2019-2023 Project Unify User Stories

The following is the collection of Project Unify User Story summaries accumulated from 2019 through 2023. Each summary explores a particular challenge in cross-domain interoperability and integration. The entire series follows the Thomson family through the trials and tribulations of their difficult lives, and the community and societal help they need to survive. Each story has been or will be developed in more complete detail as needed for demonstrations. (For example, the 2019 MITA-TAC Adult Opioid Story was fully developed as a detailed, five-page user story.)

DOD-to-VA Transition Assistance

(VA/VHA 2020 Story - Index Person: John Thomson)

Technical Sergeant John Thomson has separated from the US Air Force due to personal health and family hardship after a career with long overseas deployments. He is delighted at the idea of rejoining his wife, Sarah, and son, Jameson. His many deployments have been physically and emotionally difficult. A PTSD diagnosis contributed to his decision to leave the military. John’s deployments have also been hard on his family. During his absences, Sarah became addicted to opioids and doctors grew concerned about Jameson’s frequent trips to the emergency room for asthma attacks and physical injuries, including some that appeared to be self-inflicted.

Primarily because of those family crises, John decided to leave the military without completing the normal one- to two-year Transition Assistance Plan (TAP). His transition counselor now has the challenge of assisting John, Sarah, and Jameson as they transition without receiving the routine preparation that families normally get. Such preparation would have been particularly helpful in this case since it is so complex.

**Desired Outcome**: With appropriate cross-domain social services, case management, and healthcare coordination, Sarah could have been helped to successfully complete substance-abuse rehabilitation; Jameson could have received appropriate healthcare and therapy; and John could have been supported with PTSD therapy and been re-integrated into the family structure.

**Setup for the next scenario**: Unfortunately, the many stresses on the family, combined with each individual’s personal challenges, resulted in a divorce for John and Sarah. She and Jameson have moved into a tiny apartment in a poor area of Temperance, MI.
Adult Opioid

(MITATAC 2019 Story - Index Person: Sarah Thomson)

When Sarah Thomson was 27 years old, she divorced Air Force Sergeant John Thomson. That resulted in her becoming the single mother of Jameson Thomson, age 7. Sarah and Jameson now live just above the poverty line in a tiny apartment in a run-down, non-rent-controlled building in Temperance, MI. Her ex-husband is living in a homeless shelter in another state and is not able to contribute financially or in any other way to help his ex-wife or son.

After being injured at her warehouse job a year ago, Sarah got hooked on opioids, which caused her to develop acute kidney disease; she also had asthma. She is currently receiving court-ordered Medication Assisted Therapy (MAT). In addition, she is six months pregnant and has several nonmedical issues relating to access to food, housing, and transportation.

One day Jameson’s First Grade teacher notices that the boy has come to school in a very drowsy condition, falling asleep several times at breakfast and in early-morning classes. The teacher sends Jameson to see Florence Whitaker, the school nurse. While Florence is talking to Jameson, she notices what looks like an empty prescription bottle in his book bag; when she examines it, she finds it is from his mother’s buprenorphine prescription.

Sarah is called to the school to respond to this crisis. Driving there under the influence of her medication, which makes her very drowsy, she falls asleep at the wheel and hits a lamp post; her car is totaled. She is rushed to the hospital by ambulance. She’s familiar with the emergency room; it’s where she and Jameson get most of their healthcare when they need it. Sarah receives treatment for minor injuries while she’s in the ambulance, then again in the hospital. The next day, she’s charged in court with driving while under the influence and reckless endangerment. As a result of the charges that landed her in court – as well as concerns raised by Child Protective Services and her ex-husband’s absence – Jameson is placed in foster care and, as a result, must change schools (among many other aspects of life).

