

## ***FOUNDATIONS FOR LIVING PROJECT***

THE CORPORATION FOR  
AIDS RESEARCH,  
EDUCATION, AND  
SERVICES, INC. (CARES)

### **Service Area**

Capitol District and Monroe  
County Regions of Upstate  
New York

### **Grant Term**

1/1/2012-06/30/2015

### **Grant Funded HOPWA Eligible Activities Include:**

- Permanent Housing Placement
- Tenant-Based Rental Assistance
- Housing Information Services
- Case Management

CARES was awarded \$1,344,375 to provide permanent housing, linkages to critical supportive services, and comprehensive planning and coordination activities in the cities of Albany and Rochester, NY. The project aimed to provide 60 clients with tenant-based rental assistance and assist an additional 15 clients with permanent housing placement activities to foster housing stability.

## **STRATEGIES**

### **Increase Access of PLWHA to Vocational Services to Increase Self-Sufficiency and Decrease Reliance on Housing Assistance**

Each of CARES' employment case managers established a one-on-one relationship with the local One Stop Career Center staff to provide individual employment services and track participants' progress in the project. This relationship aided in removing barriers to client participation in the services, and it improved the case managers' ability to prep clients for receipt of employment services. CARES identified that PLWHA who were encouraged to pursue employment and who successfully engaged in employment/vocational services were more likely to reduce their reliance on continued housing assistance. Twenty-nine percent of CARES' participants had their housing subsidy decrease due to increased income from employment. Increasing access to vocational services not only improved the quality of life for program participants, but also helped CARES to serve more people with their limited grant funding.

### **Strengthen Relationships with CoCs to Improve Education and Outreach Efforts**

Through CARES' participation in local Continuum of Care (CoC) meetings, they were able to educate CoC members on how to ask incoming clients about their HIV/AIDS status and how to properly refer to CARES for services. The efforts focused on engaging homeless individuals into HIV care with the outcome of increasing ongoing access to healthcare and improvement in overall health outcomes. Through these interactions, CARES developed the AIDS Service Organization (ASO) Ambassador to Housing Project, which created a one-on-one relationship between ASOs and CoCs to encourage shelter staff to be comfortable appropriately asking a person's HIV/AIDS status at intake, recording accurately in the Homeless Management Information System (HMIS), and making proper housing and health care referrals.

### **Customize HMIS to Integrate Housing and Health Data**

CARES customized their HMIS to track client health (Viral Load and CD4 count), housing, employment, income, adherence to treatment, psychosocial stability, and housing stability. By tracking housing and health outcomes at the client, agency, and community level, CARES was able to increase coordination between housing and health systems. Measuring and tracking these quality of life measures allowed case managers to deliver a more proactive intervention and outreach model by improving the scope of data available when determining and reassessing service plans.

*“Through the IHHP project, housing was used as a platform for people living with HIV/AIDS to increase their quality of life, engage in vocational development, and maintain or increase access to care and health outcomes through becoming active, engaged members of their communities.”*

## OUTCOMES

The Foundations for Living Project provided housing assistance and supportive services to a total of 125 individuals living with HIV/AIDS. Of those 125 individuals, 50.4% were between the ages of 31-50 years old and 32.8% were 51 and older. A total of 60% were Male, 63.2% were Black, and 13.6% identified as Hispanic. All of the program beneficiaries were low-income, with 72.8% being 0-30% of the area median income (AMI), which means they were *extremely* low income. While the majority of the clients lived alone, a smaller percentage of clients (19.2%) had additional beneficiaries in the household. The majority of clients had consistent contact with a case manager (87.2%) and health care provider (95.2%), with 76.0% documented as receiving ART therapy for HIV. A total of 29.6% clients identified their prior living situation as “literally homeless” at program entry Table 1 below.

**Table 1. CARES Demographics & Additional Client Characteristics**  
n=125

Age		Race & Ethnicity		Additional Characteristics	
Younger than 18	0.8%	Black	63.2%	Consistent Contact with Case Manager	87.2%
18-30	16.0%	White	34.4%	Household included additional beneficiaries	19.2%
31-50	50.4%	Other/Multi	2.4%	Consistent Contact with Health Care Provider	95.2%
51 & older	32.8%	Hispanic/Latino	13.6%	Receiving ART therapy	76.0%
Gender		Household Income		Homelessness	
Female	39.2%	0-30% AMI	72.8%	Homeless Veteran	0.8%
Male	60.0%	31-50% AMI	24.0%	Chronically Homeless	1.6%
Transgender	0.8%	51-80% AMI	3.2%	Literally Homeless Prior to Enrollment	29.6%

CARES provided employment services in addition to HOPWA housing subsidy assistance. Ninety-four percent of clients were able to successfully access or maintain qualifications for sources of income throughout the program. Additionally, 47% of clients obtained an income-producing job during the program. Table 2A provides the health outcomes for clients receiving TBRA. Of those clients with clinical data reported, 45.9% saw improved CD4 counts, while 28.4% maintained CD4 counts during participation in the program. Individuals that saw a decrease in their Viral Load (VL) and those with VL values stabilized at or below 200 copies/ml denoting “viral suppression”, were considered to have positive or improved health outcomes (85.1%). If an individual saw their VL remain at the same (not suppressed) value (6.8%), they are considered to have maintained their previous level of health. Individuals that saw their VL increase (8.1%) were considered to have declined or negative health outcomes. Clients that did not have health data provided were excluded from the analysis and thus the denominator for the percentages in the chart below. Of those with health data collected, there is a high percentage with improved health outcomes associated with positive HOPWA performance measures and outcomes. See Table 2A and 2B below.

**Table 2A. Health Outcomes by Assistance Type**

HOPWA Service Provided	Health Improved	Health Maintained	Health Declined	Virally Suppressed	Undetectable Viral Load
TBRA (n=74)	85.1%	6.8%	8.1%	81.1%	62.2%

**Table 2B. Correlation between Health Outcomes & HOPWA Program and Accomplishment Measures**

HOPWA Measures	There is a Positive Relationship between these Measures and Improved Health Outcomes	Limitations of Analysis
Length of Time in Program	Positive relationship between length of time and improved VL	<i>There were (n=6) TBRA clients without entry and exit health data which is needed for this analysis. These 6 are excluded.</i>
Housing Stability Outcome	78.9% of those Stably Housed had improved VL	
Access to Care <sup>1</sup>	80.0% of those with high Access to Care had improved VL	
Obtained Income-Producing Job	78.6% of those that obtained employment had improved VL	

<sup>1</sup> A client’s Access to Care refers to various aspects having a Housing Plan, consistent contact with a Case Manager and Health Care Provider, and continued access to sources of income and insurance.