Housing, HIV, HRSA, and HOPWA

United States Conference on AIDS
September 11, 2015

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25 Years Ryan White HIV/AIDS Program
Moving Forward with CARE: Building on 25 Years of Passion, Purpose, and Excellence

Learning Objectives

- Differentiate between the role of the Housing Opportunities for Persons with AIDS (HOPWA) program and the Ryan White HIV/AIDS Program (RWHAP) in supporting housing stability and positive health outcomes
- Recognize the barriers communities face in aligning health and housing systems and identify solutions
- Identify models to overcome barriers and improve community-level co-o rdination between housing and health care systems for people living wit h HIV (PLWH)
- Start planning effective collaboration in their local area

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Seminar Agenda

- Overview of Federal Programs
- Technical Assistance
- Listening Session
- Parking Lot

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Federal Presenters

- **Harold Phillips**, Director, Office of Domestic & Global HIV Training & Capacity Development Programs (HRSA)
- **William Rudy**, Acting Director, Office of HIV/AIDS Housing (HUD)
- **Benjamin Ayers,** Senior Community Planning & Development Specialist, Office of HIV/AIDS Housing (HUD)
- **Amy Palilonis**, Community Planning & Development Specialist, Office of HIV/AIDS Housing (HUD)
- **Amy Griffin**, Public Health Analyst, Division of State HIV/AIDS Programs (HRSA)
- **Stephanie Bogan**, Public Health Analyst, Division of Policy & Data (HRSA)

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The Ryan White HIV/AIDS Program Legislation

- The Ryan White HIV/AIDS Treatment Extension Act is a legislative program:
  - Public Health Law 111-87 under Title XXVI
  - Enacted into law in 1990
  - Reauthorized 1996, 2000, 2006, and 2009
- The authorization for the Ryan White HIV/AIDS Program (RWHAP) expired on September 30, 2013. The Program will not sunset and can continue to operate through Congressional appropriations with or without subsequent legislation

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The Ryan White HIV/AIDS Program Overview

- The Ryan White HIV/AIDS Program provides a system of care through primary medical care and essential support services for low-income PLWH who are uninsured or underinsured
  - The program works with cities, states and local community based organizations to provide a cohesive system of care, reaching over 500,000 people living with HIV
  - A smaller but equally critical portion is used to fund technical assistance, clinical training, and the development of innovative models of care
- The Ryan White HIV/AIDS Program is funded at $2.32 billion in fiscal year 2015

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The Ryan White HIV/AIDS Program
Program Intent

- Increase access to care for PLWH
- Only disease-specific discretionary grant program for care and treatment of PLWH
- Payer of last resort – safety net for uninsured and low-income individuals living with HIV/AIDS
- Funding to support:
  - Primary health care, including medications
  - Support services
  - Provider training
  - Technical assistance
  - Demonstration projects

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Who We Serve

Ryan White HIV/AIDS Program	**Served half a million (524,675) people** 2013
Care Engagement	**~2 out 3** PLWH engaged in medical care served by RWHAP
Demographics	47% Black/African American 23% Hispanic (2013) **~90%** living at/below 200% Federal Poverty Level (2013)

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Ryan White HIV/AIDS Program
Program Parts

- **Part A (Cities)**
- **Part B (States and Territories)**
  - ADAP – AIDS Drug Assistance Program
- **Part C (Community-based Organizations)**
  - Early Intervention Services and Capacity Development
- **Part D (Women, Infants, Children and Youth)**
- **Part F (Other Programs)**
  - AIDS Education and Training Centers (AETCs)
  - Special Projects of National Significance (SPNS)
  - Dental Programs
  - Minority AIDS Initiative (MAI)

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The Ryan White HIV/AIDS Program
Core Medical Services Waiver

Under Title XXVI of the Public Health Service Act, grantees receiving Ryan White HIV/AIDS Program Part A, B, and/or C funds are required to spend at least 75% of grant funds on Core Medical Services:

- Section 2604(c) – Part A
- Section 2612(b) – Part B
- Section 2651(c) – Part C

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The Ryan White HIV/AIDS Program
Core Medical Services

Core Medical Services in the Ryan White HIV/AIDS Program statute are defined as:

- Outpatient and ambulatory health services
- AIDS Drug Assistance Program (ADAP) treatments
- AIDS pharmaceutical assistance
- Oral health care
- Early intervention services
- Health insurance premium and cost sharing assistance for low-income individuals
- Home health care
- Medical nutrition therapy
- Hospice services
- Home and community-based health services
- Mental health services
- Substance abuse outpatient care
- Medical case management, including treatment adherence services

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The Ryan White HIV/AIDS Program
Support Services

In the Ryan White HIV/AIDS Program, support services are defined as services that are needed for individuals with HIV/AIDS to achieve their medical outcomes. Examples include:

- Medical transportation
- Outreach services
- **Housing Services**
- Linguistic services
- Referrals for health care and support

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Ryan White CARE Act 25th Anniversary

"Moving Forward with CARE: Building on 25 Years of Passion, Purpose, and Excellence"

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RYAN WHITE HIV/AIDS PROGRAM MOVING FORWARD FRAMEWORK

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The Ryan White HIV/AIDS Program
Housing Support

- **Housing support services funded under Ryan White HIV/AIDS Program Parts A, B, and D.**
- **Allowable services include (Policy Clarification Notice 11-01):**
  - Housing referral
  - Short-term or emergency housing
- **Program Guidelines for Housing Support:**
  - Must be payer of last resort
  - Must ensure that housing is limited to short-term support
  - Must develop mechanisms to allow new clients access to housing services
  - Must develop long-term housing plans for every client in housing

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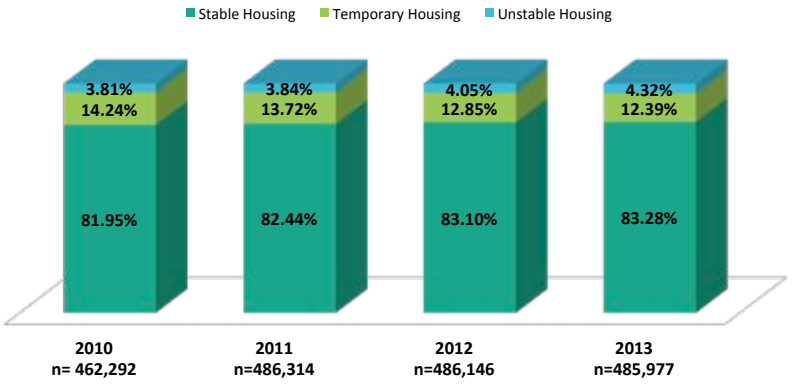
Ryan White Services Report, 2010-2013
Housing Status For Clients Served



Housing status is unknown or missing for 90,883 clients in 2010, 68,332 clients in 2011, 50,073 in 2012, and 38,698 in 2013. Housing status is required for clients who received outpatient ambulatory medical care, medical case management, non-medical case management, or housing services.

