PRC Housing Planning Program Manual

THE HIV, HOUSING, & EMPLOYMENT PROJECT

Acknowledgments

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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 Housing Planning Program intervention was implemented by PRC, a Ryan White HIV/AIDS Program Parts A and B recipient based in San Francisco.

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Housing Planning Program

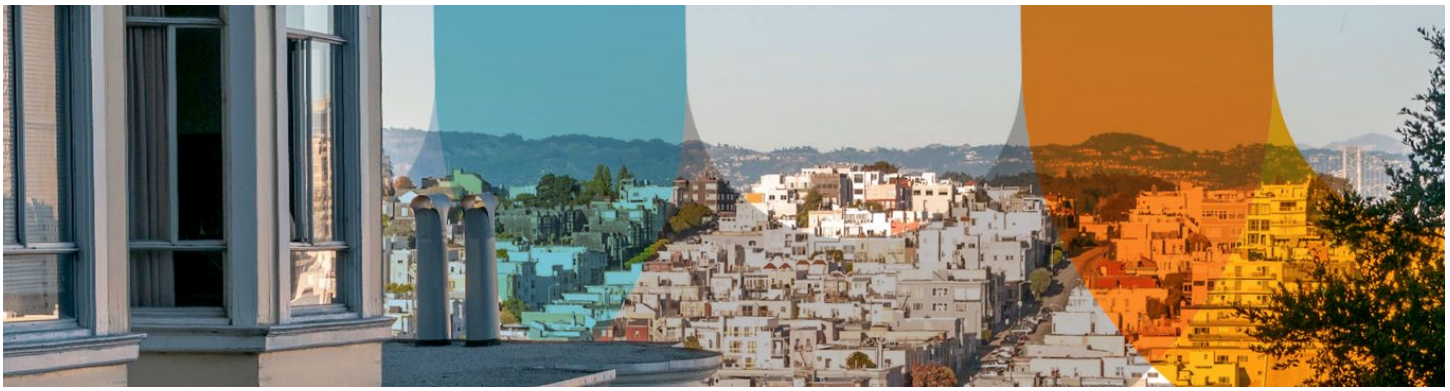
In 2017, PRC was selected as one of 10 demonstration sites for the Health Resources and Services Administration, Special Projects of National Significance Initiative, "Improving HIV Health Outcomes through the Coordination of Supportive Employment and Housing Services" (SPNS initiative). The purpose of this three-year initiative was to support the design, implementation, and evaluation of innovative interventions that coordinate HIV treatment, housing, and employment services to improve HIV health outcomes for low-income, uninsured, and underinsured people with HIV in racial and ethnic minority communities.

PRC's intervention selected for the SPNS initiative—the **Housing Planning Program (HPP)**—focuses on coordinating primary care, housing, and employment services in racial/ethnic minority communities in San Francisco by increasing collaborative efforts between PRC, local Housing Opportunities for People with AIDS (HOPWA)-funded providers, HIV primary care clinics, and other community partners.

This manual is the culmination of PRC's intervention and provides a detailed description of intervention methodology, implementation, outcomes and lessons learned. The purpose of this manual is to help other social services providers replicate intervention programs in their own communities.

Contents are designed specifically for social services providers including non-profits, social services agencies, local government departments, faith-based service providers, and other organizations working to end homelessness and improve health and wellness for people with HIV.

PRC thanks all the clients, staff, partners, technical assistance providers, and funder that participated in and supported this initiative.



Background and Intervention Overview

PRC and Partners

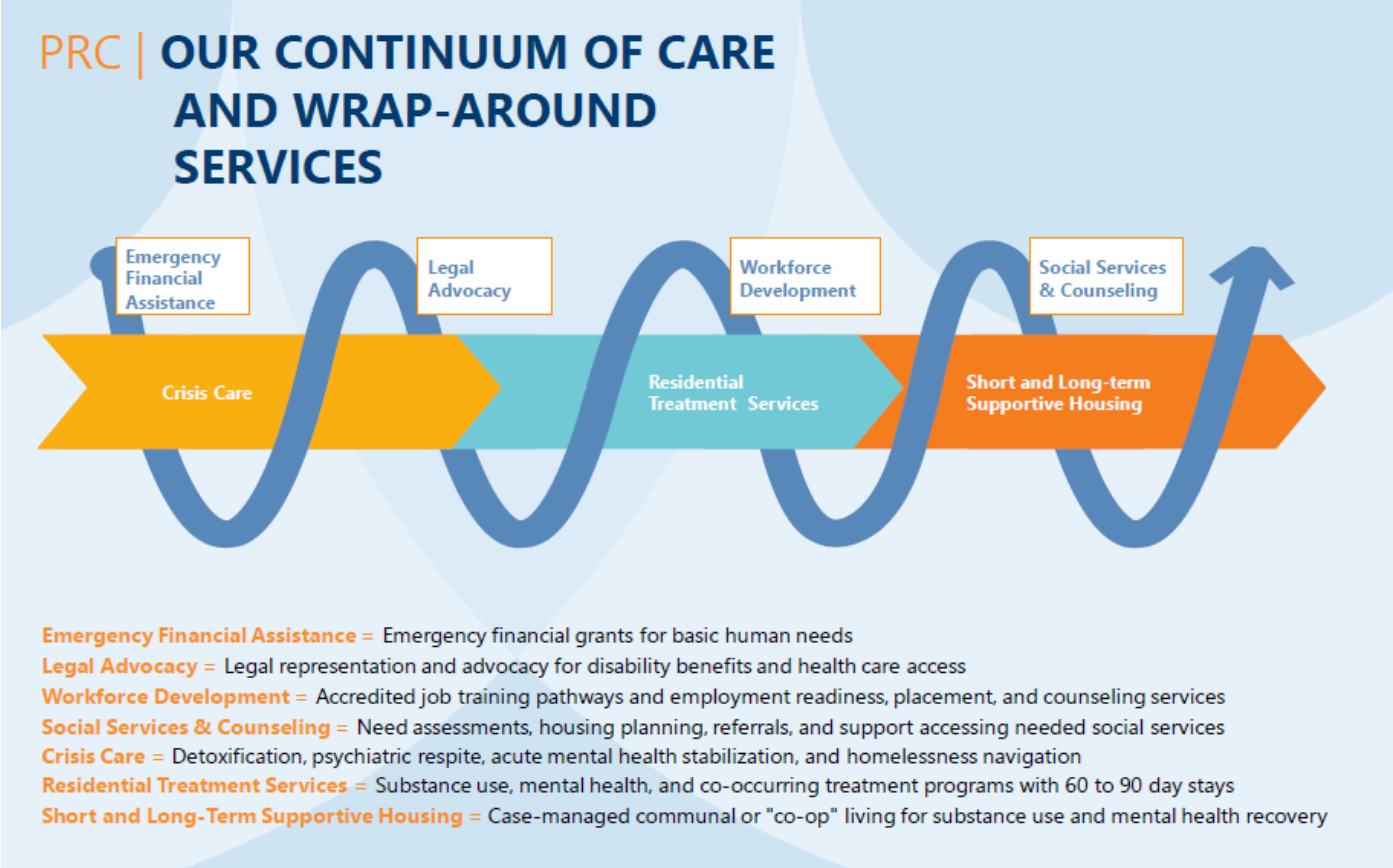
PRC is a multi-disciplinary social services organization with the mission to help people affected by HIV/AIDS, substance use, or mental health issues better realize opportunities by providing integrated legal, social, and health services that address the broad range of social risk factors that impact wellness and limit potential. PRC has a 30+ year history of serving the San Francisco community and reaches nearly 5,600 individuals annually.

PRC's continuum of services delivers evidence-based, wrap-around supports that move the most high-risk, marginalized individuals forward on a path toward long-term stability and success—effectively preventing and reducing homelessness, improving public health, and enhancing the local workforce.

Services span substance use and mental health residential treatment and supportive housing programs; emergency financial assistance for short-term stability; legal advocacy for access to necessary income and healthcare benefits for mid-term security; and workforce development for sustained social and economic rehabilitation.

Continuum of Services

- Residential Treatment and Supportive Housing
- Emergency Financial Assistance
- Legal Advocacy
- Workforce Development



Residential Treatment and Supportive Housing provides substance use and mental health treatment programs through twelve residential sites (encompassing 287 beds in total) located throughout San Francisco. Treatment programs range from crisis intervention to long-term supportive housing and reach 10 percent of San Francisco's homeless population annually.

Emergency Financial Services provides short-term financial assistance to low-income people with HIV to help pay for housing costs, medical expenses, utility bills, move-in costs, or costs to prevent eviction.

Legal Advocacy provides benefits counseling and legal representation on Social Security disability and healthcare matters. Services are provided by a team of attorneys and legal professionals through a harm reduction model.

Workforce Development provides individualized supportive services for people with disabilities to pursue vocational interests through career exploration, training, education, and job search. PRC's Workforce Development program is the longest standing program designed to work with people with HIV, and the only CARF-accredited vocational rehabilitation program specifically for people with HIV in the country.

All of PRC's non-clinical social services are provided at its integrated service center conveniently located in the South of Market neighborhood. Many clients live in this area and the majority of San Francisco's homeless population spends time in this neighborhood. The service center serves as PRC's administrative hub as well as a single-stop location where clients may access a full-range of services. The service center is located within two blocks of major transit systems and is easily accessible to the public.

Partners

In order to achieve the objectives of the SPNS initiative, PRC partnered with key external organizations and internal agency programs to reach target populations and create a network of support to minimize individuals lost to follow-up. Key partners include:

Lutheran Social Services of Northern California (LSS)

LSS's mission is to promote stability and honor the dignity of those they serve by providing supportive housing services that lead to self-sufficiency. For this intervention, HPP partnered with LSS's Forensic Housing Program, which provides emergency housing to homeless people with HIV upon release from jail or prison. The program operates out of a residential hotel in San Francisco and provides housing for up to 18 months. The longer-term objective of the program is to help people access safe, decent, and affordable permanent housing.

University of California at San Francisco, Positive Health Program (Ward 86)

Ward 86 is an internationally recognized global leader in HIV clinical care, research, and education. Ward 86 provides inter-professional, life-sustaining services including primary medical care, HIV specialty care, urgent care, mental health and substance use support, clinical pharmacy services, social work services, and case management.

PRC Ferguson Place

Ferguson Place is a 12-bed, residential treatment program for San Francisco adults with co-occurring conditions of substance use disorder, mental health disorder, and HIV/AIDS. This multi-phased program is based on a social rehabilitation model that uses the principles of harm reduction and recovery. The model uses peer and community support to enhance self-esteem, community participation, self-determination and the supports necessary to determine and follow a path toward a more sober lifestyle.

Description of Need in San Francisco

San Francisco is experiencing rapidly increasingly rates of homelessness and a striking lack of permanent housing for people with HIV. In San Francisco, people with HIV have lower incomes, are more likely to be unemployed, and are more likely to experience homelessness than the general population. In 2019, there were 8,035 people experiencing homelessness in San Francisco, a 17 percent increase since 2017. Of these, seven percent reported an HIV-related illness.[1] Furthermore, social determinants of health such as homelessness and unemployment drastically interfere with the ability and motivation to remain responsive and retained in HIV care. In recent years, the proportion of new diagnoses among persons experiencing homelessness increased from 11 percent in 2016 to 18 percent in 2019.[2] In addition, 78 percent of people with HIV in San Francisco are at risk of homelessness based on being low income (at or below 50 percent of Area Median Income) and not receiving any housing support.

HIV/AIDS and poverty are closely correlated, as studies show up to 45 percent of people with HIV are unemployed.[3] African Americans have the highest rates of HIV diagnoses in San Francisco, followed by Latinx men and women.[4] These groups also have the highest poverty rates – 24.5 percent for African Americans and 14 percent for Latinxs, compared with 12.5 percent in the general population.[5] In 2017-2018, HIV diagnosis rates were higher among people who live in areas that have a higher percentage of people below the federal poverty level, a higher percentage with less than a high school education, and a lower median household income.[6] A lack of socioeconomic resources is linked to the practice of riskier health behaviors, which can lead to higher rates of HIV transmission. To compound these social determinants for people with HIV, San Francisco rents are the highest in the country.

