

# ENHANCING SYSTEM INTEGRATION TO IMPROVE HEALTH & HOUSING STABILITY OUTCOMES FOR LOW- INCOME PERSONS LIVING WITH HIV/AIDS

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Learning from the Successes & Challenges of the  
Integrated HIV/AIDS Housing Plan Grantees

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## INTRODUCTION

In September 2011, The U.S. Department of Housing and Urban Development (HUD) awarded nearly \$9 million in Housing Opportunities for Persons With AIDS (HOPWA) competitive grant funding to seven Integrated HIV/AIDS Housing Plan (IHHP) grantees in communities across the country. The IHHP grantees were funded to provide housing assistance and supportive services to low-income persons living with HIV/AIDS (PLWHA) and their families. In addition to providing housing and services to eligible HOPWA beneficiaries, the grantees received funding to improve the coordination of HIV housing and services in their communities and streamline access to other existing local services and resources for PLWHA through community-wide strategies.

The HOPWA IHHP initiative was developed in response to the National HIV/AIDS Strategy's call for enhanced collaboration at all levels to achieve its goals. The IHHP grantees worked to accomplish the goals of the National HIV/AIDS Strategy through improved community planning, resource utilization, and service integration, including actions to increase collaborative efforts with health care systems, Homeless Continuums of Care, affordable housing programs, employment programs, and other mainstream non-HOPWA resources. The seven projects were funded to become replicable models of improved coordination of housing and care for persons living with HIV/AIDS.

Each grantee submitted a final Integrated HIV/AIDS Housing Plan report at the end of their grant period. The reports detailed each grantee's successes and challenges in their coordination and integration efforts, and outlined the systems changes to the delivery of housing and services that occurred over the grant period.

The following report highlights the strategies and outcomes for six of the IHHP grantees:

1. The Corporation for AIDS Research, Education, and Services, Inc.
2. City of Dallas, Texas
3. Frannie Peabody Center
4. Justice Resource Institute
5. Portland Housing Bureau
6. River Region Human Services, Inc.

In addition to a final IHHP report, each grantee reported specific client outcomes, which accompany the grantee summaries and follow the data collection and analysis methodology outlined in Appendix A.

### HOPWA PROGRAM GOALS:

1. Increase housing stability
2. Reduce risk of homelessness
3. Increase access to care and support

### NATIONAL HIV/AIDS STRATEGY (NHAS) GOALS:

1. Reduce HIV infections
2. Increase access to care and improve health outcomes for PLWHA
3. Reduce HIV-related disparities
4. Achieve a more coordinated national response to the epidemic

## ***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.

## STRATEGIES

### *EX-OFFENDER HOUSING AND IHHP PLANNING PROJECT*

CITY OF DALLAS, TEXAS

#### Service Area

Dallas EMSA (8 counties)

#### Grant Term

1/1/2012-12/31/2016

#### Grant Funded HOPWA

#### Eligible Activities Include:

- Permanent Housing Placement
- Tenant-Based Rental Assistance
- Case Management
- Resource Identification

The City of Dallas was awarded \$1,287,500 to provide housing support to 60 ex-offenders over the grant period. The project also provided supportive services through the City of Dallas' Project Reconnect Program and the Department of Justice's Second Chance Act to support clients on the path to permanent housing and self-sufficiency.

#### **Increase Coordination through Centralized Housing Information and Resource Identification**

Through community planning groups and needs assessments, the City of Dallas understood that housing services for PLWHA in the community were fragmented, de-centralized, and hard to navigate. Moreover, there was a lack of current and up-to-date information about housing resources. PLWHA, case managers, and landlords needed a central place to seek assistance and a central point of contact. The City of Dallas created the HIV Housing Resource Center that includes a physical location where PLWHA can access a housing specialist for one-on-one assistance in finding appropriate housing options. The housing specialist acts as a liaison with case managers and housing providers for expedited, appropriate referrals. Moreover, the Center includes a resource website and database that provides an interactive online, searchable resource database with accurate and appropriate housing resources (HIV and non-HIV) that may be available to PLWHA. Through the Center, an additional 200 households were able to obtain stable housing outside of HOPWA assistance. Additionally, the housing staff built strong relationships with local housing providers, landlords, Ryan White providers, and other AIDS service organizations.

#### **Promote the Intersection of Housing and Health through Community-Wide Workshops**

Recognizing the need for cross training and education among AIDS service organizations and housing providers, the City of Dallas developed a learning curriculum designed to: 1) Increase awareness of HIV and Ryan White services among housing providers; 2) Increase awareness of housing resources among Ryan White providers; and 3) Increase the health focus for HOPWA case managers and the housing focus for Ryan White case managers. These workshops reached over 550 providers in Dallas, and in addition to providing education, the workshops offered an opportunity for dialogue and Q&A about the intersection of housing and health care.

#### **Improve Collaboration with the Homeless Continuum of Care (CoC) to Obtain Additional Resources for PLWHA**

The City of Dallas identified a lack of permanent supportive housing (PSH) units for PLWHA in the area. Leveraging the HIV Housing Resource Center, the City actively participated in the local CoC and built relationships with local shelters and homeless housing providers. Through this effort, the groundwork was set for future HOPWA participation in the local HMIS and in the CoC Coordinated Assessment System. Closely working with the CoC also opened the option of obtaining set-aside PSH units for PLWHA in Dallas.