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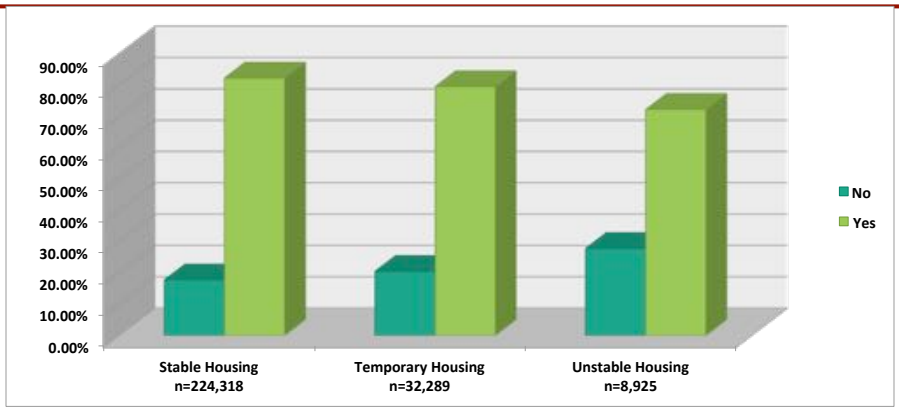
2013 RSR Data
Retention by Housing Status



Retained in care: had at least 1 OAMC visit before September 1, 2013, of the measurement year and had at least 2 visits 90 days or more apart

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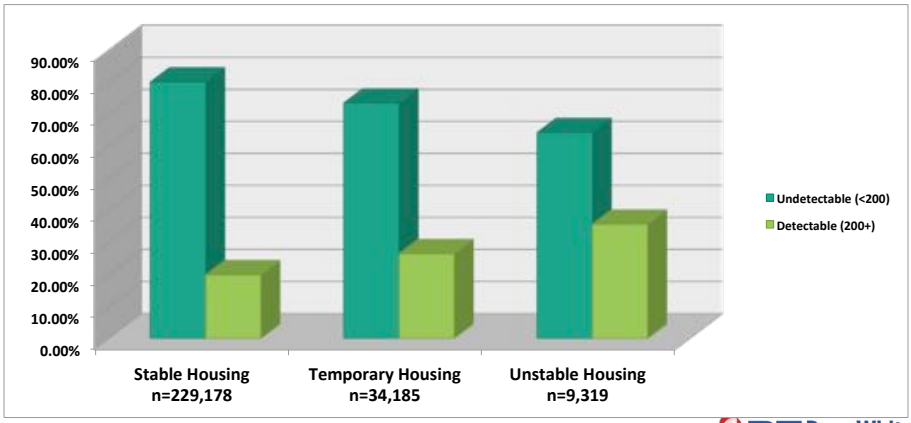
2013 RSR Data:
Suppression by Housing Status



Viral suppression: had at least one OAMC visit, at least one viral load count, and last viral load test <200

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HOPWA Overview

Office of HIV/AIDS Housing
September 2015

HOPWA Overview: Section 1

Program Origin

Statutory Purpose

HOPWA Program Goals

Benefits of Housing for PLWHA

Program Origin

Housing for PLWH serves as a vital base from which persons receive care. *National AIDS Commission, 1992*

- Unstable housing prevents ability to participate in HIV care
  - Results in negative health consequences along with increased risks of viral transmission
  - Contributes to increased mortality rates

Program Origin

- The Housing Opportunities for Persons With AIDS (HOPWA) Program was created to address the housing needs of low-income individuals living with HIV/AIDS and their families.
- Established by the AIDS Housing Opportunity Act of 1990 (42 U.S.C. 12901)

Statutory Purpose

To provide **state and local governments** with resources and incentives for devising **long-term strategies** to develop a range of housing assistance and supportive services for low-income persons living with HIV/AIDS **and their families** to overcome key barriers to stable housing - affordability and discrimination.

HOPWA Program Goals

1. Increase Housing Stability
2. Reduce Risk of Homelessness
3. Increase Access to Care & Support

Benefits of Housing

***Housing is a critical component of HIV care and prevention systems*.**

Helping homeless and unstably housed people:
- Enter into supportive housing and remain in care
- Reduce HIV risk behavior &
- Adhere to complex treatment regimens.

Cost effectiveness in behavioral health interventions:
- Reduce homeless shelter costs
- Reduce emergency care

Research demonstrates that stably housed individuals have reduced risk of HIV transmission, improved adherence and better health outcomes

