Agenda

• Review the recent housing policy updates in Policy Clarification Notice #16-02, Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds.

• Describe different approaches taken by recipients to provide housing services for Ryan White HIV/AIDS Program (RWHAP) clients using RWHAP funds.
Speakers

Laura Cheever, MD, ScM
Associate Administrator
HIV/AIDS Bureau

Tarsha Cavanaugh, PhD, MSW, LGSW
Commander, USPHS
Senior Public Health Analyst
HIV/AIDS Bureau, Division of Policy and Data

Marjorie Katz
Health Program Specialist
California Department of Public Health – Office of AIDS
HIV Care Branch (RWHAP Part B)

Jessica Heskin, MA, MPH
Health Program Specialist
California Department of Public Health – Office of AIDS
HIV Care Branch (RWHAP Part B)

Audrey S. Regan
Director, Sexual Health Promotion
Columbus Public Health RWHAP Part A

Caitlin Kapper, MPH
Ryan White Quality Improvement Manager
Columbus Public Health RWHAP Part A

Loretta Dutton
HIV Care Director
New Jersey Department of Health, Division of HIV, STD and TB Services (RWHAP Part B)

Sara Wallach
Program Management Officer
New Jersey Department of Health, Division of HIV, STD and TB Services (RWHAP Part B)
Purpose of RWHAP

• Public health approach to provide a comprehensive system of care
• Ensure low-income people living with HIV (PLWH) receive optimal care and treatment
Purpose of RWHAP (cont.)

• Increase access to care and treatment for PLWH
• Only disease-specific discretionary grant program for care and treatment of PLWH
• Payor of last resort – safety net for uninsured and low-income PLWH
• Funding to support:
  • Medical services, including medications
  • Support services
  • Provider training
  • Technical assistance
  • Demonstration projects
HOUSING AND THE RYAN WHITE HIV/AIDS PROGRAM

Why Housing Services are Important
Ryan White HIV/AIDS Program Clients (non-ADAP), by Housing Status, 2014—United States and 3 Territories

- Stable: 83.5%
- Temporary: 11.8%
- Unstable: 4.7%

N=481,745
Ryan White HIV/AIDS Program Clients (non-ADAP) Living ≤100% of the Federal Poverty Level, by Housing Status, 2014—United States and 3 Territories

- All clients: 64.1% (N=464,026)
- Stable: 60.5% (N=387,937)
- Temporary: 81.5% (N=53,939)
- Unstable: 83.2% (N=22,150)

FPL: Federal Poverty Level
Ryan White HIV/AIDS Program Clients (non-ADAP), by Gender and Housing Status, 2014—United States and 3 Territories

<table>
<thead>
<tr>
<th>Gender</th>
<th>Housing Status</th>
<th>Male</th>
<th>Female</th>
<th>Transgender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=341,229</td>
<td>12.4%</td>
<td>10.0%</td>
<td>10.3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5.0%</td>
<td>3.8%</td>
<td>16.1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>82.6%</td>
<td>86.2%</td>
<td>73.6%</td>
</tr>
</tbody>
</table>

Legend:
- **Stable**
- **Temporary**
- **Unstable**
Viral Suppression among Young, Black/African American MSM (YBMSM) Aged 13–24 Years Served by the Ryan White HIV/AIDS Program (non-ADAP), 2014—United States and 3 Territories

Note: N represents the total number of clients in the specific subpopulation.

Viral suppression: ≥1 outpatient ambulatory medical care visit during the calendar year and ≥1 viral load reported, with the last viral load result <200 copies/mL.
RYAN WHITE HIV/AIDS PROGRAM HOUSING POLICY UPDATE

Housing Service Category
Using Ryan White HIV/AIDS Program Funds to Support Housing Services

- Program letter released August 18, 2016
- RWHAP funds to support housing services under RWHAP Parts A, B, C, and D
- Policy Clarification Notice #16-02: Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds
- Replaced Policy Clarification Notice #11-01: The Use of Ryan White HIV/AIDS Program Funds for Housing Referral Services and Short-Term or Emergency Housing Needs
Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds

Policy Clarification Notice (PCN) #16-02
Replaces Policy #10-02

Housing
Description:
Housing services provide transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment. Housing services include housing referral services and transitional, short-term, or emergency housing assistance.

