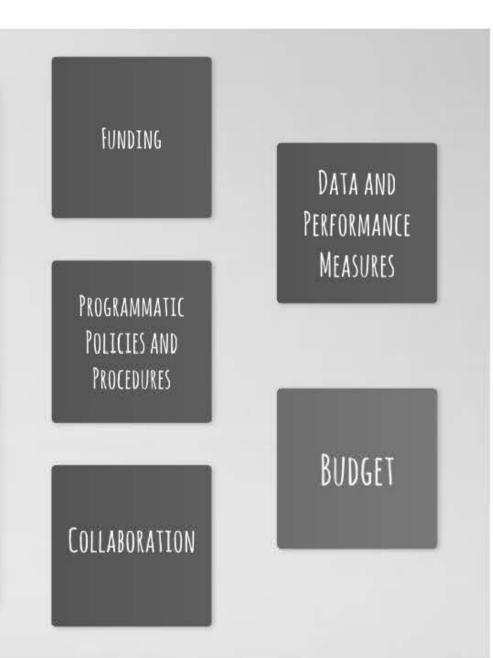




WHATS THE PLAN?

- Funding
- Programmatic Policies and Procedures
- Collaboration
- Data and Performance Measures
- Budget



HOW DO WE FUND THIS?



- HIV/AIDS Bureau Policy 16-02
- HIV/AIDS Bureau Policy 15-03
- Local/Institution Policy for Foundation Accounts

PROGRAMMATIC POLICY AND PROCEDURES

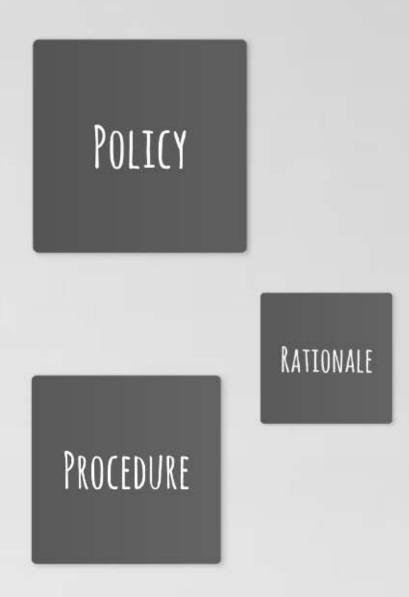
"To enable a client or family to gain or maintain outpatient/ ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care"

https://targethiv.org

https://www.huduser.gov/portal/home.html Fair market rent, Income limits

https://www.hudexchange.info/resources/housingsearchtool/? housingsearchtoolaction=public:main.client-intake-and-casemanagement-resources

https://www.samhsa.gov/homelessness-programs-resources/hprresources/housing-shelter



THE POLICY

Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).

Housing activities also include housing referral services, including assessment, search, placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.

Housing activities cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments or rental deposits, although these may be allowable costs under the HUD Housing Opportunities for Persons with AIDS grant awards.

RATIONALE - CRITERIA - TEMPORARY ECONOMIC CRISIS

Rationale:

i. For persons who lack a safe, stable place to live, housing assistance is a proven, cost-effective health care intervention. ii. Stable housing has a direct, independent, and powerful impact on HIV incidence, health outcomes, and health disparities.

iii. Housing status is a more significant predictor of health care access and HIV outcomes than individual characteristics, behavioral health issues or access to other services.

Criteria:

i. Households in imminent danger of eviction and/or,
 ii. Households in imminent danger of homelessness and/or,
 iii. Households that are currently homeless.

Temporary Economic Crisis:

i. Loss of employment

ii. Medical Disability or emergency

iii. Loss or delay of a public benefit

iv. Natural Disaster

v. Substantial change in household composition

vi. Victimization by criminal activity (including Domestic Violence)

vii. Illegal action by a landlord

viii. Displacement by government or private action

ix. Client is moving from homelessness into permanent housing

x. Obtain or maintain subsidized housing

xi. Client is moving into more affordable housing that promotes long term stability

PROCEDURE

Who: Program Management, Grants Accounting, Accounts Payable, Case Management, Financial Counselor

What: Eligibility Criteria (recommendation to follow HUD Guidelines), Housing Care Plan, Required Documentation

Where: In the department...clinic...home visits

When: At application and monthly

Why: For the clients!

DATA AND PERFORMANCE MEASURES

What are you trying to accomplish?

How can you show this?

COLLABORATION

- Team effort to jump start
- Understanding local programs
- Get together!
- Education and training

BUDGET

How far can your dollars go? What is the fair market rent?

How many clients are in need?

How far are you projecting?

"EVEN IF WE ONLY HELPED 20 CLIENTS WITH ONE MONTH RENT AT \$500 WE WERE LOOKING AT A \$10,000 OBLIGATION."





STEP 1- WHERE DOES THE DATA COME FROM?