Prior to the launch of HPP, PRC also conducted an independent investigation to understand what long-term housing and employment services were available to people with HIV residing in treatment facilities and HOPWA funded housing. After conducting interviews with staff at several housing sites, PRC learned that many sites did not have resources dedicated to client discharge planning focused on long-term housing placement or career preparation. It also became evident that there was no centralized location or agency

[1]Applied Survey Research. (2019). San Francisco Homeless Count and Survey Comprehensive Report 2019. Retrieved from https://hsh.sfgov.org/wp-content/uploads/2020/01/2019HIRDReport_SanFrancisco_FinalDraft-1.pdf
[2] San Francisco Department of Public Health. (2019). HIV Epidemiology Annual Report 2019. Retrieved from https://www.sfdph.org/dph/files/reports/RptsHIVAIDS/AnnualReport2019_Indigo_20200929_Web_fixed.pdf
[3] American Psychological Association. (2020). HIV/AIDS and Socioeconomic Status. Retrieved from https://www.apa.org/pi/ses/resources/publications/hiv-aids
[4] San Francisco Department of Public Health. (2019). HIV Epidemiology Annual Report 2019. Retrieved from https://www.sfdph.org/dph/files/reports/RptsHIVAIDS/AnnualReport2019_Indigo_20200929_Web_fixed.pdf
[5] San Francisco Department of Public Health. (2012). Community Health Status Assessment. Retrieved from https://www.sfdph.org/dph/files/chip/CommunityHealthStatusAssessment.pdf
[6] San Francisco Department of Public Health. (2019). HIV Epidemiology Annual Report 2019. Retrieved from https://www.sfdph.org/dph/files/reports/RptsHIVAIDS/AnnualReport2019_Indigo_20200929_Web_fixed.pdf

that offered long-term housing planning. The need for these services was clearly evident, and PRC could fill these service gaps with HPP.

Description of Intervention

PRC's intervention design is based on the social determinants of health paradigm, which theorizes that improvements in social determinants of health will improve health outcomes. While PRC's intervention involves various social determinants, the primary focuses of the intervention are housing and employment.

PRC's intervention services are provided through the Housing Planning Program (HPP)
HPP provides intensive housing counseling for people with HIV that are homeless or in unstable, time-limited transitional housing programs, with the goal of securing stable housing upon exit. HPP supports people with HIV in pursuing employment and income options, and prepares them to transition into stable housing and maintain HIV treatment upon existing their current housing.

The program is staffed by a team of one-and-a-half full-time Integrative Health Analysts ("interventionists"), one Data Analyst/Intaker, and a Project Director. Interventionists provide services through a case management model that coordinates and links clients to healthcare, housing, and employment resources. In addition to coordination and linkage, interventionists help clients with activities such as searching for housing, completing housing applications, and supporting clients to maintain housing once achieved. Upon enrollment in HPP, interventionists promptly link clients to PRC's in-house Workforce Development program for support with entering the workforce, pursuing educational interests, and/or developing new skills to increase earning potential. On-going intervention services are provided for 12 months to help secure permanent housing, maintain consistent access to HIV treatment, and support engagement with employment services.

Goals and Objectives

Intervention Goal

Improve HIV health outcomes for racial and ethnic minority populations that are un- or under-insured and living in unstable housing and/or un- or under-employed in the City of San Francisco.

Objective I: Clients achieve or maintain stable housing.

Objective 2: Clients improve capacity for generating income.

Objective 3: Clients are retained in HIV medical care.

Objective 4: Clients achieve and/or maintain viral suppression.

Logic model

Goal: Improve HIV health outcomes for racial and ethnic minority populations that are un- or under-insured and living in unstable housing and/or un- or under-employed in the City of San Francisco.

Assumption: Improving social determinants of health leads to improvements in health outcomes.

Inputs	Target Population	Activities	Outputs	Outcomes
• Collaborations with HOPWA and HIV primary care providers and community partners • Data sharing with HOPWA and HIV primary care providers and community partners • Data compilation on housing assistance programs • Staff experienced with working with people with HIV, substance use disorders, and mental health disorders • Robust existing programs with clients in need of housing coordination • Integrated service center where clients can access multiple services at one location	• HIV-positive • Racial/ethnic minority (primarily African American or Hispanic) • Homeless and/or unstably housed • Un- or under-employed • Un- or under-insured • Resident of the City or County of San Francisco	• Assess social determinants of health (SDH) for all clients • Capture longitudinal data on SDHs and health outcomes • Provide housing counseling through case management model • Provide group education through training and outreach on affordable housing • Identify possible income sources according to clients' capacity and goals • Use Activities Checklist and Acuity Scale to develop individualized service plans • Refer and link clients to community resources • Share information among collaborative partners • Coordinate HIV housing across the City of San Francisco	• Obtain housing • Obtain job skills • Obtain employment/income • Gain or maintain access to health insurance • Remain engaged in primary care • Access other identified social supports	• Clients achieve or maintain stable housing. • Clients improve capacity for generating income as demonstrated by engagement in employment, training, or educational program during intervention period. • Clients are retained in HIV medical care defined as having at least two HIV primary care visits during the six month medical record review period—one in months 1-3 of enrollment and another in months 4-6 of enrollment. • Clients achieve and/or maintain viral suppression as demonstrated by a HIV viral load less than 200 copies/ml at last HIV viral load test.

Priority Populations & Demographics

Priority populations include people with HIV facing unstable housing and/or employment who experience a myriad of social factors that impact their ability to achieve long-term wellness. Specific priority populations include individuals transitionally housed through the HOPWA program and existing clients of PRC's array of social service programs. Many individuals in the priority populations have dual or triple diagnoses of HIV, substance use disorders, and/or mental health issues and face difficulty accessing healthcare, employment, and housing services.

Client Demographics

Client demographics of the priority population include the following:

- 18 years and older
- Members of the re-entry population
- Transitionally housed
- Individuals with substance use/mental health diagnosis
- Low/no income
- LGBTQ+
- Gender non-conforming
- Heterosexual
- Living with HIV

PRC enrolled 100 individuals into HPP. Demographics of the client population are as follows:

Client Demographics	Number	Percent
Gender		
Man	86	86
Gender Queer/Gender Non-Conforming	6	6
Woman	4	4
Transgender Woman	4	4
Transgender Man	0	0
Other	0	0
Sexual Orientation		
Lesbian, Gay or Homosexual	65	65
Heterosexual/Straight	18	18
Bisexual	11	11
Other	4	4
Declined to State	2	2
Race/Ethnicity		
White	34	34
Hispanic	32	32
Other (includes multi-racial)	26	26
Black/African American	8	8
Mean Age	43	NA
Education		
High School Diploma or GED	30	30

Theoretical & Evidence Informed Frameworks

The theoretical framework of PRC's intervention is centered on the premise that coordinated intervention that integrates HIV care with housing and employment services decreases the effects of detrimental social determinates of health and leads to improved health outcomes for people with HIV.

In San Francisco, social determinants of health such as lack of housing and un/under employment lead to low rates of viral suppression in people with HIV. Fourteen percent (14%) of people with a newly diagnosed HIV infection in San Francisco are homeless and 68% of this population is not virally suppressed.[7] While antiretroviral therapy helps people with HIV achieve an undetectable viral load, viral suppression rates among homeless people with HIV are much lower than average. San Francisco's homeless population experiences the highest rates of new infections and are about half as likely to achieve viral suppression compared to their housed peers (39%, compared to 75% in the general people with HIV population).[8]

Research also consistently shows significant health disparities among racial/ethnic minority and low-income communities. The Department of Health and Human Services defines health disparities as "differences in health outcomes that are closely linked with social, economic, and environmental disadvantage."[9] Healthy People 2020 states "health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their:

- racial or ethnic group;
- religion;
- socioeconomic status;
- gender;
- age;
- mental health;
- cognitive;
- sensory or physical disability;
- sexual orientation or gender identity;
- geographic location;
- or other characteristics historically linked to discrimination or exclusion."[10]

PRC's HPP intervention addresses poverty, unemployment/underemployment, homelessness and other social determinants of health to support effective HIV care and improve long-term health outcomes.

[7] San Francisco Department of Public Health. (2019). HIV Epidemiology Annual Report 2019. Retrieved from https://www.sfdph.org/dph/files/reports/RptsHIVAIDS/AnnualReport2019_Indigo_20200929_Web_fixed.pdf
[8] San Francisco Department of Public Health. (2019). HIV Epidemiology Annual Report 2019. Retrieved from https://www.sfdph.org/dph/files/reports/RptsHIVAIDS/AnnualReport2019_Indigo_20200929_Web_fixed.pdf
[9] U.S. Department of Health and Human Services. (2011). HHS action plan to reduce racial and ethnic health disparities: a nation free of disparities in health care. Washington D.C.: U.S. Department of Health and Human Services.
[10] U.S. Department of Health and Human Services. (2015). Health People 2020 Progress Review. Retrieved from https://www.healthypeople.gov/sites/default/files/hp2020_LGBT_SDOH_progress_review_presentation.pdf

Pre-Implementation Activities

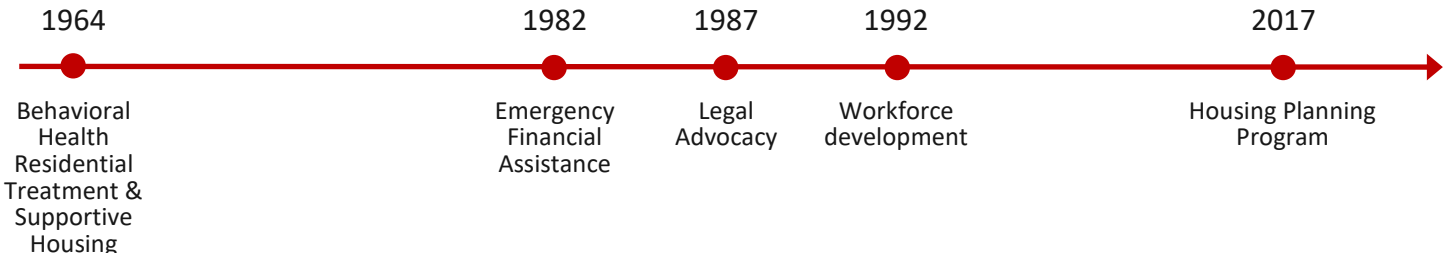
Assess Assets

Prior to implementation, PRC conducted an assessment of assets and resources available to achieve the SPNS initiative objectives. By conducting this assessment, not only was PRC was able to deploy and leverage existing resources, but it was also able to develop a plan to acquire resources it lacked.

Agency

Founded in 1987 during the height of the HIV epidemic, PRC started as a group of volunteers helping people with HIV access Social Security disability benefits. In 2017, PRC acquired Baker Places, which started providing residential treatment and supportive housing in 1964. Today, PRC is a $29 million human services nonprofit and one of the only agencies in the country that integrates legal, social, and behavioral health services to uplift disabled and marginalized individuals out of poverty and homelessness.

PRC's 30+ year experience delivering social services:



Given PRC's experience serving people with HIV and integrated continuum of social and behavioral health services, PRC was uniquely positioned to design and deliver an effective intervention to coordinate HIV treatment, housing, and employment services.

While PRC presented many assets, it lacked experience providing one-on-one housing case management. In order to address this deficiency, PRC's leadership needed to undergo housing and case management training, as well as hire experienced staff for HPP. PRC also needed to elevate its knowledge in this area by developing collaborations with other housing-related organizations and attending housing-related community meetings.

Funding – Including Leveraging Other Grant Resources

Given the intervention's focus on coordinating HIV treatment with housing and employment resources, PRC's pre-existing funding for its Workforce Development and Emergency Financial Assistance programs were recognized early on as key assets to this initiative.

The Workforce Development program is largely funded by the City and County of San Francisco (CCSF). Funds are used to provide the following program components: assessment, development of an Individual Service Plan, peer workforce training programs, computer and clerical skills training programs, on-the-job training, job search assistance, resume and cover letter development, mock interviews, salary negotiation assistance, job retention support, and career laddering guidance. PRC also receives CCSF funding to provide people with HIV intensive wrap-around vocational rehabilitation through a rapid response model, as well as assistance with housing, food, and basic needs.

Another key asset is funding PRC receives from the California Department of Rehabilitation, which funds the provision of in-depth job development, preparation, assistance, and support in obtaining and maintaining competitive employment for California residents.

Other key funding, including Ryan White HIV/AIDS Program funding to provide emergency financial assistance to help people with HIV pay for housing related emergency expenses, was also recognized as a valuable asset. With these funds, HPP clients could access financial help to pay for short-term hotel stays while waiting to secure more stable housing.

Available Services in Area

In addition to PRC's myriad of benefits and services, San Francisco offers a wide variety of services that promote health, wellness, and social justice for people with HIV. These services were identified as great assets. However, the difficulty with navigating and accessing the services was identified as a challenge. Some of the services include:

- Specialized HIV Treatment: Ward 86 at San Francisco General Hospital offers specialized HIV treatment and is the first clinic specializing in HIV/AIDS treatment to open in the country. San Francisco Community Health Center also provides comprehensive HIV care, specialized in serving people of color, LGBTQ+, and the chronically homeless.
- Dental care: University of Pacific School of Dentistry offers a specialized program for San Francisco residents with HIV. Services are provided at no charge to eligible patients.
- Food Security: Project Open Hand provides free, healthful meals to people with a variety of diagnosed medical issues including HIV/AIDS.
- Legal services: AIDS Legal Referral Panel, a non-profit law firm offers free and low-cost legal services to people with HIV in the San Francisco Bay Area.

- Residential care and Assisted Living Programs: Maitri provides residential care for people living with AIDS. Catholic Charities of San Francisco, Rafiki Coalition, and Health Right 360 all offer long-term or permanent HIV housing programs.

Although there are a great number of HIV-related services available in the San Francisco, they are often times difficult to navigate due to differing eligibility criteria and lack of coordination.