Transitional, short-term, or emergency housing provides temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Housing services must also include the development of an individualized housing plan, updated annually, to guide the client’s linkage to permanent housing. Housing services also can include housing referral services: assessment, search, placement, and advocacy services; as well as fees associated with these services.

Eligible housing can include either housing that:
- Provides some type of core medical or support services (such as residential substance use disorder services or mental health services, residential foster care, or assisted living residential services); or
- Does not provide direct core medical or support services, but is essential for a client or family to gain or maintain access to and compliance with HIV-related outpatient/ambulatory health services and treatment. The necessity of housing services for the purposes of medical care must be documented.

Program Guidance:
RWHAP recipients and subrecipients must have mechanisms in place to allow newly identified clients access to housing services. RWHAP recipients and subrecipients must assess every client’s housing needs at least annually to determine the need for new or additional services. In addition, RWHAP recipients and subrecipients must develop an individualized housing plan for each client receiving housing services and update it annually. RWHAP recipients and subrecipients must provide HAB with a copy of the individualized written housing plan upon request.

RWHAP Part A, B, C, and D recipients, subrecipients, and local decision making planning bodies are strongly encouraged to institute duration limits to housing services. The U.S. Department of Housing and Urban Development (HUD) defines transitional housing as up to 24 months and HRSA/HAB recommends that recipients and subrecipients consider using HUD’s definition as their standard.

Housing services cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments.¹

Housing services, as described here, replaces the guidance provided in PCN 11-01.

¹See sections 2604(l), 2612(f), 2651(b), and 2671(a) of the Public Health Service Act.
The Ryan White HIV/AIDS Program Housing Service Category At-A-Glance

• Policy Clarification Notice #16-02: Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds
  • Replaced Policy Clarification Notice #11-01: The Use of Ryan White HIV/AIDS Program Funds for Housing Referral Services and Short-Term or Emergency Housing Needs

• Housing services funded under Ryan White HIV/AIDS Program Parts A, B, C and D

• Allowable services include
  • Transitional, short-term, or emergency housing assistance
  • Housing referral (i.e., assessment, search, placement, advocacy, and the fees associated with these services)
The Ryan White HIV/AIDS Program
Housing Service Category At-A-Glance (cont.)

• Program Guidelines for Housing Services:
  • Must be payor of last resort
  • Must ensure that housing is limited to transition, short-term or emergency housing assistance
    • Recommended duration limit up to 24-months
  • Must develop mechanisms to allow new clients access to housing services
The Ryan White HIV/AIDS Program Housing Service Category At-A-Glance (cont.)

• Program Guidelines for Housing Services continued:
  • Must develop long-term housing plans for every client receiving housing services
    • Must be updated annually
  • Eligible housing
    • Provides core medical or support services, or
    • Does not provide a direct core medical or support services, but is essential for compliance with HIV-related outpatient/ambulatory health services and treatment
California’s Housing Plus Project: Using Ryan White Funds to Stabilize Housing, Improve Outcomes, and Reduce Disparities

Marjorie Katz  
Health Program Specialist  
Ryan White HIV/AIDS Program Part B

Jessica Heskin, MA, MPH  
Housing Specialist  
Housing Opportunities for Persons With AIDS/Ryan White HIV/AIDS Program Part B
California - Housing Plus Project

- The Housing Plus Project is a five-year housing demonstration project to stabilize housing as a targeted intervention to engage and retain clients in HIV care and treatment, and achieve and maintain viral suppression.
How was it Developed?

