NATIONAL 2018 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Innovative Approaches to Housing as Healthcare

Project HHHOME, Maricopa County Ryan White Part A

Boston Healthcare for the Homeless Program

AIDS Resource Foundation for Children and NJ DOH

Disclosures

Presenters have no financial interest to disclose.

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Commercial Support was not received for this activity.

Learning Objectives

At the conclusion of this activity, the participant will be able to:

1. Describe strategies for convening multi-sectoral stakeholder engagement to successfully address the unmet housing needs of people living with HIV/AIDS; and identify innovative mechanisms for leveraging resources and funding streams to increase access to housing resources.
2. Discuss and provide practical strategies to address common barriers homeless people living with HIV face in progressing along the standard pathway to permanent housing.
3. Using program data, describe the impact of housing on HIV care continuum and other health outcomes.

Obtaining CME/CE Credit

If you would like to receive continuing education credit for this activity, please visit:

http://ryanwhite.cds.pesgce.com

2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Project HHHOME

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Learning Objectives: Project HHHOME

At the conclusion of this activity, the participant will be able to:

1. Identify how Ryan White programs are collaborating to improve health outcomes through housing and employment initiatives
2. Understand how Ryan White programs can effectively collaborate with non-traditional partners to improve housing and employment options for Ryan White participants
3. Understand how Ryan White programs are utilizing Ryan White Part B Rebate funds to improve health outcomes

What is Project HHHOME?

- Project HHHOME (HIV, Housing, Health Outcomes, and Employment) combines transitional housing, employment, and education services into a single comprehensive program for people living with HIV/AIDS.

- Project HHHOME is funded using Ryan White Part B Rebate funds

Why is Project HHHOME Important?

Arizona's HIV programs identified homelessness as a major barrier to achieving viral suppression:

- Nine percent of the Phoenix EMA's RWPA clients identified that they were unstably housed in 2017
- Unstably housed individuals were 49% virally suppressed vs. 79% of the total RWPA clients
- Arizona's Statewide HIV Integrated Plan established goals to address homelessness as a strategy to help end the epidemic in Arizona
- Addressing the root causes that contribute to unstable housing is key to providing clients with sustainable skills to achieve permanent housing

How Is Project HHHOME Different?

- How can we address the root causes of homelessness and unemployment versus addressing the symptoms?
- How can we address a variety of challenges our participants face?
- What can we do to help participants reach their full potential and successfully complete the program?
- How can we incorporate consumer input into program development?
- How do we fund everything?

Traditional vs. Project HHHOME

Traditional Housing Programs

- Services are referral-based and siloed across agencies
- Multiple documentation systems
- Limited and fractured data collection and analysis
- Multiple ROIs required for collaboration
- Multiple program leaders across agencies
- Limited opportunities for consumer feedback

Project HHHOME

- All services are included as part of a single collaboration
- Use of shared documentation system (CAREWare)
- Data aggregated and reported from single database
- Single ROI with data sharing agreements
- Single program coordinator
- Participant advisory board

Process

- STEP 1: Participant is screened for program eligibility by the medical case management agency
- STEP 2: If eligible, participant attends a group or individual Project HHHOME orientation to learn about the program and requirements
- STEP 3: Upon completion of orientation, participant attends specialized orientation to learn about housing requirements, complete housing plan, and sign lease
- STEP 4: Participant attends individualized employment, job placement, and/or educational programming in addition to maintaining regular contact with medical case manager and housing specialist for the duration of the program

Challenges and Successes

1. **Identifying the real numbers**
   - *Challenge*: Each agency had different waiting lists that needed to be reviewed, consolidated, and updated
   - *Success*: A current list of eligible clients was created along with a priority placement strategy
2. **Getting agreements in place**
   - *Challenge*: IGAs, MOUs, and BAAs were needed before anyone could proceed
   - *Success*: IGAs are in place between State, County, City, and Health District to fund Project HHHOME

Challenges and Successes

3. **Procuring housing in a housing shortage environment**
   - *Challenge*: Phoenix is experiencing a shortage of low income units for transitional housing
   - *Success*: Collaborative community efforts identified enough units to house 50 people for 2 years
4. **Facilitating education and employment services**
   - *Challenge*: Education and employment opportunities must be funded with non-RW funds
   - *Success*: Community collaboration resulted in agencies committing their own resources to Project HHHOME

Causes of Homelessness

- *2012 Homelessness in America: Overview of Data and Causes* from the National Law Center on Homelessness & Poverty
  - Causes of homelessness for unaccompanied individuals:
    - Lack of affordable housing
    - Unemployment
    - Poverty
    - Mental illness and lack of needed services
    - Substance use and lack of needed services
  - For families:
    - Lack of affordable housing
    - Unemployment
    - Poverty
    - Low wages

Lack of Affordable Housing

- RWPA and RWPB partnered with a local behavioral health housing non-profit organization, elicited feedback from the Phoenix HOPWA program, and secured affordable housing for 50 program participants
- Units are 1 or 2-bedrooms, and participants pay 30% of their income toward rent each month (utilities included)
- The housing non-profit holds a master lease on all units
- Every participant works with both a housing specialist and a Ryan White medical case manager
- Participants can remain in Project HHHOME transitional housing for up to two years or until their income exceeds Ryan White eligibility standards

Unemployment

- Eligibility for Project HHHOME includes **an identified employment or educational need**
- Community collaborations include:
  - GED and educational services through Phoenix Public Library system
  - Job training and placement agencies
  - State of Arizona employment services
  - Other local non-profit employment and education agencies
    - ID services
    - Clothing for work
    - Interview and résumé services
    - Funding for testing and certifications

Poverty

- How do we meet basic needs?
  - Food – Market Days
    - Weekly mobile food program co-located with other services
  - Transportation – Utilizing RW/Medicaid transportation
    - Exploring options for non-medical transportation
  - Communication – Exploring options to provide phones to all participants
    - Ensures phones don’t get turned off
    - Participants can receive calls for job interviews and maintain contact with program staff
    - Participants can utilize internet on phones

Mental Illness and Substance Use

- Medical case managers will make appropriate referrals to mental health services, follow up on referrals, and ensure medications and services are paid for
- Participants are able to work on mental health/substance use issues while safely housed before exploring employment/educational programs
- The transitional housing is drug-free
- Participants who have been identified as using substances will be offered inpatient or outpatient treatment

Consumer Feedback

- “Nothing about us without us is for us”
- PHAB – Project HHHOME Advisory Board
- Monthly social activities to:
  - Build community
  - Decrease isolation
  - Provide positive social support
  - Develop volunteering opportunities
  - Provide educational opportunities
  - Market Days, social outings, local events

Monitoring and Evaluation

- **HIV/AIDS Specific**
  - Viral suppression and CD4
  - Retention and no-show rates
  - Medication adherence
- **General and Behavioral Health**
  - Medical costs
  - Ambulatory vs. ED visits
  - Depression and perceived social support
  - Food insecurity, A1c, BMI
  - Comorbidities (health conditions, substance use, mental health care)

Monitoring and Evaluation

- **Job Training and Employment**
  - Income changes
  - Employment status changes, causes, and duration
  - Program attendance and services utilized
  - Associated costs and unmet needs
- **Education**
  - Program attendance and services utilized
  - Associated costs and unmet needs

Expected Outcomes

- For the initial Project HHHOME cohort we hope to see:

Increased viral suppression
Increased retention and medication adherence
Increased employment rate
Increased level of education
Increased median income
Increased ability to pay housing costs

Decreased healthcare costs
Decreased social isolation and depression
Decreased food insecurity
Decreased ED use

Thinking Big

- **What services could Project HHHOME include in the future?**
  - Job training and employment rights training for specialized populations
  - Expanded nutritional services to include additional market days and medically-tailored meals
  - Creative community partnerships to increase job opportunities
  - Family-specific services and programming including childcare
  - Credit repair services
  - Legal expungement process
  - Expanded housing options
  - Longer-term housing options

Integrated Housing Clinic at Boston Health Care for the Homeless Program

Jen Brody, MD, MPH, AAHIVS
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James Apt, BA
Kristin Moccia, BA

BHCHP: A Simple but Vital Mission

To assure access to *quality* health care for all homeless individuals and families in the greater Boston area