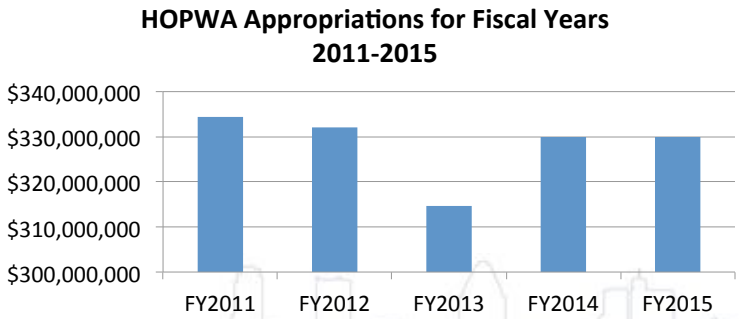
Understanding HOPWA: Section 2

Appropriations

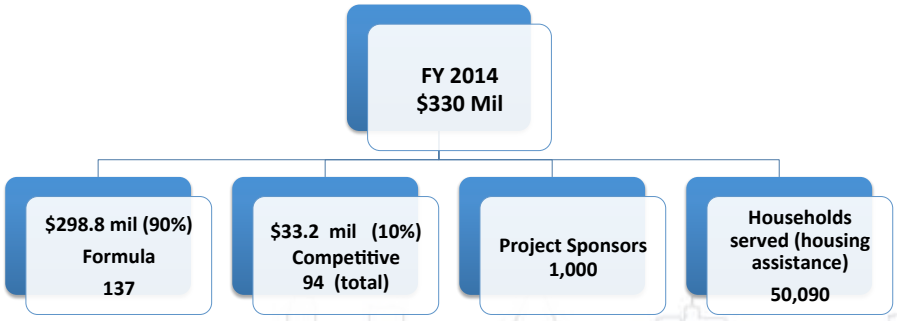
Formula grants

Competitive grants

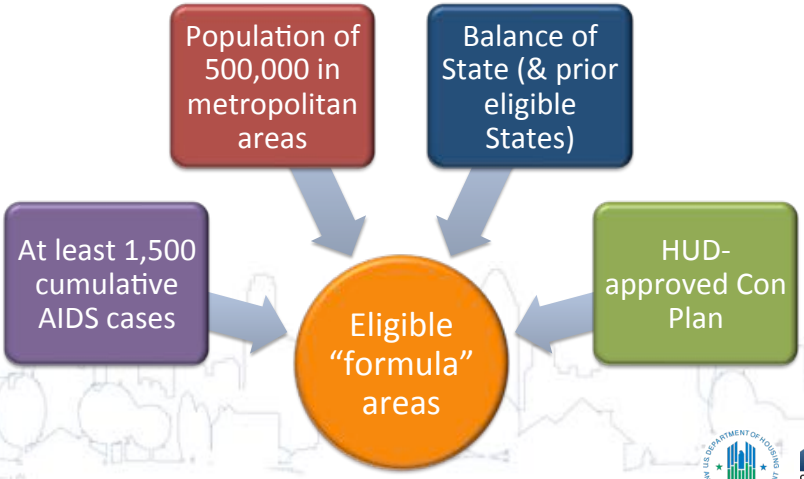
HOPWA Funding



HOPWA Structure



Formula Program



HOPWA 2015 Formula Allocations

- FY2015 Appropriation: $330 million
- $297 million to 138 eligible areas (97 Cities and 1 County on behalf of their EMSA and 40 states including P.R.)
- Projected that 12 of the EMSAs will release the administration of their grant to the state
- 1 new Formula grantee in 2015: Durham-Chapel Hill, NC EMSA

Competitive Grants

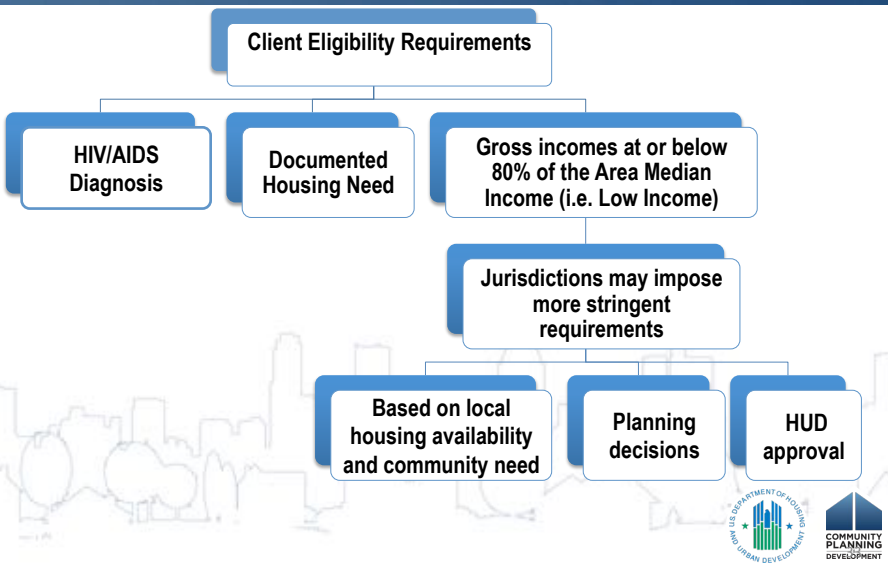
There are 2 types of competitive grants available to communities:

- **"Long-term Comprehensive Strategies"** Funding for states and localities that are not eligible for formula grants. The Pacific Insular Territories are the only U.S. funded location without HOPWA funding.
- **"Special Projects of National Significance" (SPNS**) Housing and supportive services projects which are unique or innovative and likely to serve as effective models in addressing the housing and related needs of low-income persons living with HIV/AIDS

Understanding HOPWA: Section 3

- Client Eligibility
- Eligible Activities
- Performance Reporting
- Homeless Management Information System (HMIS)

Client Eligibility



HOPWA Eligible Activities

HOPWA Eligible Activities

HOPWA Performance Reporting

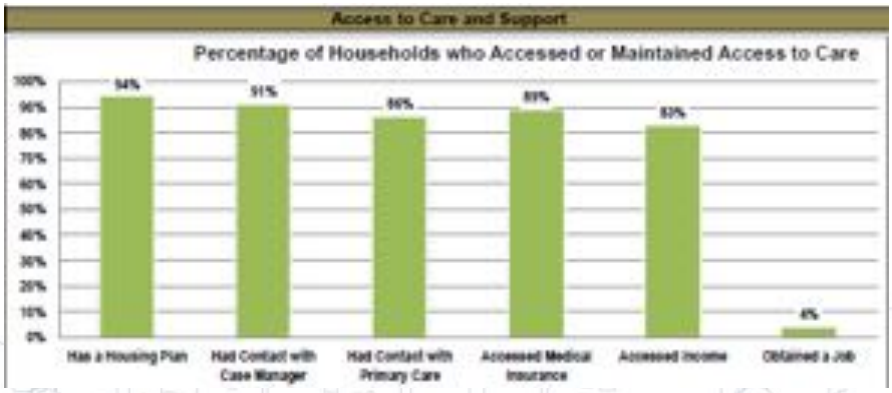
- HOPWA Program achievements are measured though performance reports submitted annually by program grantees.
- HOPWA grantees must submit a yearly performance report and use the Integrated Disbursement and Information System (IDIS) to report annual information on the use of program funds and progress towards identified goals and objectives.
- Information is reported in aggregate to HUD without personal identification

Client Demographics

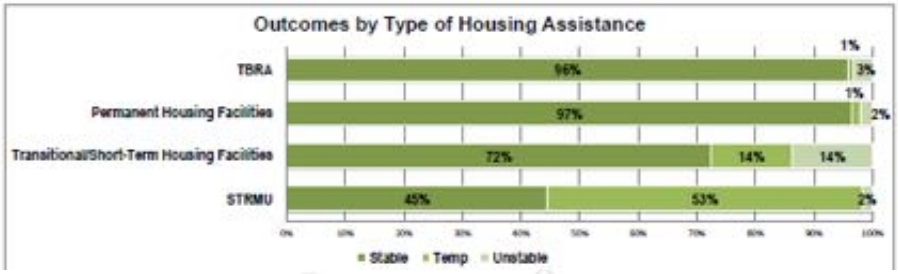
FY 2013/2014 - 50,090 households

- 78% extremely low-income, (30 percent of Area Median Income
- 16% very-low 50 percent of Area Median Income.
- Only 6% fell into the 51% to 80% category.
- Among new clients served in 2013/2014, 4,823 (19%) were homeless and HIV-positive
- 14% of those were homeless veterans.

