHC Representative, Title] Gay Men's Health Crisis, Inc.	[Date]

Marketing Materials

Appendix B: Intervention Service Delivery

Peer Group Lesson Resources

Peer Group Discussions, and Lessons were conducted utilizing the following manuals and guides. Some are available free of cost, and some are available for purchase:

Peer Education Curriculum:

Trainer Manual: http://files.icap.columbia.edu/files/uploads/Peer_Ed_TM_Complete.pdf

Participant Manual: http://files.icap.columbia.edu/files/uploads/Peer_Ed_PM_Complete.pdf

Transitions Workbook:

https://www.practiceinnovations.org/Products/Product/act-wsm-for-transition-personal-workbook-new-york/wellness-self-management-for-transition-personal-workbook-english

Wellness Self-Management Plus:

https://www.practiceinnovations.org/Products/Product/wellness-self-management-plus-workbook-english-pdf

Appendix C: Evaluation and Assessment

University of Rhode Island Change Assessment (URICA) Acuity Questionnaire

Employment Questionnaire (English)/Housing Questionnaire (English):

Client ID#_____
Date: _____/_____/_____
Assessment Point: _____

EACH STATEMENT BELOW DESCRIBES HOW A PERSON MIGHT FEEL WHEN APPROACHING PROBLEMS RELATED TO THEIR EMPLOYMENT. PLEASE INDICATE HOW MUCH YOU TEND TO AGREE OR DISAGREE WITH EACH STATEMENT. IN EACH CASE, MAKE YOUR CHOICE IN TERMS OF HOW YOU FEEL RIGHT NOW, NOT WHAT YOU HAVE FELT IN THE PAST OR WOULD LIKE TO FEEL.

THERE ARE FIVE POSSIBLE RESPONSES TO EACH OF THE ITEMS:
1=Strongly Disagree
2=Disagree
3=Undecided
4=Agree
5=Strongly Agree

INDICATE THE NUMBER THAT BEST DESCRIBES HOW MUCH YOU AGREE OR DISAGREE WITH EACH STATEMENT.

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1) It doesn't make much sense for me to consider changing my job or getting a job.	1	2	3	4	5
2) I've been thinking that I might want to change something about my current job or getting a job.	1	2	3	4	5
3) At times my current job or lack of job causes problems and I'm determined to change it.	1	2	3	4	5
4) It is frustrating, but I feel like I face the same problems with my job or getting a job over and over again.	1	2	3	4	5
5) Trying to change my current job or getting a job is pretty much a waste of time for me.	1	2	3	4	5
6) I guess I have faults, but there's nothing that I really need to change about my current job or lack of a job.	1	2	3	4	5
7) I thought once I had resolved the challenges in finding a job or staying employed I would be free of them, but sometimes I still find myself struggling these challenges.	1	2	3	4	5
8) I may have a problem with my job or lack of job and I think I should work on it.	1	2	3	4	5
9) I am really working hard to change my job or get a job.	1	2	3	4	5
10) I hope that someone will have some good advice for me about my job or finding a job.	1	2	3	4	5
11) Anyone can talk about changing their job or finding a job; I'm actually going to do something about it.	1	2	3	4	5
12) After all I had done to try and change my employment problem, every now and then it comes back to haunt me.	1	2	3	4	5

Client ID#_____
Date: _____/_____/_____
Assessment Point: _____

EACH STATEMENT BELOW DESCRIBES HOW A PERSON MIGHT FEEL WHEN APPROACHING PROBLEMS RELATED TO THEIR HOUSING. PLEASE INDICATE HOW MUCH YOU TEND TO AGREE OR DISAGREE WITH EACH STATEMENT. IN EACH CASE, MAKE YOUR CHOICE IN TERMS OF HOW YOU FEEL RIGHT NOW, NOT WHAT YOU HAVE FELT IN THE PAST OR WOULD LIKE TO FEEL.

THERE ARE FIVE POSSIBLE RESPONSES TO EACH OF THE ITEMS:
1=Strongly Disagree
2=Disagree
3=Undecided
4=Agree
5=Strongly Agree

INDICATE THE NUMBER THAT BEST DESCRIBES HOW MUCH YOU AGREE OR DISAGREE WITH EACH STATEMENT.