**Desired Outcome:** With appropriate cross-domain social services, case management, and healthcare coordination, Sarah could have been helped through successful completion of substance-abuse rehabilitation and been provided with better prenatal care for the baby she’s carrying. Jameson could have been provided with appropriate healthcare and therapy, spent less time in foster care, and re-integrated into his family.
Decarceration - Transition with Community Services

(InCK NIC/NSF OKN 2022 Story - Index Person: Sarah Thomson)

Sarah Thomson is convicted and jailed for child endangerment and DUI after her 10-year-old son, Jameson, is caught using her prescription medications, and she subsequently crashes her car while under the influence of opioids. Sarah then loses custody of Jameson, is evicted from her apartment, and is fired from her job. (For a full description of this scenario, see Project Unify Adult Opioid Use Case Scenario.)

While in jail, completing her sentence, Sarah completes a PRAPARE Survey to determine her post-incarceration needs. Based on the results of this survey, a decarceration plan of action is made for her in collaboration with a Continuum of Care Case Manager. It identifies her need for a job, childcare, food benefits, and stable housing, all in order to rebuild her life and regain Jameson from state-mandated, out-of-home care.

The decarceration plan prescribes a series of services and benefits that Sarah will need to successfully return to her community. It defines milestones for notifications of Sarah’s planned release date and actual release; the Department of Prisons or County Jail will send those notifications to the local Continuum of Care Case Management System. A case manager assigned to Sarah will use that system to send referral messages, which will include her expected release date, for:

- community homeless shelter,
- community/state public housing,
- community/state food benefits,
- community job training services,
- community job placement services, and
- community transportation voucher benefits.

By proactively submitting referrals to human services agencies before Sarah’s release, we can ensure that services and benefits are applied for on her behalf – with the aim of shortening the time between her release and the availability of food, housing, career training and transportation services. These simple steps to support released prisoners enable them to return to their communities with the support needed to reduce the chance of reoffending (recidivism) due to pressure to survive.
But each of these different systems, however, holds information that Sarah would consider very sensitive if inappropriately shared.

So, in addition to the challenge of sharing across siloed information domains – each with its own protocol standards and its own ontologies (or data models) – it’s essential to overcome the problem of gaining and transmitting consent for the exchange of necessary information across varied systems.

**Desired Outcome:** With appropriate cross-domain social services, case management, and healthcare coordination, Sarah will stand a far better chance of successfully transitioning from her incarceration back to her community with the needed support she needs to allow her to rebuild her life and regain custody of her son.

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**Family Unification Program - Alert System + Housing Voucher**

*(InCK NIC/NSF OKN 2022 Story - Index Person: Sarah Thomson)*

Sarah Thomson has lost custody of her 10-year-old son, Jameson, because he was caught using her prescription medications and because she was subsequently convicted of DUI after crashing her car (for a full description of this scenario, see Project Unify Adult Opioid Use Case). Sarah was jailed for DUI and child endangerment, then lost her apartment and her job. A decarceration plan has been made for Sarah, which identifies her need for work and stable housing in order to regain custody of Jameson from state-mandated, out-of-home care.

The decarceration plan, in coordination with the local Continuum of Care Homeless Management Information System (HMIS), prescribes a HUD Housing Choice Voucher (HCV) for Sara, after her release, to help her obtain appropriate housing for herself and Jameson. Without the voucher, Sarah could remain homeless and not be reunited with her son.

A referral notification is sent from Sarah's corrections facility to the state Children and Family Services Agency (Public Child Welfare Agency, PCWA). The agency determines that the HCV is appropriate, and makes a further referral to the local Public Housing Authority. The Authority also determines that Sarah is eligible for an HCV and notifies the PCWA, which in turn notifies the corrections decarceration plan administrators. Upon decarceration, Sarah utilizes the voucher, then finds a job and is subsequently determined by PCWA to have stable housing. After the PCWA notifies the Foster Case System, via the FUP Case Management system, Sarah is reunited with Jameson.
Desired Outcome: With appropriate cross-domain social services, case management, and healthcare coordination, Sarah may be able to transition from her incarceration back to her community with the needed support to allow her to rebuild her life and regain custody of her son.