Client Outcomes – Access to Care



Client Outcomes – Housing Stability



Homeless Management Information System (HMIS)

- HOPWA grantees that are specifically targeting the homeless population must use the Homeless Management Information System (HMIS) to undertake and track services of their homeless clientele.
- However, all projects regardless of target population are strongly encouraged to participate in the local HMIS.

HMIS Data Standards 2014

New HOPWA HMIS Data Element for 2014:

4.47 T-cell (CD4) and Viral Load

- Rationale: To measure the extent to which housing impacts health of persons with HIV/AIDS.
- Collection Point(s): At project entry, update, annual assessment and project exit.
- Subjects: Only Clients funded in a HOPWA project presenting with HIV/AIDS
- Data Collection Instructions: Indicate T-cell count and viral load measurement at 6 month intervals beginning at project entry through project exit. At a minimum for clients staying one year or more, the data must be collected at annual assessment. The updated data (6 month collection) of t-cell and viral load may be entered on different dates as information is available.

- Added to existing data elements that include medical assistance accessed, health insurance status, services provided, etc.

HOPWA Desk Officers

HUD Desk Officer	Contact Information	Field Office Area
Benjamin Ayers	Phone: (202) 402-2201 Benjamin.L.Ayers@hud.gov	Albuquerque, Anchorage, Birmingham, Columbus, Denver, Fort Worth, Kansas City, Los Angeles, Milwaukee, Minneapolis, Omaha, Phoenix, Portland, San Francisco, Seattle, St. Louis TA POTAC National Performance Reporting and Data Evaluation
Amy Palilonis	Phone: (202) 402-5916 Amy.L.Palilonis@hud.gov	Boston, Buffalo, Chicago, Detroit, Greensboro, Honolulu, Indianapolis, Jacksonville, Knoxville, Little Rock, Louisville, Manchester, Miami, Newark, New York City, San Juan
Lisa Steinhauer	Phone: (202) 402-5181 Lisa.A.Steinhauer@hud.gov	Atlanta, Baltimore, Columbia, Hartford, Houston, Jackson, New Orleans, Oklahoma City, Philadelphia, Pittsburgh, Richmond, San Antonio, Washington, DC

Federal Collaboration: Complementing Systems

- National HIV/AIDS Strategy
- RWHAP legislation specifically references coordination across HHS
- Collaborate and coordinate to:
  - Align across federal programs to reduce reporting burden on grantees
  - Partner to advance evidence base and develop interventions to improve care and treatment across the HIV Care Continuum
  - Share resources and expertise to build capacity at the grantee level

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Addressing HIV & Homelessness through Service Integration

Research highlights:

- There are key differences between RWHAP and HOPWA
- Findings suggest the importance of exploring and capitalizing on the strengths of each program
- Structure program models to focus on the integration of housing and medical care, data systems and community planning processes


Analysis of Integrated HIV Housing and Care Services

Final Report

February 2014

Mathematica Policy Research
Margaret Hargreaves, Ph.D., M.P.P.
Vanessa Oddo, M.P.H.

The Cloudburst Group
Lindsey Stillman, Ph.D.
Jonathan Sherwood, Ph.D.
Steven Sullivan, Ph.D.

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HIV Care Continuum White Paper

Research highlights include:

- Housing instability is linked to delayed HIV diagnosis and to increased risks of acquiring and transmitting HIV infection
- Housing status is among the strongest predictors of maintaining continuous HIV primary care, receiving care that meets clinical practice standards and returning to HIV care after dropout
- Homelessness and housing instability are directly linked to higher viral loads and failure to achieve/sustain viral suppression, even after controlling other factors such as substance use and mental health needs

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Integrated HIV Housing Plans

COMMUNITY PLANNING DEVELOPMENT

HOPWA Housing Opportunities for Persons With AIDS

U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

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Integrated HIV Housing Plans

- **First HOPWA new projects competition in 3 years:**
  - $8.8 million available for 6 to 8 one-time awards
  - SPNS projects to help advance understanding and improve the delivery of housing and care for low-income PLWHA
- **Funds available for:**
  1. Direct housing assistance and service delivery to low income persons and families living with HIV/AIDS
  2. Comprehensive planning and coordination of local resources in meeting housing and service needs of the population
  3. Integrated HIV/AIDS Housing Plan (IHHP) to be issued end of 3rd year of operation

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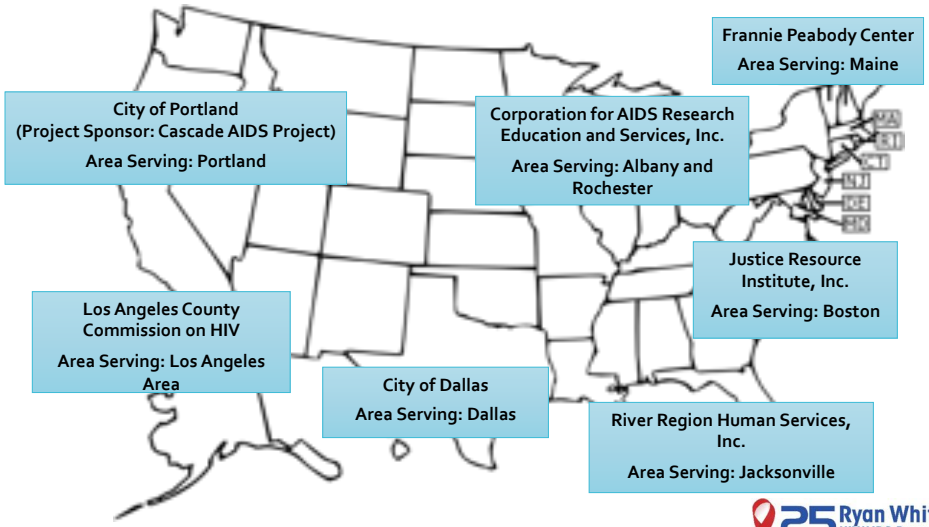
IHHP Grantees