Setting

In terms of setting, services were planned to initially take place at PRC's main office in downtown San Francisco, with a plan to move all non-clinical services to PRC's new integrated service center in the South of Market district in April 2019.

Prior to implementation in 2017, PRC underwent a merger with AIDS Emergency Fund (AEF), a small but foundational HIV-service provider in San Francisco that provided immediate, short-term financial assistance to people with HIV. The merger with AEF presented a critical asset for HPP, as clients could more easily access financial assistance through a single organization. However, AEF's operations and physical location occurred out of a separate office from PRC, which was a drawback for clients who would have to go to a different office to access financial assistance.

Also prior to implementation, PRC started the process of acquiring Baker Places, an organization that provides mental health and substance use treatment through residential programs and long-term supportive housing. This merger presented an asset for HPP, as intervention services could be provided on-site at the various Baker Places residential treatment sites and HPP clients could also gain greater access to Baker Places programs.

Services were also planned to take place on-site at LSS's Forensic Housing Program, which operates out of a residential site in the Tenderloin neighborhood. This setting was a major asset for HPP, as clients could receive services conveniently at their residence.

Potential Funders to Leverage

In addition to funding from the City and County of San Francisco through the Department of Public Health and Mayor's Office of Housing and Community Development, PRC identified the Substance Abuse and Mental Health Services Administration as a potential funder of services for this project. Other potential funders included the CA State Department of Health Office of AIDS, which works collaboratively with state and federal agencies, local health jurisdictions, and community-based organizations to combat the effects of the HIV/AIDS epidemic. PRC also identified Tipping Point Community as a potential funder for this work, as its mission is to break the cycle of poverty and it leads the Chronic Homeless Initiative, which aims to cut chronic homelessness in San Francisco by half.

Client Involvement/Consumer Advisory Board

PRC gathered client input in the development and ongoing evolution of HPP by participating in community meetings with other services providers such as the Elizabeth Taylor 50+ Network, SF AIDS Foundation, San Francisco Mayor's Office of Housing and Community Development, Shanti Project, Lutheran Social Services of Northern California, Larkin Street Youth Services, and more. Through these meetings, PRC:

- Learned that clients needed greater navigation assistance to access services,
- Coordinated with partners on challenging client cases,
- Discussed the disconnected housing assistance programs in San Francisco and how to better centralize coordinated access to these services,
- Gathered information on how to use housing programs outside of the HIV network of care for HIV-positive individuals, and
- Analyzed data on client outcomes and how to improve them through community-level efforts.

PRC also gathered input through client satisfaction surveys and by analyzing program data. For example, data from PRC's Emergency Financial Assistance program showed that 70 percent of clients needed housing supportive services, so it was evident that housing intervention was sorely needed.

Gaining Buy-In

Gaining buy-in within PRC and among partners prior to implementation was critical to the successful launch of HPP. Fortunately, the program garnered early support from PRC's administrative staff including the Chief Executive Officer, grant-writers, development team, and finance department, who believed the program was complementary to PRC's existing services and greatly needed in the community. With this support, PRC developed a strong and cohesive proposal for the intervention, which was ultimately selected for participation in the SPNS initiative.

Support from PRC's information technology department was also critical, particularly for the development of a client database. Additionally, buy-in from PRC's existing program areas, especially Workforce Development, was crucial to the development of internal referral and recruitment systems. Support was achieved by informing and educating staff through staff meetings and presentations on why the intervention was necessary and valuable for clients.

PRC achieved buy-in with external partners through education and ongoing dialogue about the purpose of the intervention and the outcomes PRC aimed to achieve. Due the widespread housing challenge in San Francisco, partners were eager to support any efforts to help clients find housing. Once buy-in was established, PRC developed formal subcontract agreements with partner agencies such as LSS to collaborate and serve mutual clients. By establishing formal agreements, PRC and its partners were held accountable for program outcomes and incentivized to support the intervention.

Planning for Sustainability

One of the initial strategies PRC took toward sustaining the program was developing a plan to integrate HPP into agency-wide programs operations. The plan included using the same agency intake forms and intake questions for HPP clients as the ones used in other program areas. The plan also included developing a similar client database that used the same data fields as the databases for other programs, and establishing streamlined screening and referral protocol.

Another sustainability strategy was to promote the intervention in the community through trainings, webinars, and discussions with local partners; and in doing so, develop a new network of partners and referral sources for HPP.

Promoting the Intervention

PRC initially promoted HPP by word-of-mouth and through interagency communications to partners as well as agencies in San Francisco's HIV services network in San Francisco, particularly those that attend Mayor's Office of Housing and Community Development meetings and other community meetings. HPP staff also promoted the program by making presentations at local community-based organizations serving people with HIV. Simple flyers outlining program services and eligibility requirements were distributed at community meetings and outreach events. *See* **Appendix 1—Program Flyer—page 41**.

Program flyers were also emailed out to the S.F. Frontline Organizing Group (FOG) listerv, which distributes messages to over 400 S.F. HIV service providers such as case managers, social workers, and navigators. The listserv is used to disseminate community information, solicit information and resources, share policy updates, and communicate educational opportunities. Emailing FOG was a quick and effective way to disseminate information about HPP.

Marketing and Communications Plan

Marketing materials such as flyers and PowerPoint presentations were developed in-house, which kept marketing costs low. PRC used Microsoft Word and Canva, an online poster maker program to develop flyers. Since PRC had existing licenses for Microsoft Word and Canva, there was no additional cost incurred to acquire these tools. The only additional costs were associated with printing and staff time.

Planning Costs

Pre-implementation planning costs were approximately $150,000, but vary depending on local factors such as salary levels and organizational overhead costs (in particular, rent). The program was designed and tested in San Francisco, which has relatively high costs for these line items compared to other locations in the U.S. Planning costs included: $105,000 in staff salaries and benefits, $12,000 in partner subcontracts, $3,000 in equipment (computers for staff), and $30,000 in overhead (primarily rent at $13,000) and indirect expenses.

Staffing Plan

Recruitment and Hiring

PRC's HPP consists of a team of four staff including one Project Director, two Integrative Health Analysts, and one Data Analyst/Intaker. The Project Director/Principal Investigator position is staffed by PRC's Chief of Programs, a member of the organization's executive management team, who provides leadership and overall management of the program. The Integrative Health Analysts and Data Analyst/Intaker positions were newly created positions for this initiative. The role of the Integrative Health Analysts is to work directly with clients and provide service interventions. The role of the Data Analyst/Intaker is to recruit and conduct intakes as well as to assist with collecting, managing, and analyzing client data.[11]

PRC recruited staff through in-reach, sharing job descriptions on community listservs, and posting on commercial job boards such as Localwise and Zip Recruiter. PRC also reviewed applicants previously submitted for other positions in the agency. Key qualifications included a commitment to social justice and demonstrated ability to work with low-income individuals, people with psychiatric disabilities, people with HIV, people of color, active drug users, people with a history of homelessness or incarceration, and people in the LGBTQ+ community. Specifically, for the Integrative Health Analyst positions, PRC sought individuals with case management experience and experience working with homeless individuals.

The most successful strategies were recruitment through word-of-mouth and reviewing previous applications for other positions in the agency. One HPP staff person previously applied for a position in PRC's Emergency Financial Assistance program. While she was not hired for that position, her experience and passion for helping homeless individuals made her a perfect fit for HPP and she was ultimately hired as an Integrative Health Analyst.

Job Descriptions and Postings

Job descriptions and minimum qualifications for each positon appear at **Appendix 2—Job Descriptions—page 42**.

[11] Data Analyst responsibilities supported the study aspect of the intervention, but could be eliminated for interventions that do not include a study component.

Staff Onboarding, Training, and Continuing Education

Staff onboarding starts with an orientation to PRC and an overview of its services. On their first day, new staff are introduced to HPP team members and introduced to staff in other departments and program areas. The Project Director provides an overview of the intervention and logic model. Initially, the Project Director also trained new staff on how to use the client databases, housing and community resources, and program processes and procedures. However, the responsibility for providing these trainings eventually shifted to existing/departing staff. Additionally, over time, the program developed written program guidelines and training references. *See* **Appendix 3—Intervention Guideline—page 45.**

Each HPP staff member is required to complete a CITI Human Subjects training every year, which covers topics such as conflicts of interest in human subjects' research, informed consent, and privacy and confidentiality. Each HPP staff member is also required to complete the Department of Labor/Housing and Urban Development Getting to Work training curriculum, which helps service providers understand HIV/AIDS in the context of employment. Additional trainings affordable housing, coordinated entry, case management, de-escalation, 5150 involuntary detentions are also provided to staff.

PRC provides all program staff a rigorous training program, including trauma-informed care and cultural competency practice. Every year, staff are required to complete a S.F. Department of Public Health Privacy and Compliance training as well as a Sexual Orientation and Gender Identity training. Additionally, discussion of staff training needs happens at least once annually after each staff member's performance evaluation, as well as continuously throughout the year in both team meetings and supervision meetings as trainings become available and/or particular needs arise. The training requirement is monitored by each staff supervisor and tracked for the agency by the human resources department.

PRC's training culture also encourages staff to share with one another lessons learned and resources acquired through off-site trainings. In 2018/19 alone, PRC's staff participated in over 35 trainings, including subjects such as harm reduction and related trauma, racism and institutional bias, sexual orientation and gender identity, diversity and inclusion, and implicit bias.

Supervision Structure

One-on-one staff supervision is provided by the Project Director on a weekly basis. Meetings last anywhere between 30 to 60 minutes and cover topics including case specific challenges, program updates, human resources, concerns, and workload management. The Project Director also leads a weekly team meeting to address team concerns, plan for upcoming projects, and discuss case matters. An additional level of supervision is provided to the staff by PRC's Managing Director of Workforce Development, who meets with staff on an as-needed basis and provides support through case conferencing, problem-solving, and discussions about self-care.

Partner Organizations

Roles and Responsibilities

HPP's program model relies heavily on internal and external partners to support clients with a variety of critical services including housing, HIV care, mental health treatment, and intensive wrap-around case management. In developing collaborations, PRC sought external partners that could contribute resources and services in areas that it lacked. Specifically, PRC sought collaborations with partners that provided housing-related services and/or healthcare, since PRC already provided employment services through its Workforce Development program. PRC also searched for partners that would serve as strong referral sources and help maintain client contact to minimize individuals lost to follow-up.

External Partners

Lutheran Social Services of Northern California (LSS) was one of the first partners PRC solicited for collaboration in HPP, as its Forensic Housing Program is HOPWA funded to serve the target population and provides 18 months of transitional housing. LSS also provides wrap-around services such as housing advocacy, money management services, linkage to HIV prevention, access to benefits counseling/advocacy, basic life skills coaching, access to medical care, access to oral healthcare, and access to behavioral health services. Additionally, with on-site staff at the residential hotel where the program operates, LSS was able to provide a high-level of support to HPP by reminding clients about intervention meetings and follow-up interviews. Partnering with LSS further presented the possibility of conducting on-site intakes and providing HPP intervention services at LSS, thereby streamlining client access to HPP services.

Ward 86 was another early partner in HPP. As a one-stop shop providing the "San Francisco Model of Care", its interdisciplinary care team of doctors, nurses, social workers, case managers, psychiatrists, addiction specialists, nutritionists and so on provide an array of medical and social services in a single facility, making it a natural partner for HPP. Furthermore, this partnership was critical to establish because certain services such as substance use treatment programs, residential housing opportunities, and mental healthcare that require clinical referral.

Internal Partner

Ferguson Place is one of PRC's residential treatment sites, and only became an HPP partner in year two of the intervention. Ferguson Place played a key role in supporting clients with mental health and substance use disorder treatment in a residential setting. Ferguson Place is staffed by on-site residential counselors 24-hours a day that work with clients through treatment planning, counseling, and group sessions to stabilize their lives. Similar to LSS, Ferguson Place's on-site staff, was able to support HPP efforts by reminding clients of intervention meetings and follow-up interviews. Additionally, Ferguson Place presented a temporary housing option for HPP clients who needed mental health and/or substance use treatment.

Identification of Internal and External Stakeholders

PRC identified internal and external partners by focusing on a few key considerations:

- Did the partner serve the target population and share a similar mission to PRC's?
- Did the provider offer services related to housing, employment, or healthcare?
- Was there an existing relationship with the partner?

Using these factors, PRC identified its internal programs, Workforce Development and Emergency Financial Assistance programs as primary internal partners. With one of the primary social determinants of health for the intervention being employment and income, the Workforce Development program was an obvious partner. The program offers training and career navigation services, including labor market research, skill interest testing, values and interest exploration, identification of workplace limitations, and assistance in defining a career goal. PRC's Emergency Financial Assistance program was also a logical internal partner because of the financial assistance it offered to help pay for housing expenses such as short-term hotel stays or first month's rent.

In identifying external partners, PRC started by identifying stakeholders in the community with shared missions and values. These included HIV healthcare providers, housing providers, mental health and substance use disorder treatment providers, local government, and the local network of frontline HIV service providers. Early on, LSS and Ward 86 were identified as important stakeholders and partners for this project.