Behavioral Health for Children and Youth

(InCK NIC/MITATAC 2020 Story - Index Person: Jameson Thomson)

Sarah Thomson, 30, is a medically complex patient with multiple chronic conditions (asthma and heroin-induced nephropathy, which has not yet progressed to end-stage renal disease). She is under court-ordered Medication Assisted Therapy (MAT) for Opioid Use Disorder. She has been divorced from Air Force Technical Sergeant John Thomson for three years and has been raising her two children as a single parent. They live in a run-down area of Temperance, MI, near a furniture manufacturer and a large farm, with associated air and water quality issues.

Since we last checked in on our family, Sarah gave birth to a daughter, Madison, who is now 3. Like her son, Jameson, Madison was born with Neonatal Abstinence Syndrome (NAS). Jameson, who is now 10, also has asthma. He has no medical home, gets minimal well-childcare, and receives most of his healthcare at the ER or urgent care facilities. He has watched far too frequently as Emergency Medical Services personnel came to his house to resuscitate his mother. He has been in and out of foster care and has been receiving behavioral health therapy ever since Child Protective Services intervened as a result of his Adverse Childhood Experiences (ACEs), which were directly and indirectly due to his mother’s addiction.

Jameson was held back to repeat first grade but has never been screened for, nor diagnosed with, any developmental disabilities. Jameson has been traumatized in many ways: being separated on-and-off from his mother and from his father for years; moving away from his friends each time he was placed in foster care and living in care with a different, unfamiliar family each time; and being placed repeatedly into new schools in which he knew no one. During the same period, he has been detached from his personal support system, even as he has been challenged by the new experiences of meetings with an overloaded case manager, appearances in family court, and the stress of his mother’s addiction and his father’s absence.

Jameson becomes withdrawn at school and testy with his foster parents. When he moved into his most-recent foster placement, he left his medications behind and has neglected to continue his asthma-controller inhaler treatments; it’s no surprise that his physical and mental health have declined. In addition, although he is getting behavioral health therapy, Jameson uses drugs and alcohol to cope with his misery and anxiety.
One day Jameson’s fourth-grade teacher notices he has again come to school appearing to be under the influence. She sends Jameson to see Florence Whitaker, the school nurse, and writes up an incident report in the School Management Information System (SMIS) on her laptop.

Florence begins taking Jameson’s vital signs and recording them in the school’s Electronic Medical Records (EMR) system. She suspects misuse of opioids to be the cause for Jameson’s drowsiness, so she opens a triage instrument to ask some questions and record her observations. The triage tool guidance suggests an intervention: notify the School Assistance Team, which is made up of Florence, the principal, and Gerald Brown LSW, a social worker in the Michigan Department of Health and Human Services (MDHHS) Monroe County office.

After discussing the case, the team determines there is enough evidence to trigger a SMIS-generated Mandatory Report to Child Protective Services. Jameson’s child welfare case manager receives the Mandatory Report and now needs to work with the boy’s assigned primary care physician, a psychologist, teachers, foster parents, and the family court to revise Jameson’s Service Plan to ensure he gets additional behavioral health support and substance-abuse rehabilitation. In addition, the case manager initiates a Health Care Plan with Jameson’s Primary Care Coordinator via a FHIR Care Plan Resource.

The Primary Care Coordinator evaluates the requested Care Plan, updates it to reflect medical necessity, and generates a FHIR eLTSS Resource (electronic Long-Term Support Services request with Care Plan and associated Referrals), which is sent to each of the behavioral and physical health specialists needed to help Jameson get well.

**Desired Outcome:** With appropriate cross-domain social services, case management, and healthcare coordination, Sarah may finally be helped through successful completion of substance-abuse rehabilitation; her daughter, Madison, could be provided with better early-life care; Jameson could receive appropriate healthcare and therapy; and, once Sarah is clean and sober, her son could be re-integrated into the family.