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Community Context

- **CARES inc. is a not-for-profit located in Albany New York which collaborates and supports our local communities to create a system of care to prevent and end homelessness.**
  - Serves as the Collaborative Applicant for five (5) Continuums of Care in the Capital Region
  - Provides housing for People Living with HIV/AIDS
  - Serves as the System Administrator for the Homeless Management Information System (HMIS) in 23 counties throughout New York State

Community Context

- Cascade AIDS Project (CAP) was founded in 1983 and incorporated in 1985. CAP is the oldest and largest community-based provider of HIV services, housing, education and advocacy in Oregon and Southwest Washington.
- CAP's Supportive Housing Program serves a 6 county area and receives Federal, State and Local funds. CAP provides housing case management as well as short and long term housing assistance to people who are homeless or at-risk of becoming homeless. Navigators and peer mentors help connect people to medical care and/or mental health or substance abuse services.

INTEGRATED PLANNING

Increased system coordination through combined needs assessment and planning processes.

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City of Portland: Combined Needs Assessment & Planning

Ryan White and HOPWA providers involved in each planning body

- CAP directly involved in 3 CoC's
- HIV service network meeting
- IHHP core planning group: Ryan White Part A and B, County Human Services, HOPWA, CoC, PHA, and WIB.

Outcomes:

- Allocation of Ryan White for housing
- Conversations on the use of funding
- Supportive Services not covered through HOPWA (or limited) vs. Ryan White
- Better coordination of funding based on community need

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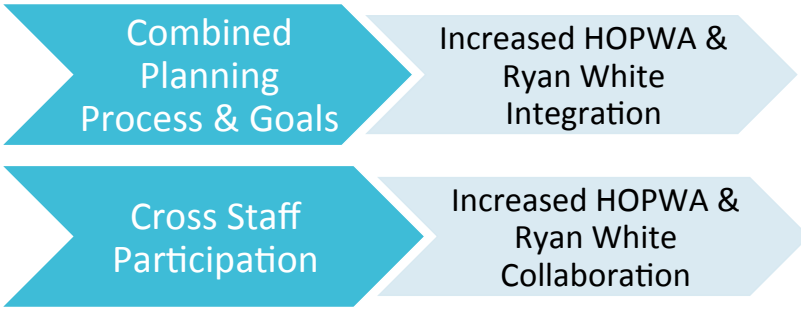
Integrated Planning Impact on HOPWA System



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COMBINED CASE MANAGEMENT

Increase coordination of HOPWA and Ryan White through a coordinated case management processes – training, combined assessments, targeted case management, and leveraged funding.

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Cascade AIDS Project: Combined Case Management System

Approaches to balancing HOPWA and Ryan White work and funding; especially on Case Manager level

Medical and Housing Case Management Team Model

- Leveraged Services between HOPWA & Ryan White
- EIS, HRSA SPNS, MAI, Peers, and Housing Case Management

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Cascade AIDS Project: Combined Case Management System

CAP's housing case managers (HCM) are assigned to Multnomah County's medical case managers (MCM) to coordinate client care as a team.

- Agreement between CAP and the County's HIV Health Services Center to identify more as a team.
- Continue the linkage and improve opportunities for clients who are linked to their MCM to easily connect with their HCM, even after they have 'graduated' if additional support is needed.

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Integrated Planning Impact on HOPWA System

Provide Tracking (Pre & Post Tests)	Increased knowledge among case managers on housing
Integrated Housing & Health Outcomes in Client Plans	Increased Coordinated Housing & Health Plans through Centralized Assessments
Housing Stability & Access to Care Tracked Across Programs	Seamless Mechanism for Linkage to Care
Leveraged HOPWA & Ryan White Funding	Improved Client Outcomes & Cost Effectiveness through a Combined Case Management Process

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INDENTIFYING COLLABORATIVE PARTNERS

Increase coordination to streamline service delivery and impact client-level outcomes

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CARES: AIDS Service Organization Ambassador to Housing Program

Strategy

- Partnership between ASOs and Emergency Shelters to provide the link and needed support to ensure that PLWHAs who present at emergency shelters are assessed and connected to services and housing.

Barriers

- Resistance from front-line shelter staff to ask status
- CoCs Collaborative Applicant reaching consensus on the Coordinated Assessment Tool design and inclusion of 'Are You Aware of Your Status?' question

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CARES: AIDS Service Organization Ambassador to Housing Program

Successes

- Planning session with ASO partners allowed the creation of a workshop design
- Emergency Shelters have the knowledge and resources to assess clients and connect them with care
- Mechanism in place that ensures that PLWHA that disclose and/or find out their status as a PLWHA will be connected to housing through HOPWA resources quickly
- Available data-creation of form within HMIS to track referrals
- Improved systems coordination to mutually share knowledge in order to improve health outcomes.

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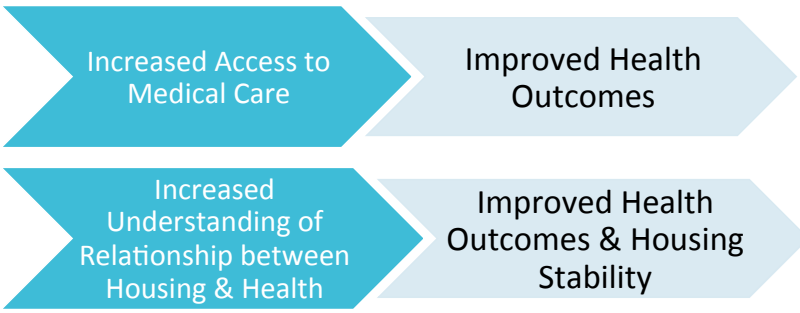

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DATA SHARING AND USING DATA TO DRIVE SYSTEM CHANGE

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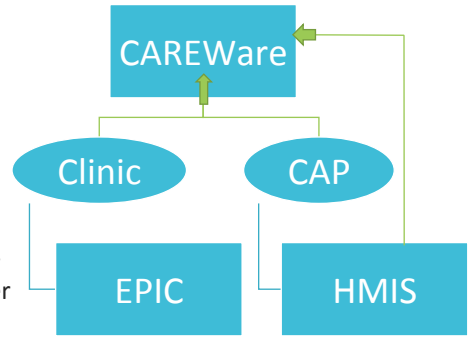
Cascade AIDS Project: Data Integration

Strategy

- Developed a data bridge through
  - A system-wide agreement regarding data usage,
  - Reports that flag individuals that are out of care or uninsured, &
  - Staff access to CAREWare for client coordination with other ASOs.