BHCHP: Delivering Care Since 1985

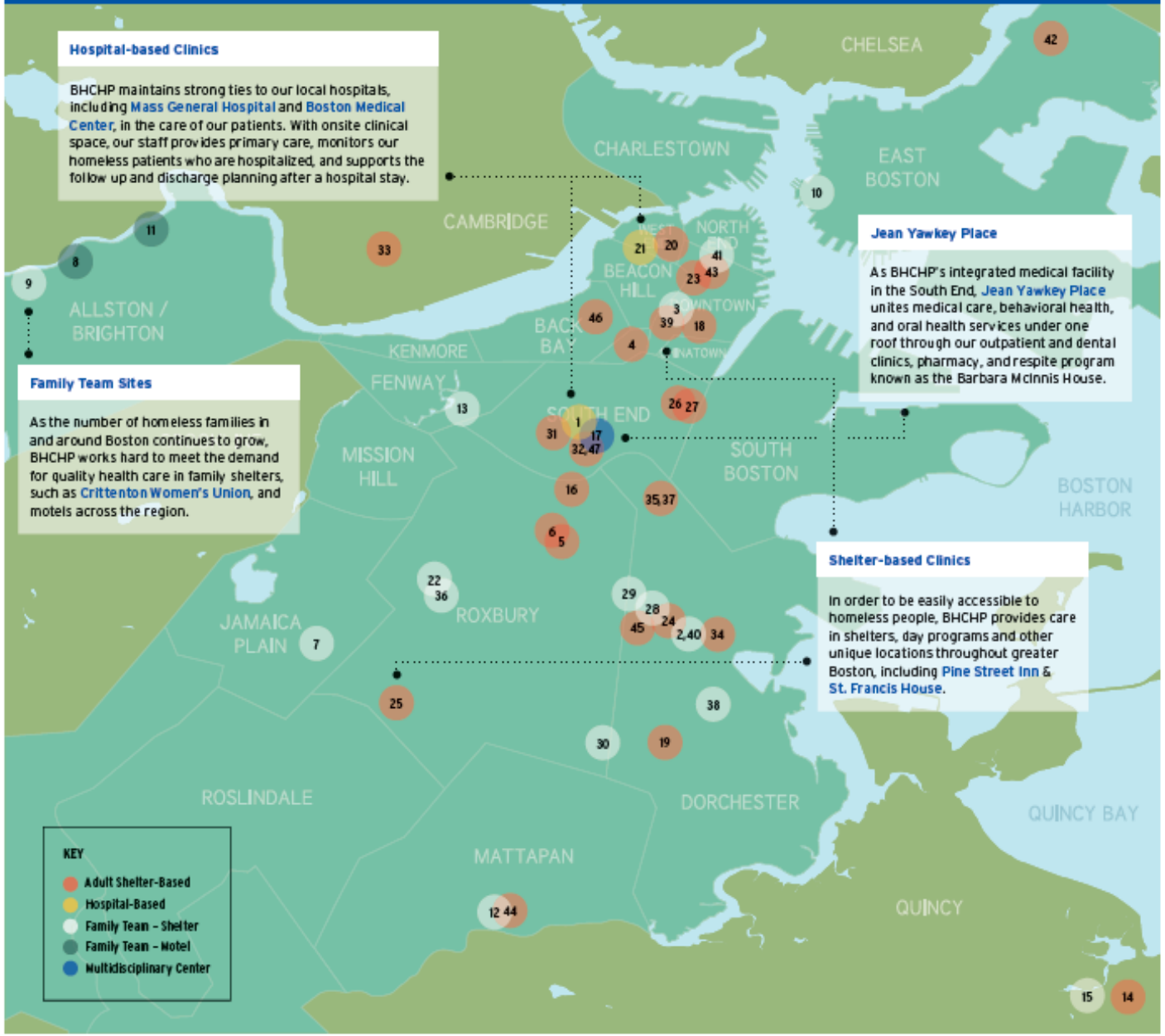
- Founded 30 years ago by the Robert Wood Johnson Foundation and Pew Charitable Trusts
- Maintains strong partnerships with the Boston medical community, homeless service organizations, and city and state government
- Provides care to more than 11,000 homeless men, women and children every year, making it the largest program of its kind in the country
- Has grown into a national model of care, emulated in cities throughout the U.S.

BHCHP Program Features

- Focus on primary care
- Integration of mental health and substance use disorder services into primary care
- Team-based, multidisciplinary approach
- Co-location of special services
- Organizational commitment to advocacy through research, medical education, legislation, and health policy

Medicine *Where* It Matters

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM



Hospital-based Clinics

BHCHP maintains strong ties to our local hospitals, including Mass General Hospital and Boston Medical Center, in the care of our patients. With onsite clinical space, our staff provides primary care, monitors our homeless patients who are hospitalized, and supports the follow up and discharge planning after a hospital stay.

Family Team Sites

As the number of homeless families in and around Boston continues to grow, BHCHP works hard to meet the demand for quality health care in family shelters, such as Crittenton Women's Union, and motels across the region.

Jean Yawkey Place

As BHCHP's integrated medical facility in the South End, Jean Yawkey Place unites medical care, behavioral health, and oral health services under one roof through our outpatient and dental clinics, pharmacy, and respite program known as the Barbara McInnis House.

Shelter-based Clinics

In order to be easily accessible to homeless people, BHCHP provides care in shelters, day programs and other unique locations throughout greater Boston, including Pine Street Inn & St. Francis House.

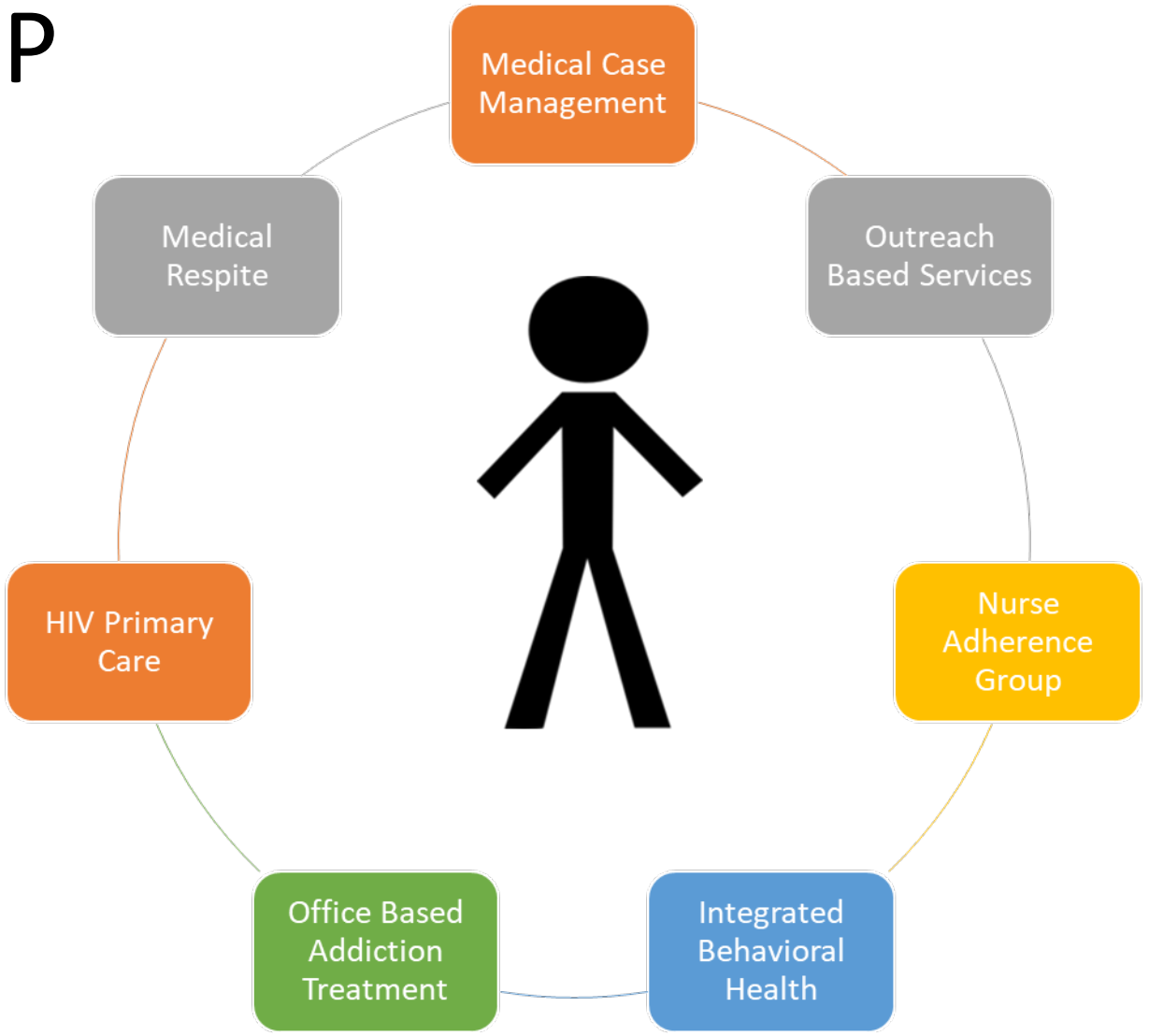
1 Boston Medical Center
2 Bridge Home
3 Bridge Over Troubled Waters
4 Cardinal Medeiros Center
5 Casa Esperanza Men's Program
6 Casa Esperanza Women's Program
7 Casa Nueva Vida
8 Charles River Hotel
9 Crittenton Women's Union
10 Crossroads Family Shelter
11 Days Hotel
12 Entre Familia
13 Families in Transition
14 Father Bill's Place
15 Friends of the Unborn
16 Hope House
17 Jean Yawkey Place
18 Kingston House
19 Kit Clark Adult Day Health
20 Lindemann Mental Health Center
21 Massachusetts General Hospital
22 Nazareth Residence
23 New England Center For Homeless Veterans
24 Pilgrim Shelter
25 Pine Street Inn at Shattuck
26 Pine Street Inn Men's Clinic
27 Pine Street Inn Women's Clinic
28 Portis Family House
29 Project Hope
30 ReVision House
31 Rosie's Place
32 Safe Harbor
33 Salvation Army
34 Shepherd House
35 SOAR
36 Sojourner House
37 Southampton Street Shelter
38 St. Ambrose
39 St. Francis House
40 St. Mary's Center for Women & Children
41 Temporary Home for Women and Children
42 The Eighth Pole at Suffolk Downs
43 The Night Center
44 Transitions
45 Women's Hope
46 Women's Lunch Place
47 Woods Mullen Shelter