• Determined type of housing assistance project:
  - 30% shallow/partial rent subsidy
  - 24-month subsidy limit
  - % of allocation allowed for implementation
  - Number of contractors desired (2-5)

• Established contractor selection criteria
• Selected 4 contractors
Program Components

- Client eligibility
- Case Managers
- Housing Coordinator
- Individualized housing plans
- Data collection
- State technical assistance
Client Housing Plan Agreement

• **Housing Goals**
  – Establish a stable living environment
  – Improve access to HIV care and treatment
  – Achieve and maintain viral suppression

• Service Participation

• Financial Resources

• Permanent Housing

• Client Compliance Agreement
Client Housing Plan Agreement
Service Participation

Service Participation
I agree to participate in the following low-cost/no-cost services once made available to me and will seek the assistance of my case manager to secure such services or will follow through on referrals made.

<table>
<thead>
<tr>
<th>Service</th>
<th>Selection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistance with benefit applications or insurance documents (e.g., Medi-Cal, Covered CA, ADAP)</td>
<td></td>
</tr>
<tr>
<td>Medical care</td>
<td></td>
</tr>
<tr>
<td>Nutritional services</td>
<td></td>
</tr>
<tr>
<td>Legal services</td>
<td></td>
</tr>
<tr>
<td>Substance abuse treatment</td>
<td></td>
</tr>
<tr>
<td>Mental health services</td>
<td></td>
</tr>
<tr>
<td>Peer support/mentor program</td>
<td></td>
</tr>
<tr>
<td>Utility/phone/internet assistance programs</td>
<td></td>
</tr>
<tr>
<td>Money budgeting skills training</td>
<td></td>
</tr>
<tr>
<td>Vocational training</td>
<td></td>
</tr>
<tr>
<td>Conflict or anger management skills training</td>
<td></td>
</tr>
<tr>
<td>Other (specify):</td>
<td></td>
</tr>
<tr>
<td>Other (specify):</td>
<td></td>
</tr>
</tbody>
</table>
Client Housing Plan Agreement

Financial Resources

I agree to take the following action steps to improve my financial status, including seeking or restoring additional forms of income, reducing my monthly expenses, and/or adhering to a new monthly budget.

<table>
<thead>
<tr>
<th>Action Step(s)</th>
</tr>
</thead>
</table>

Measures to Increase Financial Resources
For example, apply for additional benefits; take measures to have benefits reinstated; seek employment or vocation/job training

1.
2.
3.

Measures to Reduce Monthly Expenses
Ways to save: reduce cable television plan to basic cable; eliminate extra phone charges; reduce debt finance charges; be more frugal with personal spending; seek subsidized transportation and child care; reduce car payments by trading in for less expensive vehicle; participate in discount phone/internet/utility programs

1. 
2. 
3. 

Monthly Household Budget

<table>
<thead>
<tr>
<th></th>
<th>Old Budget</th>
<th>New Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electricity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Water &amp; Sewer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Out-of-Pocket</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Car Payment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Car Insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Auto Fuel/Maintenance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Credit Card/Debt Payments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Permanent Housing

I agree to take the following action steps to obtain permanent housing.

<table>
<thead>
<tr>
<th>Measures to obtain permanent housing</th>
<th>Action Step(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>This may include: apply for housing</td>
<td>1.</td>
</tr>
<tr>
<td>assistance programs, e.g., Housing</td>
<td></td>
</tr>
<tr>
<td>Choice Voucher, Public Housing Program</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
</tbody>
</table>
In order to receive housing assistance through a monthly rent subsidy from the Ryan White Part B Program, I, __________________________, agree to all of the above and I understand that I must:

1. Make all efforts toward achieving these goals and completing these action steps to keep my housing assistance I receive from the Ryan White Part B program.
2. Discuss my success(es) and/or difficulty(ies) with achieving any of the above goals or accomplishing any of the above action steps with my Ryan White Case Manager.
3. Provide a copy of a viral load test result at least once a year to my Ryan White Case Manager.
4. Not be receiving HOPWA rental assistance, Housing Choice Voucher (formerly known as Section 8), or other housing assistance.

Client Signature: ___________________________ Date: ____________
Print Name: ___________________________

I, ___________________________, have determined that Ryan White housing assistance will be essential for client, __________________________, to access and maintain HIV-related medical care and treatment for the client listed above.