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Cascade AIDS Project: Data Integration

Barriers

- Each ASO in the system has different legal obligations to collect and protect information
- Staff capacity to send and troubleshoot the migration of files
- Transition time

Successes

- Generation of reports to flag individuals who have fallen out of care
- Staff ability reach out and re-engage clients
- Collaboration with medical case managers to develop strategies to coordinate services for people with multiple barriers to staying in care

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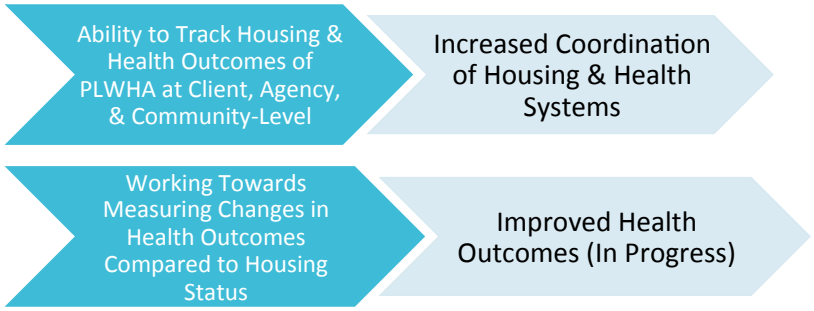
Integrated Planning Impact on HOPWA System



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RESOURCES

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IHHP Grantee Resources

- **CARES**
  - Coordinated Assessment Tool
  - Workshop design
- **Cascade AIDS Project**
  - Supportive Housing Application Checklist
  - Client Satisfaction Survey
  - 2012 Client Satisfaction and Needs Assessment Results

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Med-HEART
Medical Home-HIV Evaluation & Resource Team

Successful Collaborations for Health & Housing

HRSA/SPNS Initiative Building a Medical Home for multiply diagnosed HIV-positive homeless/unstably housed persons

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Presenting Partners

- Serena Rajabiun, Boston University School of Public Health, Boston MA
- Lisa McKeithan, CommWell Health, Dunn NC
- Manisha Maskay, AIDS Arms Inc, Dallas TX

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Learning Objectives

- Describe challenges faced by persons living with HIV/AIDS who are homeless/unstably housed
- Share approaches from the HRSA/SPNS initiative
  - CommWell Health, Dunn, NC
  - AIDS Arms Inc, Dallas, TX
- Identify opportunities to build collaborations between health & housing partnerships at home

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HRSA/SPNS Initiative: Building a Medical Home for HIV Homeless Populations

Goal: To engage homeless/unstably housed persons living with HIV who have mental illness and/or substance use disorders in HIV and behavioral health care and obtain stable housing

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Priority population

- **Persons living with HIV/AIDS who are 18 or older**
- **Persons who are homeless or unstably housed**
  - Literally homeless
  - Unstably housed
  - Fleeing domestic violence
- **Persons with one or more co-occurring mental health or substance use disorders**

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Challenges

Individual

- Active/increased substance use
- Untreated mental illness
- Incarceration history
- Trauma
- Stigma
- No or limited income
- Bad credit history
- Frequent visits to ER
- Weak employment history
- Not as adherent to HIV meds
- Comorbidities such as Hepatitis C, diabetes, hypertension, and depression

System

- Lack of permanent, affordable housing
- Lack of availability of behavioral health care
- Fragmented system
  - Poor coordination

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Intervention Models

- **Building a medical home for HIV positive homeless population**
  - Building collaborative partnerships with behavioral health care and housing agencies
  - Use of network navigator/care coordinators

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Building Collaborative Partnerships

- Co-location of health care in housing/shelter units
- Creating special needs units for PLWHA in housing programs
- Mobile health teams to housing agencies/health centers
- Emergency housing programs
- Establishing relationships with non traditional landlords

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Building Collaborative Partnerships

- **City/county wide Ryan White and housing committees- Coordinated Access Initiatives**
  - Greater New Haven Opening Doors Committee Health and Housing Team Meetings
  - Peer Navigator serves on the Coordinated Access Committee for Pasadena County as the key contact for working with HIV Homeless
  - UF Cares & River Region in Jacksonville Florida
  - Harris County ,Houston, TX Coordination with Ryan White Part A for housing support

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Building Collaborative Partnerships

- **Increased access to behavioral health care**
  - Use of medication assisted therapy (Vivitrol and Suboxone)
  - Increased internal coordination with behavioral health as part of primary care team
    - Priority access to residential treatment
    - Access to Behavior Health Nurse Practitioners & case managers

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Use of network navigators/care coordinators

- **Client Tracking and Outreach**
  - Find those who have fallen out of care
  - Connect with people coming out of prison
- **Supporting Retention in Care**
  - Accompaniment to appointments
  - Transportation
  - Appointment reminders
  - Help with getting/scheduling appointments
  - Bridging communication with providers

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Use of network navigators/care coordinators

- **Providing Emotional Support**
  - Relationship building/trust
  - Encourage clients to keep going to their appointments
  - Coaching and support
  - Reducing stigma
- **Systems navigation & Service coordination**
  - Educating on how systems work
  - Brainstorming on how to get resources

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"Some of these people just needed somebody that cared…for them. With this program, they are shown that we care about them 'cause I'll call a patient or call a client four or five times a day just to see where they at…Once they realize that you not gonna let up on them, that's when they start coming around and meeting you halfway."

