

Progress Report



Permanent Supportive Housing, Transitional Supportive Housing and Emergency Single Room Occupancy HASA Housing Pilots: Enrollments from September 21, 2018 to March 15, 2020

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Executive Summary

Pilot overview: The HIV/AIDS Services Administration (HASA) initiated the Permanent Supportive Housing (PSH) pilot and Transitional Supportive Housing (TSH) pilot in September 2018, and the Emergency Single Room Occupancy (ESRO) housing pilot in May 2019. The pilot projects in New York City feature specialized units of HASA caseworkers whose caseloads are determined based on client acuity, as determined by housing status. Many clients living in ESROs and TSHs tend to have more complex needs stemming from mental health and substance use disorders. Therefore, the pilots are designed around the hypothesis that residents of ESRO or TSH would benefit from more intensive HASA intervention, while clients living in PSH, particularly durably virally suppressed clients, could tolerate a less intensive intervention from HASA. Consequently, the caseload ratio is decreased to 25:1 for HASA caseworkers in the TSH or ESRO pilot and increased to 50:1 for HASA caseworkers in the PSH pilot. The TSH and ESRO caseload ratios are lower than non-pilot caseload ratios, and the PSH caseload ratio is higher than non-pilot caseload ratios. Other notable changes to standard practice across all three pilots include: 1) housing-specific assignment, i.e., HASA caseworkers having all TSH cases at pilot housing provider sites versus caseworkers having clients with a mix of housing categories at non-pilot sites, and 2) HASA and housing providers prioritizing case support related to viral suppression and health promotion. HASA caseworkers were also responsible for gaining client consent to use Healthix, and pilot caseworkers were trained on Healthix before non-pilot caseworkers and have more access to Healthix information than non-pilot caseworkers. The purpose of Healthix in the pilots is to allow client demographic and laboratory data on HIV treatment outcomes to be shared amongst participating providers. Healthix, which serves patients throughout New York State, is the largest health information exchange (HIE) in the country, with over 8,000 participating facilities and 20 million patients.

Aim: The aim of the Pilot Progress Report was to describe available data on pilot fidelity and the implementation process at all three pilots.

Methods: We summarized programmatic data from HASAWeb, an internal HASA database, and generated descriptive statistics on pilot caseworker to client ratios, client enrollment, consents to Healthix, and average number of visits received by clients. Enrollments through March 15th, 2020, were included in the quantitative analysis, due to suspension of the pilot following the governor's 'NYS on Pause' executive order halting the work of non-essential businesses statewide on March 20, 2020 during the COVID-19 pandemic.¹ Qualitative data were collected from notes from two sources: 1) monthly PSH and TSH provider calls, and 2) monthly HASA planning meeting calls (attended by program and evaluation staff at the New York City Department of Health and Mental Hygiene, HASA, and City University of New York (CUNY)) to understand implementation barriers and facilitators and best practices. Notes from the meetings were analyzed via conventional content analysis methods and coded into related categories to identify various challenges and facilitators to successful implementation. Meetings through June 2019 were included in the analysis.

¹ The pilots resumed July 6th 2020 with HASA caseworker in-person visits to clients remaining suspended, and all interactions conducted by telephone.

Quantitative results

Enrollment, caseload ratios, and visits to clients

From September 2018 to March 2020:

- A cumulative total of 374 clients had enrolled in the **PSH pilot**, and 298 people were currently enrolled.
 - On average, clients were enrolled in the pilot for more than 365 days (mean: 436 days and median: 541 days). The caseload ratio as of March 15, 2020 was 43:1.
 - The PSH pilot required the HASA caseworker and support team to meet bi-annually with the client versus quarterly in the non-pilot, and the PSH caseworkers had higher caseload ratios relative to non-pilot caseworkers. The progress reports captured successful visits, which was defined as successful contact with the client.² The proportion of clients with a successful visit that occurred bi-annually or more frequently was aligned with the pilot protocol and, as expected, was lower among pilot clients than non-pilot clients (64% versus 76%).

- A cumulative total of 688 clients had enrolled in the **TSH pilot**, and 206 people were currently enrolled.
 - On average, clients were enrolled in the pilot for approximately five months (mean: 151 days and median: 108 days). The caseload ratio as of March 15, 2020 was 23:1.
 - The TSH pilot required the HASA caseworker to conduct monthly face-to-face home visits. Visit frequency in the TSH pilot is the same frequency as TSH non-pilot but caseload ratios are lower in the pilot relative to non-pilot. The proportion of TSH pilot clients with a successful monthly visit was low, but the proportion was nearly double the frequency of non-pilot clients (21% of pilot clients versus 12% of non-pilot clients). Additionally, the proportion of TSH clients with 1 visit every three months was higher among pilot versus non-pilot clients (57% and 39%, respectively).

From May 2018 to March 2020:

- A cumulative total of 341 clients had enrolled in the **ESRO pilot**, and 199 people were currently enrolled.
 - On average, clients were enrolled in the pilot for a little less than 6 months (mean: 170 days and median: 171 days). The caseload ratio as of March 15, 2020 was 25:1.
 - In the ESRO pilot, HASA caseworkers were to conduct monthly face-to-face visits (or more frequently, as needed). Visit frequency in the ESRO pilot is the same

² Data on HASA caseworker attempted or unsuccessful visits were unavailable per the MOU for the evaluation of the HASA pilots. An unsuccessful visit may mean that the HASA caseworker attempted but did not meet with the client.

frequency as ESRO non-pilot but caseload ratios are lower in the pilot relative to non-pilot. The proportion of pilot clients with a successful monthly visit was low and was nominally lower than non-pilot clients (8% versus 10%, respectively). The proportion of pilot clients with a successful visit every 3 months was higher in the pilot than non-pilot (46% versus 39%, respectively). This suggests that overall, pilot and non-pilot clients had similar visit frequencies with 54% and 49% having a visit once a quarter or more frequently.

