SPOTLIGHT

INTEGRATING HIV CARE, HOUSING, AND EMPLOYMENT SUPPORT IN A FEDERALLY QUALIFIED HEALTH CENTER: A NO WRONG DOOR APPROACH

Lessons learned from Fenway and AIDS Action in building a system between the Medical Case Management (MCM) and Housing programs to meet clients' social and medical needs, including access to HIV care, housing support and employment services.

SUMMARY

Fenway Health provides HIV care and treatment, including access to Medical Case Management. AIDS Action Committee (AAC), the public health division of Fenway Health, provides comprehensive housing services, including housing search and rental assistance. With funding from the HRSA HIV/AIDS Bureau (HAB) Ryan White HIV/AIDS Program (RWHAP) Part F, Special Projects of National Significance (SPNS) Initiative "Improving HIV Health Outcomes through Coordinated Housing and Employment Services", Fenway partnered with MassHire Downtown Boston, a division of Jewish Vocational Services (JVS), Greater Boston's largest workforce development provider, to provide employment services.

Clients worked with medical case managers to engage and remain in care and treatment, and were referred for housing services and employment assistance. A RWHAP SPNS-funded Project Coordinator facilitated this care coordination between the medical case management program, employment services agency, and each housing program.

Through this project, Fenway Health/AAC and JVS/MassHire developed integrated systems of referrals, case coordination and resource sharing. The systems developed through this SPNS project allowed for program sustainability. Initially funded as a RWHAP SPNS project to focus on people with HIV who were unstably housed and in need of employment services, the program expanded to other Ryan White HIV/AIDS Program clients who are looking for employment opportunities.

THE HIV, HOUSING & EMPLOYMENT PROJECT

WHY THIS SPOTLIGHT?

- **Why:** People with HIV who experience unstable housing may have competing social and medical needs which require multiple interactions with various parts of the care system. This can lead to duplication of effort, confusion between provider and client, or lapses in communication. Staff from each part of the system need to communicate and coordinate to meet multifaceted client needs. We call this the "no wrong door" approach.
- **What:** The spotlight describes Fenway Health's best practices for building a comprehensive system to address medical and social needs for people with HIV through a two-pronged approach:
  - Integrating existing services at a Federally Qualified Health center (FQHC) & AIDS Services Organization (ASO)
  - Identifying and building partnerships to address employment needs

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This Spotlight will:

- **Review key steps in breaking silos to support team integration and coordination at the organizational level such as: creating & merging staff roles & data systems**
- **Discuss the challenges of different data systems and struggling with documentation and tracking clients**
- **Reflect on the importance of co-location and regular team meetings between groups to share client cases, & communicate about client acuity**
- **Share strategies on building organizational capacity and systems for clinic and community-based partnerships such as utilizing a central project coordinator**

Organizational & Intervention Background: Describing the players/partners, their roles, and services

Fenway Community Health Center, Inc. (Fenway Health) is a FQHC and longtime recipient of Ryan White CARE Act funding under Parts A and C to provide case management and early intervention services to people with HIV. Fenway Health is the largest non-hospital provider of HIV/AIDS medical and behavioral health services in Massachusetts, serving 2,576 people with HIV annually. In 2013, in strategic response to health care reform and evolution of the HIV/AIDS epidemic, Fenway Health began a merger process with AAC of Massachusetts, Inc. Until then, AAC was operating independently as Massachusetts' largest community-based AIDS Service Organization. AAC brought to the partnership extensive experience and infrastructure for providing housing services.

Following a five-year strategic partnership, Fenway Health merged with AAC in 2018, just as this SPNS project began. As the Public Health Division of Fenway Health, AAC provides community-based services to people with or at risk for HIV, regardless of where they receive primary medical care. These services include the Sexual Health Program, Drug User Health Program, and Social Determinants of Health (SDOH) services, including housing, legal, a homeless youth program, and case management programs. The Housing Department was a key part of this intervention and receives funding through Housing Opportunities for Persons with AIDS (HOPWA), RWHAP and state allocations.

MassHire Downtown Boston is a division of Jewish Vocational Service (JVS) and is supported by the US Department of Labor (DOL), whose mission is "to empower individuals from diverse communities to find employment and build careers, and to partner with employers to hire, develop and retain productive

workforces." The MassHire career center is embedded in JVS, a major workforce development provider in Massachusetts. Clients are able to access a wide range of services and activities, free of charge, as well as obtain valuable information, resources, and potential acceptance to a variety of skills training programs, English classes, and adult education services. The RWHAP SPNS project and its funding were used to create an innovative partnership between Fenway Health and JVS/MassHire to address the unmet need of income and employment identified among Fenway/AAC clients. The project was created with buy-in from both leadership and front-line staff, cultivated by cross-training onsite at both Fenway and MassHire locations.

Project Goals:

The goals of our innovative model were twofold:

- Integrate employment services into existing clinical and housing services provided by Fenway Health via screening, referrals and ongoing coordination with employment services by JVS/MassHire Downtown Boston;
- Build and strengthen systems of integrated care within Fenway Health, coordinating clinical case management and housing services.