A valuable lesson PRC learned in the partnering process was the importance of recognizing a partnership that is not working and releasing that partnership. At the start of this initiative, PRC partnered with an organization that serves primarily HIV-positive youth. However, over time, the partnership eroded because that organization did not share the same or similar service population with PRC, which made it difficult to make and receive referrals between the two organizations. Ultimately, only two clients materialized through the partnership. In year two of the initiative, it was mutually decided to forgo a renewed partnership, which allowed PRC to pursue new partnerships and make adjustments to the initiative design.

Strategies for Informing/Partnering with Stakeholders

Once stakeholders were identified, PRC initiated conversations with each organization to discuss the initiative and the benefits of collaboration. PRC held several meetings to ensure each partner understood the goals of the intervention and was committed to working with PRC. Formal partnerships were established by entering into mutually beneficial contracts, instituting policies and procedures for referrals, setting up case conference meetings, developing client releases for information sharing, and other co-enrollment practices.

Engaging Department of Labor (DOL) / Department of Housing & Urban Development (HUD)

PRC did not develop any formal partnerships with the Department of Labor or Department of Housing & Urban Development for HPP. However, PRC has a longstanding partnership with the CA Department of

Rehabilitation (DOR) through its Workforce Development program. Under this partnership, PRC is contracted with DOR to provide assistance with job search, developing interview techniques, resume writing, demonstrating appropriate work behavior, and practicing appropriate grooming. Under this partnership, PRC also supports clients for 90 days after placement in employment to assess job satisfaction, progress, and any ongoing need for additional supports or resources.

Intervention Implementation/Service Delivery Model

Core Components of Intervention

Services Provided – Individual Level

Intervention staff use a case management model to coordinate HIV care with employment and housing resources for HPP clients. Services focus on helping clients identify and access housing and employment opportunities, as well as referral and linkage to community resources to address other needs.

Intake

Clients are enrolled in the intervention upon completion of initial intake and the first day of service. At intake, clients are asked to provide information including: full name and pronoun, contact information, emergency contact, HIV status, income, employment status, healthcare provider, and insurance provider.

Clients also complete an **Activity Checklist (*see* Appendix 4—Activity Checklist—page 52),** which is a list of activities/needs that clients use to indicate their most pressing and immediate needs. The checklist includes activities such as accessing dental care, acquiring personal hygiene supplies, making a shelter reservation through the 311 telephone system, or getting a public transit card. Finally, the intaker reviews with the client PRC's internal service agreement documents, which the client signs. Once the intake is completed, the intaker forwards the client's contact information and completed Activity Checklist to an interventionist for follow-up. Interventionists contact the client within seven days of the intake to schedule a first day of service.

First Day of Service

During a client's first day of service (FDS), typically a one-hour meeting, interventionists conduct a detailed screening and assessment to gain a thorough understanding of client needs and circumstances around housing, employment, and healthcare. Interventionists use an **Interventionist Questionnaire (*see* Appendix 5—Interventionist Questions—page 53)** to conduct the assessment, which includes questions related to housing, medical treatment, income, credit/debt history, substance use, and employment.

Information collected from the assessment is used to develop a customized service plan for the client and to make referrals for services. Interventionists also review the Activity Checklist with clients to help them take immediate action—same day if possible—to address their most critical needs.

Since all HPP clients at intake are either homeless or unstably housed, interventionists screen clients to check if they are connected with Coordinated Entry, the gateway into San Francisco's system of programs and housing opportunities for adults experiencing homelessness. If clients are not connected, interventionists make a referral for intake with Coordinated Entry. Interventionists also screen clients to check if they are active on DAHLIA, San Francisco's affordable housing portal. If they are not, interventionists help them create a user profile.

To explore or initiate vocational services, interventionists link clients to PRC's Workforce Development's Getting to Zero (GTZ) program, a rapid-response, high-touch program that aims to reduce health disparities for people with HIV by addressing vocational rehabilitation needs. Linkage is made via warm handoff and when appropriate, linkage may be established same day.

Fortunately, in San Francisco, most HPP clients are already well connected to HIV treatment, and linkage to medical care is seldom a primary concern.

Finally, interventionists review PRC's internal service agreement documents such as Client Rights and Responsibilities, Grievance Policy, and Release of Information. The Release of Information is a critical tool that allows PRC to discuss service coordination with other case managers and social workers, or with family and friends if appropriate.

Shortly after the FDS, staff independently complete an **Acuity Screening Tool (*see* Appendix 6—Acuity Screening Tool—page 58)** to assess the severity of the client's needs in a broad range of life areas including medical, mental health, substance use, housing, income, legal, food security, and more. Using the Acuity Screening Tool, Interventionist Questionnaire, and the Activity Checklist, interventionists work with the client to develop an initial service plan to meet the client's self-defined priorities, needs, and goals.

Physical and Electronic Files

After the FDS, interventionists create both physical and electronic files for clients. Signed service agreement documents, correspondences, and other documents collected or developed for the client are stored in physical files. Electronic versions are saved in electronic files.

Additionally, information collected during intake and FDS is entered into a custom-designed client database. The database functions as a repository for basic intake information, but also serves as a program and case management tool. Interventionists enter case notes into the database for every client interaction and service provided for the duration of the service relationship. Time spent on cases is also tracked in the database in 15 minute increments. The database is capable of generating various reports pertaining to case activity, demographics, and more.

Staff Activities & Ongoing Intervention

Interventionists work with clients to finalize an initial **Service Plan (*see* Appendix 7—Service Plan Form—page 62)** within 30 days of the FDS. The service plan sets out the client's short, mid, and long-term goals and objectives. The plan also identifies barriers to achieving client goals. Using the plan as a guide, interventionists provide services including:

- **Linkage to HIV treatment** and periodic check-ins to support retention in care
- **Assistance with creating a user profile in DAHLIA,** San Francisco's affordable housing portal
- **Referral to Coordinated Entry** and assistance with completing intake
- **Identification and linkage** to housing resources
- **Notification of housing** opportunities
- **Assistance with checking** subsidized/low-income housing lists
- **Assistance with completing** housing applications and paperwork
- **Identification of alternative housing options/resources** including temporary housing, residential treatment for substance use and/or mental health disorders, private market opportunities, etc.
- **Accompany clients** to service provider appointments or housing interviews
- **Referral and linkage** to mental health and/or substance use disorder treatment

Services are provided on an ongoing and client-driven basis. As clients receive services, interventionist support clients with follow-through and work with other service providers to achieve the client's housing, employment, and/or healthcare goals. Interventionists generally contact clients at least once every month or more to check-in. Depending on the client's situation, such as homelessness, incarceration, or other circumstances, check-ins may be more or less frequent. Check-ins are opportunities to interact with clients, monitor progress toward goals, manage crises, plan for life events, or simply to update client contact information. Check-ins may be in the form of a phone call, email, or in-person visit.

Once every six months, staff review or update the client's personal information, employment and housing status, and service plan.

Tangible Reinforcements

Supporting clients with tangible reinforcements is important to establishing a relationship that clients find valuable and helpful. In addition to the Activity Checklist previously described, interventionists offer a number of other tangible reinforcements throughout the service relationship.

Water and food, including healthy vegan snacks and an assortment of chips, cookies, and fruit and nut bars, are routinely offered by HPP staff during client meetings. PRC also provides hygiene kits supplied for free by a local non-profit. Providing items such as these helps clients feel they have left their appointment with something tangible that addresses their most immediate and basic needs.

One of the intervention staff uses a housing picture collage, a collection of pictures of housing complexes with details about how to get on housing lists. This visual allows clients to physically see housing complexes they may be interested in living in one day. The picture collage inspires and motivates clients by instilling in them an image of what their housing and future could look like. In addition to the pictures, eligibility requirements are posted so clients can gauge what is realistic for them.

Acuity Scale

Other tangible reinforcements include an Acuity Screening Tool, which is a form that is completed after the client leaves their FDS and then redone every six months or after a crisis situation. This tool guides the provision of services during the intervention. It is also used as a tool to determine the client's readiness for graduation from the program.

System Level—Organizational Staff Meetings

HPP team meets weekly to address case questions, share resources, and discuss upcoming projects. In addition to the team meetings, one-on-one meetings take place between staff and the Project Director on a weekly basis. Informal meetings are held between HPP staff and Workforce Development staff to case conference on mutual clients as necessary. Full agency programs staff meetings are held approximately every quarter. During these meetings, staff share program updates and gather for joint trainings. Every other month, PRC holds an all staff meeting, during which senior staff provide agency updates and address staff questions.

Communication

Partnerships/Committees' Activities and Accomplishments

Internal communications about partnerships, activities, and accomplishments are done through staff meetings and email. Community outreach events, presentations, and client successes are discussed during weekly team meetings and one-on-one check-ins between interventionists and the Project Director. Broader agency announcements are made at full staff meetings that occur every other month.

Internal communications between HPP interventionists and staff in other PRC program areas, such as Workforce Development and Emergency Financial Services occur on an ad hoc and as needed basis. Communication is mostly done by telephone and email, but may also occur conveniently in person, as staff in these programs all work out of PRC's integrated service center.

HPP Staff attend and participate in community meetings including:

- HIV Housing Case Conferencing Group for San Francisco frontline providers
- Ryan White HIV Community Planning Council Meeting
- HIV Housing Workgroup
- HIV Housing Board

Methods of Internal & External Communication; Timeline and Meeting Schedules

Communication with partner agencies happens over email and telephone as needed. Interventionists also attend weekly in-person community meetings held at the LSS residential hotel. This meeting presents an opportunity to engage clients and remind them about PRC services. It also serves as a fantastic opportunity to locate clients, complete intakes, or complete paperwork as all LSS Forensic Housing Program clients are required to attend this meeting.

Interventionists also attend a monthly provider meeting held at the LSS residential hotel. The meeting is usually attended by six to eight community service providers that share mutual LSS Forensic Housing Program clients. Meeting participants discuss each client and review how each one is doing, identify any service needs, and collaborate on how best to support the client. For example, a medical case manager might share that her client missed an appointment with his doctor to evaluate the effectiveness of his medication. The client's other community providers would then know to follow-up with the client on this matter.

A similar case conference meeting takes place at Ferguson Place on a monthly basis. Meetings are hosted by Ferguson Place's Project Director and address topics such as client successes, planning for discharge, or supporting client through relapse.

Meetings with other community providers are held on an ad hoc basis as needed. Periodically, staff attend local community meetings including the Ryan White HIV Community Planning Council meetings, HIV Housing Workgroup meetings hosted by the Mayor's Office of Housing and Community Development, HIV Housing Board meetings, and the HIV Housing Case Conferencing Group for San Francisco frontline providers.

Transitioning to Standard Care

The HPP program is a low-barrier program that serves as an entryway into PRC's services as well as San Francisco's broad network of supportive services. Upon completion of the intervention, HPP staff work with clients to develop a program exit plan. Clients are encouraged to continue accessing other PRC services, and interventionists make referrals and warm hand-offs to other outside providers. Interventionists also help clients successfully transition to standard care by providing clear and concise communications about client goals and plans to outside providers via case conferencing, emailing, and telephone prior to the client's program exit. If additional services are identified through the exit planning process, intervention staff assist clients link to those services. HPP staff verify that clients are maintaining HIV care. If clients have fallen out of care or at risk of falling out of care, they are referred to appropriate supportive services such as medical case management.

Documentation

Documentation of the intervention is important for tracking client progress, recording impact on health outcomes, and managing the overall program. While PRC is not a medical provider and does not use medical records, service notes are captured in a centralized client database and hard copy documents are maintained in paper files.