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1) It doesn't make much sense for me to consider changing where I live.	1	2	3	4	5
2) I've been thinking that I might want to change where I live.	1	2	3	4	5
3) At times the place I live causes problems and I'm determined to change it.	1	2	3	4	5
4) It is frustrating, but I feel like I face the same problems with housing over and over again.	1	2	3	4	5
5) Trying to change where I live is pretty much a waste of time for me.	1	2	3	4	5
6) I guess I have faults, but there's nothing that I really need to change about where I live.	1	2	3	4	5
7) I thought once I had resolved the problems with my housing I would be free of them, but sometimes I still find myself struggling these problems.	1	2	3	4	5
8) I may have a problem with where I live and I think I should work on it.	1	2	3	4	5
9) I am really working hard to change where I live.	1	2	3	4	5
10) I hope that someone will have some good advice for me about my housing situation.	1	2	3	4	5
11) Anyone can talk about changing where they live; I'm actually going to do something about it.	1	2	3	4	5
12) After all I had done to try and change my housing problem, every now and then it comes back to haunt me.	1	2	3	4	5

Employment Questionnaire (Spanish)/Housing Questionnaire (Spanish):

Client ID#_____
Date: _____/_____/_____
Assessment Point: _____

CADA ESTADO A CONTINUACIÓN DESCRIBE LA MANERA EN QUE UNA PERSONA PUEDE SENTIRSE AL ENCONTRAR PROBLEMAS RELACIONADOS CON SU EMPLEO. POR FAVOR, INDICAR CUÁNTO TENDE EN ACEPTAR O EN DESACUERDO CON CADA DECLARACIÓN. EN CADA CASO, HAGA SU ELECCIÓN EN TÉRMINOS DE CÓMO SE SIENTA AHORA MISMO, NO LO QUE HA SIDO EN EL PASADO O QUIERO SENTIRSE.

HAY CINCO POSIBLES RESPUESTAS A CADA UNO DE LOS ARTÍCULOS:
1 = Muy en desacuerdo
2 = en desacuerdo
3 = Indeciso
4 = de acuerdo
5 = Muy de acuerdo

INDICAR EL NÚMERO QUE MEJOR DESCRIBE EL ACUERDO O DESACUERDO CON CADA DECLARACIÓN.

1) No tiene mucho sentido para mí considerar cambiar mi trabajo o conseguir un trabajo. 1 2 3 4 5

2) He estado pensando que me gustaría cambiar algo sobre mi trabajo actual o conseguir un trabajo. 1 2 3 4 5

3) A veces mi trabajo actual o la falta de trabajo causa problemas y estoy decidido a cambiarlo. 1 2 3 4 5

4) Es frustrante, pero siento que enfrento los mismos problemas con mi trabajo o que obtengo un trabajo una y otra vez. 1 2 3 4 5

5) Tratar de cambiar mi trabajo actual o conseguir un trabajo es casi una pérdida de tiempo para mí. 1 2 3 4 5

6) Supongo que tengo fallas, pero no hay nada que deba cambiar en mi trabajo actual o en la falta de un trabajo. 1 2 3 4 5

7) Pensé que una vez que hubiera resuelto los desafíos para encontrar un empleo o mantenerme empleado, me liberaría de ellos, pero a veces todavía me encuentro luchando contra estos desafíos. 1 2 3 4 5

8) Es posible que tenga un problema con mi trabajo o la falta de trabajo y creo que debería trabajar en ello. 1 2 3 4 5

9) Realmente estoy trabajando duro para cambiar mi trabajo o conseguir un trabajo. 1 2 3 4 5

10) Espero que alguien me dé un buen consejo sobre mi trabajo o sobre cómo encontrar un trabajo. 1 2 3 4 5

11) Cualquiera puede hablar sobre cambiar su trabajo o encontrar un trabajo; En realidad voy a hacer algo al respecto. 1 2 3 4 5

12) Después de todo lo que había hecho para tratar de cambiar mi problema de empleo, de vez en cuando vuelve a atormentarme. 1 2 3 4 5

Client ID#_____
Date: _____/_____/_____
Assessment Point: _____

CADA ESTADO A CONTINUACIÓN DESCRIBE LA MANERA EN QUE UNA PERSONA PUEDE SENTIRSE AL ENCONTRAR PROBLEMAS RELACIONADOS CON SU VIVIENDA. POR FAVOR, INDICAR CUÁNTO TENDE EN ACEPTAR O EN DESACUERDO CON CADA DECLARACIÓN. EN CADA CASO, HAGA SU ELECCIÓN EN TÉRMINOS DE CÓMO SE SIENTA AHORA MISMO, NO LO QUE HA SIDO EN EL PASADO O QUIERO SENTIRSE.

HAY CINCO POSIBLES RESPUESTAS A CADA UNO DE LOS ARTÍCULOS:
1 = Muy en desacuerdo
2 = en desacuerdo
3 = Indeciso
4 = de acuerdo
5 = Muy de acuerdo

INDICAR EL NÚMERO QUE MEJOR DESCRIBE EL ACUERDO O DESACUERDO CON CADA DECLARACIÓN.