Case Manager Signature: ___________________________ Date: ____________
Print Name: ___________________________
Evaluation Plan

• Process evaluation will examine (a) the number of clients served, (b) the duration of housing assistance, and (c) the client's demographics and household characteristics.

• Outcome evaluation will analyze the degree to which clients who received housing assistance (a) are stably housed, (b) are retained in HIV care, and (c) achieve and maintain viral load suppression.
Lessons Learned & Best Practices

• Take into account time needed to amend and execute contracts
• Coordinate with housing programs to benefit from their experience, resources, and processes/systems
• Establish program parameters that will ensure equity, parity, and appropriate use of funds
Success in Housing

Ryan White HIV/AIDS Program
Part A
Columbus, Ohio

Audrey S. Regan, PhD
Caitlin Kapper, MPH
Housing Challenges Before Ryan White

- Inadequate housing resources
- No resources for homelessness prevention
- Barriers for special populations
Success in Housing @

• A Federally Qualified Health Center focused on providing health care for the homeless.
• Other programs administered include:
  • mental health services
  • a men’s homeless shelter
  • a housing program for persons leaving incarceration
  • a housing program for persons with mental health conditions
<table>
<thead>
<tr>
<th>Service Category</th>
<th>Number of Clients Served (FY15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing Services</td>
<td>354</td>
</tr>
<tr>
<td>Emergency Financial Assistance</td>
<td>231</td>
</tr>
<tr>
<td>Case Management (Non-Medical)</td>
<td>632</td>
</tr>
<tr>
<td><strong>UNDUPLICATED TOTAL</strong></td>
<td><strong>635</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Units of Service (FY15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing Services</td>
<td>557 - Rent Payments</td>
</tr>
<tr>
<td></td>
<td>3 - Housing Placement/Emergency Shelter Services</td>
</tr>
<tr>
<td>Emergency Financial Assistance</td>
<td>312 - Utility Payments</td>
</tr>
<tr>
<td></td>
<td>54 - Housing Application Fees</td>
</tr>
<tr>
<td></td>
<td>16 - Moving Expense Fees</td>
</tr>
<tr>
<td>Case Management (Non-Medical)</td>
<td>1,897 - Service Orientation/Coordination Units</td>
</tr>
<tr>
<td></td>
<td>1,605 - Face-to-Face Units</td>
</tr>
<tr>
<td></td>
<td>175 - Non Face-to-Face Units</td>
</tr>
<tr>
<td></td>
<td><em>(1 Unit = 15 Minutes)</em></td>
</tr>
</tbody>
</table>
Clients Served

- A total of 635 clients were served between March 1, 2015 and February 29, 2016
- 70% were male
- 59% were Black/African American
- Average age = 41 years old
### Acuity Score

<table>
<thead>
<tr>
<th>Acuity Scoring</th>
<th>Self-Management (0)</th>
<th>Basic Need (4)</th>
<th>Moderate Need (6)</th>
<th>Intensive Need (8)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Housing Acuity Criteria</strong></td>
<td>Clean, habitable, stable, affordable housing</td>
<td>Needs short-term assistance with rent/utilities to maintain stable housing</td>
<td>Eviction imminent</td>
<td>Homeless</td>
</tr>
<tr>
<td></td>
<td>Housing is in jeopardy due to projected financial strain</td>
<td>Home completely uninhabitable due to health and/or safety hazards</td>
<td>Recently evicted</td>
<td>Recently evicted</td>
</tr>
<tr>
<td></td>
<td>Housing is marginally habitable</td>
<td>Living in shelter</td>
<td>Arrangements to stay with friends and family have fallen through</td>
<td>Arrangements to stay with friends and family have fallen through</td>
</tr>
<tr>
<td></td>
<td>Formerly independent person temporarily residing with friends or relatives, reasonable stable</td>
<td>Lives in transitional or temporary housing</td>
<td>Not able to live independently and needs referrals</td>
<td>Not able to live independently and needs referrals</td>
</tr>
</tbody>
</table>