Not shown:
- Alleyways, park benches, under bridges
- Asian Task Force Against Domestic Violence *(Boston)*
- Colonial Traveler *(Saugus)*
- Finex House *(undisclosed location)*
- Holiday Inn *(Brockton)*
- Home Suites Inn *(Waltham)*
- New England Motor Court *(Malden)*
- Paul Sullivan Housing *(varied)*
- Super 8 Hotel *(Brockton)*
- Town Line Inn *(Malden)*

*as of June 2015

HIV Program at BHCHP

A Person Centered Multidisciplinary Team Approach Tailored to the Needs of People Experiencing Homelessness



Inequities in HIV Outcomes by Housing Status

Research at the national level shows homeless people are 5-7 times more likely to die of HIV/AIDS

Housing is a stronger predictor of HIV health outcomes than

- Gender
- Age
- Race
- Drug and alcohol use
- Mental health issues
- Receipt of social services

ORIGINAL INVESTIGATION

Mortality Among Homeless Adults in Boston

Shifts in Causes of Death Over a 15-Year Period

Travis P. Baggett, MD, MPH; Stephen W. Hwang, MD, MPH; James J. O'Connell, MD; Bianca C. Porneala, MS; Erin J. Stringfellow, MSW; E. John Orav, PhD; Daniel E. Singer, MD; Nancy A. Rigotti, MD

Cohort of 28,033 adults seen at BHCHP in 2003-2008

Drug overdose was the leading cause of death

Opioids implicated in 81% of overdose deaths

Baggett TP, et al. Mortality among homeless adults in Boston: shifts in causes of death over a 15-year period. JAMA Internal Medicine 2013; 173(3): 189-195.

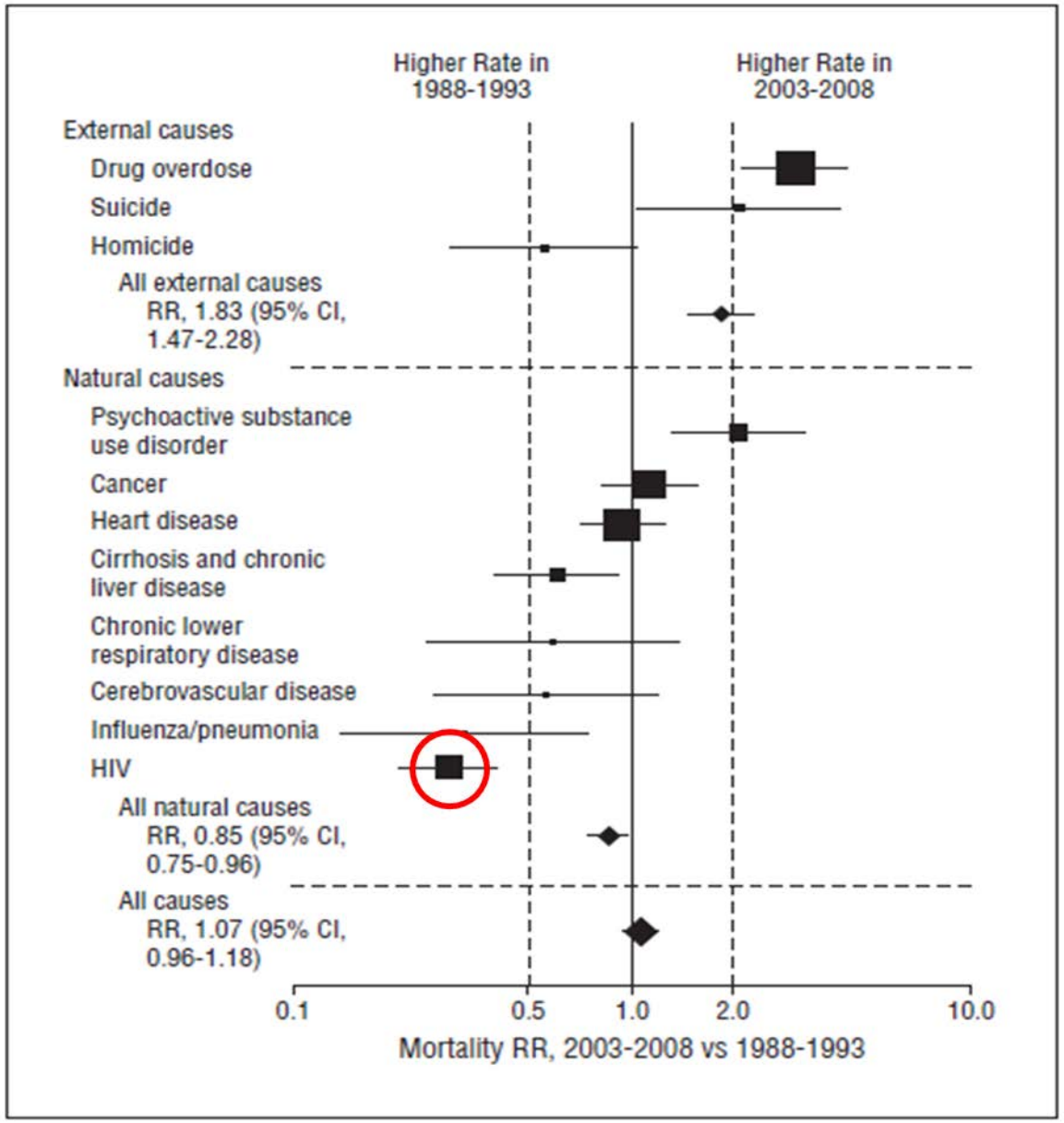
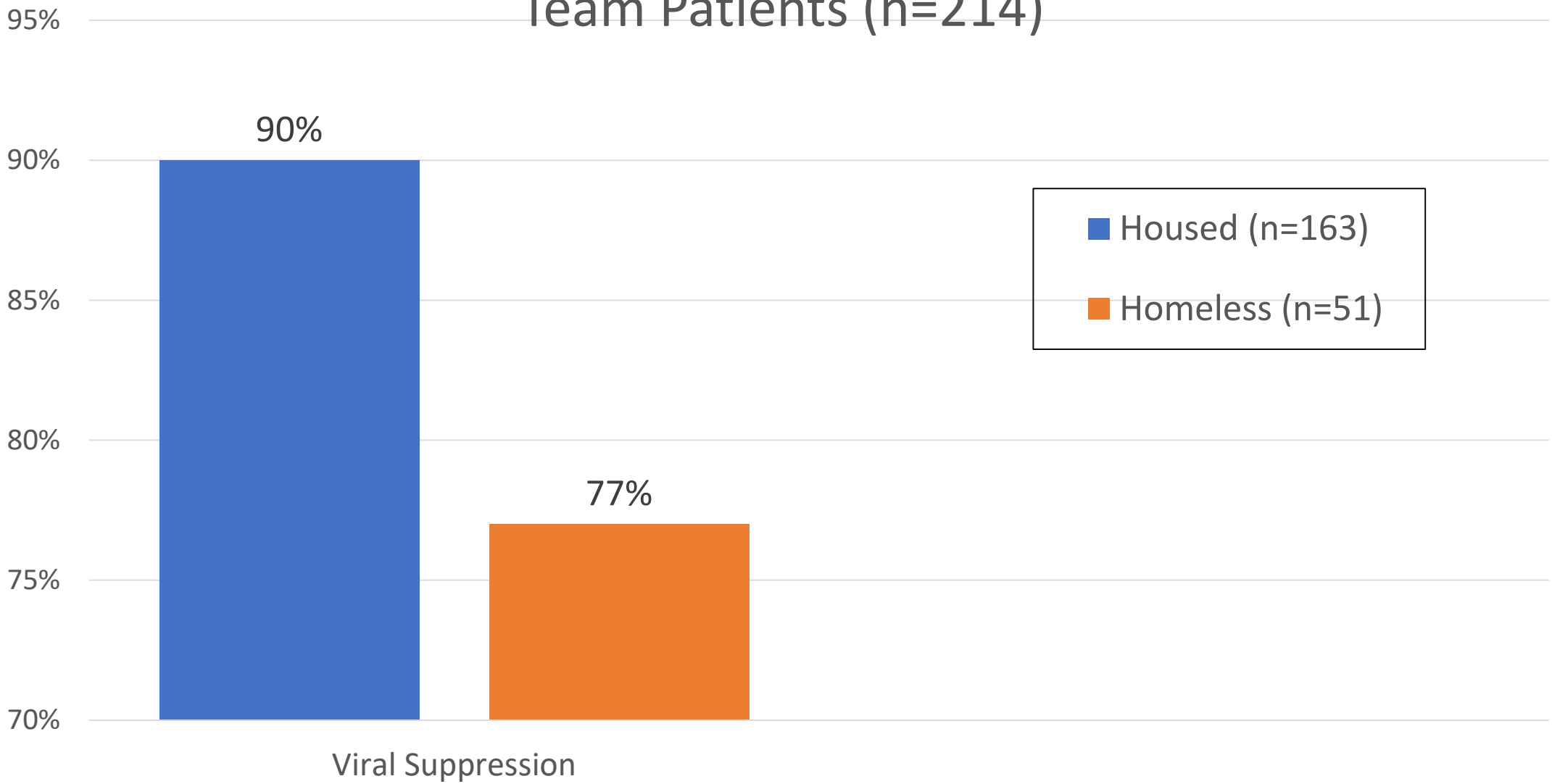

