

## **Bridging HUD and HRSA:**

Collaborating with Local Coordinated Entry to Ensure Access to Permanent Housing for PLWH

City of Kansas City, MO Health Department

## Presenter





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## Session Objectives



1. Distinguish how similarities/differences between Ryan White, HOPWA, and Continuum of Care housing programs create obstacles, and describe solutions to overcome.

2. Gain knowledge of how to prevent disclosure or confidentiality breaches when working to coordinate housing with their local Continuum of Care.

3. Explain 2 to 3 ways to advocate for PLWH within their local Continuum of Care to promote housing access for PLWH.

Our philosophy...

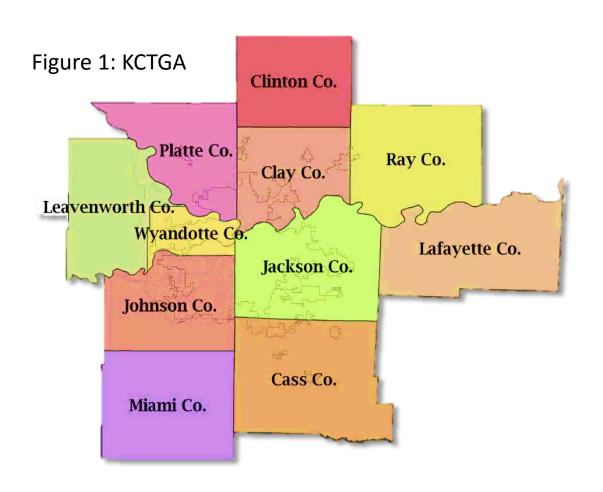


# Housing is a necessary structural intervention to end the epidemic.



# HIV Housing in Kansas City, MO





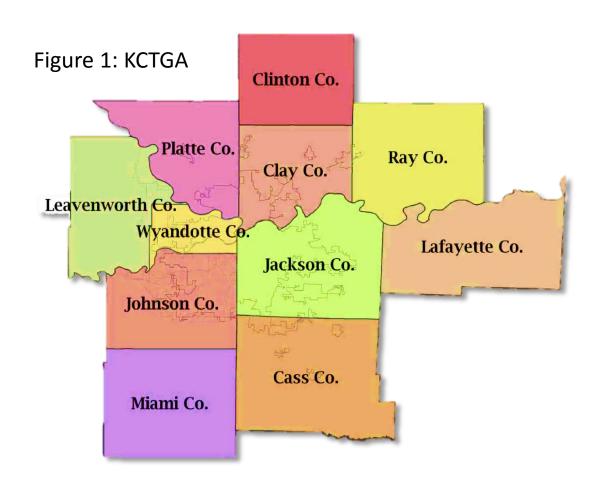
From a **Ryan White funding** perspective, Kansas City is a Transitional Grant Area, or TGA

- 4 counties in Kansas
- 7 counties in Missouri

Collaborative work with:

- Part B in MO and KS
- Part C and D funded agency in KCMO

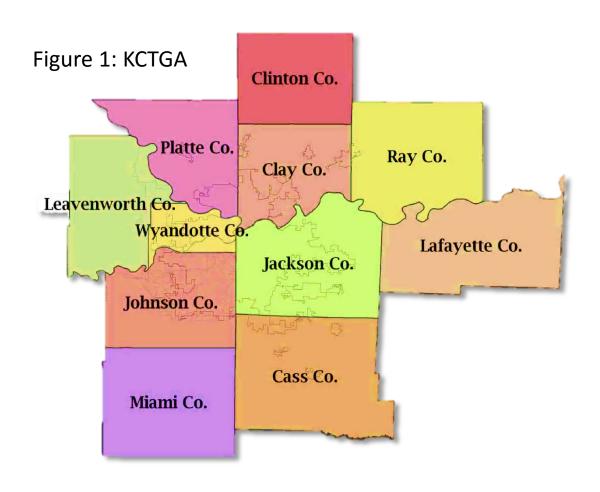




Kansas City, MO Health
Department HIV Services
receives a variety of funding
resources to support housing
for PLWH:

- Ryan White Part A
- HOPWA
- HUD Continuum of Care (CoC)
- HOPWA VAWA
- Ryan White Part F SPNS

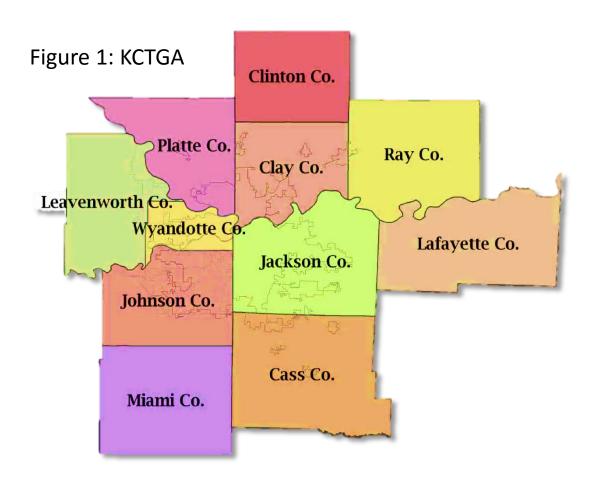




# Ryan White and Housing (HRSA)

- Historically, KC Planning
   Council did not fund housing
- Began funding transitional housing a couple of years ago
- Ryan White housing mostly matches what is provided via HOPWA short-term housing





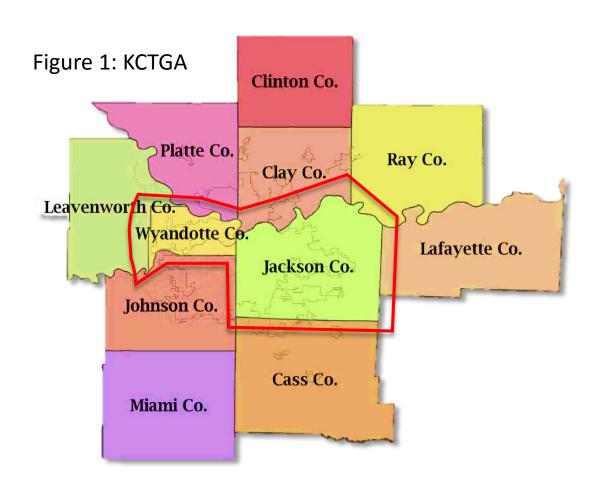
#### **HOPWA (HUD)**

Long-term funding source to support:

- Tenant-Based Rental Assistance (TBRA)
- Short-Term Rent, Mortgage, and Utility Assistance (STRMU)
- Short-Term Housing, aka "Transitional Housing"
- Support Services

#### Greater KC CoC





#### **Continuum of Care (HUD)**

KC Health Department primarily works with the Greater KC CoC

- Funded for Shelter+Care as a pass-through entity
- Note that coverage area is only 2 of the 11 counties in our TGA

## **Accessing Housing Services**



#### Ryan White (HRSA)

- Proof of HIV status
- Openings announced through lottery process within HIV system; can also "graduate" from in-shelter to off-site apartment
- Must be at 300% or below for Federal Poverty Level
  - \$38,280 for individual

#### **HOPWA (HUD)**

- Proof of HIV status
- Openings announced through lottery process within HIV system; can also "graduate" from in-shelter to off-site apartment
- Must be at 80% or below for Area Median Income
  - \$46,350 for individual

## **Accessing Housing Services**



#### **Continuum of Care (HUD)**

- HIV status is helpful in accessing some housing options – particularly when disability is a requirement (Shelter+Care)
- Most important factor: Meeting HUD's definition of homeless, and chronicity of homelessness
- Other important factors: Mental Health and/or Substance Abuse, Veteran Status, Fleeing Domestic Violence
- Accessed through Coordinated Entry System



#### Continuum of Care



#### Continuum of Care (CoC) – What is it?

#### From HUD's website\*:

 The Continuum of Care (CoC) Program is designed to promote communitywide commitment to the goal of ending homelessness; provide funding for efforts by nonprofit providers, and State and local governments to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness; promote access to and effect utilization of mainstream programs by homeless individuals and families; and optimize self-sufficiency among individuals and families experiencing homelessness.