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**Single-Parent Social Determinants of Health**

**(SDoH Story - Index Person: Sarah Thomson)**

Sarah Thomson, who is 30, has had a tough life since she divorced her husband, John Thomson. She has no personal savings and is barely making ends meet with a minimum-wage factory job. She has two children, 3-year-old Madison and 10-year-old Jameson. Jameson has returned from foster care, in which he was placed due to Substance Use Disorder challenges for both Sarah and Jameson. Each is doing better as a result of behavioral and physical health intervention. Sarah has continued to work with a social services case manager to gain benefits and services to support her and her two children. The social services case management system
has some Social Determinants of Health (SDOH) screeners that are triggered and, consequently, a patient search is generated in their local/regional Health Information Exchange (HIE).

Finding a match for Sarah's health record in the County Health Department system, the case management system transmits her SDOH data to the HIE. The HIE adds this data to Sarah's patient health record, which may be combined with SDOH data from other sources, including medical survey results. With five high-risk SDOH elements for Sarah and her family, emergency intervention resources are recommended. With integration of SDOH information across both social services case management and healthcare coordination systems, there is the ability to identify supportive social benefits and services, determine eligibility, complete and submit referrals and applications, and closed-loop enrollment notifications to all systems.

**Desired Outcome:** With appropriate cross-domain social services, case management and healthcare coordination, Sarah and her family could be helped through continued substance-abuse rehabilitation; be provided with better resources to stabilize her family's lives and improve their well-being, based on an understanding of her SDOH needs such as secure housing, career training, a job apprenticeship, food stamps, and cash assistance.

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**Homeless Social Determinants of Health**

**(SDoH Story - Index Person: John Thomson)**

Technical Sergeant John Thomson has had a tough life since he separated from the Air Force. He returned from his final deployment anxious to save his marriage, support his wife through her opioid rehabilitation, and reunite with his son. Things didn't go as he hoped, however. Because he left the service without the required Transition Assistance Planning, he has had difficulty finding a steady job, lacks savings to buffer his transition and, with untreated PTSD, has had an angry and violent relationship with his wife, Sarah. He self-medicated with alcohol and, after many tempestuous months, the couple agreed to a divorce.

Without any savings or a job, John is now homeless in Michigan. He enrolls in a shelter program supported by a Homeless Management Information System (HMIS). The HMIS monitoring his enrollment has some Social Determinants of Health (SDOH) screeners that are triggered and, consequently, a patient search is generated in the homeless client's local/regional Health Information Exchange (HIE). Finding a match for that homeless person's health record in the County Health Department System, the HMIS transmits his SDOH data to the HIE. The HIE adds this HMIS-transmitted data to the homeless patient's health record, which may be combined with SDOH data from other sources. With five high-risk SDOH elements for this individual, emergency intervention resources are recommended for him.
Desired Outcome: With appropriate cross-domain social services, case management, and healthcare coordination, John could be helped through substance-abuse rehabilitation, and he could be provided with better resources to stabilize his life and further his well-being, based on an understanding of his SDOH needs such as secure housing, career training, a job apprenticeship, food stamps, and cash assistance. With John “back on his feet,” he also might reconnect with his family, whom he misses dearly.

Homeless Infectious Disease Transitions

(COVID Story - Index Person: John Thomson)

Technical Sergeant John Thomson has been enrolled in a shelter program supported by a Homeless Management Information System (HMIS). He has been living in various congregate shelters during an infectious disease pandemic. Unfortunately, such shelters make it difficult to "socially distance" and many do not allow daytime "shelter in place,” resulting in daily physical health challenges and high disease transmission rates. John has been feeling unwell for a couple of days and notices he is especially fatigued as he is turned out of the shelter for the day.