Higher Rate in 1988-1993
Higher Rate in 2003-2008
External causes
Drug overdose
Suicide
Homicide
All external causes
RR, 1.83 (95% CI, 1.47-2.28)
Natural causes
Psychoactive substance use disorder
Cancer
Heart disease
Cirrhosis and chronic liver disease
Chronic lower respiratory disease
Cerebrovascular disease
Influenza/pneumonia
HIV
All natural causes
RR, 0.85 (95% CI, 0.75-0.96)
All causes
RR, 1.07 (95% CI, 0.96-1.18)
0.1
0.5
1.0
2.0
10.0
Mortality RR, 2003-2008 vs 1988-1993

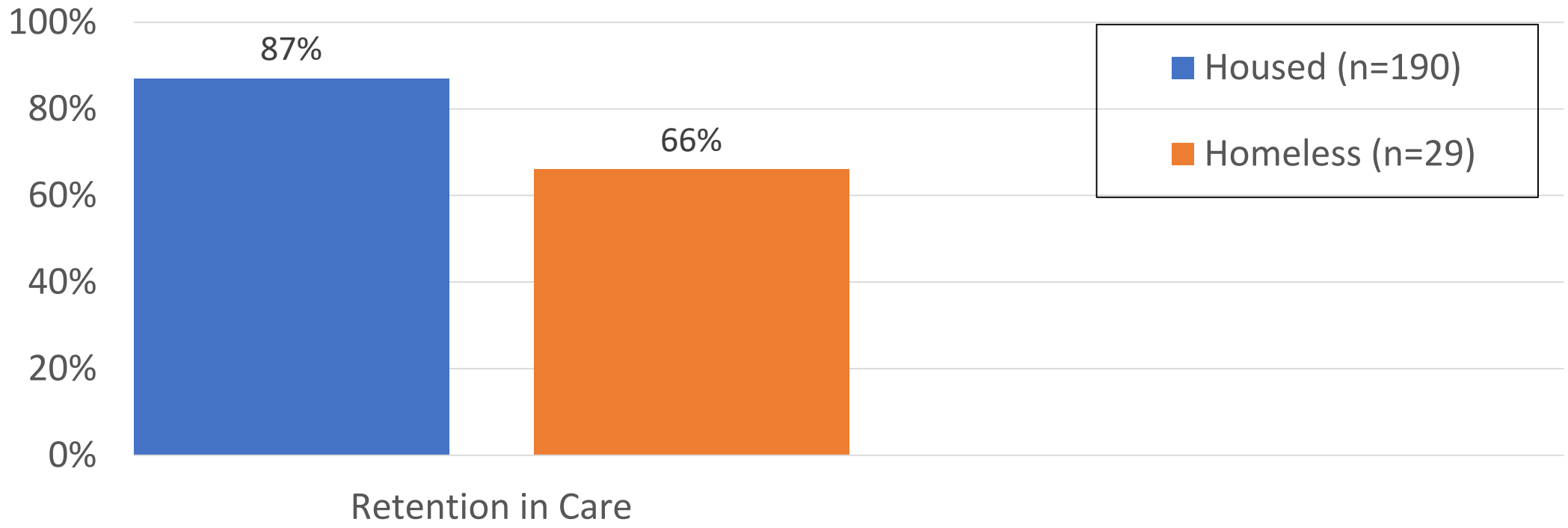
Table 3. Leading Causes of Death and Race-Adjusted Mortality Rate Ratios (RRs) by Age Group and Sex

Cause	No.	CR[a]	Race-Adjusted RR[b] (95% CI)
Men 25-44 Years			
Drug overdose	92	346.9	16.0 (12.6-20.3)
Heart disease	24	90.5	5.1 (3.1-8.4)
Psychoactive substance use disorder	24	90.5	22.1 (14.0-34.9)
HIV	21	79.2	17.3 (10.1-29.8)
Suicide	15	56.6	7.1 (4.2-11.8)
All causes	252	950.1	8.6 (7.4-9.9)
Women 25-44 Years			
Drug overdose	28	172.6	23.6 (15.2-36.6)
Heart disease	8	49.3	3.6 (1.2-11.1)
HIV	7	43.1	9.7 (2.9-32.4)
Psychoactive substance use disorder	7	43.1	33.0 (13.0-83.7)
Liver disease	6	37.0	21.3 (8.4-53.9)
All causes	95	585.6	9.6 (7.4-12.4)