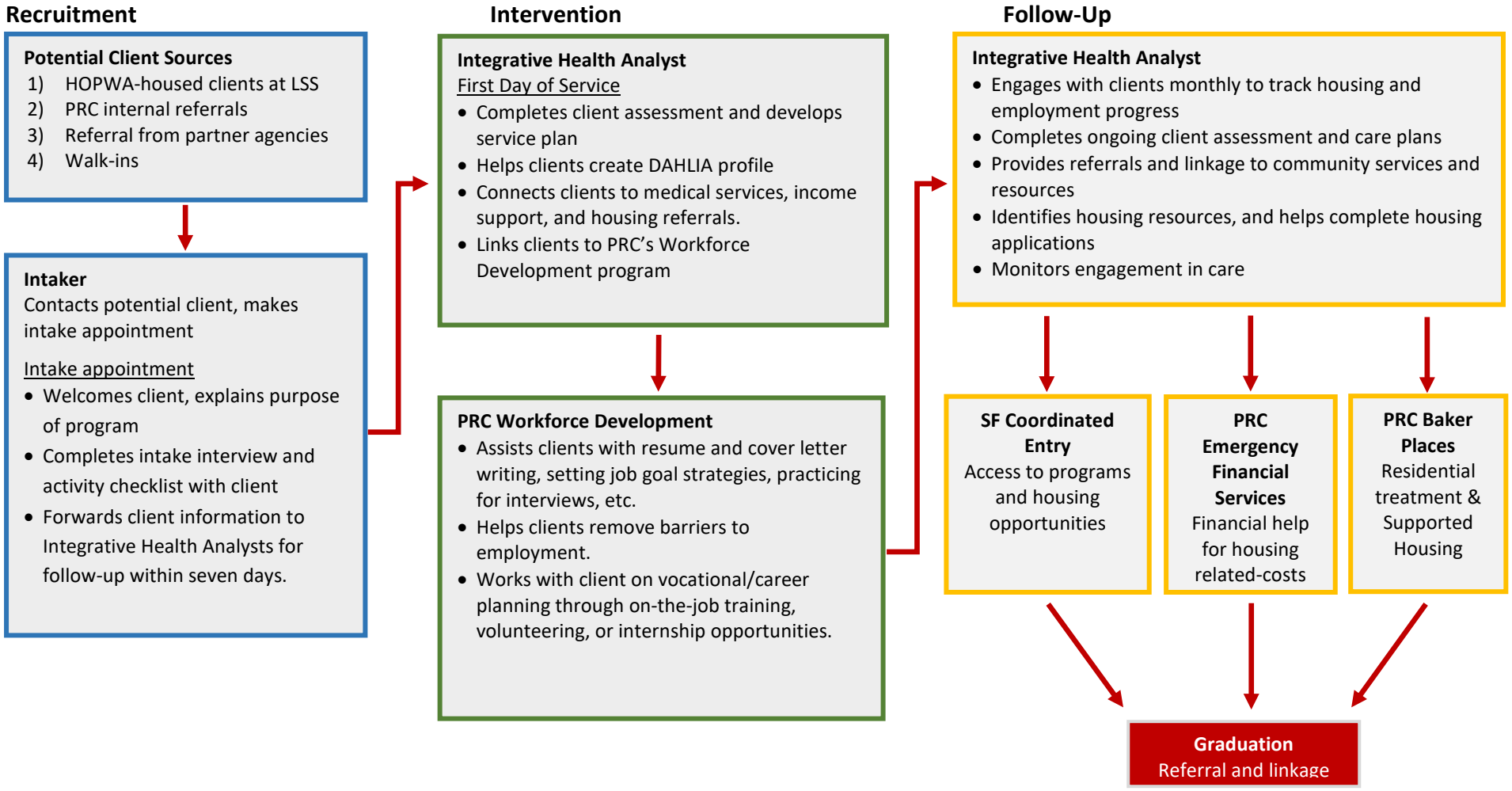
Case Notes

Staff write case notes to document all service efforts and time spent on client matters. Case notes document details of client interactions, issues raised, solutions and plans developed, and also any progress from previous sessions. Case notes are written in a complete, concise, and relevant manner, and end with next steps. PRC uses P-I-R-P as a guide for writing service notes: P—What is the problem? I—What is the intervention? R – How did client respond to the intervention? P—What is the plan moving forward? Interventionists complete service notes concurrently with or immediately after the service encounter.

Other Data Management Systems

Case notes are entered into a custom designed database for this program. In addition to HPP interventionists, the database is accessible by Workforce Development staff, which allows for efficient information sharing and case collaboration. Forms, applications, and other documents are saved electronically and hard copies are placed in the client case files, which are stored in a locked filing cabinet in secure room.

Intervention Flow Chart



Partner Activities

In addition to individual treatment planning, counseling, and group sessions, Ferguson Place holds a weekly client council meeting during which clients talk about what is going on in the program, how services are working and room for improvement, and requests for special events. Ferguson Place also holds quarterly program mixers, which involve former clients returning to the program to talk with current clients about where they currently are in recovery, programs they engaged in to assist with their stability, and recommendations for resources.

Programming at LSS includes weekly community meetings that are used to spotlight organizations and their services. Trainings are also provided during these meetings for staff. On one occasion, HPP staff provided a training about affordable housing for LSS during a community meeting.

Modifications Made During Implementation

HPP was initially designed as a housing benefits counseling program offering intensive housing placement assistance for clients exiting HOPWA sites. However, soon after implementation, it became evident that PRC did not have adequate resources to sustain this level of service. Therefore, PRC moved toward a housing case management model, focusing on helping clients identify housing opportunities and coordinating wrap-around services, and also leveraging in-house resources such as Emergency Financial Assistance and residential treatment and supportive services.

After the first year of the program, staff determined that sharing database access between HPP and Workforce Development would improve information sharing and collaboration between the two programs. Therefore, HPP and Workforce Development staff were granted access to both program databases, which allowed for much more efficient information sharing.

A drop-off in retention during year two of HPP also pushed PRC to modify the intervention by developing client engagement tools such as the Activity Checklist and the housing picture collage previously described under Tangible Enforcements.

Intervention Implementation Costs

Year 1 implementation costs

During the first year of intervention implementation, costs were approximately $485,000 and included: $294,000 in staff salaries and benefits, $20,000 in partner subcontracts, $1,500 in supplies (higher in the initial year due to set up – laptops, office furniture, etc.), $600 in client incentives, $1,000 for staff cell phones, and $165,000 in overhead (primarily rent at $75,000) and indirect expenses.

Year 2 implementation costs

During the second year of implementation, costs were approximately $370,000 and included: $210,000 in staff salaries and benefits, $6,000 in partner subcontracts and $155,000 in overhead (including rent and insurance) and indirect expenses.

Note that these costs would vary depending on local factors such as salary levels and organizational overhead costs (in particular, rent). The program was designed and tested in San Francisco, which has relatively high costs for these line items than other locations in the U.S.

Intervention Outputs and Outcomes

Intervention Outputs

In order to inform the community of PRC's intervention, staff conducted outreach, trainings, and sent out informational emails to provider listservs. Outreach consisted of trainings and case conferences with local HIV service providers, presentations to the San Francisco HIV Planning Council, consumer focused trainings about affordable housing, and many impromptu conversations about the program. Over the three-year intervention, an estimated 50 outreach, training, and case conference events were conducted by HPP staff reaching a conservative estimate of 300 people consisting of case managers, social workers, and other service providers in the social sector.

Intervention Outcomes

As part of the multi-site evaluation, PRC collected health, employment, and housing related data for 100 individuals enrolled in HPP over a two-year period. Data was collected through baseline interviews at the time of enrollment and interviews at approximately six months and 12 months thereafter. Additionally, medical records were requested six months and 12 months after enrollment. All 100 individuals completed baseline interviews, but not all completed subsequent interviews; and not all medical records were received for every individual enrolled into HPP.

Objective 1: Clients achieve or maintain stable housing

The greatest success in outcomes was achieved in the area of maintaining or achieving stable housing. The data shows a positive correlation between enrollment in HPP and maintaining and/or achieving stable housing with only two individuals stably housed at baseline, but ***58 stably housed at six months*** and ***15 stably housed*** **at twelve months** after enrollment.

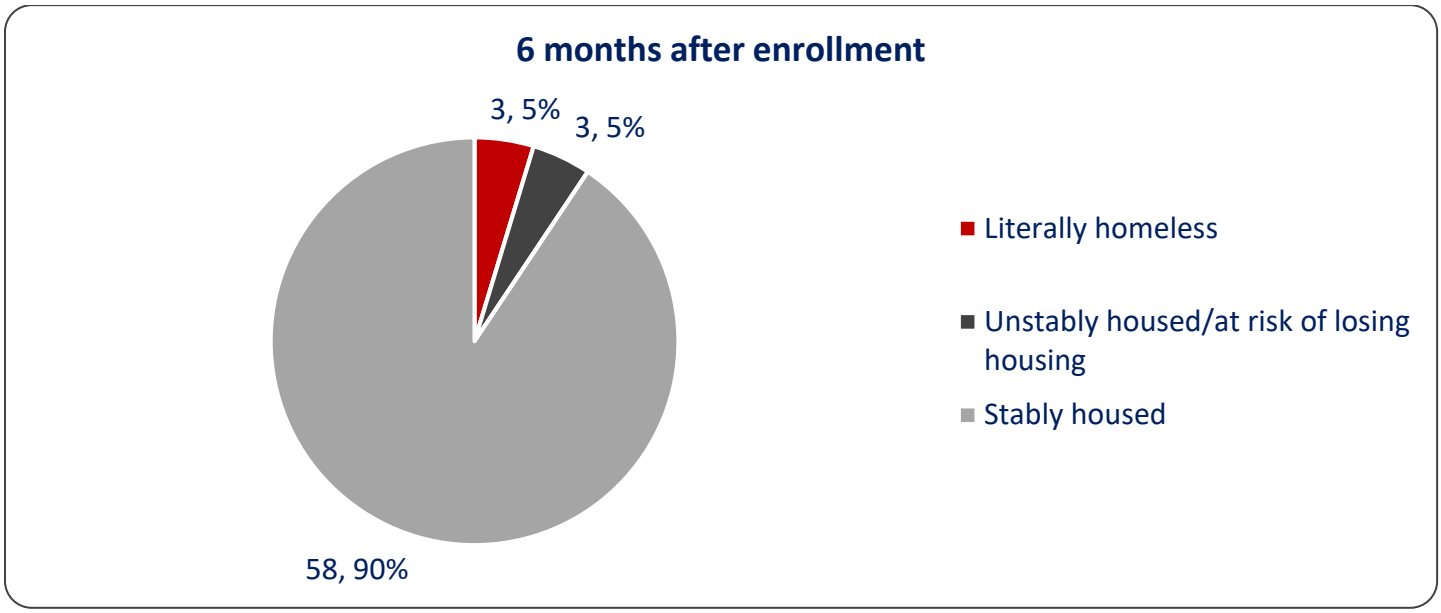
Persons who are stably housed are in a stable housing situation and not at risk of losing that housing.

At baseline:
PRC conducted **100 interviews**.

- 57 individuals (57%) were literally homeless
- 27 individuals (27%) were in imminent risk of losing housing
- 15 individuals (15%) were unstably housed/at risk of losing housing
- 1 individuals (1%) were stably housed

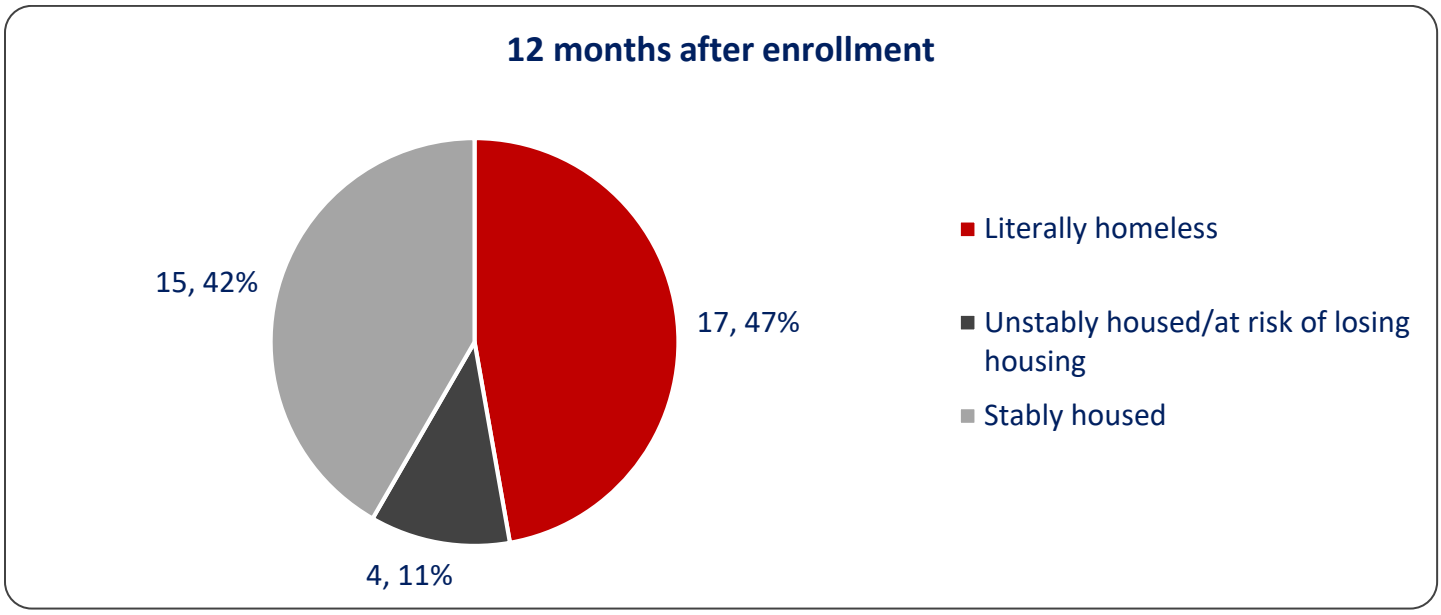
At **six months** after enrollment:
PRC conducted **64 interviews.**