- Case Management Action Plan (ISP)
 Social Determinants of Health
 - Social Determinants of Health
- Acuity Assessment
- Medical Appointments



STEP 2-CAREWARE PERFORMANCE MEASURES

Current: HIV/AIDS Bureau Performance Measure Portfolio

- 1. HIV Viral Suppression
- 2. HIV Medical Visit Frequency
- 3. Gap in HIV Medical Visits
- 4. Housing Status
- 5. Prescribed ART

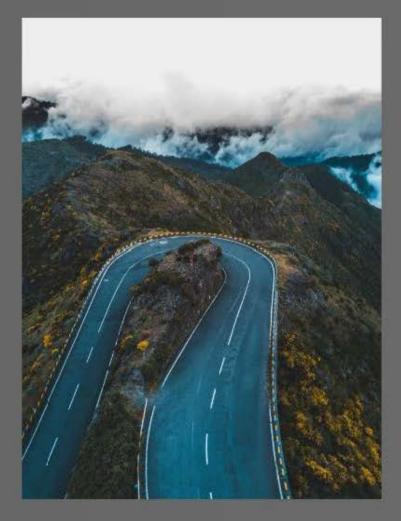
Developed:

- 1. Stable housing- VLS
- 2. Received housing assistance/Housing Care Plan- VLS
- 3. Stable housing- Gap in HIV Medical Visits
- 4. Received housing assistance/Housing Care Plan- Gap in HIV Medical Visits
- 5. Stable housing- prescribed ART
- 6. Referral Processed, VLS



STEP 3- THE OUTCOMES

Set short and long term goals that are S.M.A.R.T. Specific, Measurable, Achievable, Relevant, Time-based





THE NUTS AND BOLTS

THE ASSESSMENT AND APPLICATION

START HERE

THE REVIEW

START HERE

- Outpatient/Ambulatory Service
- Case Management Service
- Mental Health Service
- Nutrition Service
- Psychosocial Support Service
- 340B Pharmacy Service



THE APPLICATION AND ASSESSMENT

- 1. Social Determinants of Health
- 2. Acuity Assessment
- 3. Case Management Action Plan (ISP)
- 4. Client Assistance Application
- 5. Release of Information
- 6. Housing Care Plan



SOCIAL DETERMINANTS OF HEALTH

What is your housing situation today?

I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

I have housing today, but I am worried about losing housing in the future

🔽 I have housing

ACUITY ASSESSMENT

Housing

Client owns/rents: no financial assistance needed Client owns/rents: needs financial assistance Client in temporary housing (transitional, family, friends) Homeless, shelter

Utilities

Requires no financial assistance Utilities in Jeopardy of disconnection One utility disconnected or in imminent danger of being disconnected More than one utility disconnected

Food

Client is eating at least two meals daily. Client is able to eat at least two meals daily 75% or more. Client at risk of being malnourished Client is malnourished

CASE MANAGEMENT ACTION PLAN (ISP)

- 1. Identify Service Needs
- 2. Specify Goals and Objectives
- 3. Referrals

Examples: Increase adherence to medical appointments... Increase medication adherence... Maintain housing stability... Achieve housing stability... Achieve stability of medical coverage... **As evidenced by...**

CLIENT ASSISTANCE APPLICATION

- 1. What is the need?
- .2 What has put you in this situation?
- 3. Have you applied for other assistance?
- 4. What are your future plans related to this or a similar scenario?

HOUSING CARE PLAN

Who is involved? What is a Housing Care Plan? Where are they created? When are they drafted? Why are they important?

Housing history:

1. Tell me about the last place you lived that worked well for you.

2. Have you had a lease before?

3. Have you ever lived in public housing or Section 8 before? How did that end?

4. Do you know if you have any housing related debt?

Housing Goals:

- 1. Where would you like to live next? Is there an area where you want to avoid (due to domestic violence or recover needs)?
- 2. Where do you have any friends or family? Where is your childcare set up? Job transportation?
- 3. What kind of apartment are you looking for? Do you need any special accommodations?
- 4. How much do you think you can afford each month?

Housing Challenges

- 1. Have you tried applying for a new lease recently? What was the outcome? What did they tell you about your application?
- 2. Do you have any concerns about moving back into your own place? What are they?

HOUSING CARE PLAN CONTINUED

The Actual Plan:

- 1. Client identification: name, DOB and address
- 2. A date of the plan and a date for the next review
- 3. Barriers identified
- 4. Specific goals with a purpose including who needs to complete them and a deadline
- 5. A statement such as:

"The above barriers, goals and action steps were developed in partnership with my case manager. I understand that each barrier, goal and action step listed above will support my efforts in securing permanent housing. I agree to work on these goals in partnership with my case manager. I will update my case manager as I complete the above goals and will communicate any challenges I experience and understand my case manager can offer me support as needed. Failure to work toward achievement of these goals could result in termination from the program."