<sup>\*</sup>https://www.hudexchange.info/programs/coc/

## **Coordinated Entry**



#### **Coordinated Entry – What is it?**

Coordinated Entry standardizes the way individuals and families at risk of homelessness or experiencing homelessness access, are assessed for, and are referred to the housing and services that they need for housing stability.

In Kansas City, our CoC was using the **Vulnerability Assessment Tool (VAT)** up until the COVID-19 isolation began. Since then we have moved to a screening process through the local United Way 211 and then a mobile assessment using the VI-SPDAT (Vulnerability Index – Service Prioritization Decision Assistance Tool).

## KC Coordinated Entry



#### **Coordinated Entry System in Kansas City**

- 1. Client completes Vulnerability Assessment Tool (VAT) interview
- 2. Each VAT is further assessed in bi-monthly Prioritization Meetings
- 3. Client's name appears on the By Name List
- 4. Client is potentially referred to housing program
- 5. Client potentially finds a place to live



## By Name List



#### By Name List (BNL)

- Lives outside of local HMIS, but will be integrated soon
- Kansas City BNL has between 800 to over 1,000 names on it at any given time
- HIV status is one of the demographics collected
- Names can be de-identified



## **Housing Support Specialist**



- Started May 2019, previous extensive experience in HIV care and prevention and some experience in homeless services
- Became a mobile VAT assessor shortly after starting, with focus on PLWH referred from medical case management system
- Big increase in HIV+ names on BNL over last year



## **Housing Support Specialist**



- Increased communication between Coordinated Entry and HIV Medical Case Management Systems
- Tracking clients on BNL initial entry, referrals, returns to list
- Creation of CE tracking and communication in MCM database, SCOUT



## **Housing Support Specialist**



- Providing technical assistance and guidance to MCMs for complicated CE process, e.g. DMH eligibility packet
- Communication back to CE system on client housing situations that may have changed since time of VAT
- Diverting low-scoring clients to other housing resources





# Disclosure and Confidentiality

## Confidentiality and CoC



- Coordinated Entry Systems use local By Name Lists meaning clients are listed by their name
- This list also includes information on HIV status.
- Though all members of the CoC agree to standard privacy and confidentiality policies, not all clients feel comfortable with their name and HIV status being "out there" on a list

## Confidentiality and CoC



## HIV service providers can work with the local CoC to help address these concerns:

- Learn how the local CoC handles de-identification for clients coming from Domestic Violence systems
- Request the option for de-identification for anyone who goes through Coordinated Entry, particularly for PLWH, but really it should be an option for everyone
- Have at least one person from your HIV system regularly and actively involved in Coordinated Entry System
- Offer to provide training on HIV stigma to Coordinated Entry System



# Engaging with Your Local CoC



#### **Step 1: Find Your Local Continuum of Care(s)**

 Use the HUD Exchange "Contact a CoC" search tool to locate your local CoC

https://www.hudexchange.info/grantees/contacts/

Depending on your coverage area, you may have more than one CoC



#### **Step 2: Connect with Your Local Continuum of Care(s)**

 Using the information from the CoC Program locator, contact the staff at the local coordinating agency to schedule a "getting to know you and your programs" meeting

 Check out their website (if they have one) for any meetings open to the public and attend these meetings



#### **Step 3: Become an Active Member in Coordinated Entry**

- Attend meetings where policy and procedures decisions are made about how Coordinated Entry is conducted in your CoC – better yet, become a member of any committees or work groups!
- Advocate for policies and procedures that will help PLWH feel more comfortable being included in process
- Become an assessor and/or advocate for assessors within the HIV system



#### **Step 4: Apply for CoC Funding**

- If not already funded, apply for CoC program funding
- For HIV programs, Shelter+Care is a great program to apply for
- Also consider using funding to create/support positions such as Coordinated Entry Systems Navigator

### **Contact Information**



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