1) No tiene mucho sentido para mí considerar cambiar el lugar donde vivo. 1 2 3 4 5

2) He estado pensando que me gustaría cambiar el lugar donde vivo. 1 2 3 4 5

3) A veces el lugar donde vivo causa problemas y estoy decidido a cambiarlo. 1 2 3 4 5

4) Es frustrante, pero siento que me enfrento a los mismos problemas con la vivienda una y otra vez. 1 2 3 4 5

5) Tratar de cambiar el lugar donde vivo es una gran pérdida de tiempo para mí. 1 2 3 4 5

6) Supongo que tengo fallas, pero no hay nada que realmente deba cambiar acerca de dónde vivo. 1 2 3 4 5

7) Pensé que una vez que hubiera resuelto los problemas con mi vivienda, ya no estaría con ellos, pero a veces todavía me encuentro luchando contra estos problemas. 1 2 3 4 5

8) Es posible que tenga un problema con el lugar donde vivo y creo que debería trabajar en ello. 1 2 3 4 5

9) Estoy realmente trabajando duro para cambiar el lugar donde vivo. 1 2 3 4 5

10) Espero que alguien tenga un buen consejo para mí sobre mi situación de vivienda. 1 2 3 4 5

11) Cualquiera puede hablar de cambiar el lugar donde vive; En realidad voy a hacer algo al respecto. 1 2 3 4 5

12) Después de todo lo que había hecho para intentar cambiar mi problema de vivienda, de vez en cuando vuelve a atormentarme. 1 2 3 4 5

Local Evaluation Qualitative Interview Guide

Baseline Qualitative Interview Guide Questions (English; Also available is 12-month guide, and all Spanish guides):

PROJECT HEALTH
INDIVIDUAL INTERVIEW QUESTION GUIDE
v1.2 // 16 October 2018

NOTES TO INTERVIEWER

- Questions to be asked are **numbered in brackets** and appear in **Bold regular type.**
- Probes and clarifying questions are in plain text and indented with bullets.
- Instructions to the interviewer are in brackets.

THE GOALS OF THE INTERVIEW ARE:

a) To document the lived experience of clients enrolled in Project HEALTH prior to, and during the initial 60 days, of their enrollment in the program.
b) To elicit information that will help to construct a life history timeline for each client.
c) To explore lived experience of HIV diagnosis, disclosure, and experiences of HIV stigma (internalized or externalized).
d) To document the lived experience of mental and behavioral health issues in the client's life, including both substance use and mental illness.
e) To document the client's housing and employment history.
f) To document the client's interest in, and expectations of, the project HEALTH program.

INTERVIEWER SCRIPT TO BEGIN

[Please follow this script closely.]

Thank you very much for your participation in the Project HEALTH Evaluation. Your voice is very important in helping us understand this program and how it can benefit persons living with HIV.

Today we're going to have an interview that asks some questions that are similar to the survey you've taken, but today you'll be able to answer in your own words and tell your story. This helps us understand your personal experience in ways that we cannot learn from the survey. And today, our specific purpose will be to ask you to tell us about your life before you enrolled in Project HEALTH and during the first weeks of your participation in the program.

As we discussed in the consenting process when you enrolled in the evaluation study, we are audio-recording this interview, but everything you say will be confidential. We will have the interview transcribed—that is, typed up so we can read it—and that transcript will be identified only by your study ID. Thus your name will never be associated with this interview transcript. The program staff whom you see here will not have access to the contents of your interview transcript. We will ask the person transcribing the interview to change names that you mention to initials—like JS for John Smith. The audio recordings will be held in password protected file and destroyed after the program is finished.

Finally, it's important to know that the program evaluation is only about how the program works. We're not evaluating any persons—neither staff nor clients. Our only goal is to gain an accurate picture of the program and how it works, so that we can help it reach more and more people who could benefit from it.

Do you have any questions for me before we begin?

[Answer the respondent's questions, then begin.]

[Be sure to test the audio recording device to check input levels and output volume.]

SECTION 1. PERSONAL BACKGROUND

NOTES AND TIME STAMPS

[1] Where were you born and raised?

[Use this section to establish the client's backstory and allow them to ease into the interview by telling us where they're from and how they got to New York City.]

Probing and clarifying questions:

- Try to follow-up in ways that will trace their steps to New York.
- Ask, "So what happened next?" or "Where did you go next?" after the person completes a description of the episode.
- Look for "adverse childhood events" (ACES) that could help establish a history of trauma, abuse, or any form of victimization. Try to get details on these events (what, when, where, who) but take care to gauge the client's emotions. Have tissues ready. Let them stop, breathe, turn off the recording if needed.
- If they are from NYC explore their life here, movements away from the city, around the boroughs, experiences of life here as an adolescent.

[As you establish personal history you will learn about family. That will be the next section. you may also learn about sexual orientation, experiences coming out, and HIV diagnosis and disclosure. Ask those questions from the other sections when appropriate.]

[2] Can you tell us about the home you grew up in?

[Through this question and follow-ups try to get the shape of family structure, which you'll return to in Section 4.]

Probing and clarifying questions:

- Was this your parents' home?
- Did your parents live together?
- When did they split up?
- Who were your main caretakers or grown-ups who looked after you as a child?