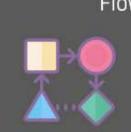
6. Client and case manager signatures

THE REVIEW

Checklist:



Assistance Application Release of Information Lease/Rental Agreement Access to Other Assistance Eviction Documentation Itemized Statement for Rental Agreement W9 Housing Care Plan Others as applicable

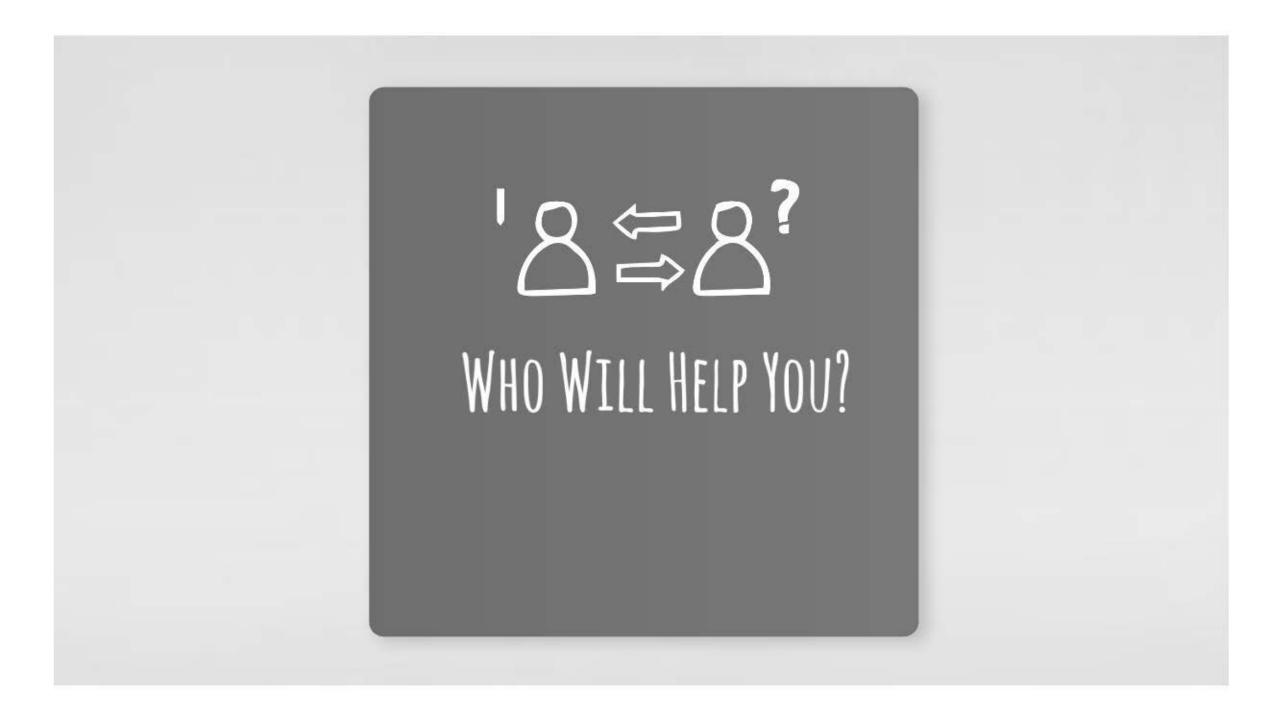


Flow Chart: Program Eligible? Assistance Eligible? Qualifying Event? All Documentation?

The Solution:



Approved? Alternative Assistance? Referral?





THE SUCCESSES



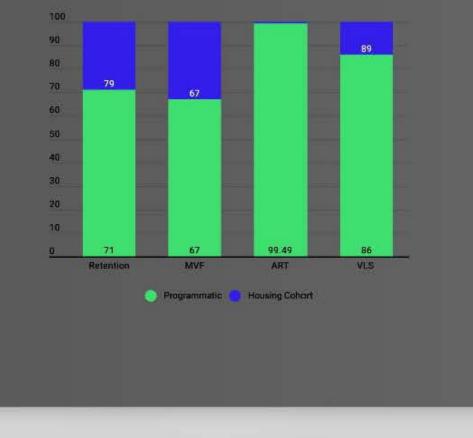
Anticipated:

- Increase in client engagement
- Increase in retention rates
- Increase in medication adherence
- Increase in viral load suppression Newly Identified:
 - Exponential increase in need due to COVID19
 - Increase in client satisfaction
 - Increase in other care- such as women's health and immunizations

THE OUTCOME

THE OUTCOME

2019 Calendar Year Data



LESSONS LEARNED

- Navigating layers of the University
- Ensuring success stories
- Limited local resources
- Access to basic goods

WHATS NEXT....

- Updated protocol with HCP associated with client accountability
- Identify relationships with local housing agencies
- Develop strategies for storage of donated goods

HOW A ROOF AND BED LEAD TO TAKING MEDS!

RESOURCES:

Prezi Presentation Link: https://prezi.com/view/KYkJH7RfMZ8FCTpR7n4k/

<u>https://targethiv.org</u> <u>https://hab.hrsa.gov/about-ryan-white-hivaids-program/about-ryan-white-hivaids-program</u> <u>https://www.hudexchange.info/</u>