Healthix consents

- The proportion of people with documented consents to Healthix was highest among the PSH pilot (77%), followed by the TSH and ESRO pilots (61% and 57%, respectively).
- In the non-pilot, the proportion of people with documented consents to Healthix by facility type ranged from 43% to 48%.

Qualitative results

- The early implementation challenges identified included insufficient communication to clients about caseworker change, caseworker turnover, Healthix consent and connectivity delays, and system-level interferences with transferring an eligible client to the pilot.
- Despite these challenges, best practices and potential successes were identified including instituting an initial check-in meeting between HASA caseworker and the housing provider case managers, and faster transition to independent housing for PSH clients.

Conclusions:

- The final recruitment targets were met in the PSH pilot after 18 months of recruitment, and interim recruitment targets were met in the TSH and ESRO pilots, which should help to ensure an adequately powered assessment of pilot effectiveness for the final report.
- Caseload ratios were at or under the pilot thresholds as of March 2020, and the pilots have consented a higher proportion of persons to Healthix than non-pilots, which may help with the prioritization of viral suppression as a program goal and in case management, given increased access to viral load information via Healthix.
- In the PSH pilot, successful caseworker visit frequency occurred in line with the protocol, and visits were less frequent than in the non-pilot (as expected).
- In the TSH pilot, successful visits were less frequent than per protocol (monthly). However, the frequency of successful visits every 30 or 90 days was higher among TSH pilot than TSH non-pilot clients and may help with the prioritization of viral suppression.
- In the ESRO pilot, the frequency of successful monthly visits was low, and ESRO pilot and non-pilot clients had a similar frequency of visits, despite lower caseload ratios in the pilot relative to non-pilot.
- Recommendations to improve further intervention roll-out include creation of an intervention manual, providing intervention refresher trainings, providing technical assistance and fidelity checks to housing providers and HASA caseworkers, and ensuring

clients are contacted by telephone, in addition to a letter, to inform them of caseworker change.

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Abbreviations

CBO	Community-Based Organization
ESRO	Emergency Single Room Occupancy
DSD	Differentiated Service Delivery
HASA	HIV/AIDS Services Administration
HRA	Human Resources Administration
ICP	Integrated Care Planning
MOU	Memorandum of Understanding
PSH	Permanent Supportive Housing
PWH	Persons with HIV/AIDS
TSH	Transitional Supportive Housing
VLS	Viral Load Suppression

Pilot Overview

The HIV/AIDS Services Administration (HASA) is a program of the New York City Human Resources Administration (HRA) that serves low-income persons living with HIV in New York City. HASA provides public benefits, case management, housing, and other services to its clients. HASA clients face barriers to effective care that can result in high utilization of health care services yet poor health outcomes. New collaborations among HASA and community-based partners offer the opportunity for integrated care planning and differentiated service delivery (DSD) strategies designed to better coordinate existing HASA resources with housing, health care, and psychosocial services to achieve improved HIV and housing outcomes for all HASA clients.

DSD is a patient-centered approach to HIV prevention and care that provides a framework for reexamining service delivery in order to tailor HIV services across the treatment cascade to reflect the needs and circumstances of different groups of people with HIV, reduce unnecessary burdens on systems of care, and refocus resources to target clients most in need. HASA, in collaboration with community partners, has developed three demonstration projects that incorporate DSD principles in order to improve the experience of clients who move through the HASA system and to make HASA services more efficient and better aligned with health care integration.

In September 2018, HASA initiated the Permanent Supportive Housing (PSH) pilot and Transitional Supportive Housing (TSH) pilot. Three housing providers participated in the TSH pilot, and four in the PSH pilot. In May 2019, HASA initiated the Emergency Single Room Occupancy (ESRO) housing pilot, with three emergency housing facilities. The pilot projects feature specialized units of HASA caseworkers whose caseloads are based on client acuity as indicated by housing status. Each pilot will run for three years.

The pilots presume that residents of TSH or ESRO housing are in greater need of intensive HASA intervention, while clients living in PSH, particularly durably virally suppressed clients, are more stable and in need of a less intensive touch from HASA. Consequently, HASA caseworkers in the TSH or ESRO pilot have a 25:1 caseload ratio while HASA caseworkers in the PSH pilot have a 50:1 caseload ratio. The TSH and ESRO pilot caseload ratios are lower than non-pilot caseload ratios, and the PSH pilot caseload ratio is higher than non-pilot caseload ratios. Other notable changes to standard practice across all three pilots include 1) housing-specific assignment, with HASA caseworkers having all TSH cases at pilot housing provider sites, while caseworkers have clients with a mix of housing categories at non-pilot sites, and 2) HASA and housing providers prioritizing viral suppression and health promotion. HASA caseworkers were also responsible for consenting clients to Healthix, and while the Healthix consent practice was implemented HASA-wide, the pilot caseworkers were trained on Healthix before non-pilot caseworkers, and pilot caseworkers have more access to Healthix information than non-pilot caseworkers (where access is limited to supervisors). The purpose of Healthix is to allow client demographic and lab data to be shared amongst participating providers. Healthix, which serves patients throughout New York State, is the largest health information exchange (HIE) in the country with over 8,000 participating facilities and 20 million patients.