John visits a local critical care facility; his recent health history and vitals (a temperature of 100.3) indicate he has an "unspecified respiratory infection." As a result, he is tested for COVID-19 at a site adjacent to the care facility. While he waited to be tested, the facility’s Electronic Health Records (EHR) system issued a standard Admit Discharge Transfer (ADT) alert to the Regional Health Information Exchange, indicating John had been transferred to the testing facility. This ADT triggered an independent homeless person COVID screener to recognize that this specific homeless person may have COVID. The screening system issued a message to the originating EHR to direct John to a special quarantine shelter after discharge from the facility.

(This independent screener attempts to protect the homeless client’s privacy and housing status from the healthcare system, while also protecting the general public’s healthcare information from the homeless management information system, by providing a neutral trusted system to subscribe to ADT COVID alerts for a set of pre-matched patient IDs. As far as the healthcare system can tell, these pre-match patient IDs could represent foster children, homeless persons, recent travelers, or any number of other target groups of concern for COVID infection. The HMIS will only get the medical records of homeless people who are suspected or confirmed to have COVID and who have consented for the HMIS to access those records.)

Desired Outcome: With appropriate cross-domain homeless shelter management and healthcare coordination, John could be directed to a quarantine shelter (often in hotel rooms). This would reduce the potential for continued disease spread through the shelter populations.
Prison->Homeless->Health & Human Services Transitions

Decarceration to Community with eConsent for Sensitive Personal Information Exchange between Prison Systems and Community-Based Service Organizations

(Decarceration Story - Index Person: John Thomson)

While bouncing between homeless shelters and “living rough” in New York City, former Technical Sergeant John Thomson is arrested for shoplifting at a grocery store to feed himself. This is not his first offense as he has tried to get out of the terrible social problems that homeless people face. Given his numerous history of numerous misdemeanors and felonies, the judge sentences him to a year in prison.

John does his time and faces being released back into New York City without the support of family and friends. Fortunately, new programs have been created to support decarcerated people so that, when they leave incarceration, they get immediate support from halfway homes and the homeless shelter system to ensure they have a roof to sleep under. In addition, human services agencies are proactively notified of an inmate’s imminent release to ensure that services and benefits are applied for on their behalf to shorten the time between their release and the availability of food, housing, career training and transportation services, as well as enrollment in Medicaid.

These simple steps to support John and others like him prisoners are designed to enable them to return to their communities with the necessary support they needed to reduce the chance of reoffending due to survival pressure (recidivism).

Prior to his arrest, John occasionally shot up methamphetamine with others on the street. At one point just before his arrest, he visited a harm-reduction center for clean needles and, while there, was offered rapid HIV and Hepatitis B & C testing. That’s when he learned that he was infected with HIV. His arrest took place before he could establish care with an HIV treatment program or even a case manager. During his year in prison, concerned about the way he might be treated by other inmates and guards, he did not disclose his status.

After he is decarcerated, HIV is not at the top of his list of concerns because he feels fine, he still does not mention it to anyone.

Desired Outcome: To enable this type of proactive support for decarceration, we need to enable interoperability between NIEM-based Justice Department systems, HUD HMIS-based HUD shelter management systems, FHIR-based healthcare systems, and FHIR/IX4HS/360X-based human services referrals.
Cross-Jurisdiction Family Reunification

This is a transitional user story for the Thomson Family to move them to Chicago to live with John’s parents – creating a cross-state child welfare transfer use case and setting the stage for a multi-generational SDOH challenge and a maternal health challenge.


Sarah and John reunite after a long-distance romance. Sarah has been successful with rehab and recovery. John has been successful with PTSD counseling and job training. John returns to Michigan from New York City to be with the family. While they are not quite ready to retake their wedding vows, they want to try again to be a functional family.

Unfortunately, the job market in rust-belt Michigan is still challenging for John and Sarah. And John is another mouth to feed and another person living with Sarah’s mother, Ruth, in a tiny, subsidized apartment. With winter approaching, John suggests that the family travel to his hometown, Chicago, where they can get more family help and improve their chances of getting better employment. Ruth, while sad to be parted from her extended family, chooses to stay behind in Michigan, where she has a strong social network and will have sufficient resources once her household shrinks.