-Peer Navigator

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Successful collaborations Site: CommWell Health

Lisa McKeithan

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Program

- **Model**
  - Care coordination provided by HIV Nurse
  - Network Navigator
  - Intensive housing coordination
- **Target Audience**
  - HIV+ homeless/unstably housed, some farmworkers
- **Innovation**
  - Coordinated, intensive service provision spanning across departments and local service providers

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Geographic location

- Rural, southeast North Carolina

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Housing Partnerships

Barriers to housing

- Limited resources- housing units, transitional housing
- Services for homeless but not HIV+
- Red tape- background checks, drug screens
- Cost for emergency shelters

Strategy

- Convene local housing providers
- Pull them together to:
  - Introduce program
  - Learn about resources

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Housing Partnerships

- **What was meant to be a one (1) time meeting turned into:**
  - Forum for local housing providers
  - Quarterly meetings
  - Development of shared goals and objectives
  - Venue to share resources
  - 2-way street: connecting clients to housing and medical

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Resources

LOCAL SERVICES INVENTORY FOR COMMWELL SPNS MEDICAL HOME PROJECT

GENERAL INFORMATION				SERVICES PROVIDED											
Name of Center	Key contact person	Location	Shelter	Housing assist	Substance use	Mental Health	Case Mgmt	Primary Medical Care Assistance	Meals Assistance	Domestic Violence	Financial Assistance	HIV prevention	Social support	Other (specify)	Notes
Adult Health Clinic Harnett Co. Health Dept	Debra Hawkins 910-814-6350	307 W cornelius Harnett Blvd Lillington NC	No	No	no	Yes	yes	Yes	no	No	no	Yes	no	N/A	
Alliance of AIDS services-Carolina	Stacy Duck 919-834-2437	324 S. Harrington st. Raleigh, NC	No	Yes	Yes	Yes	Yes HIV	Yes	Yes	No	Yes	Yes	Support	n/a	n/a
Beacon Rescue Mission	John Cooke 910-892-5772	207 W. Broad Street Dunn, NC	Yes	yes	no	Yes	no	no	yes	yes	no	no	no	n/a	Homeless shelter
Betsy Johnson Regional Hospital	910-892-8000	600 Telephman Dr. Dunn NC	No	No	Detox only	Yes	no	Yes	no	No	no	no	yes	N/A	detox thru ER only
Carolina Outreach	Rhonda Nordin 910-433-0939	907 Hay St. Fayetteville NC	No	No	Yes	Yes	Yes	No	No	No	No	Yes	Yes	N/A	
Cape Fear Valley Behavioral Health services	Laura Taylor 910-615-3753	3425 Melrose Rd Fayetteville NC	No	Yes	yes	yes	yes	yes	no	no	no	yes	yes	n/a	
City Rescue Mission	Gladys Thompson 910-323-0446	120 North Cool spring st.	Yes	yes	no	Yes	no	no	Yes	yes	yes/ case by	no	yes	n/a	Female only cost $50.00/
Community Health Interventions	Elazzea McArthur 910-488-6388	2409 Marshinson Rd Fayetteville NC	No	No	no	no	yes	no	no	no	yes	yes	yes	n/a	
Christian Faith Ministries	Tabatha Franklin 919-776-8474	708 Chatham St. Sanford NC	Yes	No	no	no	no	no	Yes	No	No	no	Yes	n/a	Homeless shelter
Cumberland County Health	Phyllis McLethore 910-433-3600	1235 Pamsey St. Fayetteville NC	No	No	yes - by referral	Yes	no	Yes	no	No	no	Yes	n/a	N/A	
Cumberland Interfaith	Denise Jiles 910-826-2454	113 Sneb St. Fayetteville NC	No	yes	no	no	no	no	Yes	no	no	no	no	n/a	In county only
Good Neighbor House for women	Karen Earp 919-934-3639	Smithfield NC	Yes	Yes	no	no	yes	no	yes	yes	no	no	yes	n/a	Female only, mandatory drug screen,
Healing Place of Wake County	Dennis Tripp 919-838-8800	1251 Goode St. Raleigh NC	Yes	Yes	no	no	Yes	no	Yes	yes	No	no	Yes	n/a	Cost or County case
Hope Center	Evelyn Campbell 910-309-6729	310 Person St. Fayetteville NC	Yes	yes	yes	yes	no	no	yes	no	no	yes	yes	n/a	cost $7.00/day
House of Fordham Shelter	Linda Burroughs 919-736-7352	412 N. William st. Goldsboro NC	Yes	Yes	no	no	no	no	Yes	No	no	no	p	N/A	no cost
New Life Mission churchshelter	Pastor Grace Kim 910-864-4670	203 Maloney Ave. Fayetteville NC	Yes	No	No	No	No	No	Yes	No	No	no	Yes	n/a	
Potter's Wheel Ministries	Manager John	1477 Faith Ln Mount Olive NC	Yes	Yes	No	No	Yes	No	Yes	No	No	No	Yes	n/a	
Port Crisis Center, Human Services	252-443-1637	200 Government str. Greenville NC	No	No	yes/det ox	Yes	yes	Yes	no	No	no	Yes	yes	N/A	Detox facility
Project Homeless Fayetteville PD	Officer Stacey Sanders Community	467 Hay St. Fayetteville NC	No	liason only	no	no	no	no	liason	liason	no	no	yes	N/A	homeless liason

Community Housing Coalition Luncheon on Wednesday, June 10th, 2015: In order to address housing needs for low-income persons who are living with HIV/AIDS and their families, CommWell health hosted a Community Housing Coalition Luncheon on Wednesday, June 10th, 2015. A representative from Oxford House, Inc was here to discuss and provide comprehensive information about their program. We also had representatives from Woodforest National Bank to inform us of the array of services they provide in the community. Additionally, they discussed financial education and the basics of banking and personal finance for our patients. This was a wonderful opportunity to learn more about these agencies and how they can specifically benefit our patient's needs. Mirna Allende, Kyrstal McCullen, Lisa McKeithan, Jorge Talledo

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Health, Hope and Recovery AIDS Arms, Inc.

Manisha H. Maskay, PhD
Principal Investigator

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Program Model

- **Care Coordination provided by three full-time licensed social workers. It includes:**
  - Use of motivational interviewing and strengths based counseling to engage clients in identifying goals related to housing, medical care, mental health and/or substance use treatment.
  - Weekly meetings with clients to address barriers to accomplishing goals.
  - Significant collaboration with medical providers, pharmaceutical assistance programs, housing resources and others to connect clients with critical resources.

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Program Model (contd.)

- **Care coordination also includes:**
  - Providing supportive services to clients to maintain housing and reduce risky behaviors.
  - Making relevant supportive programs available for clients such as the HIVE, WRAP groups, etc.
  - Providing ongoing advocacy on behalf of clients.
  - Ensuring that clients are receiving appropriate and respectful care.
  - Enabling clients to build resiliency.