ESRO Selection Process for Pilot

- For the PSH or TSH pilot, there is one HASA caseworker unit per borough dedicated to the pilot. Clients are assigned to a caseworker based on assignment to a pilot housing provider or pilot unit. When a client leaves the pilot site, the client is assigned a new caseworker.
- For the ESRO pilot, caseworkers from two sites were asked to volunteer to participate in the pilot, or the least senior caseworker was selected as a pilot caseworker. HASA randomly selected 200 clients for the pilot. Client assignment to a caseworker is based on location of the client, and the desire to group a caseload for a caseworker by geographic location for ease of service/pilot delivery. To maintain 200 clients overall, the number of pilot clients is refreshed weekly.

Table 1 details the key pilot elements, aims, and intended outcomes. Table 2 details key pilot milestones. All pilots were paused from March 20 to July 6, 2020 due to the impact of the COVID-19 pandemic on HASA operations.

Table 1. Key Elements of the Pilots: PSH, TSH and ESRO Models

Pilot	Pilot design	Estimated # of unique clients to be enrolled over 3 years	Caseload to caseworker ratios <u>intervention</u> arm & type of clients	Caseload to caseworker ratios <u>control</u> arm & type of clients	Research aims and intended outcomes
PSH	Cohort study	~ 370 (intervention) ~4900 (control)	50:1 Single clients. Non-mix/single housing	Mandated 34:1, for single clients. 25:1 family cases. Mixed housing types	<u>Maintain</u> rates of VLS and housing outcomes (stability and transition to <u>independent living</u>) relative to non-pilot clients
TSH	Cohort study	~1300 (intervention) ~3400 (control)	25:1 Single clients. Non-mix/single housing	Mandated 34:1, for single clients. 25:1 family cases. Mixed housing types	<u>Improve</u> rates of VLS and housing outcomes (stability and transition to PSH) relative to non-pilot clients
ESRO	Randomized Selection	~840 (intervention) ~12,180 (control)	25:1 Single clients. Non-mix/single housing	Mandated 34:1 for single clients. 25:1 family cases. Mixed housing types	<u>Improve</u> rates of VLS and housing outcomes (stability and transition to PSH or TSH) relative to non-pilot clients

Table 2. Pilot Milestones

Date	Pilot	Updates to Pilot	Rationale/Details
July, 2018	PSH/TSH	Motivational Interviewing training for staff	HASA staff conducted joint Motivational Interviewing training with PSH Providers on 7/17/18 and with TSH Providers on 7/25/18
July, 2018	PSH/TSH	Training on pilot procedures for housing providers	
September 18, 2018	PSH/TSH	Training on pilot procedures for HASA staff	Training on the PSH and TSH Housing pilot models for HASA staff on 9/18/18
September 21, 2018	PSH/TSH	Pilots Launched	
October 5, 2018*	PSH/TSH	HASA begun consenting people to Healthix	Pilots launched prior to Healthix trainings

Date	Pilot	Updates to Pilot	Rationale/Details
October 19, 2018*	PSH	Dropped the moving-on component ^a .	Did not want clients to feel like they had to 'move on'. Pilot team had questions about how to correctly implement the move-on assessment
October 22, 2018	PSH/TSH/ESRO	Healthix consent trainings	Healthix consent trainings for HASA staff
November 7, 2018	PSH/TSH	Established a 'coordination meeting' for pilot clients	The first meeting should be with the provider and caseworker to review the roster of client.
November 16, 2018	PSH/TSH	All pilot staff trained on consenting to Healthix. Outside of the pilot, persons with a supervisor-2 title were trained	
April, 2019	PSH	25 cases transferred from SUS Jerome – Palladia Court site to new pilot site, West Farms/Comunilife – Congregate	SUS Jerome – Palladia Court site was closed.
April 8, 2019*	PSH/TSH	HASA uploading information daily to Healthix	
April, 2019	ESRO	Training on ESRO pilot procedures for HASA staff	Training on the ESRO Housing Pilot Model for HASA staff
May 24, 2019	ESRO	Cases randomly selected	
May 28, 2019	ESRO	Pilot launched	
July 2019	PSH/TSH	Refresher training on pilot procedures for housing providers	Housing providers requested additional training
March 20, 2020	All	Pilots suspended	Pilot suspended due to COVID-19. The suspension included but was not limited to new enrollments, assignments, placements, etc. Non-essential home visits were suspended and all HASA clients are receiving weekly wellness calls.
July 6, 2020	All	Pilots resumed	

*These dates reflect the meeting where the milestone was discussed. Thus, the event may have occurred earlier
^a Suspension of Moving On component: For PSH providers in the pilot, implementation of 'Moving On' was a component of the pilot with the primary aim to promote transition to independent living. Housing provider case managers were to conduct the Moving On Assessment, developed by the Corporation for Supportive Housing, at least once per year with clients if deemed appropriate, shortly before the client's face-to-face meeting.

Report Aims

The aim of the pilot progress report was to describe available data on pilot fidelity and the implementation process. In program evaluation, fidelity examines the extent to which an intervention is conducted as it was originally designed. A common reason for assessing fidelity is to document deviations from the program model and to triangulate fidelity metrics with programmatic effectiveness findings, which is particularly useful when effectiveness findings are negative or ambiguous[1]. Over time fidelity metrics can inform course corrections; thus, maximizing the effectiveness of the intervention and the likelihood of observing the desired outcome.