John reaches out to his parents in Chicago to ask if they might come and visit during the coming holidays and try to find employment and housing of their own in the area. His parents Randal Thomson and Geraldine Thomson are delighted at the prospect of having their kids and grandkids visiting for Christmas. However, they point out that they have a very small house and the only place they have that is big enough for the family to stay is the garage. Despite the substandard housing offered, John and Sarah are still enthusiastic about the move and the potential to gain better employment in Chicago.

Before they can move from Michigan, they need to consult with their Michigan Family and Children’s Services to both gain approval from Family Court for the move and to arrange for the family’s case to be transferred to the Illinois Department of Children and Family Services. Sarah is visited by her case manager, Angela Gabriella. Angela has discussed the situation with the Family Court Judge who had been overseeing Sarah and her childrens’ case. She told the Judge of the excellent progress of Sarah in rehab and recovery, John’s counseling for PTSD and job training, John and Sarah’s reconciliation, and the children’s improvement with both their own counseling and with the reuniting of the entire family. Angela tells Sarah that the Judge favors Sarah and her plan and congratulates her on the wonderous future the Judge sees for her family.
Just before they load up John’s old Pinto station wagon for the trip, Sarah discovers that she is pregnant. This complicates the journey and will force Sarah to find maternal health in a strange city as soon as she arrives.

Maternal Health and Gestational Diabetes

(Maternal Health Story 2023 – Index Person: Sarah)

Just before Christmas, the family piles into the old Pinto and sets off on the trip to John’s parents house in the Bronzeville neighborhood of Chicago <4136 S. Langley Ave. Chicago is a single family two-bedroom ranch with an attached garage>. It should have been a four-and-a-half-hour trip, but Sarah was having Waffle House cravings, Sarah and the kids needed frequent bathroom breaks, and a snowstorm made the final hours treacherous in the late afternoon glooming. When they finally pulled into John’s parent’s driveway it was after dark. The older Thomsons welcomed them warmly to their cramped home and showed them how they had fixed up the garage for the family so that it looked inviting, if a little cool and drafty in the middle of a snowstorm.

After her grazing at the Waffle House that afternoon, Sarah felt incredibly thirsty, needed a lot of bathroom stops, was having blurry vision and feeling very fatigued and weak. But most disconcerting was a feeling of numbness in her hands and feet. At first, she just assumed these were side effects of the long uncomfortable journey. But Grandma Geraldine said she had the same symptoms when she was pregnant with John decades ago. She recommended that Sarah use the new health chatbot that her church had recently told the congregation about.

Sarah downloads the chatbot app and engages in a text chat interaction which encourages her to share her health concerns and follows-up with a few SDOH survey questions to enable a case manager to know what issues to help Sarah with.

At the end of the session, the chatbot offers to connect Sarah with a community health worker to discuss her situation and any services for which Sarah might be eligible. Sarah agrees to have her personal details and contact information shared with the community health care coordination system.

The next morning, Sarah is contacted by Betsy Inara, a Community Health Worker. Betsy interviews Sarah first regarding her personal health history, second her recent gestational diabetes concerns she shared with the chatbot, and finally her family health and social issues raised in the PRAPARE survey the chatbot incorporated in their chat. Betsy is able to refer Sarah to an Obstetrician who can begin to further assess Sarah’s maternal health needs and further diagnose her potential gestational diabetes health concern. Betsy is also able to begin the process for signing up Sarah and her children for WIC, Sarah and John for SNAP, and help them apply for subsidized housing and rental assistance. Betsy refers Sarah and John to a
church-sponsored job placement agency in the area. Finally, Betsy refers John’s parents to the local Area Agency on Aging for further assessment and services for which they might be eligible now that they have a temporarily larger household with the “kids” in the garage.