[3] When did you leave the home you grew up in?

Probing and clarifying questions:

- Leave once and for all? For school? Military service? Other reasons?
- Return? Go back and forth?
- Live with friends?
- Have own apartment? Lease?
- How did you earn income to pay for yourself on your own?
- Age?

SECTION 2. HOUSING

NOTES AND TIME STAMPS

Preamble: As you know, Project HEALTH is about helping you improve your housing and employment, so we'd like to ask a few questions about your experiences with these things. Let's start with housing.

[4] What kind of housing do you have now?

[4a] How long have you lived there?

Probing and clarifying questions:

- Where?
- How did you come to live there?
- Is there a specific reason you are living there now?
- Establish what kind of housing: SRO, shelter, friend's place, how stable or unstable.
- If SRO or other housing with supportive services, ask what services were there and what the client used.
- Ask what issues seem to explain the client's experiences with housing.
- You might have to make a brief chain of housing experiences in the notes column.

[4b] Over the past three years where have you lived? [Always follow up with] And how long were you there?

Probing and clarifying questions:

- Where?
- Why did you move in there?
- If SRO or other housing with supportive services, ask what services were there and what the client used.
- Did you live with others? Who were they?
- Were you on your own?
- Why did you leave there?

[5] Depending on the foregoing answers, EITHER:

[5a] It sounds like you've some specific issues with housing [LIST what they talked about above, reasons why they had to move or stay in a particular kind of residence]. Are these issues things that keep coming up for you?

OR

NOTES AND TIME STAMPS

[5b] Is the first time you've had these sorts of issues with housing?

Whether 5a or 5b: Probing and clarifying questions:

- Ask questions to reconstruct how they began to have problems with housing.
- Alone or in a family
- Why did you lose your housing?
- Why did seeking a place to live, or staying housed, become a problem?
- What caused you to move out?

[6] Have you ever had these kinds of experiences: [follow the list below, take YES/NO, and then follow up] What was the experience like?

- **Ever evicted? What was the experience like?**
- **Have experience with housing courts? What was it like?**
- **NYCHA? What was the experience like?**
- **HASA? What was the experience like?**
- **Section 8 vouchers? What was the experience like?**
- **Group residence? (Sometimes called "congregate living") What was the experience like?**
- **SROs? What was the experience like?**

[7] Where do you go when you have no place to stay?

[8] How have you looked for housing in the past?

- Where did you look?
  - Newspaper?
  - Craigslist?
  - Ask friends?
  - other sources?

[9] Do you have:

- **A bank account?**
- **Utilities records?**
- **Other evidence of living in a place?**
- **A lease?**

[10] How do you think the Project HEALTH can help you with housing?

Probing and clarifying questions:

- How would this help address the challenges we've been talking about?

NOTES AND TIME STAMPS

SECTION 3. EMPLOYMENT

[11] Do you have a job right now? [Y/N leads down different probing paths.]

Probing and clarifying questions, IF YES:

- Where do you work?
- How long there?
- Full time/part time? Temporary/seasonal/permanent position?
- What do you do?
- Are you satisfied? Why?
- Does it provide enough income to meet your needs?
- What would you like to change?

Probing and clarifying questions, IF NO:

- Are you looking work? How's that going?
- How long have you been looking?
- Is this your first time looking for a job?
- Do you have a résumé? Cover letter?
- Have you been interviewed for jobs? What was the result?
- What kinds of problems have you experienced looking for work?
- Is this the first time you've had these kind of problems finding work? Ask them to explain or provide examples.

[12] Where have you worked over the last three years?

Probing and clarifying questions:

- Try to construct a timeline of past work and intervals out of work.
- What kind of problems have you had finding work?
- Have you had difficulties staying employed at the same job?
- What were those difficulties?

[13] What have you done to get by, or to get cash, when you haven't had a job?

[14] How do you think that Project HEALTH can help you with finding a job [or finding another job]?

Probing and clarifying questions:

- How would this help address the challenges we've been talking about?

NOTES AND TIME STAMPS

SECTION 4. LIVING WITH HIV, MENTAL HEALTH, AND SUBSTANCE USE

In the next section we will explore more closely your experience HIV, medical care, any mental health issues you might talk about, and substance use.

[15] When were you diagnosed with HIV?

Probing and clarifying questions:

- Newly positive: help them tell the story of why they tested now, motivation, feelings about the result.
- Previously positive: construct a timeline and ask if they have had HIV medical treatment. Establish a timeline of episodes of engagement and periods out of care.

[16] Did you tell anyone about your HIV status after diagnosis?

