THE HIV, HOUSING, & EMPLOYMENT PROJECT

H.O.M.E.S.
(Housing Opportunities, Medical, Employment Services)

Project Staff

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LEAD AGENCY: POSITIVE IMPACT HEALTH CENTERS

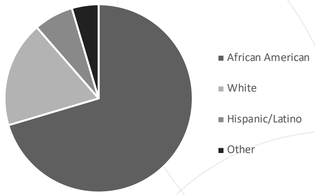
Introduction

Geographic Landscape

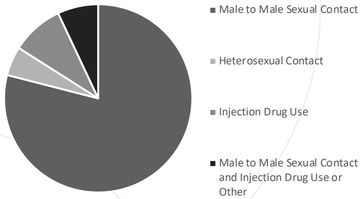
Brief description of local HIV epidemic

According to the CDC, 1 in 51 Georgians will be diagnosed with HIV in their lifetime. This fact, combined with no statewide Medicaid expansion and failing rural hospitals, has left the state of GA in a position of crisis. The metro Atlanta 20 County EMA (9th largest in America) also suffers from lacking or absent services for stable housing, adequate employment and accessible transportation.

HIV Prevalence by Race/Ethnicity



HIV Prevalence by Risk



77% Viral suppression

14% homeless or unstably housed

39% unemployed or underemployed

The Challenge

Housing: A deficit of affordable housing in the City of Atlanta.

Employment: A high rate of poverty and lack of employment services friendly to PLWH.

HIV Medical Care: The second highest occurrence of new HIV transmissions in the country: 24.9 new HIV transmissions per 100,000 people.

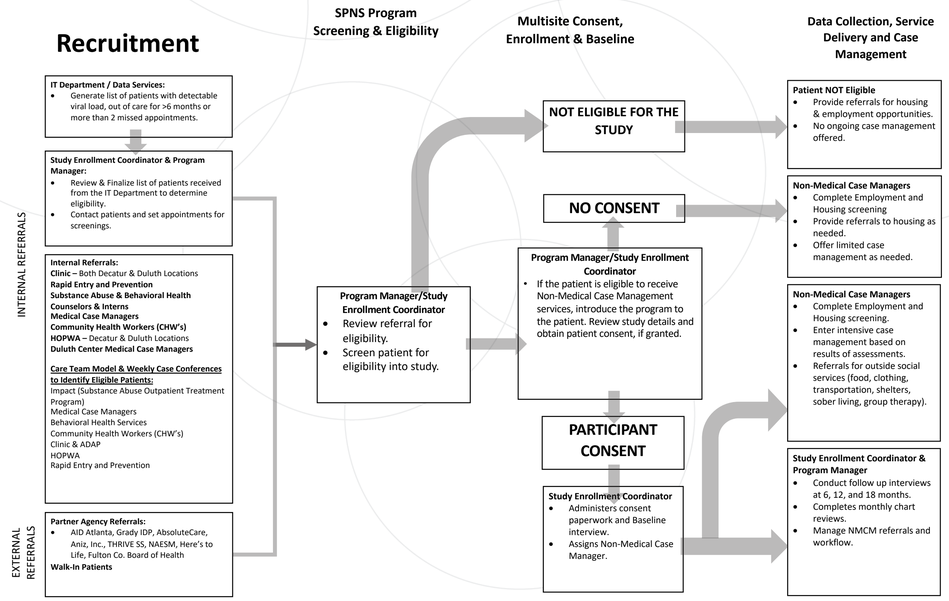
Key Partnerships

- Housing Urban Development (HUD)
- Department of Labor (DOL)
- Ryan White Part A / B / C

Focus population

The focus population for the study was people living with HIV (PLWH), who are out of care (or in danger of falling out of care) and are seeking stable housing and employment. All demographic populations are welcome, with an emphasis on the black MSM community.

The Program Model



Lessons Learned

Housing: As access to affordable housing diminishes, the task of housing homeless patients has become more difficult. The City of Atlanta needs to increase access to affordable housing subsidies for PLWH.

Engagement & Collaboration: The participants who were most successful with regards to housing and employment followed an individual service plan, developed in partnership with their case manager. Patient engagement and input were major drivers of success.

Clinic Care: Homeless patients are at a high risk of falling out of care and missing appointments – intensive case management can mitigate issues and support positive health outcomes.

Key Innovation

Intensive Case Management

The incorporation of intensive case management with a housing first model, helps PLWH address their housing instability while working towards employment and maintaining consistent medical care. Previous housing models have not provided the ability to offer case management while searching for housing. This plan eliminates barriers and allows patients the comfort of searching for work while stably housed and in care.

Preliminary Outcomes

Individual level

100 Patients Enrolled
50 Housed
10 Receiving Housing Subsidy
60 Participants have income:
44 Employed /16 with Benefits
80 Retained in Care

System level

Housing and employment services fully integrated into the agency which previously did not offer such services. The agency added four new service providers who are dedicated to implementing and sustaining the program moving forward.

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