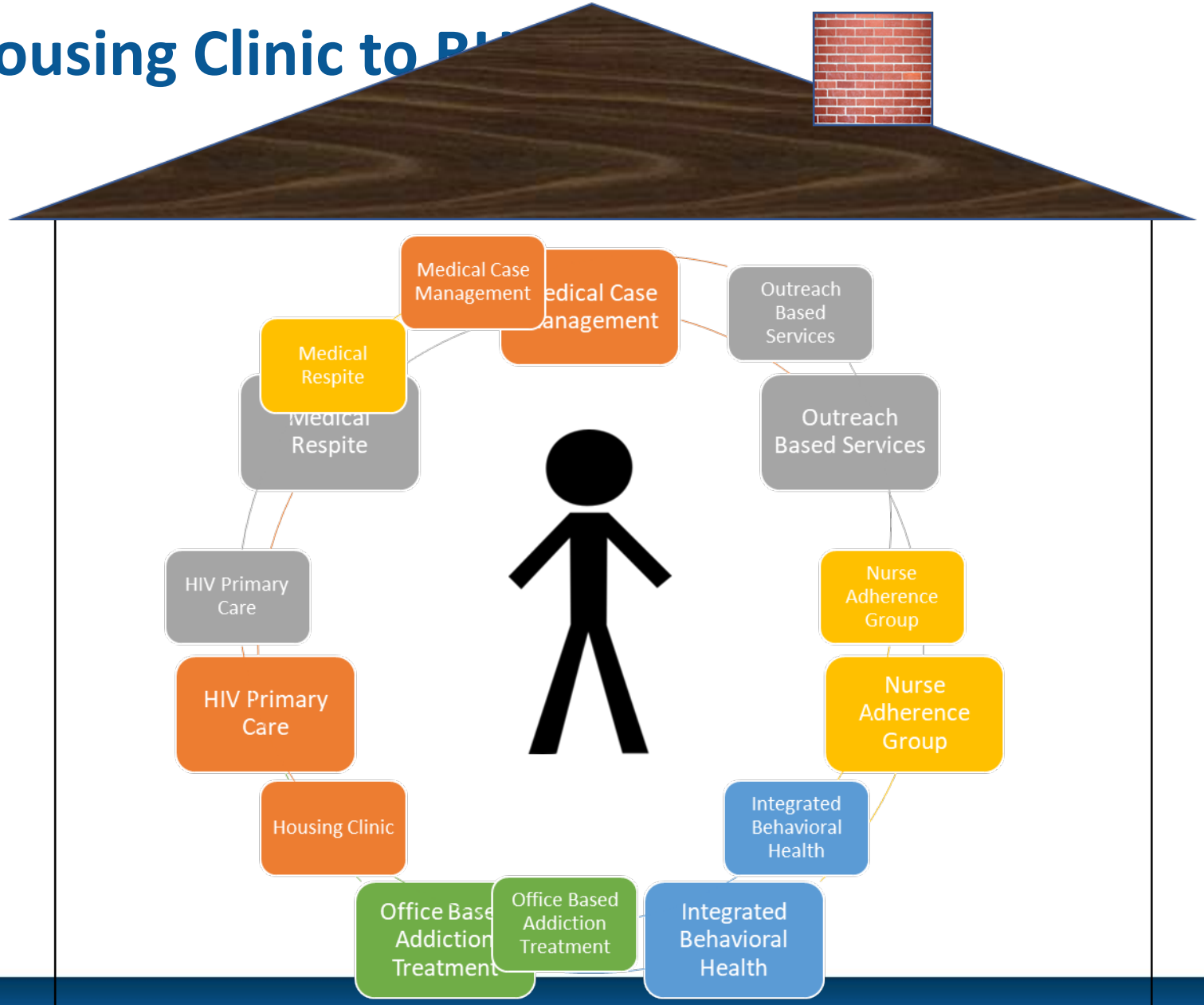
Inequities in HIV viral suppression among BHCHP HIV Team Patients (n=214)



Inequities in Retention in Care among BHCHP HIV Team Patients (n=219)



Bringing a Housing Clinic to Pl



Housing Clinic Goals

- Centralize housing services within a medical clinic
- Expedite connecting patients to housing advocates
- Facilitate completion of housing applications
- Provide patients support in progressing through housing process
- Create opportunities for enhanced housing advocate/case manager collaboration

Background challenges among BHCHP patients

- High rates of mental illness (83%), substance use disorder (72%), and both disorders (42%)
- High rates of illiteracy/limited literacy
- High rates traumatic brain injury and cognitive deficits
- Competing survival needs

Common logistical barriers to obtaining housing

- Highly bureaucratic process requiring multiple steps, strict deadlines, long wait times, and cumbersome applications
- Poor or non-existent credit history
- No reliable means of communication
- No reliable transportation
- No place to store necessary documents
- Criminal records
- Inconsistent ability of patient and medical case management staff to follow up with housing advocates

Engaging Community Partners

Identified existing agencies providing housing search and advocacy (both HIV focused and general) that MCM team already worked with peripherally

- AIDS Action Coalition
- Justice Resource Institute
- Home Start
- Heading Home
- Commonwealth Land Trust
- Caritas Communities

Reached out to partners regarding interest in formal collaboration via email

Partner agencies met face to face with Medical Case Management team to introduce services, and housing opportunities, review each agency application process/materials

Initial Steps

- Set up a standing monthly schedule for each housing agency to come to BHCHP weekly on a rotating basis to work with patients
- Set up formal MOAs with each agency
- Multiparty release of information developed for all housing agencies
- Digital, password protected/secure folder established to save electronic copies of all necessary patient documents for easy access

Intersection with Medical Case Management Program

One medical case manager (MCM) served as the lead on the intervention

- Organized and attended weekly housing clinics
- Served as contact person/liason for housing agency contacts
- Managed electronic patient files and documents
- Tracked housing applications and outcomes
- Monitored when home visits were necessary

Entire MCM team supported patients in obtaining necessary documents and accompanied them when necessary to critical housing appointments

Interventions post-housing

- MCM team developed a checklist to use on home visits for newly housed patients
- Anecdotal evidence of increased rates of substance use relapse, overdose, worsening mental health and isolation following receipt of housing

Red Team Newly Housed Checklist

Patient: _____

Previous housing status: _____

Housing address: _____

_____

Housing Agency/Subsidy: _____

Rent Responsible for: _____
Utilities Responsible for: _____

Is there on-site case management: _____

If so, contact info: _____

Income/Payee:

- ☐ Does the patient receive income?
- ☐ If from SSA, what is monthly income?
- ☐ Has the patient updated their address through SSA?
- ☐ Has the patient requested SSP change of living situation forms?
- ☐ Is the patient interested in a rep payee for rent payment?

Transportation:

- ☐ What is patient's current transportation?
- ☐ Has the address been updated with Mass Health?
- ☐ Has PT-1 Transportation/OneCare been set up? (Where eligible)
- ☐ Has the patient applied for a Disability Fare TAP Pass?

Medications/Nursing:

- ☐ What is patient's preferred pharmacy?
- ☐ Any changes to medication schedule?
- ☐ Is the patient eligible or interested in medication delivery?
- ☐ Is the patient's HDAP active?
- ☐ Would the patient benefit from VNA services?

Food Security:

- ☐ Is the patient enrolled in Community Servings?
- ☐ Have other food resources been provided?
- ☐ Does the patient get Ensures? Have they updated their address for delivery?

Day Program/Community Resources

- ☐ Is the patient interested in participation in a day program?
- ☐ Referral to Kit Clark, Rogerson Adult Day Health, other day programs?
- ☐ Is the patient connected to the Boston Living Center or interested?
- ☐ Is the patient aware of Weds/Thurs support groups at JYP?

Rental Start Up/Utilities Assistance/Community Resources:

- ☐ Does the patient need assistance with Rental Start up?
- ☐ Is the patient connected to AAC, JRI or other client advocacy programs?
- ☐ Is the patient connected to Utilities Assistance? (AAC, ABCD)

Furniture/Household Goods:

- ☐ Has the patient ever applied for a Bob's Discount Furniture Gift Card?
- ☐ Has the patient ever been referred to a furniture bank? (Acton, Lynn)

Home Visit:

- ☐ Is the patient open to a case management home visit?
- ☐ Can this visit be scheduled within first two weeks post move in?
- ☐ Has the patient agreed to outreach visits from CM team if not able to reach or not heard from?
    - o If so, is this documented somewhere in the chart to refer back to?