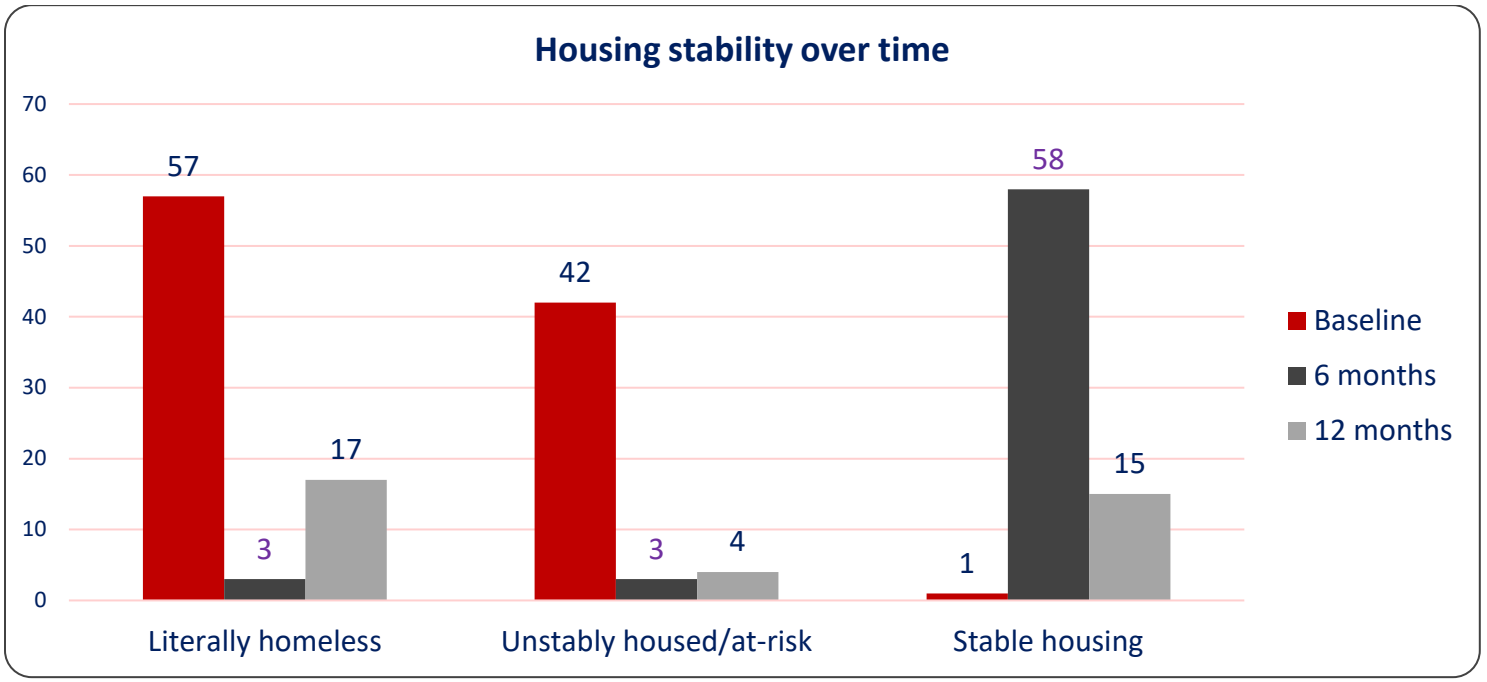
- 3 individuals (5%) were literally homeless
- 3 individuals (5%) were unstably housed/at risk of losing housing
- **58 individuals (90%) were stably housed**



At **12 months** after enrollment:
PRC conducted **36 interviews.**

- 17 individuals (47%) were literally homeless
- 4 individuals (11%) were unstably housed/at risk of losing housing
- 15 individuals (42%) in stable housing





Objective 2: Clients improve capacity for generating income.

Improved capacity for generating income is demonstrated by engagement in employment, training, or any educational program during intervention period.

At baseline

- 10 individuals (10%) were employed
- 90 individuals (90%) were not employed
- 15 individuals (15%) were engaged in training
- 85 individuals (85%) were not engaged in any training
- 6 individuals (6%) were engaged in educational program
- 94 individuals (94%) were not engaged in any educational program

At **six months** after enrollment:
PRC conducted **64 interviews**.

- 11 individuals (17%) were employed
- 53 individuals (82%) were not employed
- 13 individuals (20%) were engaged in training

- 51 individuals (80%) were not engaged in training
- 8 individuals (13%) were engaged in any educational program
- 56 individuals (88%) were not engaged in any educational program

Additionally, at **six months** after enrollment, **38 individuals (59%) increased their income** from income reported at baseline.

At **12 months** after enrollment:
PRC conducted **36 interviews**.

- 7 individuals (19%) were employed
- 29 individuals (81%) were not employed
- 8 individuals (22%) were engaged in training
- 28 individuals (78%) were not engaged in training
- 6 individuals (17%) were engaged in any educational program
- 30 individuals (83%) were not engaged in any educational program

Additionally, at **12 months** after enrollment, **24 individuals (38%) increased their income** from income reported at baseline.

Objective 3: Clients are retained in HIV medical care.

At **six months** after enrollment:
PRC collected medical records for **75 individuals**.

Retained in HIV medical care six months after enrollment is defined as having at least two HIV primary care visits during the six month medical record review period—one in months 1-3 of enrollment and another in months 4-6 of enrollment.

- 43 individuals (57%) were retained in care
- 28 individuals (37%) were not retained in care
- Insufficient data for 4 individuals (5%) to determine if in care or not

At **12 months** after enrollment:
PRC collected medical records for **62 individuals**.

Retained in care at 12 months after enrollment is defined as having two HIV primary care visits in the 12 month medical record review period with a gap of at least 90 days.

- 16 individuals (25%) were retained in treatment
- 41 individuals (66%) were not retained in treatment
- Insufficient data for 5 individuals (8%) to determine if retained in care or not

Objective 4: Clients achieve and/or maintain viral suppression.

Viral suppression is demonstrated by a HIV viral load less than 200 copies/ml at last HIV viral load test.

At **six months** after enrollment:
PRC collected medical charts for **75 individuals**.

- 8 individuals (11%) were not virally suppressed
- 38 individuals (51%) were virally suppressed
- Insufficient data for 29 individuals (38%) to determine viral suppression

At **12 months** after enrollment:
PRC collected medical charts for **62 individuals**.

- 7 individuals (11%) were not virally suppressed
- 30 individual (48%) were virally suppressed
- Insufficient data for 25 individuals (40%) to determine viral suppression

Lessons Learned

Barriers and Challenges

Over the course of the intervention, HPP experienced numerous barriers and challenges, but ultimately gleaned several important lessons.

One of the most difficult challenges HPP faced was staff turnover and inconsistent staffing over the course of the intervention. Within two years, all of the staff that designed the initial program concept left the agency and as a result, a great deal of institutional knowledge was lost. In the third year of the intervention, the replacement Project Director also went on extended leave, which left the program without consistent leadership in its final year. Due to staff turnover, the program underwent unnecessary reinvention and revision.

Other barriers include challenges with maintaining client contact. Clients are frequently lost to contact for reasons such as not having a phone or a working number. Maintaining contact is extremely important to sustain client motivation and engagement, but especially important to take advantage of time-limited housing opportunities. Over the course of the intervention, there were instances where clients missed housing opportunities because they were lost to contact.

The extreme shortage of available affordable housing in San Francisco was also a major challenge for HPP. In 2019, there were 8,000 homeless residents[12] and 1,000 individuals on the 90-day shelter waitlist.[13] The average rent for a one-bedroom apartment was $3,690.[14] The median home value was $1,400,000.[15] With astronomical rental rates, all housing on the open market was eliminated as options for HPP clients.

Facilitators of Success

One of the most significant facilitators of success is PRC's unique organizational model, which offers a full array of in-house social services. Clients benefitted from easy access to emergency financial assistance, employment services and training, and/or legal services, often times accessing these services same-day. The ease with which clients could access services helped motivate clients and keep them engaged with the intervention.

Focusing on clients' immediate needs at the start of the service relationship also helped foster engagement, trust, and motivation. Use of the Activity Checklist helped interventionists engage clients early in the intervention by focusing on their most immediate and pressing matters. While addressing the client's immediate concerns may not directly relate to acquiring housing, resolving pressing problems such as dealing with debt, signing up for General Assistance, or seeking treatment for substance removes barriers and supports housing readiness.

Narrowing the scope of services also allowed interventionists to better utilize their time and resources. Previously, interventionists provided intensive services, but this quickly led to staff burnout. The service was neither effective at achieving intervention goals nor unsustainable in the long-term. HPP shifted its focus to helping people access housing and coordinating wrap-around services, which created more bandwidth for interventionists to assist with housing applications, identify housing opportunities, and collaborate with partners.

[12] Applied Survey Research. (2019). San Francisco Homeless Count and Survey Comprehensive Report 2019. Retrieved from https://hsh.sfgov.org/wp-content/uploads/2020/01/2019HIRDReport_SanFrancisco_FinalDraft-1.pdf
[13] City and County of San Francisco. (2019). Shelter Reservation Wait-list. Retrieved from www.sf311.org/information/waitlist
[14] Zumper. (2019). Zumper National Rent Report: March 2019. Retrieved from www.zumper.com/blog/zumper-national-rent-report-march-2019/
[15] Zillow. (2020). San Francisco Home Values. Retrieved from www.zillow.com/san-francisco-ca/home-values

Developing strong partnerships—especially personal relationships with service providers—proved effective for service collaboration. Interventionists established personal relationships with services providers by meeting in-person and maintaining regular communication about client needs, plans, objectives, and goals. Personal relationships encouraged information sharing, which allowed for early communication about housing expiration, emergency situations, and/or medical needs.

Dissemination Activities

PRC engaged in several dissemination activities to about HPP. Staff developed a program flyer with initial outcomes and conducted outreach at local HIV service organizations including Shanti Project, AIDS Legal Referral Panel, and Ward 86. HPP was discussed at meetings with Coordinated Entry staff and the Mayor's Office on Housing and Community Development HIV Housing Work Group. Staff also presented about HPP to the San Francisco HIV Planning Council and developed a webinar for the HIV Learning Network. The Pacific AIDS Education & Training Center hosted the webinar for clinicians and medical social workers.

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Attachments

1. Client Flyer
2. Job Descriptions
3. Intervention Guideline
4. Activity Checklist
5. Interventionist Questions
6. Acuity Screening Tool
7. Service Plan Form

PRC's Housing Planning Program (HPP) was previously named **Integrative Health Analysis, which is referenced at times in the attachments.*

Appendix 1: Client Flier

Take steps to secure your future with

INTEGRATIVE HEALTH ANALYSIS

STUDY AND PROGRAM

We can help you plan your:

Housing

Long-term housing planning and advocacy

Employment, Education, or Volunteer Work

Increasing income, skillset, and/or investigating paths for future

Medical Care

Choosing the medical team that is right for you
Helping you to stay connected

Are You Eligible?

You must be:
✓ 18+, HIV-Positive
✓ Not fully engaged in medical care
✓ Living in a shelter, transitional housing site, couch surfing, treatment center, etc.
✓ Unemployed/on SSI or SSDI

Questions?

Contact Rebecca Levin
415-972-0891
rebecca.levin@prcsf.org

Appendix 2: Job Descriptions

Project Director/Principal Investigator

Duties & Responsibilities

- Participates as a member of the Executive Leadership Team.
- Directs the successful execution of existing programs and services across the organization.
- Leads the development of new programs and services that address health disparities among people and communities living with or at-risk for HIV/AIDS; including leading efforts to integrate services with local health systems.
- Manages program staff, including providing coaching, mentoring and professional development to program directors.
- Promotes internal collaboration among programs to create a comprehensive network of services that links clients to the full array of services offered by the foundation.
- Develops annual programmatic work plans and budgets that allow for the advancement of the foundation's strategic programmatic goals.
- Assures compliance of all program contracts with private and public funders.
- Monitors the quality of programs and leads efforts to assure the effectiveness and efficiency of services, including creating meaningful ways to obtain input from consumers of services.
- Pursues and promotes partnerships with other local and national health care and social service organizations which advance the foundation's mission.
- Represents the agency and its programs at local, national, and international meetings/conferences; connecting sound science and community experience, as budget allows.
- Assists with private and public fundraising that supports the sustainment and expansion of programming.
- Develops, informs, communicates and promotes organizational and programmatic policies and procedures organization-wide.
- Coordinates training opportunities and other professional development opportunities for program staff, including assuring service delivery staff receive clinical supervision and support.
- Collaborates and communicates effectively with other members of the foundation's leadership team to advance the organization's mission, strategy, and operations.
- Participates in meetings and promotes communication with the agency's board of directors.

Minimum Qualifications

- Extensive experience in creating and managing social programs for people with HIV/AIDS
- Advanced degree in public health, social work, law, or related field required.
- At least 7 years in leadership positions (which includes supervision of staff) within a public health, health care or social service agency required.