| **Medical Needs Acuity Criteria** | Stable health with access to ongoing HIV medical care | Needs primary care referral | Needs referral for treatment or medication for non-HIV related condition | Client is pregnant |
|                                | Virally suppressed (Viral Load <40) | Short-term acute condition; receiving medical care | OI diagnosis or hospitalization within 6 months | Client post-partum (within 6 weeks of delivery) |
|                                | Chronic, non-HIV related condition under control with medication/treatment | Chronic, non-HIV related condition under control with medication/treatment | Detectable viral load (>1000) | Needs immediate linkage to medical care due to acute problems related to low body weight, poor appetite, nausea, vomiting, or other urgent health issues that impact nutritional status |
|                                | HIV symptomatic (i.e. nausea, weight loss, night sweats) with one or more conditions that impair overall health | HIV symptomatic (i.e. nausea, weight loss, night sweats) with one or more conditions that impair overall health | History of cognitive impairment- moderately functioning (TBI, Dementia) | Newly diagnosed within last 6 months |
|                                | Detectable viral load (40-1000) | Detectable viral load (40-1000) | History of cognitive impairment- moderately functioning (TBI, Dementia) | CD4 < 200 (AIDS diagnosis) and detectable viral load >1000 and inconsistent or refusing meds |
|                                | | | | History of cognitive impairment- diminished functioning (TBI, Dementia) |
Referral

Success in Housing
Referral Form

Through grant funding from the Columbus Public Health (CPH) Ryan White Part A program, Southeast, Inc. provides short-term, emergency financial support for individuals who meet the following eligibility requirements:
- HIV/AIDS diagnosis
- Low-income (less than 100% Federal Poverty Level)
- Uninsured or underinsured
- Living in Delaware, Fairfield, Franklin, Licking, Madison, Monroe, Pickaway or Union County.

Please complete all sections of the referral form and fax it to (614) 292-7425, along with the client’s most recent CPH Part A Eligibility Form. Please note, incomplete forms may be returned to the referrer. Following a thorough review of the referral, a housing case manager will be assigned to the client. Success in Housing will contact the client within two business days.

<table>
<thead>
<tr>
<th>Referral Source Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Referring Case Manager:</td>
</tr>
<tr>
<td>Date of Referral:</td>
</tr>
<tr>
<td>Agency Name:</td>
</tr>
<tr>
<td>Phone Number:</td>
</tr>
<tr>
<td>Email Address:</td>
</tr>
</tbody>
</table>

By signing this form, I verify that all client eligibility information has been properly reviewed and documented per Columbus Public Health policy and that the client is approved to access Columbus Ryan White Part A services.

Case Manager Linkage to Case Coordinator Signature (region): 
Client's Ryan White Part A Eligibility Expiration Date: |

Client Contact Information

| First Name: |
| Last Name: |
| Preferred Name: |
| Date of Birth: |
| Gender Identity: Male Female Transgender (MTH) Transgender (FTH) |
| Home Address ( mailing at site and street): |
| Phone Number: |
| Email Address: |

Preferred Methods of Contact (check all that apply): 
May confidential messages be left on voicemail? Yes No

Additional Client Information

Which financial service assistance does the client need at this time? 
- Rent 
- Utility 
- Application Fee 
- Moving Expense

Has the client received an eviction notice? Yes No 
Has the client received a utility disconnection notice? Yes No 
Is transportation needed for housing services? Yes No

Monthly Income $ Source of Income (e.g. SSI, SSDI, employment): 

Primary Language Spoken: 
Is an interpreter needed? Yes No

Total Number of Individuals in Household: Total Number of Children in Household:

Did the client receive a psychological, mental health, and substance abuse screening within the last 6 months? Yes No

City of Columbus - Columbus Public Health
# Individualized Housing Plan

**Success In Housing Housing Plan**

<table>
<thead>
<tr>
<th>Client Contact Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name:</td>
<td></td>
</tr>
<tr>
<td>Last Name:</td>
<td></td>
</tr>
<tr>
<td>Preferred Name:</td>
<td></td>
</tr>
</tbody>
</table>

**Preventing Problem**

Describe the client's circumstances and the reason for the request for assistance.