Housing Advocacy:

- ☐ Does the patient have a designated housing advocate?
- ☐ Does the patient need help setting up an appointment to continue housing work?
- ☐ Does the patient have up to date releases on file for communication between MCMs and Housing Advocates?

Tracking

Spreadsheet developed with patient name, date, housing agency involved and status of referrals

MCM lead used this system to follow up closely with housing advocates to ensure patients moved through the process as quickly as possible and helped clarify any missing documentation

Process Outcomes

50 housing clinics hosted

150 individual encounters to the housing clinic

62 unique individuals served

Housing Outcomes

36 patients housed (includes 7 people rehoused) via BHCHP housing clinic intervention since 11/2016.

100% remain housed to date

- With exception of 3 deceased patients, and 3 patients who transferred care

HIV Outcomes

Of 36 people housed; 30 remain in our program

- 3 transferred care, 3 deceased

83% (25/30 active patients) are virally suppressed

- **86%** of entire group (31/36) virally suppressed if include VS at time of transfer/death

100 % (30/30) retained in care

Systems Outcomes

-Stronger housing/medical collaboration and fewer siloes as a result of collaboration

- → streamlined referral processes
- → improved transitions from chronic homelessness to housing due to enhanced MCM level support, and improved coordination with housing agencies
- →actually able to taper back # of monthly housing clinics

-Increased housing advocacy skill set amongst MCMs

Lessons Learned

Co-location of a housing clinic within a medical clinic is a promising strategy for leveraging existing resources to improve housing and HIV outcomes for a vulnerable populations of homeless PLWHA

…And What We Might Have Done Differently

More robust tracking of baseline HIV metrics, so we can better monitor changes pre and post housing

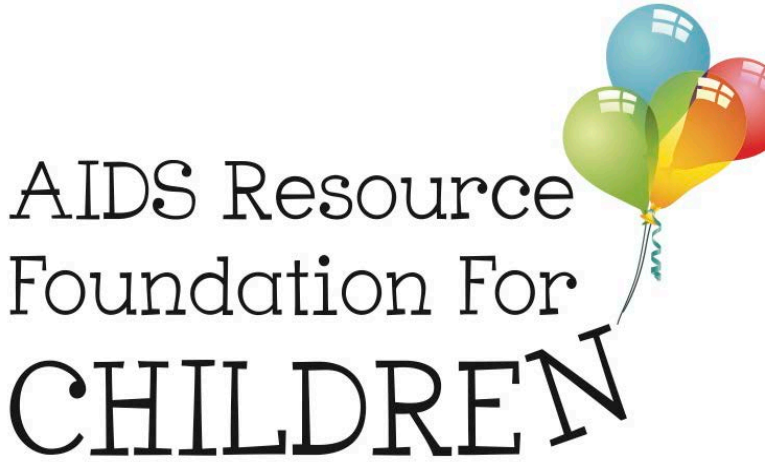
More robust tracking of how many people we housed on average in the years prior to this intervention, to determine full impact

Thank You!

AIDS Resource Foundation for Children

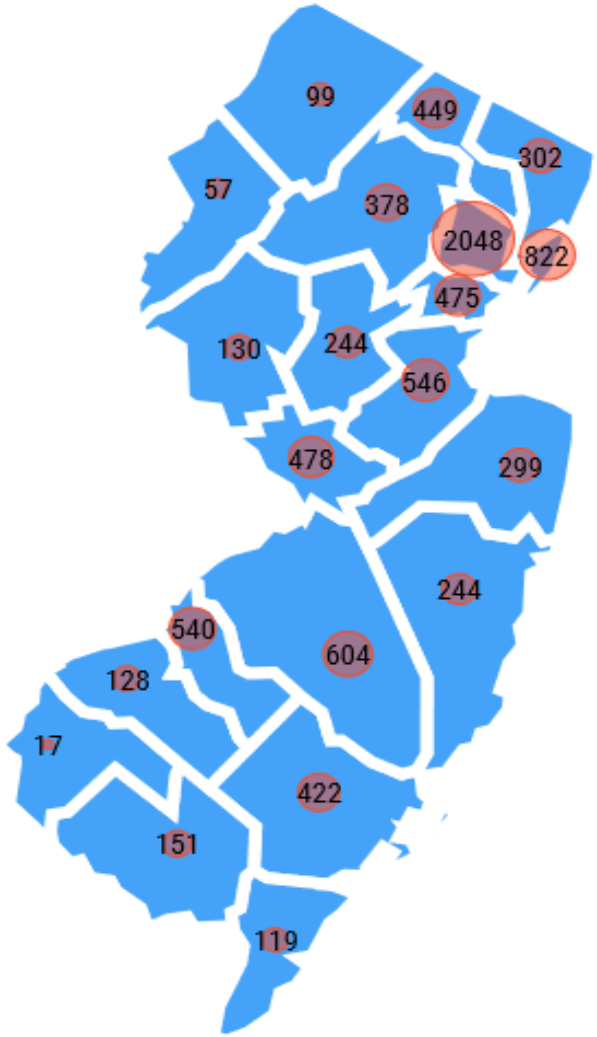
in partnership with

New Jersey Department of Health Division of HIV, STD, and TB Services



Annie Chen, Chief Operating Officer
Luis Ulerio, Director of Housing
Sara Wallach, NJ DOH
Kevin Zealand, Executive Director

Homelessness in New Jersey



Total Homeless Persons – **8,532**

*Total Homeless PLWHA – **180** (2%)*

*Total Homeless Young Adults, Ages 18 to 24 – **761** (8.9%)*

Total Chronically Homeless Persons – **1,092**

*Total Chronically Homeless PLWHA – **39** (4%)*

Total Unsheltered Homeless Persons – **1,415**

*Total Unsheltered Homeless PLWHA – **30** (2%)*

Source: NJ's 2017 Point-in-Time Count, Monarch Housing

Partnership

AIDS Resource Foundation for Children (ARFC) was founded in 1985.

- 3 Pediatric Transitional Homes for Medically Fragile Children
- 4 Adult Transitional Homes
- Owns and manages 86 units of scattered site housing (with subsidies)
- HOPWA-provider to 145 individuals and families
- Lead on NJ HIV Homeless Collaborative

New Jersey Department of Health, Division of HIV, STD and TB Services

- Responsible for Ryan White B Care and Treatment, State Care and Treatment, as well as Prevention and Surveillance
- Was encouraged by HRSA to use Ryan White Rebate funding in creative ways
- Housing was an unmet need for many years, and we saw HIV incidence going up in young gay men ages 13 to 24
- On-going collaboration grant recipient ARFC– almost daily emails, bi-weekly monitoring phone calls, quarterly progress reports, annual site visits, additional program planning meetings

Creative Funding

- 2015: Applied for and received **Ryan White B Supplemental** funding.
  - Supportive Transitional Housing Program for Young Gay Men Living with HIV – Northern NJ.
    - RFA result – ARFC awarded

- 2016: Applied for and received **Ryan White B Supplemental** funding.
  - Continuation of funding for Essex County home.
  - Used **Ryan White Rebate** funding to open a second men's home – Southern NJ.
    - RFA result – ARFC awarded

- 2017: Both homes funded by **Ryan White Rebate**.
  - Creation of the NJ HIV Housing Collaborative with **Ryan White Rebate**.
    - RFA result – ARFC awarded as lead agency
  - Applied for and received **Ryan White B Supplemental** funding for a Supportive Transitional Housing Program for Women Living with HIV who have Experienced Early Childhood Sexual Abuse and/or Intimate Partner Violence in Essex County.
    - RFA result – ARFC awarded

- 2018: Both homes and the Housing Collaborative funded by **Ryan White Rebate**.
  - Applied for and received **Ryan White B Supplemental** funding for the women's home.