Probing and clarifying questions:

- Who? When? Establish a timeline to disclosure and explore episodes of isolation.
- Who was the first person you told about your HIV status?
- Was it hard to do?
- Did you ever feel any shame or embarrassment about being HIV-positive?
- Are there specific people you do not tell about your status? Are they different from the people you've disclosed to?
- Does your HIV status have any effect on your housing or employment? On the issues we've been talking about? Elicit examples.
  - Lost housing?
  - Lost job?
  - Treated differently by colleagues

[17] Have you ever seen a medical provider for HIV care?

Probing and clarifying questions:

- If very recent—is seeing that provider part of this program for you? Project HEALTH?
- If more than 6 months ago, try to establish the history of HIV care—when first engaged, fall out of care, why fell out of care, when re-engaged, why re-engaged …
- How frequently do you see the HIV provider? Doctor or other professional? [Find out title –PA, NP, etc.]
- If NO—ask if they've been set up with a provider in Project HEALTH.

[18] If seeing a HIV provider: Are you taking HIV medications?

Probing and clarifying questions:

- Name of medication and how often they take.

NOTES AND TIME STAMPS

- Is it hard to remember to take it?
- Do you have any systems or things you do to help you remember to take your medications?
- *If they were in care before and stopped meds: Refer back and then ask:* Are you worried about stopping your meds again, like you did last time?

NOTES AND TIME STAMPS

[19] Have you had "coordinated care" before?

Probing and clarifying questions:

- Have you begun coordinated care in this program yet?
- What do you expect from coordinated care with Project Health?

[20] Do you have anyone who helps you keep your medical appointments and take meds?

Probing and clarifying questions:

- Who, relationship—refer back to previous mentions of friends and family. Do they help you at all?
- What about peer navigators or people employed here or other agencies that help clients stay involved in their medical care?

[21] Are there other things you do to stay healthy besides doctors and medical professionals?

Probing and clarifying questions:

- Things like exercise, eating healthy, special diets, non-traditional medicine, alternative medicine, meditation, etc.
- How or why did you start doing these things?
- How does this benefit you?

[22] Do you have any history of mental health concerns or substance use?

Probing and clarifying questions:

- If YES, as "What were your experiences?"
- Ask about mental health first, substance use next.
- If the respondent says "self-medicating" with regard to substance use, ask: What does it mean to "self-medicate?" Play "dumb;" we want the respondent to tell us in their own words what self-medicating is.
- Did self-medicating help?
- Did you stop using substances? Explore stories of recovery and relapse.
- These mental health issues—have they stayed with you? Do you still get …?
- Did mental health issues [name what they've said if possible] ever prevent you from working? Staying housed? Keep up you HIV medical care and treatment?

NOTES AND TIME STAMPS

SECTION 5. SOCIAL AND FAMILY SUPPORT

[By this point you might have a lot information on family and friends, so you can start referring back to earlier pieces of the interview to fill in facts.]

Now we're going to start the last section, talking about family and friends and the kind of support you might (or might not) receive from them. You've talked a lot about family and friends already, but we want to make sure to fill in the blanks.

[23] Do you ever talk to anyone else about the things we've been talking about?

Probing and clarifying questions:

- Who are they? [Elicit a list and then determine who are friends and who are family.]
- What kinds of things related to housing or employment do you talk to them about?
- What other things do you talk to them about?
- Do you consider these persons or relationships to be supportive for you?
- Do they provide advice or help you solve problems?

[24] Are you close to your family?

Probing and clarifying questions:

- How frequently do you see them?
- If a family member was on list of people they talk to about these issues [Question 22]—so you said you talk to your [family member] about the kinds of issues we're talking about, but what about the others?
- Are there family members with whom you do not speak about HIV? Who don't know your status?
- Is anyone else in your family HIV-positive?
- Do you ever experience feelings of stigma or shame around them for any reason? THEN: What are those reasons?
- Make a list of family: verify mother and frequency of contact, father, siblings, cousins, grandparents, godparents, anyone else.

[25] Considering your friends [refer back to ones they talked about, if possible]—how many people would you call your "close" friends? How about "medium" sort of friends, not so close, but well-acquainted.

Probing and clarifying questions:

- Get the #'s from the respondent then fill in how strong the relationships.
- How frequently do you see them?
- If a friend was on list of people they talk to about these issues [Question 22]—so you said you talk to your [friend] about the kinds of issues we're talking about, but what about the others?

- Are there friends with whom you do not speak about HIV? Who don't know your status?
- Do you have close friends who are also HIV-positive?
- Do you ever experience feelings of stigma or shame around them for any reason? THEN: What are those reasons?
- Make a list of friends orally—you're verifying things they've said earlier for the recording: frequency of contact, who they are, and where they are.

[26] Do you ever get help from your friends or family related to the things you talked about with housing or employment, or with HIV and medical issues?

Probing and clarifying questions:

- How do they help?
- Can you stay with your friends or family when you need some place to live?
    - Who?

SECTION 6. CLOSING

[27] Is there anything you would like to add that I've not asked you about? Anything else you want make sure that we know?