For fidelity, we aimed to compare how well the implementation of intervention components aligned with what was prescribed in the intervention model. We utilized quantitative and qualitative methods to assess fidelity. We present best practices and challenges, as well as

limitations to data interpretation and recommendations to improve implementation roll-out and inform expansion to other sites, if the pilots are found to be effective.

Note: Data on client VLS were omitted from this report, as this information was summarized in the concurrent Impact Report for PSH and TSH pilots (data were not yet available for the ESRO pilot). Due to restrictions on data access as a result of COVID-19 and the short timeframe to develop the report, data on short- vs. long-term stayers in the ESRO pilot was not included in this report. These data will be available for future reports.

Data Sources

HASAWeb data shared with the Department of Health and Mental Hygiene (DOHMH)

The DOHMH receives pilot datasets from HASA each quarter. The analysis utilized HASA pilot data on enrollments, housing type (PSH or TSH or ESRO, pilot or nonpilot), Healthix consents and caseworker visits. For these analyses, we used PSH and TSH enrollments reported from October 24, 2018 through March 15, 2020, and ESRO enrollments reported from May 28, 2019 to March 15, 2020 due to suspension of the pilot following the governor's 'NYS on Pause' executive order halting the work of non-essential businesses statewide on March 20th, 2020 during the COVID-19 pandemic.

HASA Planning and Housing Provider Meetings

Qualitative data were gathered through feedback from two reoccurring monthly meetings that took place by phone: 1) HASA pilot planning meeting, and 2) housing provider meeting.

HASA planning meetings met at least once a month and were attended by various program and evaluation team members (study team) from HASA, New York City Department of Health and Mental Hygiene (DOHMH), City University of New York (CUNY), and Housing Works. A summary of call notes was recorded by a project manager from Housing Works and an evaluation staff member from CUNY. For this assessment, we utilized notes from October 2018 through June 2019.

For the PSH and TSH **housing provider meetings**, invitations to participate were extended to representatives (usually Director-level staff, or high performing housing case managers) from the four PSH, and three TSH providers participating in the pilot. ESRO housing providers have memorandums of understanding (MOUs) with HRA/HASA to only provide housing placement and informal linkage to social services provided off-site by Community-Based Organizations (CBOs). Since social services are not included in their MOUs, ESRO housing providers do not provide case management services directly to clients and therefore were not represented in the monthly meetings. The calls took place approximately once a month and were led by the project manager at Housing Works. The meeting allowed housing providers to discuss pilot implementation progress and to share best practices. CUNY along with Housing Works developed a fidelity monitoring Excel form with topics covering understanding of, and adherence to the pilot model, best and worst practices, and Healthix connectivity issues. The fidelity monitoring form was completed by the Housing Works project manager during the meeting and shared with the CUNY evaluation team. Seven monthly housing provider meetings took place from October 2018 to June 2019. *NB: Monthly provider meetings did not take place in December 2018, or February 2019.* Qualitative findings were primarily derived from the housing provider meeting notes, given CUNY and Housing Works had developed a pre-specified framework for meeting documentation to assist with qualitative analyses.

Qualitative data collected from pilot clients and HASA caseworkers were unavailable for this evaluation.

Quantitative Data: Results from HASAWeb

We present summary statistics (frequencies and proportions). To summarize visit frequency, the number of visits documented during enrollment was divided by the length of enrollment. We used any visit reported (e.g., initial assessment, ongoing case maintenance, case conference, housing pilot, check delivery).

Table 3. Number of Client Enrollments in the PSH and TSH Pilots from September 24, 2018 to March 15, 2020 and in the ESRO Pilot from May 28, 2019 to March 15, 2020

Pilot	Cumulatively Enrolled as of 03/15/2020	Enrolled as of 03/15/2020	Moved on ¹ as of 03/15/2020	Enrollment length in days – All Enrolled (Mean/ Median)	Currently re-enrolled ² as of 03/15/2020	Caseload ratio as of 03/15/2020
PSH Pilot	374	298	76	436/541	N/A	43:1
TSH Pilot	688	206	482	151/108	N/A	23:1
ESRO Pilot	341	199	142	170/171	2	25:1

¹Moved on (no longer in pilot) at any point in time.

²Re-enrolled was defined as having more than one ESRO pilot assignment with at least one day between assignments. Re-enrollment was specifically tracked for the ESRO pilot, as we assumed more turnover was possible. One person had a 17 day gap and the other had a 52 day gap.

From September 2018 to March 2020:

- A cumulative total of 374 clients had enrolled in the **PSH pilot**, and 298 people were currently enrolled in the PSH pilot. On average clients were enrolled in the pilot for more than 365 days (mean: 436 days and median: 541 days). The **caseload ratio** as of March 15, 2020 **was 43:1**.
- A cumulative total of 688 clients had enrolled in the **TSH pilot**, and 206 people were currently enrolled in the TSH pilot. On average clients were enrolled in the pilot for approximately five months (mean: 151 days and median: 108 days). The **caseload ratio** as of March 15, 2020 **was 23:1**.