Addressing Homelessness in NJ

NJ HIV Housing Collaborative

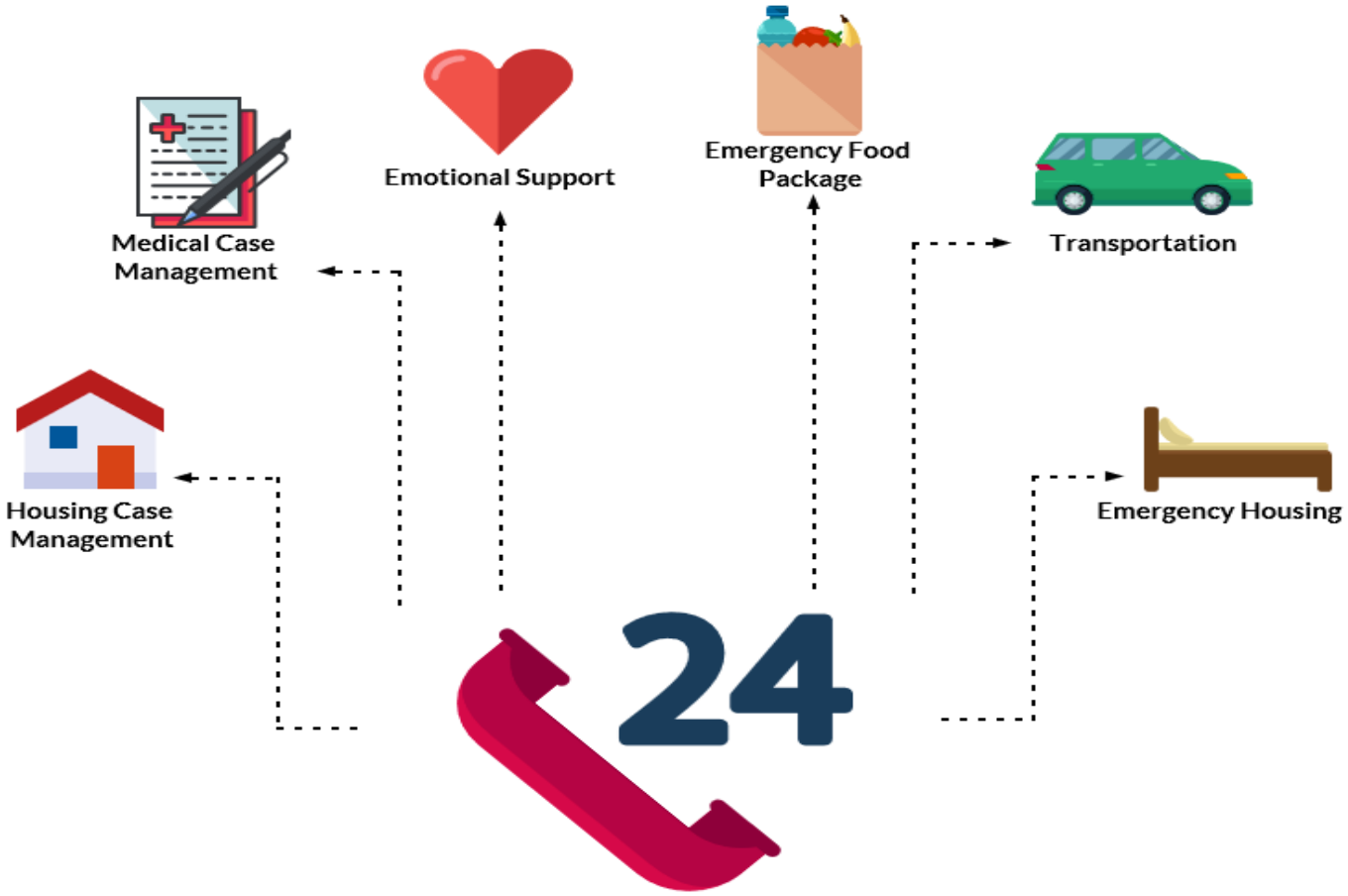
- Collaboration of HIV service providers across the state
- Emergency Housing
- Capacity-building with case managers
- Professional Learning Community
- Assessment of housing resources, barriers, and needs

Transitional Housing: Project Nest

- YGBM and other young MSM
- 2 locations in New Jersey
- Multi-phase system
- Dialectical behavioral therapy
- Comprehensive services in the home
- Psychosocial elements
- Addressing trauma

New Jersey HIV Housing Collaborative

- *Single point-of-entry for Emergency Housing and HIV Care in New Jersey*
- *Web of service providers across the state collaborating to improve health and stability among PLWHAs*
- *Training and support for non-medical case managers to provide housing-focused case management (Housing Ambassadors)*
- *Evaluating Homeless Systems in NJ*



Housing Partnerships

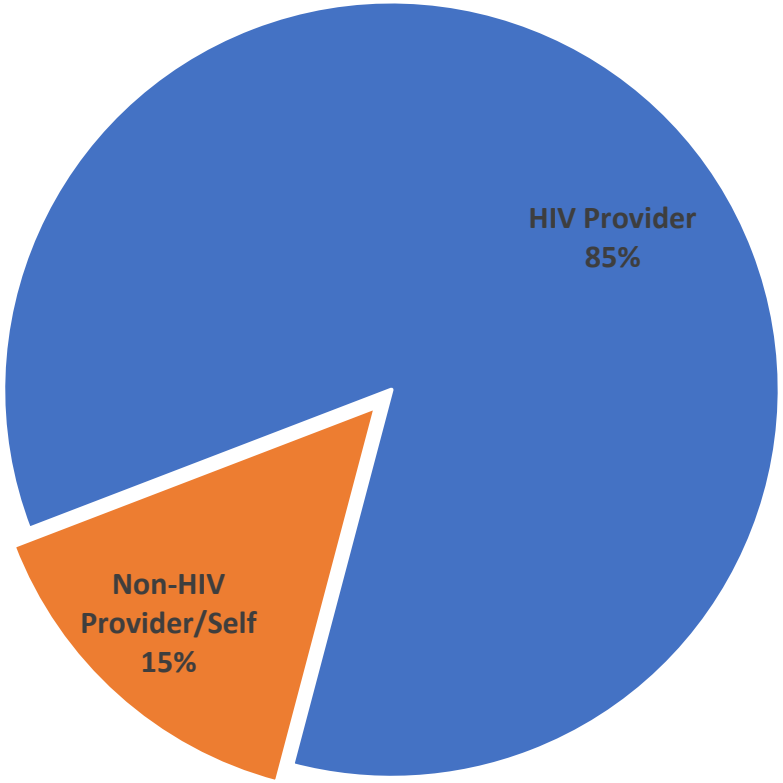
Housing Partnerships

- Emergency Shelters
- Specialized Housing Providers
- Hotels and Motels
- Transitional Housing Providers
- Permanent Housing providers
- Continuum of Care (CoC) Funded Housing and Housing Assistance
- NJ DOH-funded Providers of Housing and Housing Services