Grandparents Raising Grandchildren

(Aging Grandparents with a Refilled Nest 2023 – Index Persons: Randal, Geraldine, Sarah, John, Jameson, Madison)

With Sarah and John out looking for work, John reconnecting with old childhood friends, and Sarah going to maternal health appointments and birthing classes, the daytime tasks of childcare have fallen to grandparents Randal Thomson and Geraldine Thomson. They don’t mind. It is a joy to have their grandchildren living with them. But it puts an additional strain on their physical stamina, ability to keep up with household chores (all the extra laundry!), and finances.

The Community Health Worker who is working with Sarah and John has referred the grandparents to the local Area Agency on Aging, AgeOptions. A case worker from AgeOptions reached out to Randal and Geraldine to discuss their situation and offer up services that might help them both as individual older Americans and through the ACL Grandparents Raising Grandchildren program.

In addition, as an ACL Community Care Hub, AgeOptions is able to help Sarah and John work with the Illinois Department of Children and Families to get an appointment with their new child welfare case manager and ensure that there are no follow-on Family Court problems as a result of their move.

Older American Housing Unstable Veteran

(HIMSS 2023 Consent-mediated SDOH Referral – Index Person: Ruth)

Ruth Hernandez was initially relieved when Sarah, John, Jameson and Madison moved out of her small apartment to travel to Chicago for improved employment opportunities. However she underestimated how much Sarah had been contributing to covering her expenses. In addition, in the months following their departure Ruth’s health began to deteriorate.

As a 20 year veteran of the U.S. Air Force who had deployed to the Persian Gulf in the early 1990s, Ruth is registered with the VA’s Airborne Hazards and Open Burn Pit Registry. Since her retirement from the service she has suffered from asthma and chronic bronchitis. Recently her community primary care practitioner has noted symptoms that could be related to military
airborne hazards exposure. Given her military history which could contribute to these health concerns, she has been referred to the VA for follow-up assessment and treatment.

During check-in at the VA, the receptionist gave her a standard PRAPARE survey to determine if there are other social determinants of health concerns that could add challenges to her health recovery. In this survey Ruth indicated she was having difficulty paying her rent, affording food, and getting transportation to go to medical appointments or buy food. When interviewed by a VA care coordinator she admitted that her financial situation was so perilous that she was in danger of being evicted from her apartment. The care coordinator referred Ruth to the U.S. Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) rental assistance program. However, recognizing that there were other community services available to Ruth through other Federal, State, and local agencies, the care coordinator also referred her to her local Area Agency on Aging (AAA).

After she returned home, her local AAA sent a case manager to her apartment to interview her and perform a more comprehensive assessment of her needs. This resulted in referrals to additional rental assistance, medically appropriate meals delivery programs, application for SNAP benefits, transportation vouchers for local public and agency provided transportation, and other long term support services (LTSS) to help her stay in and thrive in her home.
Future Potential User Stories

(based on Project Unify meeting on 1/5/22)

**Domain** - User Story (Member Stakeholder)

- **Education/Health** - Education Chronic Absentee Asthma Alert (NJ InCK, OH OHIP)
- **Education/Health** - Contact Tracing COVID Alert (NJ InCK, NY InCK, OH OHIP)
- **Education/Health** - School/Headstart Enrollment Health (NJ InCK, NY InCK, OH OHIP)
- **Education/Homelessness** - (NY InCK)
- **Early Childhood Education/Healthcare/Childcare** - Early Intervention… (CEDS, NJ InCK, CCAoA)
- **Child Welfare/Human Services** - NYC ACS WIC Referral (NY InCK)
- **Child Welfare** - (NY InCK, ChildWelfare Domain WG)
- **Human Services/Legal** - Family Law Legal Referral (NJ InCK)
- **Child Welfare/Justice** - Juvenile Justice Legal Referral (NIEM PMO)