This model leveraged existing HIV care and housing services, and introduced integrated employment services. Clients served in this program primarily received HIV care and medical case management at Fenway Health, while some others received care at external clinics throughout Greater Boston. At Fenway Health, medical case managers (MCMs) help with communication and navigation of Fenway Health services. They link patients to community resources, refer to other agencies, and help patients apply for benefits programs when applicable/eligible. AAC provided the housing services involved in this intervention, through three different housing programs: Housing Search, Rental Assistance Programs, and Supportive Housing programs. Fenway partnered with JVS/MassHire to provide employment services to clients through this project. The RWHAP SPNS Project Coordinator served as a hub for referrals and ongoing case coordination.

Assessment of employment & income needs for people with HIV: JVS/MassHire Downtown Boston, as a Department of Labor partner, provided the employment services component of the intervention. Clients underwent an extensive intake and assessment by a dedicated career navigator who helped map out an individualized job search plan.

Employment services included access to free daily workshops; networking groups; job search strategy groups; information and referral to skills training programs; advice and assistance with citizenship, green cards and criminal background checks; resources for ex-offenders; English classes, adult education, and other educational programs.

The key components of our partnership with JVS/MassHire were co-location of services, collaborative communication, cross-training staff, data sharing, consistent case coordination and having a bilingual career navigator dedicated to this project.

Integrating a Bilingual Career Navigator into the MCM and Housing Care team: The dedicated bilingual career navigator was a single point of contact for all Fenway staff, enabling case managers and housing advocates to follow up regarding individual clients and ensuring quick and efficient processing of all new referrals. The RWHAP SPNS Project Coordinator worked closely with the career navigator: communicating almost daily, sending referrals, following up on existing clients, and meeting weekly for case coordination discussions.

Fenway and JVS/MassHire staff were cross-trained in the services provided by each agency. Fenway case managers and housing advocates toured JVS/MassHire and the career navigator presented the orientation session offered to new MassHire clients. These visits and trainings allowed Fenway staff to be more knowledgeable about the employment services offered and facilitated more detailed conversations with clients at the time of referral.

Documentation of employment services for people with HIV in DOL database and Fenway Health: JVS/MassHire documented client work in their Efforts to Outcomes (ETO) and provided client level data reports to Fenway on a monthly basis. The project coordinator added key client outcomes and progress indicators to AAC's ETO. This sharing and consolidation of data allowed project staff to track client outcomes on the individual and aggregate levels, and to use data to identify trends.

CHALLENGES

As this RWHAP SPNS project began, Fenway Health and AIDS Action Committee finalized the merger between the two organizations. We immediately recognized several barriers:

- **Need for communication and coordination between MCM and Housing:**
    - Lack of internal communicating structures and protocol between medical case management and housing programs
    - Different data and documentation systems that are not interoperable
        - Fenway: EHR – Centricity Practice Solution (CPS)
        - AIDS Action: ETO
    - Separate offices for clinical and social determinants of health work
    - Service areas and teams operating in silos, requiring buy-in from both leadership and front-line staff in order to increase integration
- **Overburdened MCMs and Housing case managers; there was a need for dedicated staff to coordinate various client needs.**

Strategies

- No wrong door approach: 4 components

1) Co-location

- Initially, all clients were referred for services on-site at JVS/MassHire. Midway through the intervention, we adjusted our model to one of co-location: the career navigator was on-site at AIDS Action for weekly drop-in hours for new and existing clients.
- Clients often have difficulty navigating a fragmented service system. Therefore, whenever possible, it is best to offer multiple services in one location so that clients can access needed resources in one place. Clients eligible for this program often have multiple needs and the ability to address them in one location provides a productive and beneficial experience for clients.
- The addition of JVS/MassHire's drop-in hours on a weekly basis at AIDS Action's main location allowed RWHAP SPNS clients that had difficulty connecting and following up with JVS/MassHire to meet the employment navigator and begin working towards employment goals. The co-location of services shifted the intervention to a lower-threshold model. Clients were also able to meet with their behavioral health provider, housing advocate, attorney, and MCM at the same location in the same day.

2) Integrated data system to bring medical and social needs through an informatics team

Fenway Health brings a particular strength in managing and leveraging data. Fenway's Informatics Team is embedded within The Fenway Institute, Fenway Health's integrated research arm. This team maintains the electronic medical record in the form of CPS. The Informatics team also provides real-time, filterable reports from CPS in Tableau Server. A subset of the Informatics Team also maintains AAC's database, an instance of Efforts to Outcomes (ETO). ETO also contains a built-in reporting and visualization platform called ETO Results. The Informatics Team also maintains an instance of REDCap; one of the many projects we maintain in REDCap is one for managing referrals for the RWHAP SPNS project.