- Experience in public benefits systems, especially those pertaining to housing
- Experience in vocational rehabilitation with an understanding of workforce development.
- Demonstrated ability in leadership, program management, supervision and training.
- General knowledge of computer programming languages, such as Python, R, SQL, etc.
- Experience in data management and statistical analysis
- Advanced skills in creating and delivering trainings and presentations
- Demonstrated ability to handle escalated client situations
- Demonstrated ability in working with low-income individuals, people with psychiatric disabilities, people with HIV/AIDS, people of color, active drug users, people with a history of homelessness or incarceration, and people in the LGBT community

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Integrative Health Analyst

Duties & Responsibilities

- Intake clients and assess baseline of social determinants using HPP screening tool.
- Gather data on health outcomes.
- Prepare Housing Benefits Plan with clients and assist them in implementation.
- Prepare Income Benefits Plan by performing preliminary assessment of the client's level of interest and capacity for employment.
- Identify detrimental social determinants of health other than housing and employment, such as access to healthcare, education, transportation, and refer to internal external services to mitigate such social determinants.
- Refer clients to appropriate resources to combat stigma associated with HIV or racism, transphobia, etc., which negatively affect self-image and chance of vocational success.
- Establish and follow referral protocols with partner agencies to make sure clients receive seamless services and prevent clients being lost in the referral process.
- Coordinate one-on-one meetings and group trainings at the two HOPWA housing sites.
  Participate in the Housing Advisory Group.

Minimum Qualifications

- One-on-one advocacy experience essential.
- Bilingual and bicultural (Spanish, Cantonese, Mandarin, Arabic, Vietnamese or Russian) highly desirable.
- Ability to be sensitive to and work well with low-income individuals, people with psychiatric disabilities, people with HIV/AIDS, people of color, active drug users, people with a history of homelessness or incarceration, sexual minorities and gender minorities is essential.

- Strong ability in working with government agencies, nonprofit organizations, and community stakeholders
- Substantial experience in working with people living with HIV/AIDS desirable
- Ability to work effectively with service providers.
- Knowledge of harm reduction theory and practice desirable.
- Strong organizational skills with attention to detail and accuracy
- Timely follow-through and ability to meet deadlines
- Ability to work independently with minimum supervision and to prioritize and deal with diverse tasks

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Data Analyst/Intaker

- Enter client data into HPP database.
- Recruit, evaluate, intake, follow-up with and check eligibility for clients participating in the HRSA study.
- Gather data on housing, employment and health outcomes as necessary.
- Attend community meetings on homelessness and advocate for clients on a systems level.
- Establish and maintain partnerships with community providers who can support in implementation of the intervention.
- Enter client self-reported and medical chart data into Redcap.
- Run periodic reports to ensure data integrity.
- Modify data collection tools as necessary.
- Conduct follow up with HPP clients to gather post-service data.
- Coordinate with community partners to share client data (with appropriate releases).

Minimum Qualifications

- BA or 2 years one-on-one advocacy experience essential.
- Bilingual and bicultural (Spanish, Cantonese, Mandarin, Arabic, Vietnamese or Russian) highly desirable.
- Ability to be sensitive to and work well with low-income individuals, people with psychiatric disabilities, people with HIV/AIDS, people of color, active drug users, people with a history of homelessness or incarceration, sexual minorities and gender minorities is essential
- Strong ability in working with government agencies, nonprofit organizations, and community stakeholders
- Substantial experience in working with people living with HIV/AIDS desirable
- Ability to work effectively with service providers.
- Knowledge of harm reduction theory and practice desirable.
- Strong organizational skills with attention to detail and accuracy
- Timely follow-through and ability to meet deadlines

- Ability to work independently with minimum supervision and to prioritize and deal with diverse tasks
- Substantial data management/data entry experience desirable

Appendix 3: Intervention Guideline

Housing Planning Program (HPP) Intervention Guideline

I. HPP Purpose and Goal

a. Purpose

i. The purpose of the integrated health analysis (HPP) program is to improve clients' health outcomes by connecting clients to employment and housing resources. HPP uses a case management model to support clients in accessing opportunities to improve wellness.

II. Intake Checklist

a. Explain to client the purpose of HPP (housing, employment, healthcare, etc.)
b. Complete and review **Activity Checklist** with client and try to understand client priorities, barriers, and goals
c. Review the following documents with client and get them signed:
    i. Client Rights and Responsibilities
    ii. Grievance Policy
    iii. Release of information for providers as well as family and friends if appropriate
d. Forward client information and Activity Checklist to interventionist for follow-up within seven (7) days.

III. Interventionist First Day of Service (FDOS) Checklist

The first day of service (FDOS) is the first date a client meets with an interventionist to initiate housing and employment services. Complete the following at the FDOS:

a. Complete **Interventionist Questionnaire**, make appropriate referrals
b. Complete Database
c. Sign Client up for Dahlia & Plus Housing if client is ready, able, and willing.
d. Refer clients to Coordinated Entry
e. Invite client to Workforce Development (WD) orientation on Wed at 2 p.m.
    i. Make warm hand-off to Workforce Development if possible and appropriate
f. Discuss Next Steps with Client, which will include development of Service Plan
    i. Schedule next meeting or follow-up
g. After client leaves
    i. Complete Assessment/**Acuity Screening Tool**
    ii. Create physical file and put the docs in the proper order
        1. Store all physical files in file room

iii. Create an electronic client file in the HPP Shared Drive under your name. This is where Word docs, PDFs, etc. should be saved.

NOTE: If Client did not show up for intake, follow-up with the client to re-schedule intake. Make at least three (3) attempts to follow-up.

IV. Program Coordination

a. Referral and Linkage to Healthcare
   i. Link clients not engaged in HIV treatment immediately to care
      1. For primary care, refer the client to healthcare using the SF HIV Care Options reference sheet.
      2. For mental health care, refer to PRC Behavioral Health Referral Sheet
      3. For dental care, refer to University of the Pacific, Tom Waddell, Project Homeless Connect, Native American Health Center.
   ii. Document when/if linkage made in database.

b. Referral and Linkage to Housing
   i. Help clients create a user profile in Dahlia during the first day of service.
   ii. Refer clients to Coordinated Entry and assist them with completing intake within **3 months** of intake.
   iii. Proactively identify and link clients to housing resources
      1. Regularly check subsidized/low-income housing lists and communicate opportunities to clients
      2. Help clients navigate housing systems, prepare for intake/meetings, complete/compile paperwork, etc.
      3. Explore alternative housing options/resources including temporary housing with AIDS Emergency Fund subsidy, residential treatment, housing in the private market, etc.
   iv. Document in database when/if linkage made

c. Referral, Linkage, & Coordination with PRC Workforce Development
   i. Link all clients to the WD program.
      1. Encourage and support clients to engage with PRC's Workforce Development (WD) program. HPP interventionists are responsible for referring and linking clients to the WD program and confirming their engagement.
      2. Refer all clients to WD orientation, make warm hand-off when possible
      3. Follow-Up
         a. Check WD database two (2) weeks after FDOS to see if the client has completed ES intake
         b. If the client has not completed WD intake, follow-up with client regularly and support intake and engagement with WD

c. Check WD database for all clients that have not engaged with services on 1st and 15th of each month.

4. Documentation
    a. Document when/if linkage made
    b. Ex. “Checked WD database: clt completed intake on X date.”

ii. Monthly Workforce Development Case Conference
1. HPP interventionists meet on a monthly basis with WD staff for client case conferences. Matters discussed may include:
    a. Which clients that completed FDOS attended WD orientation
    b. Which clients completed intake with ES
    c. Which clients completed workshop or training
    d. What type of support client may need from HPP, other matters including housing, healthcare, etc.
    e. Specific case issues (use **Case Conference worksheet**):
        i. Enter client names, barriers/issues/questions on the Case Conference worksheet
        ii. Send Case Conference worksheet to WD **three (3) days** prior to case conference.
        iii. Complete notes in Case Conference worksheet during case conference
        iv. Save completed worksheet in archive folder for future reference.
2. Document all case conference notes in the database

iii. Six Month WD Status/Progress Review
1. Complete WD status/progress assessment **every six (6) months** after FDOS
    a. Has the client been intaked with WD?
    b. Has the client developed an Workforce Development plan?
        i. If yes, what does the plan involve?
        ii. If no, why? What assistance/support does client need from HPP?
    c. What progress made toward employment services plan?
    d. What are the next steps?
2. Document assessment/review in database.

d. Referral and Linkage to PRC Programs & Community Resources
i. Refer clients to PRC’s Aids Emergency Fund (AEF) for emergency financial assistance
ii. Refer clients to PRC’s Legal Advocacy program for public benefits and healthcare advice and legal representation
iii. Refer clients to mental health and substance & alcohol use treatment, including residential treatment
iv. Refer clients to community resources (use **Frequent Resource List**).

v. Document when referral and/or linkage made in database.

V. Service Standards

a. Assessment/Acuity Screening
   i. Complete acuity screening tool during FSOS to identify client's needs and their urgency
   ii. Complete acuity screening tool at close of service to assess impact.
   iii. Assess and identify client strengths?

b. Service Plan Development and Follow-Up
   i. Develop a Service Plan with the client, focusing on identifying client strengths and removing barriers to achieve the client's goals related to health, housing, and employment.
      1. Use **HPP Service Plan form** to identify short-term, mid-term, and long-term goals to overcome barriers
      2. Develop plan based on the activity checklist and the client's priorities.
      3. Incorporate the use of client strengths to help overcome barriers.
      4. Complete development of initial service plan within **30 days** of FDOS
      5. Document completion of Service Plan in database
      6. Save service plan in client's electronic file
   ii. Identify next steps, and who is responsible for completing them

c. Connecting Clients to Services and Supports
   i. Identify community services/resources to help address client's needs
   ii. Connect client to services/resources
      1. While referrals may be appropriate for some clients, many others will need more support to connect with resources. Supports may include reminder calls, assistance with setting up/showing up to appointments, organizing and collecting documentation, completing paperwork, reading mail, escort, navigation, etc.
   iii. Advocacy, coordination, technical assistance.
      1. Advocacy, coordination, collaboration, and technical assistance may be necessary to help client access services. These additional supports may include drafting letters of verification or support, reviewing/completing applications, researching opportunities, etc.

d. Monitoring Progress & Follow-Up
   i. Check-in and Client Follow-Up
      1. Generally, contact clients at least once every **month** to check-in. Depending on the client's situation, such as homelessness, incarceration, or other factors, check-ins may need to be more or less frequent. Check-ins are opportunities to

interact with clients, monitor progress toward goals, identify crises, update client contact information, etc. Check-ins may be in the form of a phone call, email, or in-person visit.

2. **At least once every 6 months, check the following:**
    a. **What is the client's employment status?**
        i. Currently employed
        ii. Currently part-time looking for additional work
        iii. Per diem work
        iv. Under the table
        v. Other employment status? (Describe)
    b. **What is the client's housing status?**
        i. HOPWA
        ii. HUD rental assistance
        iii. Public Housing
        iv. Non-HUD funded housing
        v. Other housing (Describe)
    c. **Is client engagement in care*?**
        i. Not engaged in care
        ii. Engaged in care
        iii. *Specify if by lab value, electronic record, or by self-report
    d. **Is client virally suppressed*?**
        i. Not virally suppressed
        ii. Virally suppressed
        iii. *Specify if reported by lab value, electronic record, or by self-report
3. Document all client contact and efforts to contact client in the database.

ii. Review & Revise Service Plan

1. Review and revise service plans at least **every 6-months** or as circumstances and goals change.
2. Document review and/or revision in database, including the following
    a. What were the client's goals?
    b. What progress made toward achieving those goals?
    c. What prevented client from achieving goals?
    d. What are client's current goals?
    e. What is the plan for achieving the client's current goals?
    f. What are next steps for accomplishing current goals? Who is responsible for completing next steps?

VI. Service Notes, Record Keeping, and Tracking Time

a. Document all service efforts and track time spent on efforts in the database
    i. 1 Unit of Service (UOS) = 15 minutes

ii. Contact UOS = time spent speaking with or meeting with client, emailing with the client when it is expected that the client will return respond.
iii. Non-Contact UOS = time spent on the client's behalf that does not involve direct client interaction, e.g. research, calling third parties, reviewing paperwork, case conferencing, etc.
iv. Interventionists are expected to track an average of 28 UOS/day

b. How to Write Service Notes
   i. Service notes should be complete, concise, and relevant
   ii. Service notes should address the following questions, and always end with NEXT STEPS
   iii. Use P-I-R-P as a guide in writing service notes:
      1. P—What is the problem?
      2. I—What is the intervention?
      3. R – How did client respond to intervention?
      4. P—What is the plan moving forward?
   iv. Other questions to consider:
      1. Who did the service/contact involve?
      2. What type of service/contact was involved (in-person, over the phone, email correspondence, etc.)?
      3. When & where did the service/contact occur?
      4. What topics/issues were discussed or addressed (what was discussed, what information was shared, what advice was provided, etc.)?
      5. What information or assistance was provided?
      6. What are the next steps? To be completed by whom and by when?
   v. Interventionists should complete service notes concurrently with or immediately after the service/contact. Service notes should entered within the same day of service/contact.

c. Record Keeping
   i. Copies of all documents created on the client's behalf should be stored electronically in the client's electronic file
   ii. All paper documents should be kept in the client's physical file.
   iii. Do not keep original documents for safekeeping.