From May 2018 to March 2020:

- A cumulative total of 341 clients had enrolled in the **ESRO pilot**, and 199 people were currently enrolled in the ESRO pilot. On average clients were enrolled in the pilot for a little less than 6 months (mean: 170 days and median: 171 days). The **caseload ratio** as of March 15, 2020 **was 25:1**.

Table 4. Proportion of Pilot and Non-Pilot Clients with Healthix Consents

	Total Enrolled in Reporting Period	Healthix consented in reporting period (N, row %)	Healthix Declined in reporting period (N, row %)	Healthix Unknown (N, row %)
PSH Pilot	374	287 76.7	49 13.1	38 10.2
PSH Non-Pilot	5,004	2156 43.1	421 8.4	2427 48.5
TSH Pilot	688	421 61.2	187 27.2	80 11.6
TSHI Non-Pilot	2,679	1299 48.5	608 22.7	772 28.8
ESRO Pilot	341	193 56.6	103 30.2	45 13.2
ESRO Non-Pilot	4,563	2,196 48.1	867 19.0	1500 32.9

- The proportion of people with documented consents to Healthix was highest among the PSH pilot (77%), followed by the TSH and ESRO pilots (61% and 57%, respectively).
- In the non-pilot, the proportion of people with documented consents to Healthix ranged from 43% to 48%.
- Notably, more than one-quarter of clients in the TSH pilot (27%) and ESRO pilot (33%) declined to consent to Healthix. A high proportion of non-pilot clients had an unknown Healthix consent.

Table 5. Average Visit Frequency by Housing and Pilot Status

	PSH		TSH		ESRO	
	Pilot N (%)	Non-Pilot N (%)	Pilot N (%)	Non-Pilot N (%)	Pilot N (%)	Non-Pilot N (%)
Total (All Visits)	374 (100)	5004 (100)	688 (100)	2679 (100)	341 (100)	4563 (100)
Every 30 Days	3 (1)	72 (1)	147 (21)	320 (12)	27 (8)	435 (10)
Every 90 Days	50 (13)	1686 (34)	390 (57)	1042 (39)	156 (46)	1782 (39)
Every 183 Days	186 (50)	2043 (41)	39 (6)	308 (11)	55 (16)	741 (16)
Every 365 Days	87 (23)	461 (9)	4 (1)	66 (2)	16 (5)	288 (6)
Every >365 Days	23 (6)	263 (5)	0 (0)	6 (0)	0 (0)	0 (0)
No Visits	25 (7)	479 (10)	108 (16)	937 (35)	87 (26)	1317 (29)

To estimate visit frequency, the number of visits documented during enrollment was divided by the length of time enrolled.
N=the number of clients receiving that level of visit frequency
'Visits' included any documented visit type
Shaded rows indicated expected frequency

- Specific to the PSH pilot, bi-annual meetings with the client that included the HASA caseworker and other support staff (i.e., client’s supportive housing caseworker, etc.) were required. For this pilot, wellness checks were only required every quarter that a HASA caseworkers did not make a home visit.
 - Approximately 80% of Pilot PSH, did **not** have a documented wellness check.
 - Data shows that 13%, 50% and 23% of enrollees in the PSH pilot had a visit documented in HASAWeb every 90 days, 183 days, and 365 days, respectively. In the non-pilot PSH, 34%, 41% and 9% of clients had a visit documented in HASAWeb every 90 days, 183 days, and 365 days, respectively.
 - Thus, 63% of pilot clients and 74% of non-pilot clients had a successful visit semi-annually or more frequently.
- Specific to the TSH pilot, monthly face-to-face client home visits that included the HASA caseworker and other support staff (i.e., client’s supportive housing caseworker, etc.) were required.
 - Data shows that 21%, 57% and 6% of enrollees in the TSH pilot had a visit documented in HASAWeb every 30 days, 90 days, and 183 days, respectively. In the non-pilot TSH, 12%, 39%, 11% of clients in non-pilot TSRO had a visit documented in HASAWeb every 30 days, 90 days, and 183 days, respectively.
 - Thus, 78% of pilot clients and 51% of non-pilot clients had a visit at least every 90 days.
- Specific to the ESRO pilot, monthly face-to-face client home visits by the HASA caseworker that included the clients’ ICP team were required, in addition to completion of an initial home visit assessment.

- More than two-thirds of ESRO pilot clients (n = 239, 70%) had an initial home visit assessment completed.
- Data shows that 8%, 46% and 16% of ESRO pilot enrollees had a visit documented in HASAWeb every 30 days, 90 days, and 183 days, respectively. In the non-pilot ESRO, 10%, 39%, and 16% of clients had a visit documented in HASAWeb every 30 days, 90 days, and 183 days, respectively.
- Thus, 54% of pilot clients and 49% of non-pilot clients had a visit at least every 90 days.

NOTE: Data on HASA caseworker attempted or unsuccessful visits are unavailable. The MOU for the evaluation of the HASA pilots was restricted to data on successful visits. An unsuccessful visit may mean that the HASA caseworker attempted but did not meet with the client. Given that attempted visits would not improve VLS or housing outcomes, successful visits seem like the better evaluation metric for understanding differences in outcomes.

Qualitative Results

Conventional content analysis methods were used to code the meeting notes from the two data sources.[2] The notes were combined, and initially read through multiple times by a member of the evaluation team to obtain an over-arching list of categories (e.g. program/system-level, staff-level, client-level) and subcategories. The text notes were then coded deductively into these categories and divided into challenges and best practices. The qualitative analysis covers meetings that occurred through June 2019, the early stages of implementation.