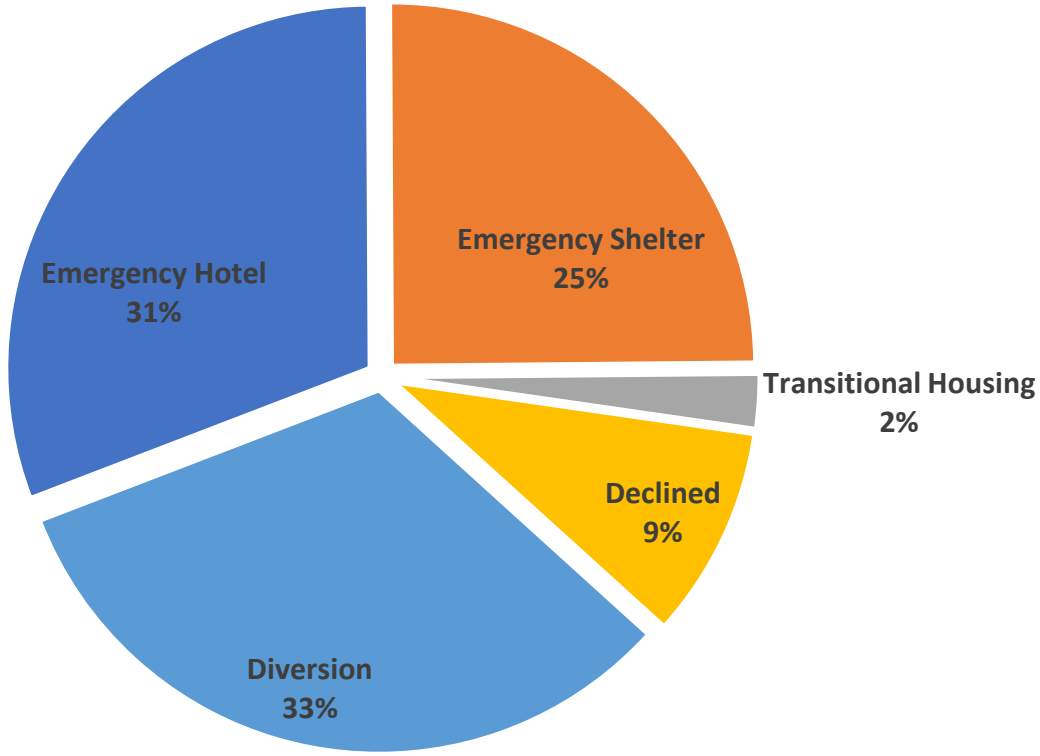
428 Hotline Callers

Gender	Composition	Age	Income	SB	MH
Male (61%)	Individuals (82%)	18 - 30 (16%)	SSD/SSI (41%)	Yes (35%)	Yes (44%)
Female (38%)	Families (18%)	31-50 (45%)	Employed (13%)	No (65%)	No (56%)
Transgender (1%)		51+ (39%)	None (38%)		
			Other (8%)		

Referral Source



Emergency Placement



Key Challenges & Successes

- Level of Housing Case Management among service providers varied greatly
- Housing resources in each county varied dramatically
- Generating “buy-in” and participation from all collaborators
- Quick start-up; and emergency housing needs outpaced resources
- Collaborators were excited for this new resource to help their clients
- Housing Ambassadors eager to learn more about housing
- Over 240 placements in just 1 year
- Data integration for determining health outcomes

Transitional Housing Program

Project Nest: Program Elements

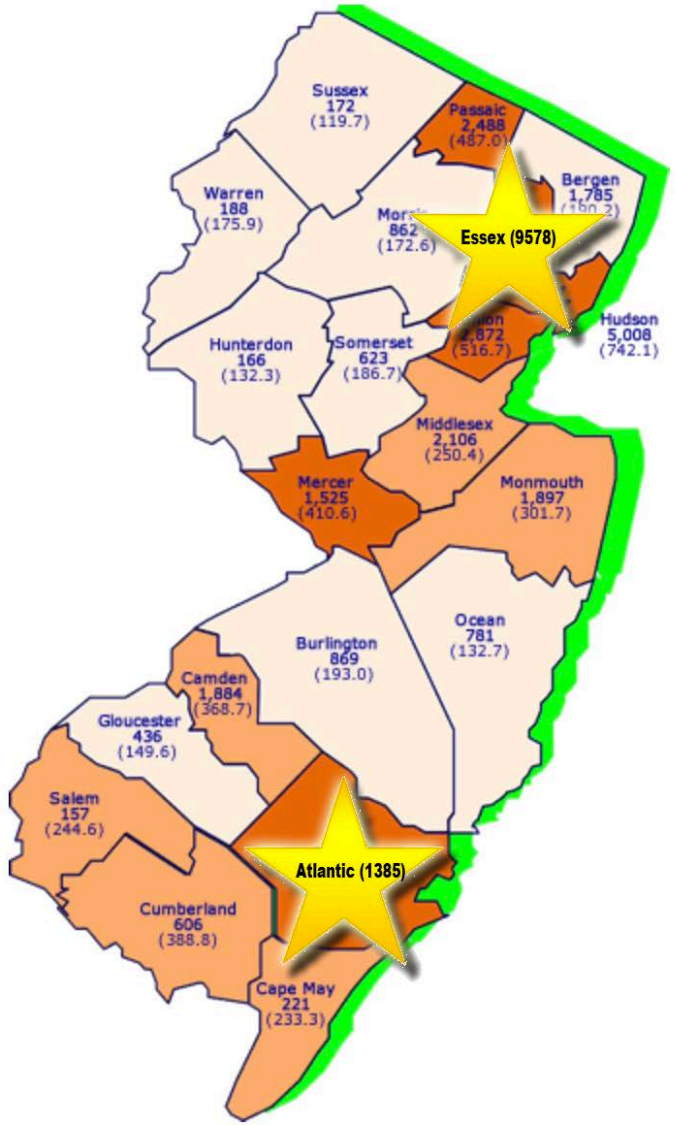
- **Supportive transitional housing project co-locating and providing:**
  - Medical Case Management
  - Behavioral Health: Dialectical Behavioral Therapy (LCSW) and Substance Abuse Prevention (LCADC)
  - Directly observed therapy by a nurse
  - Psychosocial Support Services
  - Independent living and career development skills
  - Transportation Services
- **2 locations in New Jersey serving up to 27 individuals at a time – Northern NJ (2016) and Southern NJ (2017)**
- **Multi-phase System:**
  - Progress through the phases is dependent on benchmarks predetermined in treatment plans
  - Phase progression leads to increased freedom and responsibility
  - After two years, residents are given the ability to move to an apartment.

Health Outcomes

- As of **June 2018**, 54 residents have been inducted into the program, with 30 having stays longer than three months. Of the 30 residents:
  - 100% have prescriptions for ART
  - 90% have achieved viral suppression
  - 0 gaps in HIV medical visits in the last three months
- As of **September 30, 2018**, units of service across both homes include:
  - Bed Days – 10,405
  - Medical Case Management – 6,511 (encounters of any duration)
  - Dialectical Behavioral Therapy – 982 group and 368 individual
  - Substance Abuse Prevention – 1,591
  - Other Mental Health group and individual sessions – 719

Key Challenges & Successes

- Building trust with residents… a challenge AND a success
- The “right fit” in staff
- Substance use – drug-free environment and harm reduction
- Access to mental health services vary across NJ
- DBT “culture” throughout the homes
- 2 residents completed full 2-year program and have sustainable housing; 1 in last phase
- All residents participate in employment and/or education within 3-months



Trauma-Focused Care

NJ HIV Homeless Collaborative

- Understanding that loss of housing is a traumatic event
- Intake questions & placement process (avoiding re-traumatization; companion animals)
- Making the process as stress-free for the client as possible
- Ongoing training of staff and partners

Project Nest

- Peer Buddy System
- Care after discharge/Re-entry plan
- Use of harm reduction model for substance use and other behaviors
- Celebrating successes, holidays, and birthdays; validating chosen families
- Making space for expression and culture
- Ongoing training of staff (de-escalation, DBT skills, trauma education)
- Use of trauma baseline survey

Lessons Learned in Starting Innovative Housing Initiatives

- Start with a flexible mind-set as these programs are new, evolving, and best serve clients when all stakeholders are heard.
- Asset-based thinking. *What do we do really well? How do we use it to bring us to the next level?*
- Adaptive Challenges and Iterative Learning. Identify the hard-to-articulate challenges and ask "what do we not know." Learn and repeat across all levels of the organization.
- Engage your collaborative partners in a genuine partnership – what do you need from them and what do they need from you to make both orgs successful.
- Make trauma-informed care a priority throughout the organization – staff, clients, board-level
- Get creative with your resources; ask questions about innovative ways to use funding.

What's Next

- In August of 2018, ARFC and NJ DOH opened a new **trauma-focused transitional housing program for women** living with HIV who are also survivors of domestic violence, sexual assault, or intimate partner violence.
- As the existing Project Nest programs reach capacity, NJ DOH will seek to support a 3rd Nest home in NJ.
- With NJ HHC entering Year 2 of its start-up, ARFC looks for opportunities to restructure the initiative based on first year learning – changing policies, strengthening housing case management, and increasing engagement with collaborators.
- Continued participation in NJ DOH's statewide initiatives to integrate trauma-informed care and prioritize behavioral health in ARFC's existing systems.

Questions

Project HHHOME at Maricopa County Ryan White Part A Program

Integrated Housing Clinic at Boston Health Care for the Homeless Program

NJ HIV Housing Collaborative and Project Nest at AIDS Resource Foundation for Children