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Building and Sustaining Partnerships

- Partnerships with Shelter Plus Care, Legacy Master Leasing and the Dallas Housing Authority provide "preferred" status for clients to receive permanent supportive housing.
- Emergency housing at an extended stay motel for clients that are extremely shelter resistant or have significant barriers to being at a shelter
- Ongoing efforts to build relationships with a variety of providers to ensure respectful and appropriate care for clients and decrease barriers.

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Building and Sustaining Partnerships

- Ongoing Advocacy to promote 'Housing First', trauma informed care and other key elements related to providing care for people who are HIV+, multiply diagnosed and homeless.
- Ongoing education and technical assistance for community partners regarding best practices.
- Conversations with key influencers regarding the needs of the priority population.

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Challenges

Individual Level:

- Shelter resistance
- Substance use, mental health disorders
- Previous experiences related to stigma and discrimination

Systems level:

- Discrimination related to HIV status, substance use, criminal history
- Ongoing resistance to Housing First Model resulting in lack of consistency related to admission processes
- Inconsistent enforcement of policies by agencies

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Tools that Promote Client Engagement

- Acuity guidelines to inform the scope and intensity of interventions required by a client based on level of need.
- Pre-paid cell phones with medical appointments and medication reminders programmed in, given to clients.
- Tangible reinforcements such as pre-packaged foods, food vouchers and bus passes to support clients at medical and other key appointments.
- Assistance with obtaining necessary documentation for clients.

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Outcomes

Individual level - Improvements in:

- Housing status
- Attendance at medical visits
- Adherence to medication regimens
- Viral suppression and overall health outcomes

Systems level

- Increased adoption of 'housing first model' by housing providers
- Improved collaboration with housing providers
- Better understanding regarding needs of HIV+ people with substance use and/or mental health disorders
- Better access to permanent housing options for clients

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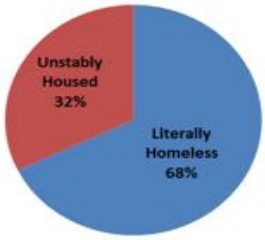
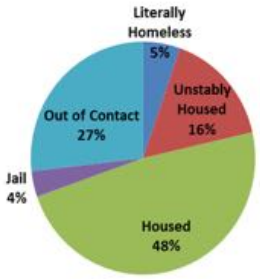
Outcomes

Housing Status at Baseline (n=56)
Clients Enrolled ≥ 6 Months



Housing Status at August 2015 (n=56)
Clients Enrolled ≥ 6 Months



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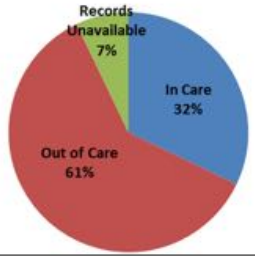
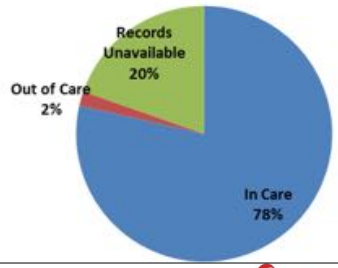
Outcomes

Engagement in HIV Medical Care at Baseline (n=56)
Clients Enrolled ≥ 6 Months



Engagement in HIV Medical Care at 6 Months (n=56)



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Outcomes

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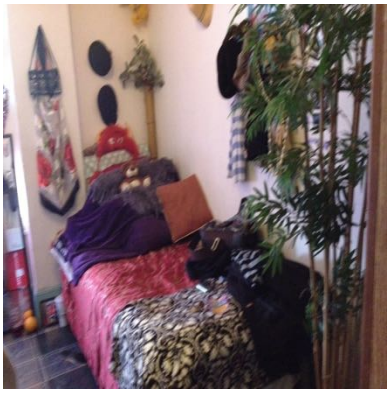
Outcomes



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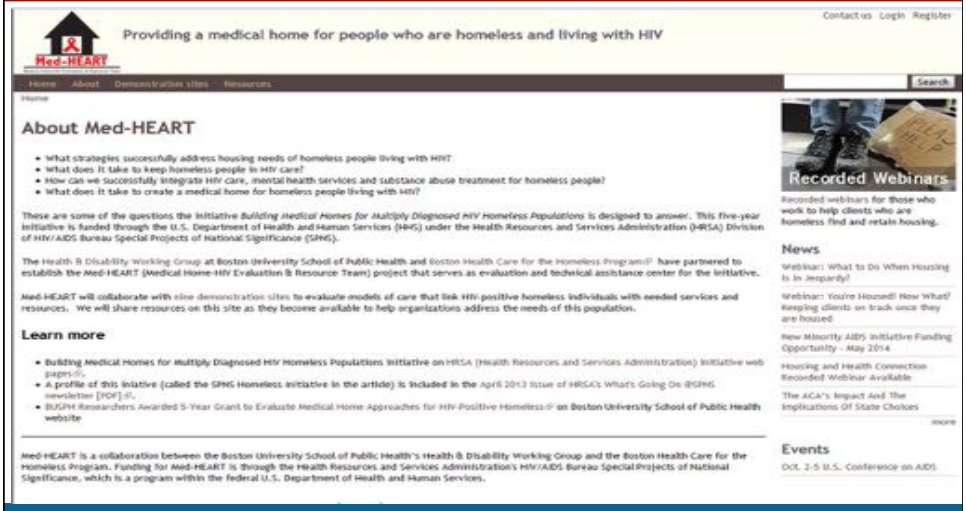
Resources

- http://medheart.hdwg.org/



Presenter Contact Information

- Serena Rajabiun, Boston University School of Public Health, rajabiun@bu.edu
- Lisa McKeithan, CommWell Health, LMcKeithan@commwellhealth.org
- Manisha Maskay, AIDS Arms Inc. manisha.maskay@aidsarms.org

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TA & Capacity building to help strengthen housing & health collaborations

- H2 Initiative
- HOPWA TA
- TARGET Center

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Listening Session

- **Your Federal partners want to hear from you!**
- **Questions:**
  - How well do housing and health systems work together for persons living with HIV?
  - What types of collaboration work well in your community?
  - What challenges exist in your community?
  - How could the federal government better support local efforts to coordinate housing and health care for PLWH?

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Learn More/Additional Resources

HOPWA page on the HUD Exchange:
https://www.hudexchange.info/hopwa/

To join the HOPWA mailing list, visit:
https://www.hudexchange.info/mailinglist/

Health Resources Services Administration, HIV/AIDS Bureau:
http://www.hab.hrsa.gov/

Ryan White HIV/AIDS Program TA Resources:
https://careacttarget.org/

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