Implementation barriers and challenges

Following PSH and TSH pilot initiation on September 24th, 2018, we identified three broad categories of implementation challenges related to client, staff, and system. These challenges are summarized below.

Client challenges

Insufficient communication with some clients. During the early months of the pilot (September 2018- January 2019), some PSH and TSH pilot housing providers reported that there was insufficient communication from HASA to clients about HASA caseworker change and the pilot in general. However, no additional communication issues were reported by housing providers from February to June 2019.

Staff-level challenges

Training of pilot staff. Although training on the pilot procedures for **housing providers** (distinct from HASA caseworkers) took place in July 2018, housing provider pilot staff requested additional training seven months into the pilot. Refresher training for the pilot was conducted in July 2019. HASA caseworkers were trained September 18th, 2018 before the pilot launched this included training on Healthix as well as pilot design. HASA staff also received an additional Healthix consent training in October 2018, in addition to other trainings. All major trainings are noted in Table 2.

Joint home visits not occurring. Some housing providers voiced concerns about on-going challenges with conducting joint home visits. Some pilot housing providers were not participating in the visits. There was also a complaint by one TSH provider that joint home visits are too time consuming. In January 2019, all housing providers present on the monthly call (n=6) reported that integrated case conferencing was happening.

HASA caseworker turnover. Challenges with caseworker turnover were reported by at least two housing providers.

System-level challenges

Healthix consent and connectivity delays. Collection of Healthix consents was delayed, with at least two housing providers not starting collection of consents until November or December of 2018.

System-level interferences with transferring a client. A couple of housing providers voiced concerns that new clients were not automatically transferred into the pilot and that it could sometimes take up to a month to register on the pilot caseworker's roster.³ However, improvements in speed of transferring clients to caseworker rosters was later reported.

Implementation best practices and successes

The pilot has hit many milestones, and housing providers reported early best practices and lessons learned to facilitate implementation.

Healthix consenting routinized. During an April 2019 HASA planning meeting, a study team member reported that HASA began daily uploading and sharing of data on their client encounters to Healthix. In June 2019, a study team member also noted that pilot HASA caseworkers were having greater success in obtaining Healthix consent than non-pilot caseworkers.

Caseworkers dedicated to specific housing providers. In the pilot model, there are now one to three HASA caseworkers serving a specific housing provider versus a larger number of caseworkers serving at non-pilot housing providers, allowing for staff and clients served by those housing providers to build rapport and stronger relationships with the HASA caseworkers.

Instituted first meeting check-in. In November 2018, it was reported during a HASA planning meeting that a 'first meeting' was instituted, where housing providers and HASA caseworkers review client details, before meeting with the client. The meeting ensures that housing provider case managers and HASA caseworkers are well prepared to meet with the client, understand their roles within the pilot, and coordinate efforts to address and respond to client needs.

³ Case transfer delay was partly due to the fact that each client has two case records; the HASA Web Electronic Case Record for social services and the NYS Welfare Management System (WMS) record for Cash Assistance benefits. NYS OTDA sets specific time tables for case transactions and client notices required in WMS when transferring a case, including change of client and landlord addresses, landlord name, and updated budgets reflecting new rent amounts. As a result, both case records are transferred in compliance with NYS WMS processing timelines.

Improving occurrence of joint home visits. Despite challenges with scheduling and attendance of joint home visits by housing provider case managers and HASA caseworkers, some housing providers reported practices that facilitated the success of these meetings occurring such as giving clients advance notice of upcoming visits or making dedicated space and a computer available for HASA caseworkers at the housing site.

NOTE: Attendance rates for monthly housing provider calls from the seven housing providers mostly decreased over time –from 85% of housing providers attending the call in March 2019 to only one housing provider participating in June 2019. Given that the monthly housing provider calls were initially set to troubleshoot challenges and provide technical assistance, providers more frequently voiced concerns than accomplishments, thus, findings are weighted toward challenges.

Discussion

Enrollment Goals. After the first 18 months of enrollment in the PSH/TSH pilots, half of the pre-planned recruitment period, PSH enrollment targets were met, and TSH pilot enrollment targets were on track. After the first 10 months of enrollment in the, 27% of the pre-planned recruitment period, ESRO pilot enrollment targets were on track. Given the pilots were paused for three and a half months because of the COVID-19 pandemic, these targets should be monitored closely throughout the remainder of the pilot period.

- The pre-specified sample size for the PSH was a cohort of 5,270 enrollments with N = 370 in the pilot. The sample size after 18 months was 5,004 people in the PSH cohort with 374 pilot enrollments. **Thus, enrollment goals were met in the PSH cohort.**
- The pre-specified sample size for the TSH was a cohort of 4,700 enrollments (with N = 1,300 in the pilot). The sample size after 18 months was 2,679 enrollments with 688 pilot enrollments. One-half of the overall sample size ($0.50 * 4,700$) is N=2,350 and N = 650 pilot enrollees. **Thus, the TSH pilot was on track to meet enrollment goals.**
- The pre-specified sample size for the ESRO was a cohort of 13,020 enrollments (with N = 840 in the pilot). The sample size after 10 months was 4,563 enrollments with 341 pilot enrollments. One-quarter of the overall sample size ($0.25 * 13,020$) is N=3,255 and N = 210 pilot enrollees. **Thus, the ESRO pilot was on track to meet enrollment goals.**