[28] Do you think it would be helpful to be able to talk to someone about the things we've been discussing?

NOTES AND TIME STAMPS

Appendix D: Protocols

Mental Health Protocol

SPNS Mental Health Protocol

Purpose:

The purpose of this document is to respond to incidents where evaluation staff may encounter situations where a client may require escalated mental health intervention.

People:

The staff involved in the documentation process are:

Alexa Kreisberg – Senior Director of Analytics and Evaluation

John Guidry – Lead Evaluator

Shivang Shah – Evaluator

Daniela Solis – Research Assistant

Julean DeJesus – Research Assistant

Maria Eva Dorigo – Research Assistant

Kristobal Kipper Sanchez- Managing Director of Mental Health Services

Training Requirements:

All staff in the Analytics & Evaluation Department who will be conducting data collection through surveys and qualitative interviews have received training in Mental Health First Aid (MHFA), and Trauma-Informed Care (TIC) as a supplement to this protocol.

Procedures:

Steps of Internal Referral:

1. Encounter a client in distress and determine if they need someone to remain in the room with them or if they can be asked to wait while staff gets Mental health services personnel.
    a. If the client requires a person to remain in the room with them contact another evaluation team member or directly contact the crisis hotline (ext 1300) or the mental health clinic (ext 1225)
    b. If the client can be left calmly in the room step out and calmly and quietly contact the mental health clinic (ext 1225)
2. Once assistance is confirmed to be on its way, utilize the MHFA training to take control of the situation and remain with client until mental health services arrives to assist the client.
3. Mental Health Services will assess the client. Client will then be screened for eligibility in GMHC mental health services programs.
    a. If eligible mental health services will complete a program intake with the client
    b. If the client is not eligible at the agency, they will be given emergency intervention, and if needed, will be referred to alternative mental health service providers. (follow-up by the client's case manager will follow to confirm complete referral and receipt of services.)
4. Once the client is comfortable with the mental health intervention provided and the client expresses a desire to continue with the evaluation:
    a. the client should fill out a HIPAA release form (DOH5032) for mental health data.
        i. Staff will contact mental health services and confirm that continued participation would not be detrimental to the client nor those around them.
            1. Evaluation or Case Management Staff will utilize the supplementary "Mental Health Case Management Consent Form" to have mental health provider notes on file as a follow-up to incident reports if continue participation is requested.
    b. If they do not express a desire, but the evaluation team would like to ask the client to continue with the evaluation, they must FIRST fill out a HIPAA release form (DOH5032) with the client, and subsequently contact or have their case manager case conference with mental health services or their external mental health provider and confirm that continued participation would not be detrimental to the client nor those around them.
        i. Evaluation or Case Management Staff will utilize the supplementary "Mental Health Case Management Consent Form" to have mental health provider notes on file as a follow-up to incident reports if continue participation is requested.
        ii. Then, an evaluation team member may contact the client to ask if they would like to continue with the evaluation
            1. If the client does not wish to continue, they should be withdrawn from the evaluation.
            2. If they do wish to continue, then evaluation activities continue as normal, but with the understanding of previously identified trauma and triggers.
5. At this point, if the client is approved to continue by mental health services a time could be set to complete the survey and enrollment can continue normally. If the mental health services provider(s) advise(s) against their continued participation the client should be withdrawn from the study.

Appendix

Contacting Mental Health Services:

"Hello this is (your name), with [name of program]. I am calling regarding [client's name]. This client was seen by you following a survey on [date of incident]. The visit was in response to an incident triggered during [name of program] evaluation activities [at GMHC] (if the client received mental health services at a different organization). The client has expressed a desire to continue in the evaluation. (or – We would like to ask the client if they have a desire to continue in the evaluation.) Before we can re-engage the client in the evaluation, we would need to confirm with you that this would be in their best interest."

Chart Review Checklist Protocol:

Purpose:

The purpose of this document is to organize chart information for all clients of a SPNS demonstration project at Gay Men's Health Crisis (GMHC) called Project HEALTH. Project HEALTH is a program that seeks to improve the health of persons who are living with HIV by coordinating their medical care and services. The special aim of Project HEALTH is to provide support to clients who are unstably housed and either un-employed or employed in a job that does not take full advantage of their skills. The evaluation process includes keeping physical copies of various documents which include 1. Consent Documents; 2. Waivers of Compensation; 3. HIPAA Release Consents; 4. HIV/CD4 information including lab results, diagnosis dates, and evidence of HIV primary care visits; 5. Evidence of antiretroviral therapy prescriptions/refills; 6. Hepatitis C tests, positive results if they exist, and subsequent treatment information; 7. Mental Health/Substance Use Condition Diagnoses; 8. Emergency Room Visits; 9. Hospitalizations; 10. Opportunistic Infections.