- As part of this project, we customized forms in our Electronic Medical Record (CPS) for medical case management, such as RWHAP intake or discharge, acuity assessments, and outreach. We also developed an innovative approach to tracking case coordination and navigation in our Community-based work (ETO).
- ETO also included a built-in data reporting and visualization platform called "ETO Results". We used this platform to build real-time reporting dashboards that program staff and managers were able to run at any time, not just evaluators. These reports were structured to be useful for quick information that programs needed for operations, as well as for reviewing outcomes and data quality.
- For visualization and analysis of the data, we used Tableau because were able to connect it directly to real-time data sources through queries, including CPS and REDCap data. This allowed us to show HIV outcomes data for participants of this project who were receiving their medical care at Fenway Health.

"Fenway Health brings a particular strength in managing and leveraging data"

3) Hiring a Dedicated Project Coordinator: Roles & responsibilities

The Project Coordinator facilitated the completion of referrals to appropriate programs, establishing several systems of communication to do so:

- The Project Coordinator followed up with referring MCMs to confirm the client's housing need and provide information about connecting with appropriate housing supports, including housing search and rental assistance. After clients were referred to housing services, the existing program coordinators in the Housing Search and Rental Assistance Programs processed the referrals and communicated with the referring case manager.
- The Project Coordinator provided the medical case management liaison with an updated spreadsheet regarding clients' housing referral status on a bi-weekly basis. This allowed the MCM liaison to follow up with their team and stay updated on the status of clients' housing referrals.

- The Project Coordinator attended a monthly meeting with the Fenway MCM team to provide and receive updates regarding housing referrals.
- The Project Coordinator and Housing Search Coordinator met monthly to follow up on SPNS/Housing Search referrals and were in consistent communication regarding these clients.
    - The Project Coordinator also met with employment services navigator on a weekly basis to remain updated on client activities and progress; after we started co-located drop-in employment services this sometimes took place in person.
- The Project Coordinator also facilitated referrals for MassHire's employment services using a standardized referral form. The referral included basic, necessary identifying information including client name, DOB, and contact information, case manager's contact information, and any notes regarding current employment situation. The project coordinator sent these referrals to the MassHire liaison via secure email. The liaison then reached out to the client directly to schedule an initial Welcome Session at MassHire and one-to-one career coaching session. The Welcome Sessions were offered daily and provided a general overview of services, trainings, workshops, and other employment related resources that clients can utilize at MassHire.

4) Established Standard Communication Processes

Creating space for regular meetings that are part of the integrated program structure, as well as joint training opportunities are examples of action steps developed with the goal of increasing internal collaboration across programs. We held consistent biweekly meetings that included Housing, MCM and Evaluation staff. These meetings came to include quality improvement (QI) staff with increasing frequency, ultimately with the QI staff member attending all meetings. These meetings provided space to discuss data, client engagement and barriers, and to work toward systems level changes through the QI framework.

"Creating space for regular meetings that are part of the integrated program structure"

OUTCOMES

Client outcomes:

92 clients were served (75% were male, 14% female, 11% Transgender, non-binary or unknown gender identity); all were unstably housed at enrollment and not employed

65 clients received housing support services

74 clients received employment support services

23 clients were able to obtain a job or which 20 received full or part time work via MassHIRE services

68% were virally suppressed

64% were retained in care

Systems Outcomes

Housing and MCM team integration

- Program leadership know each other and their work
- Team members know each other and their work
- New work flows that support coordinated care with new, revised, improved protocols and procedures
- Service coordination: staff coordinate locating clients and traveling between locations
- Working on data integration: Training managers in using and understanding each others' data systems to view notes and find clients, and to view aggregate-level data

Employment services integration

- Fenway/AAC staff know MassHire services and referral process is bidirectional

Data sharing

- Dashboard reports were developed for AAC housing clients receiving medical care at Fenway, including waitlist status, housing advocate assignment, housing placements, and engagement in services to support MCMs informed across service areas.
- CPS form was developed for documenting housing search referrals and program enrollments consistently, to allow follow-up and process improvement.
- Inspired by this project, we strategized to create shared identifiers between CPS and ETO, by creating a custom field in ETO and entering the client's medical record number. This allows for data extraction from both databases to a platform such as Tableau, creating reports showing client work on aggregate and individual client levels.

NEXT STEPS

- Continuation of Project Coordinator role by leveraging existing HOPWA Supportive Services funds
- Expansion of referral and coordination relationships with employment services providers
- Ongoing QI work to enhance housing search waitlist and enrollment
- Ongoing service strengthening between Housing and MCM, including trainings for the MCM team on key housing search strategies, developing a guide for MCMs working with clients to prepare for housing search, and establishing ongoing quarterly case coordination meetings.

FIND OUT MORE

Further information about this project can be found at https://targethiv.org/housing-and-employment. Here you can find other site spotlights, program implementation manuals, client stories, and other resources.

ACKNOWLEDGMENTS

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number H97HA31428 Special Projects of National Significance (SPNS) Initiative, Improving Health Outcomes Through the Coordination of Supportive Employment & Housing Services, in the amount of $299,908.00 awarded to Fenway Community Health Center. No percentage of this project was financed with non-governmental sources. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.