Caseload Ratios. **The caseload ratio was at or under the specified targets** (PSH 43:1; TSH 23:1; ESRO 25:1) as of March 15, 2020. Neither CUNY nor DOHMH had access to caseload ratios for earlier months. However, based on discussions with HASA team, CUNY believes that the pilot caseload ratio has been at or under the target ratio throughout the duration of the pilot due to the assignment process. In the PSH or TSH pilot, assignment is apartment-based and in the ESRO pilot, assignment is random selection, these elements are expected to constrain the caseload ratio to the pre-specified levels. Given that caseload ratios are a core element of this pilot project, we should track any instances of exceeding or varying caseload ratios. If caseload ratios consistently remain under the pre-specified targets, as occurred in the PSH and TSH pilots, this should be considered when/if the pilot model is expanded throughout HASA. Caseload ratios that are under the target are, to a degree, expected, given that filling a unit takes time and given not all buildings have the exact number of units for the correct ratio.

Healthix Consent. **The Healthix consent rate was higher in the pilot than the non-pilot.** This finding aligns with what we know about the Healthix rollout and Healthix training. 1) Pilot caseworkers were trained earlier than non-pilot caseworker. 2) More pilot staff than non-pilot staff have access to Healthix. Specifically, all staff, including caseworkers, were trained on Healthix in the pilots, whereas Healthix training was limited to supervisors and directors in the non-pilot arms. This encouraging finding has broad implications for medical care, public health and organizations that utilize Healthix outside of HASA. The utility of Healthix from the HASA caseworker perspective, particularly related to prioritizing viral load suppression, was not addressed in the data sources utilized in the current progress report.

Visit Frequency. Our calculation of visit frequency was liberal and included all visits reported. Notably, we report on successful visits and not all attempted visits (which were unavailable to the team), and attempted visits would capture efforts to adhere to the pilot model. Arguably, however, successful visits are the more important metric, given the pilot aims to 1) increase viral load suppression and housing stability in the TSH and ESRO pilots and to 2) maintain viral load suppression and housing stability in the PSH pilot. Clients in the ESRO and TSH pilots may have more complex needs such as mental health and substance use disorders which make setting up visits more challenging, and the lower caseload ratios in the ESRO and TSH pilot relative to the non-pilot are supposed to allow for a more intensive assistance from the HASA caseworker. Successful **visit frequency in the PSH pilot aligns with what was expected** and indicates good fidelity to the model. Successful **pilot visit frequency in TSH was lower than expected** per the pilot model, **but** successful visit frequency was **higher in the TSH pilot than TSH non-pilot. Successful pilot visit frequency in the ESRO pilot was lower than expected** and did not appear different than non-pilot.

- PSH pilot: As part of the core elements for the PSH pilot, HASA caseworkers were to conduct “wellness check” phone calls with clients every quarter that they do not make a home visit. Home visits occurred only when requested by the clients, however a meeting with the client, which includes the client’s care team was to take place bi-annually. Findings show that half (n=186) of the of the 374 clients cumulatively enrolled in the pilot received a visit bi-annually, with up to 64% receiving a visit bi-annually or more frequently versus 76% of clients in the non-pilot PSH. The lower proportion among pilot clients is expected given the higher caseload ratio in the pilot relative to non-pilot, the requirement for less frequent visits in the pilot relative to non-pilot, and the presumption that these clients require a less intensive touch from HASA caseworkers to maintain current levels of viral suppression.
- TSH pilot: As part of the core elements of the TSH pilot, HASA caseworkers were to conduct monthly face-to-face home visits that include the client’s care team. Visit frequency in the TSH pilot was the same frequency as TSH non-pilot but caseload ratios were lower in the pilot relative to non-pilot. The proportion of TSH pilot clients with a successful monthly visit was low but was nearly double the frequency of non-pilot clients (21% of pilot clients versus 12% of non-pilot clients). Additionally, the proportion of TSH clients with 1 visit every three months was higher among pilot versus non-pilot clients (57% and 39%, respectively).

- **ESRO pilot:** As part of the core elements to the ESRO pilot, caseworkers were to conduct an initial home visit assessment shortly after client enrollment and complete the Joint Initial Home Visits to Single ESRO form. This assessment would be used to document outcomes of initial home visit, to establish Healthix consent, and to help create an integrated care planning (ICP) team. There were 239 clients (70%), who had this assessment completed indicating good fidelity to the intervention. Clients in the pilot were also to receive monthly face-to-face visits (or more frequently, as needed) that included the ICP team. The monthly visit frequency in the ESRO pilot was the same frequency as ESRO non-pilot. The proportion of pilot clients with a successful monthly visit was low and was not higher than non-pilot clients (8% of pilot clients versus 10% of non-pilot clients). Despite lower caseload ratios in the pilot relative to non-pilot, the visit frequency was similar, with 54% of pilot clients and 49% of non-pilot clients having a visit once a quarter or more frequently.

Prioritizing Viral Suppression and Health Promotion. A core pilot element was HASA and housing providers prioritizing viral suppression and health promotion. All PSH or TSH housing providers should report VLS data quarterly and health promotion visits should occur quarterly or monthly in the PSH or TSH pilot, respectively, to discuss viral load. In the ESRO pilot, caseworkers should intensely promote VLS by discussing the client’s viral load, the importance of viral suppression, and the client’s plans to become or remain virally suppressed. We do not have quantitative data related to this core pilot element, as this is not collected in HASAWeb administrative data.