People:

The staff involved in the documentation process are:

Alexa Kreisberg – Director of Analytics and Evaluation

John Guidry – Lead Evaluator

Shivang Shah – Evaluator

Daniela Solis – Research Assistant

Julean DeJesus – Research Assistant

Maria Eva Dorigo – Research Assistant

Procedures:

Steps of Chart Review Check:

1. Have the evaluator pull a chart from the locked file cabinet designated for Project HEALTH charts and have it ready to review and note the study ID on the folder. If this is a new client enrolled into the study, have a new folder ready and labeled with all documentation provided at the initial evaluation study session.
2. Open BU SPNS Website (BEDAC) and note the client information
3. Open TREAT (GMHC EHR) and search the client
4. Navigate to 'External Documents' for the client once selected and print medical documentation as is available for the client that does not match any documentation that has been previously printed and placed into the chart (note, Mental Health and Substance Use information will not be available, so this must be requested directly from the Mental Health/Substance Use department.)
5. Print a chart review checklist document and open the client folder with the printed TREAT information.
6. Proceed down the checklist from section 1, Survey Consent, to section 11, self-reports. Note the color code and documentation standards on page markers in the section entitled 'Documentation Standards' below.
7. Once all sections are complete, proceed to the document noted as 'Review' and fill out your First Name and Last Name in 1 box under the 'First Reviewer' column. Proceed to the adjacent box in the same row and place your initials in the box under the 'Initials' column. Follow this by writing the date of review in the box under the 'Date' column, and then include a brief description of what was updated in the box under the 'What Was Updated' column.
8. Pass the reviewed client chart to the Evaluator or 'Second Reviewer' to conduct a Mock Chart Review as detailed below in the section 'Mock Review' and then fill in the First and Last Name in the box under the 'Second Reviewer' column, followed by Initials and Date.
9. Once there is a signature by the Second Reviewer, the chart review is complete as it stands until new information is added to the client's chart. Complete a review for each time period (6 Months, 12 Months, 18 Months, and 24 Months.)
10. The evaluator is to place the client's chart back into the locked file cabinet designated for Project HEALTH charts.

Documentation Standards:

Page Marker Color Convention:

1. Consent Documents - Red
2. Waiver(s) of Compensation – Light Pink
3. HIPAA Release Consent(s) – Orange
4. Chart Review HIV/CD4 – Yellow
5. Prescription/Refill – Forest Green
6. Hepatitis C – Neon Green
7. Mental Health/Substance Use – Blue
8. Emergency Room Visits – Purple
9. Hospitalizations – Hot Pink
10. Opportunistic Infections – Magenta
11. Self-Report – No color (There are no documentation requirements, but this is helpful for other considerations as noted below.)

Self-Report:

The self-report section is a hand-written page of notes that mention whether something was self-reported such as mental health/substance use information. If self-reported information is not supplemented with data, due diligence is required to attempt to obtain the data. (e.g. if the client self-reports mental health/substance use services at the agency, request the information from the department according to official policy as that information is not readily available to all staff.)

TREAT Place-Holder:

The purpose of the TREAT place-holder is to point to items available on the TREAT (EHR) but not printed and placed directly into the physical chart for a Project HEALTH client. The place-holder document

should detail the exact location the information can be found for easy access during a Mock or Formal Chart Review Audit. An example is detailed below:

Project HEALTH Chart Checklist

The following document is found on TREAT and this document holds its place in the chart:

HIV Diagnosis Date on 11/13/2018 Found under central intake on 11/13/2019 under the medical information section.

(Description of information on TREAT and the value(s) associated)

Shivang Shah		11/13/2019
(First Name Last Name)	(Signature)	(Date)

Once the document is properly filled out, the person filling in the document must also print and sign the document before placing it into a client's physical chart.

Page Marker Written Documentation Standards:

1. Consent Document(s)
   a. Survey Consent = "Survey"
   b. Local Interview Consent and Guide Baseline = "Local Interview (Baseline)"
   c. Local Interview Consent and Guide Post = "Local Interview (Post)"
   d. BU Interview Consent and Guide = "BU Interview"
2. Waiver(s) of Compensation
   a. Survey Waiver of Compensation = "Survey Waiver"
   b. Local Interview Waiver of Compensation = "Local Interview Waiver"
   c. BU Interview Waiver of Compensation = "BU Interview Waiver"
3. HIPAA Release Consent(s) = "HIPAA"
4. Chart Review HIV/CD4
   a. HIV Diagnosis Date = "HIV Diagnosis"
   b. Perinatally Infected = "Perinatal Infection"
   c. AIDS Diagnosis = "AIDS Diagnosis"
   d. Date of last HIV primary care visit BEFORE enrollment = "HIV Visit Before"
   e. Date of last CD4 BEFORE enrollment = "CD4 Before"
   f. Date of first CD4 test in 6 MONTH chart review period = "CD4 6 Month (1)" (continue this way for g-u if available (2), (3), (4) and other chart review periods; 12 Month, 18 Month, and 24 Month.)
   v. Date of last Viral Load BEFORE enrollment = "Viral Load Before"
   w. Date of first Viral Load test in 6 MONTH chart review period = "Viral Load 6 Month (1)" (continue this way for x-ll if available (2), (3), (4) and other chart review periods; 12 Month, 18 Month, and 24 Month.)
   mm. Primary Care Visits in 6 MONTH chart review period = "HIV Visit 6 Months (1)" (continue this way for nn-pp (2), (3), (4) and other chart review periods; 12 Month, 18 Month, and 24 Month.)
5. Prescription/Refill
   a. New Prescription/refill in 6 MONTH chart review period = "Prescription/Refill 6 Month" (continue this way for b-d for other chart review periods; 12 Month, 18 Months, 24 Months.)
6. Hepatitis C
   a. Last screen date (at 6 MONTH chart review) = "Hep C Screen 6 Month" (continue this way for other chart review periods f, k, p; 12 Month, 18 Month, and 24 Month.)
   b. History of Hepatitis C – Diagnosis Date (at 6 MONTH chart review) = "Hep C Diagnosis 6 Month" (continue this way for subsequent chart review periods; 12 Month, 18 Month, and 24 Month)
   c. Treated for Hepatitis C (at 6 MONTH chart review)
      i. Medication = "Hep C Meds" (continue this way for subsequent chart review periods; 12 Month, 18 Month, and 24 Month)
   d. Attain SCR (HCV viral load undetectable) 3+ months post treatment (at 6 **MONTH** chart review)
      i. Date attained SCR = "Hep C SCR 6 Month" (continue this way for subsequent chart review periods; 12 Month, 18 Month, and 24 Month)
   e. Spontaneously clear infection without treatment (at 6 MONTH chart review)
      i. Date of confirmation = "Hep C No Meds 6 Month" (continue this way for subsequent chart review periods; 12 Month, 18 Month, and 24 Month)
7. Mental Health/Substance Use
   a. Has the client been diagnosed with a Mental Health Condition?
      i. Diagnosis 1 (EVER) = "MH Diagnosis (1)" (continue this way if available (2), (3), and for subsequent chart review periods; 6 Month, 12 Month, 18 Month, and 24 Month)
   b. Internal Referrals – Mental Health
      i. In 6 MONTH chart review period = "MH Ref to Treatment" (continue this way for subsequent chart review periods; 12 Month, 18 Month, and 24 Month)
         1. Attended appointments = "MH Appointments" (continue this way for subsequent chart review periods; 12 Month, 18 Month, and 24 Month)
   c. External Referrals – Mental Health
      i. In 6 MONTH chart review period = "MH Ref to Treatment" (continue this way for subsequent chart review periods; 12 Month, 18 Month, and 24 Month)
         1. Attended appointments = "MH Appointments" (continue this way for subsequent chart review periods; 12 Month, 18 Month, and 24 Month)
   d. Has the client been diagnosed with a Substance Use disorder?
      i. Diagnosis 1 (EVER) = "SU Diagnosis (1)" (continue this way if available (2), (3), and for subsequent chart review periods; 6 Month, 12 Month, 18 Month, and 24 Month)
   e. Internal Referrals – Substance Use
      i. In 6 MONTH chart review period = "SU Ref to Treatment" (continue this way for subsequent chart review periods; 12 Month, 18 Month, and 24 Month)
         1. Attended appointments = "SU Appointments" (continue this way for subsequent chart review periods; 12 Month, 18 Month, and 24 Month)
   f. External Referrals – Substance Use
      i. In 6 MONTH chart review period = "SU Ref to Treatment" (continue this way for subsequent chart review periods; 12 Month, 18 Month, and 24 Month)
         1. Attended appointments = "SU Appointments" (continue this way for subsequent chart review periods; 12 Month, 18 Month, and 24 Month)
8. Emergency Room Visits
   a. Emergency Room Visits BEFORE enrollment (up to 12 months prior) = "ER Before enrollment (1)" (continue this way if available (2), (3), (4) and for subsequent chart review periods; 6 Month, 12 Month, 18 Month, and 24 Month)
9. Hospitalizations
   a. Hospitalizations BEFORE enrollment (up to 12 months prior) = "ER Before enrollment (1)" (continue this way if available (2), (3), (4) and for subsequent chart review periods; 6 Month, 12 Month, 18 Month, and 24 Month)
10. Opportunistic Infections
    a. Opportunistic Infections in 6 MONTH chart review period = "Opportunistic 6 Month (1)" (continue this way if available (2), (3), (4) and for subsequent chart review periods; 6 Month, 12 Month, 18 Month, and 24 Month)
11. Self-Reports – No color (There are no documentation requirements, but this is helpful for other considerations as noted above.)