VII. Program Graduation

a. Reasons for Exiting Program
   i. Client wishes to disengage
   ii. Client out of touch for 6 months or more
   iii. Violation of program policies, ex. engaging in inappropriate behavior and unable to remediate

iv. Unable to meet the client's needs, client needs higher level of service.
v. Client moved out of service area
vi. Client achieved goals and ready to move onto next phase

b. Exiting Assessment
   i. Review the activity checklist, perform acuity screening, and review the service plan to help client and interventionist decide if graduation is appropriate.
   ii. Review Activity Checklist
      1. What priorities have been addressed?
      2. What additional support may be provided, if any?
   iii. Perform Acuity Screening/Assessment
      1. Interventionist should consider whether there has been any reduction in acuity.
      2. If acuity is still high, it may not be appropriate for client to graduate from services.
   iv. Review Service Plan
      1. What progress made toward achieving goals from FDOS?
      2. What progress made toward achieving goals from current service plan
      3. Are there other supports/resources more appropriate to address client's goals at this time?
      4. Is the client capable of connecting to services/resources independently?
      5. What progress made toward employment, housing, health outcomes?
c. Plan for Next Stage
   i. Discuss program graduation with client and devise a plan for the next stage
   ii. Identify successes, any ongoing barriers, resources to address ongoing barriers, and next steps.
   iii. Identify resources for next stage
   iv. Coordinate with other services providers where appropriate.
d. Exit Interview
   i. Review plan for next stage with client
   ii. Communicate that the client has graduated from the program, but should circumstances change or if the client needs further support, we are available.
e. Closing Summary
   i. Document case closure in the database including the following:
      1. Reason for case closure
      2. Outcomes/goals achieved during services, if any

Appendix 4: Activity Checklist

The HIV, HOUSING & EMPLOYMENT PROJECT

Date: _____

Integrative Health Analysis

Client ID: _____

MEDICAL / DENTAL / VISION

- ❑ HIV Medical Care
- ❑ Dental or Vision Care
- ❑ Mental Health Care

PERSONAL HYGIENE

- ❑ Hygiene Supplies
- ❑ Free Haircuts

FINANCE

- ❑ Open an account with one of "BankOn San Francisco" sites
- ❑ Consumer Credit Counseling Service
- ❑ Money Management
- ❑ General Assistance or CAAP

LEGAL

- ❑ Benefit Counseling: SSI, SDI, SSDI (PRC)
- ❑ Immigration/Housing/Bankruptcy/Conservatorship/Tax, etc.
- ❑ Criminal Justice issues

EMPLOYMENT

- ❑ Employment Services (PRC)
- ❑ DOR Orientation (PRC)
- ❑ Barista Training
- ❑ CHEFS Program
- ❑ Volunteer Programs
- ❑ Mental Health Day Treatment
- ❑ Group Therapy & Support groups
- ❑ GED Classes

HOUSING

- ❑ DAHLIA / Plus Housing
- ❑ Coordinated Entry
- ❑ Treatment Programs with Housing
- ❑ 311 Shelter Reservation Waitlist for a 90 day bed
- ❑ Housing Clinics
- ❑ Housing in other cities or States

OTHERS

- ❑ DMV IDs
- ❑ MUNI CLIPPER Card
- ❑ Public Library Card
- ❑ Lifeline Mobile Phone
- ❑ Low Cost Computers
- ❑ Food Stamps & Food Banks

prc℠ WE MOVE PEOPLE FORWARD

Appendix 5: IHA Interventionist Questions

Contact Information

Address_____

Phone_____ Email_____

Additional Contact

Name_____ Relationship_____

Phone_____

Demographics

Gender_____ TG Detail_____

Sexual Orientation_____

Ethnicity 1:_____Ethnicity 2:_____

PART 1: HOUSING QUESTIONS

Current Living Situation_____ Current Since_____

Living Situation 1 Year Ago_____

1. If you are in transitional housing, what was your entrance date and what is your projected exit date?
Entrance_____ Exit_____

2. Are you a citizen? If not, are you a documented immigrant? We ask this so that we know what type of government benefits you might be eligible for.

3. Are you a veteran? (y/n)

4. Where (geographically) would you most like to live?

5. If you would most like to live in San Francisco, are you willing to relocate?

6. Do you have any debt? If yes, how much?

7. Are you interested in credit/debt counseling services?

8. What is your credit score, if you know? This question is relevant for private housing application.

9. Have you experienced an eviction within seven years?

10. Have you been convicted of a felony within the past seven years? This question is relevant for private housing application.

11. Do you have any of the following?

- COP_____
- Displaced tenant_____
- Live/work in SF_____

12. Do you receive any housing subsidies?

13. Have you used the AEF $500 grant?_____ $1,000?_____

14. Do you have a family member or friend member that you can and want to live with?

If yes, what is your relationship to that person?_____

Where is this person geographically? _____

15. Do you have a mental health diagnosis?

Source:_____ Provider:_____

Provider Phone_____

PART 2: MEDICAL TREATMENT QUESTIONS

HIV Disease Stage_____ HIV Diagnosis Source_____

HIV Diagnosis Date_____ Viral Load_____

Private Insurance_____ MediCare_____ MediCal_____

16. How frequently do you experience treatment interruptions?

17. Would you like reminders to take your medication?

18. What transportation do you primarily use to get around the city?

19. Does a lack of transportation options prevent you from making appointments?

20. Would you like someone to contact you to help explore available transportation options that could help you make appointments?

21. Would you like someone to accompany you to your medical appointments?

22. Are substances interfering with your daily life?

23. Would you be interested in a residential treatment program for substance use?

24. Are you interested in a Sober Living Environment?

PART 3: INCOME QUESTIONS

25. Do you have any regular sources of income?
    a. If yes, please list your income sources and approximate monthly amount.
    (I.e. work, public benefits, cash work, subsidies, and help from family/friends/significant other).

Income Source	Approximate Monthly Amount

    b. Do you have anyone dependent on you for income? If yes, who and how many.

26. Which of the following categories best describes your current employment status?

    a. Employed, working 40 or more hours per week
    b. Employed, part-time
    c. Not employed
    d. Choose not to answer
    e. Maintained employment since_____

If currently unemployed:

27. If you are currently not employed, are you interested in employment?
    a. Yes, I am interested in full time work
    b. Yes, I am interested in part time work
    c. Yes, I am interested in both full and part time work
    d. No, I am not interested in any work right now
    e. Not sure
    f. Choose not to answer
    g. n/a

28. Do you consider yourself disabled from work?
    a. Yes, completely
    b. Yes, but I think I can do some part time work
    c. No
    d. I am not sure

29. If you are currently receiving public benefits (i.e. GA, UI, SDI, SSDI, SSI, LTD, or STD), please answer questions below:

    a. On a scale of 1-10, when thinking about returning to work, how concerned are you of losing your income benefits? (scale 1-10) and
    b. Health insurance benefits? (scale 1-10)

30. If you consider yourself disabled but you are not receiving disability based income such as SSI, do you want help with getting these benefits, e.g. an social security attorney?

    a. Yes
    b. No, I don't want to be on disability benefits like SSI or CAPI right now
    c. No, I already have someone helping me (request name and contact info)
    d. n/a

<u>If currently employed:</u>

31. If you are currently employed, please tell us about your current job. Where? Title? For how long? What is your rate of pay?

32. Please rate the satisfaction of your current job on a scale of 1-10
    a. (scale 1-10)

33. Do you need emotional or practical support in daily activities (i.e. laundry, house cleaning, grocery support)?

Appendix 6: Acuity Screening

Intervention Acuity Screening

Client's Name: _____ Date: _____ Staff: _____

Please check one box for each life area.

Life Area	Self-Management	Moderate Needs	Urgent Needs
Medical & Mental Health			
Linked to HIV care	☐ Engaged in consistent HIV medical care	☐ Completed 50% or more HIV medical appointments in the last 6 months	☐ Has completed less than 50% of HIV medical appointments in the last 6 months
Health Insurance / Medical Care Coverage	☐ Has own medical insurance, able to access medical care	☐ Enrolled in medical care benefits programs, needs occasional assistance accessing care	☐ Needs referral, no health insurance or inadequate benefits, needs immediate assistance
Current HIV Health Status	☐ Virally suppressed, no hospitalization in the last 6 months	☐ Detectable viral load, no hospitalization in the last 6 months	☐ Refuses ARVs with CD4< 200, or newly diagnosed in the last 6 months
Medication Adherence	☐ Adherent to medication 100% of time	☐ Adherent to medication 50% or more time, reminder not needed	☐ Resistance or minimal adherence to medications, or reminder needed
Mental Health	☐ No history of mental health Issues; no treatment required or getting adequate care	☐ History or current difficulties, already engaged in mental health care	☐ Immediate intervention needed; danger to self or others or gravely disabled
Substance Use	☐ No difficulties or long term stability or no history	☐ History or recurrent problems, not impacting daily functioning	☐ Current use impacting daily functioning, immediate Intervention needed

Client's Name: _____ Date: _____ Staff: _____

Life Area	Self-Management	Moderate Needs	Urgent Needs
Dental Care	☐ Has own dentist, no oral hygiene issues at this time,	☐ Need dental care but not urgent, has access to dental care, referral may be needed	☐ Need urgent dental care, referral needed
Vision Care	☐ Has own optometrist, no vision issue, or no corrective lenses needed at this time	☐ Need vision care but not urgent, has access to vision care, may need new corrective lenses	☐ Need urgent vision care, referral needed
Psychosocial Health			
Housing / Living Situation	☐ Living in safe, stable housing, no housing need at this time	☐ Unstably housed; transitional housing, tx programs, etc. or stably housed but difficulty with rent payment	☐ Urgent needs of housing; homeless on streets/ shelters, or facing eviction
Culture / Language	☐ Understands service available and is able to navigate it, no cultural stress or difficulty	☐ May be functionally illiterate and needs assistance with written materials or limited English comprehension but no translator needed	☐ Unable to understand or navigate services due to illiteracy or limited English comprehension; needs translator
Support System	☐ Has healthy support system other than service providers	☐ Has a limited support system, would like to expand and knows how to go about	☐ Has no support system at all, in jeopardy of social isolation, need intervention

Client's Name: _____ Date: _____ Staff: _____

Life Area	Self-Management	Moderate Needs	Urgent Needs
Legal			
Legal	☐ No recent or current legal problems or the issue has been addressed, no further action needed	☐ On probation or recently released in the last 3 months, or may need legal referral	☐ Has legal crisis; active warrants, etc., legal referral needed
SSI / SSDI Benefits	☐ No needs for disability benefits, or is pending, no action needed at this time	☐ Applied for benefits but denied; needs further assistance, or lost benefits and wants to re-apply	☐ Needs referral to benefit counseling
Employment / Community Engagement			
Employment	☐ Gainfully employed or actively engaged with Employment Services	☐ Somewhat engaged with Employment Services, not being employed in the last 6 months	☐ Not engaged or minimal participation in employment activities or not seeking employment due to disability
Vocational Training /School	☐ Enrolled in school/vocational programs, no attendance issue, or no needs of additional training or education	☐ In process of enrolling in school/vocational programs, or has not taken action needed to enroll, additional support may needed	☐ Needs full support and assistance; not sure of areas of study or training needed or how to register
Volunteer / Other Community Engagement	☐ Fully engaged with the community; actively participating in volunteer work	☐ In process of signing up for volunteer work or other activities, additional support may needed	☐ Needs full support and assistance; has no community resources

Client's Name: _____ Date: _____ Staff: _____

Life Area	Self-Management	Moderate Needs	Urgent Needs
Income / Finance			
Income	☐ Has steady income; employment, SSI, SSDI, etc.	☐ On GA seeking employment or SSI/SSDI pending	☐ No income, immediate intervention needed
Money Management	☐ Has no issue managing own finance; pay all bills on time 90% or more time	☐ Has some difficulty with managing own finance; pay all bills on time 50% or more time	☐ Has significant problems; behind with bill payments 90% of time, no money left by mid month, or often borrow money from others to get basic needs met
Credit History	☐ Has a good credit history; no issue with renting a house, no substantial debt history	☐ Has a moderate level of credit history; usually no issue with renting a house, financial education may needed	☐ Has a significant amount of debt with no payment plan, urgent needs of credit counseling
Other Needs			
Food Security	☐ Has a full access to food and knows how to obtain them	☐ Has a full access but not sure how to obtain them	☐ Has a limited or no access to food, needs immediate assistance
Photo IDs /Clipper Card / Library Card	☐ Has official IDs, SS Card, and/or Clipper card, no referral or assistance needed	☐ Needs to obtain official IDs or/and Clipper card, referral may needed but no assistance needed	☐ No IDs or Clipper card, requires assistance accessing IDs/Clipper card
Telephone/ Internet Access	☐ Has a working phone and full access to internet	☐ Has a working phone but often struggle to pay the bill on time, access to internet at public space only	☐ Has no working phone, no access to internet, need referral or assistance

Appendix 7: Service Plan Form

IHA SERVICE PLAN

Today's Date: _____ Entry Date: _____

Client Name: _____

Client Strengths: _____

Barriers	Short-Term	Mid-Term	Long-Term
	Goal:		
	Objective:		
	Goal:		
	Objective:		
	Goal:		
	Objective:		

Client Signature _____ Staff Signature _____