Early Implementation. Qualitative results indicate that initial roll-out of the PSH and TSH pilots faced implementation challenges at the client, staff and system-levels. Pilot staff requested additional training and voiced concerns about lack of fidelity to some of the pilot elements. These findings can be triangulated with quantitative results to help explain the data. For example, some housing providers expressed frustrations with the occurrence of home visits as they were deemed too time-consuming and some staff members were not participating in the meetings. This may partially explain why 21% of enrolled clients in TSH were found to have had a monthly visit. Additionally, data on *attempted* visits, which may provide a more accurate assessment of **efforts** toward visit fidelity to the pilot, were unavailable due to MOU restrictions. Despite these challenges, housing providers expressed that improvements to implementation were made over time. For example, the ‘first meeting check-in’ was instituted, and Healthix consenting was routinized. Consequently, more clients were consented to Healthix in pilots than non-pilots.

Limitations

Quantitative Data

Findings are limited to what is documented in HASAWeb. Thus, Healthix consents and caseworker visits could be underestimated if the information is not documented in HASAWeb. Second, we did not have data on caseload ratios for the non-pilot arms. These ratios are expected to be fairly stable and not thought to exceed the 34:1 ratio of single clients.

Qualitative Data

First, attendance rates for monthly housing provider calls from the seven housing providers mostly decreased over time –from 85% of housing providers attending the call in March 2019 to only one housing provider participating in June 2019. The median number of housing providers represented each month was three. Due to varying and decreasing attendance, it is unknown if some challenges were eventually addressed, or how common and pervasive implementation barriers were across housing providers. Second, the last housing provider call occurred in June 2019, thus we are unaware if some challenges have been resolved. Third, the qualitative data and findings are largely from the housing provider perspective, and we do not have data in this report on challenges or best practices discovered by HASA caseworkers and other staff participating in the pilot.

Fourth, client perceptions of, and experiences with the pilot are also unknown. Further, given that the monthly housing provider calls were initially set to troubleshoot challenges and provide technical assistance, providers more frequently voiced concerns than accomplishments, thus, findings are weighted toward challenges. Lastly, due to the type of the qualitative data we are able to collect, we are unable to provide information on the extent to which some core elements of the pilot are being implemented (i.e., HASA and housing providers always prioritizing viral suppression and health promotion).

Recommendations

The “fidelity of implementation” model^[1], identifies four moderators that may influence the degree of fidelity to which an intervention is implemented: 1) comprehensiveness of policy description, 2) strategies to facilitate implementation, 3) quality of delivery, and 4) participant responsiveness. Based on this framework and the challenges to implementation noted, a few action items are recommended to improve future intervention fidelity and uptake. As this is an unfunded pilot, we recognize that the adoption and implementation of some of these recommendations may not be possible.

1. The creation of a detailed intervention program manual (including a FAQ sheet, forms, and all data collection tools) could serve as a beneficial guide for pilot staff to consult.
2. Visit frequency did not align with the protocol for ESRO models. This may be remedied via additional trainings or creation of a program manual.
3. To address any additional questions or scenarios raised by caseworkers and case managers, a dedicated intervention manager could be made available by phone and/or email to help troubleshoot issues.
4. Continuing collection of fidelity data from housing providers and beginning fidelity collection and technical assistance meetings for HASA caseworkers may help improve implementation of the intervention.⁴
5. Trainings should be provided to both HASA caseworkers and housing provider staff before intervention implementation, and refresher trainings should be available at some

⁴ Housing Works led the scheduling of housing provider calls/meetings and the provision of technical assistance with the last one taking place in June 2019. However, Housing Works reported in October 2019 that they left the pilot due to lack of payment for technical assistance provision for fiscal year 2019.

frequency to provide additional training to new staff brought on board. This may be needed following the COVID pause in pilot activities and may help to increase organizational buy-in of the intervention.

6. To improve participant responsiveness, informing clients of caseworker change through alternative methods such as phone or text message (in addition to the standard letter they receive by mail), if possible, is recommended to ensure clients are reached and aware of the change.

Conclusions

We have met final recruitment targets in the PSH pilot and have met interim recruitment targets in the TSH and ESRO pilots, which should help to ensure an adequately powered final assessment of pilot effectiveness. The core elements of these pilot were related to 1) changes in caseload ratios, 2) housing specific assignment, and 3) HASA and housing providers prioritizing viral suppression and health promotion at routine client visits. Caseload ratios were at or under the pilot thresholds as of March 2020, and the pilots have consented a higher proportion of persons to Healthix than non-pilots, which should help with the prioritization of viral suppression given increased access to viral load information. Caseworker visit frequency occurred in line with the protocol in the PSH pilot. The frequency of successful visits was lower than monthly in the TSH pilot; however, the frequency of successful visits was higher in the pilot than non-pilot, with most clients having quarterly visits. The higher frequency of successful visits in the TSH pilot may help with prioritization of support related to viral suppression. The frequency of successful visits in the ESRO pilot did not appear different than non-pilot visit frequency, despite lower caseload ratios in the pilot. This data point should be triangulated with viral suppression findings for the ESRO pilot. Future progress and impact reports will provide additional data on pilot implementation and outcomes.

References

1. Carroll, C., et al., *A conceptual framework for implementation fidelity*. Implement Sci, 2007. **2**.
2. Hsieh, H.F. and S.E. Shannon, *Three approaches to qualitative content analysis*. Qual Health Res, 2005. **15**(9): p. 1277-88.