**Housing Goals**

- To obtain temporary shelter
- To obtain permanent housing
- To obtain emergency financial assistance to maintain current housing
- Other:

**Emergency Financial Assistance**

- To obtain emergency financial assistance with:
  - utility payment
  - application fee
  - moving expenses
- Other:

**Housing Case Management**

- To enroll in:
  - housing assistance programs
  - utility assistance programs
  - utility company
- To establish a payment plan with:
  - landlord
  - utility company
  - to resolve tenant/landlord issues
- Other:

## Approved Service Information

- What service assistance is the client approved to receive? (Check all that apply):
  - Rent
  - Utility
  - Application Fee
  - Moving Expense
  - Housing Case Management

<table>
<thead>
<tr>
<th>Amount Approved</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Units Approved:</td>
<td>1</td>
</tr>
<tr>
<td>Company Name:</td>
<td></td>
</tr>
<tr>
<td>Phone Number:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AddWth (including city, state, and zip code):</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount Approved</td>
<td></td>
</tr>
<tr>
<td>Units Approved:</td>
<td>1</td>
</tr>
<tr>
<td>Company Name:</td>
<td></td>
</tr>
<tr>
<td>Phone Number:</td>
<td></td>
</tr>
</tbody>
</table>

## Budget Information

<table>
<thead>
<tr>
<th>Category</th>
<th>Old Budget</th>
<th>New Budget</th>
<th>Old Budget</th>
<th>New Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rent/Mortgage</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Home/Mortgage Insurance</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Electricity</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Gas</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Phone</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Water/Sewer/Trash</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Cable/Internet</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Food</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Child Care</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

**Monthly Income:** $  
**Total Old Budget Expenses:** $  
**Total New Budget Expenses:** $

## Referrals

<table>
<thead>
<tr>
<th>Agency Name/Address</th>
<th>Agency Phone Number</th>
<th>Agency Hours of Operation</th>
<th>Services(s) Provided</th>
</tr>
</thead>
</table>

## Client Agreement

I acknowledge I have helped make this plan and understand I am responsible for parts of this plan. My housing case manager has explained this plan to me. I agree to follow this plan and to let my housing case manager if anything changes. I agree to stay in contact with my housing case manager.

**Client Signature:**  
**Date:**

**Housing Case Manager Signature:**  
**Date:**
Funded Service Units

• Housing Case Management interactions
  – Unlimited
  – Units are 15 minutes

• 3 units of service (unless exception) = EFA and Housing
  – 1 unit = 1 payment
Partners

- Landlords
- Utility companies
- Non-profit organizations
- Medical case management agencies
Housing Stabilization

- Budgeting skills
- Transition to long-term housing programs
- Short-term payment is all that is needed
Lessons Learned

• This can be the entry point to medical care
• There is significant administrative burden for sub-recipients
• This program is always helping people in a crisis, yet our general program is designed for a non-crisis environment
Lessons Learned con’t…

• Better integration with other housing organizations is needed
• Access to safe, affordable housing is a challenge
• There is a need for a good Information Management System
• Educating MCM and EIS staff is a continuing process
• Address the lessons learned
• Embrace employment training
• Consider, what services and gaps exist that could be tailored to our clients
Thank You

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New Jersey Transitional Housing Initiative

LORETTA DUTTON, HIV CARE DIRECTOR
SARA WALLACH, PROGRAM MANAGEMENT OFFICER
Purpose and Vision

• Address the gaps identified in the 2015 epi profile in housing services for HIV-positive young (18-26) gay and bisexual men (YGBM) who are unstably housed, or experiencing homelessness.

• Target population faces homelessness and abandonment, as well as stigma, mental health disorders, substance use disorders, history of sexual abuse, and post traumatic stress disorder.

• Homelessness and lack of access to basic needs impedes the goals set forth by NHAS 2020.

• Stable housing produces tremendous outcomes along each step of the care continuum.

• This initiative serves to address the homeless faced by YGBM, and also the other factors that impede retention in care, viral suppression and thereby...
Program Model

• Start Date: April 1, 2016
• Residential Program: the vision is to create a “home”

This is a place where you don’t have to worry about where your next meal is coming from or how you are going to get your clothes washed. Someone is waiting for you to come home at night.

• Transitional Housing: HUD’s definition of
## Service Elements

<table>
<thead>
<tr>
<th>Housing</th>
<th>Medical Case Management (with Treatment Adherence)</th>
<th>Mental Health Services</th>
<th>Psychosocial Support (NEW!)</th>
<th>Medical Transportation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• A home that differs from a shelter – “you mean I get to stay”</td>
<td>• Encounters with medical case managers</td>
<td>• DBT group and individual sessions</td>
<td>• Support groups</td>
<td>• Trips to medical appointments</td>
</tr>
<tr>
<td></td>
<td>• Encounters with the house nurse</td>
<td>• Talk therapy sessions</td>
<td>• Health education</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Wellness</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Independent living</td>
<td></td>
</tr>
</tbody>
</table>

This is consistently evolving to “meet the residents where they’re at.”
Multi-phase System

<table>
<thead>
<tr>
<th>Orientation Phase</th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
<th>Apartment Phase</th>
</tr>
</thead>
</table>

With the exception of the Orientation Phase, Phase movement is dependent on benchmarks predetermined in the treatment plan.

- **Freedom & Responsibility**
- **Independent Living Skills & Treatment Adherence**
# Barriers and Solutions

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>First program of its kind</td>
<td>Practice, evolve, patience</td>
</tr>
<tr>
<td>Shelter stigma and implications</td>
<td>Marketing plan, moving the house</td>
</tr>
<tr>
<td>Filling the house to capacity + having a waitlist</td>
<td>Marketing plan</td>
</tr>
<tr>
<td>Privileges to include overnight passes</td>
<td>Moving this back in the phase</td>
</tr>
<tr>
<td>Miscommunication</td>
<td>Clearly stated goals, consistent communication, flexibility</td>
</tr>
</tbody>
</table>
# Successes

<table>
<thead>
<tr>
<th>Viral Load Suppression</th>
<th>Prescription of Antiretroviral Therapy</th>
<th>HIV Medical Visit Frequency</th>
<th>Gap in HIV Medical Visits</th>
<th>Prescribed PCP prophylaxis</th>
</tr>
</thead>
<tbody>
<tr>
<td>71%*</td>
<td>100%</td>
<td>100%</td>
<td>0%</td>
<td>7%</td>
</tr>
</tbody>
</table>

- Opening another house soon
- Pride in the program
- Feels like a family

The program will instill in residents the knowledge and skills they need to not only engage in self-care, independent living, and treatment adherence, but also to be advocates for themselves and others.
Lessons

• These programs are brand new: be patient, be flexible, be clear, be attentive
• Programs: work flexibility into your plans
• Get to know your collaborative partners
• Make trauma-informed care a priority
• Don’t neglect staff development and wellness; don’t be afraid of staff turn-over
Thank you

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How Can Ryan White HIV/AIDS Program Recipients Better Support Housing?

• Examples of better coordination may include some of the following:
  • Inclusion of housing services in planning processes and procurement
  • Focus on housing for needs assessment studies
  • Co-located housing and care services
  • Targeted adherence programs for PLWH experiencing unstable housing
  • Enhanced strategic relationships with housing providers/experts
  • Inclusion of a housing indicator as a risk for non-adherence and/or medical retention
  • Assessment of housing status as part of a care plan
  • Resource commitment as appropriate
QUESTIONS AND ANSWERS
Part II: Housing Services Webcast for Recipients

October 25, 2016 at 2 PM ET - Recipient webcast
Innovative Strategies for Coordinating Health and Housing for Persons Living with HIV who are Unstably Housed or Experiencing Homelessness
Thank you!

Tarsha Cavanaugh, PhD, MSW, LGSW
HIV/AIDS Bureau, Division of Policy and Data

Follow-up questions, please email AskHAB@hrsa.gov