*“The HIV Housing Resource Center is a worthwhile investment (with a relatively low cost)... Even though it does not provide housing directly, it can open up doors to existing resources that might never have been discovered or utilized by HIV+ persons, and it does help identify gaps in service quicker than a needs assessment.”*

## OUTCOMES

The City of Dallas' Ex-Offender Housing and IHHP Planning Project provided direct housing assistance and supportive services to a total of 51 individuals living with HIV/AIDS. Of those 51 individuals, 58.8% were between the ages of 31-50 years old and 35.3% were 51 and older. A total of 84.3% were Male and 78.4% were Black. All of the Ex-Offender Housing and IHHP Planning Project beneficiaries were low income, with 96.1% having an income that was at or below 30% of the area median income (AMI), which means they were *extremely* low income. While the majority of the clients lived alone, a small percentage of clients (9.8%) had additional beneficiaries in the household. The majority of clients had consistent contact with a case manager (90.2%) and health care provider (92.2%), with 76.5% documented as receiving ART therapy for HIV. A total of 29.4% clients identified their prior living situation as "literally homeless" at program entry, however, none of these individuals identified as also being a homeless veteran or chronically homeless. See Table 3 below.

Table 3. Ex-Offender Housing and IHHP Planning Project Demographics & Additional Client Characteristics					
n=51					
Age		Race & Ethnicity		Additional Characteristics	
Younger than 18	0.0%	Black	78.4%	Consistent Contact with Case Manager	90.2%
18-30	5.9%	White	17.6%	Household included additional beneficiaries	9.8%
31-50	58.8%	Other/Multi	3.9%	Consistent Contact with Health Care Provider	92.2%
51 & older	35.3%	Hispanic/Latino	0.0%	Receiving ART therapy	76.5%
Gender		Household Income		Homelessness	
Female	13.7%	0-30% AMI	96.1%	Homeless Veteran	0.0%
Male	84.3%	31-50% AMI	3.9%	Chronically Homeless	0.0%
Transgender	2.0%	51-80% AMI	0.0%	Literally Homeless Prior to Enrollment	29.4%

The City of Dallas' Ex-Offender Housing and IHHP Planning Project provided HOPWA-funded Tenant-Based Rental Assistance (TBRA). The City of Dallas encountered challenges in moving towards the implementation of HMIS and the development of a data bridge between housing and health information systems. Some HOPWA providers funded by the City of Dallas are also Ryan White-funded, and have access to the local Ryan White data system (ARIES) through their dual roles. For this reason, CD4 and Viral load data were only collected for a handful of clients (n=8). From this group, 75% achieved or maintained not only viral suppression but viral loads deemed "undetectable" (threshold = 20 copies/ml). Additionally, 100% of these clients reported perceived health levels at program exit as "Excellent" or "Very Good"; 50% of these individuals saw an improvement in their perceived health from entry to exit. Additionally, the chart below describes the correlation between health outcomes and HOPWA program and accomplishment measures for the clients retained in the analysis. See Table 4 below.

Table 4. Correlation between Health Outcomes & HOPWA Program and Accomplishment Measures		
HOPWA Measures	There is a Positive Relationship between these Measures and Improved Health Outcomes	<i>Limitations of Analysis</i>
Length of Time in Program	Positive relationship between length of time and improved VL	<i>The majority of the City's HOPWA providers did not have access to client health information. This chart reflects outcomes solely for the clients with reported health data (n=8).</i>
Housing Stability Outcome	100.0% of those Stably Housed also had improved VL	
Access to Care <sup>2</sup>	100.0% of those with high Access to Care also had improved VL	
Obtained Income-Producing Job	100.0% of those obtaining employment also had improved VL	

<sup>2</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)

## STRATEGIES

### MAINE INTEGRATED HIV/AIDS HOUSING PLAN

FRANNIE PEABODY  
CENTER (FPC)

#### Service Area

State of Maine

#### Grant Term

12/1/2011-11/30/2015

#### Grant Funded HOPWA

#### Eligible Activities Include:

- Permanent Housing Placement
- Tenant Based Rental Assistance
- Case Management
- Resource Identification

FPC was awarded \$930,909 to provide housing assistance and supportive services for PLWHA in Maine. As part of their coordination efforts, FPC coordinated with Public Housing Authorities and other housing providers across the state to expand linkages between housing providers and secure preferences for persons living with HIV/AIDS in subsidized housing programs.

#### **Strengthen Mainstream Housing Partnerships to Increase Affordable Housing Options for PLWHA**

One of the main goals of FPC's program was to strengthen partnerships with Public Housing Authorities (PHA) and other housing programs and providers across the state. FPC developed a partnership with a local YMCA dormitory program, allowing FPC to house numerous individuals in need of immediate transitional housing in their Single Room Occupancy (SRO) program. Through this partnership, clients' housing was stabilized while case managers worked with them to find other housing options, address barriers to housing stability (finances, substance abuse, mental health issues), and re-engage in HIV care and treatment. FPC's efforts to increase partnerships with other housing providers resulted in their housing team securing preferences for PLWHA in a Housing First project for medically sensitive individuals that was under development during the grant period.

#### **Expand Case Management Education to Improve Client-Level Housing Outcomes**

FPC noticed that many case managers would immediately refer PLWHA with housing needs to HOPWA, whether HOPWA was the most appropriate resource or not. To address this issue, FPC educated case managers at ASOs across the state about non-HOPWA housing resources such as Shelter Plus Care, Maine's General Assistance Program, Section 8 Housing Choice Vouchers, and other housing assistance programs, and provided them with the information and tools necessary to refer PLWHA to the most appropriate housing programs and services based on the needs of the household. Case managers began to see and understand that referrals to housing were not just about putting a roof over someone's head, but were about finding the right fit for a client based on the individual's choice and needs. FPC reported that education and outreach efforts changed the way case managers assessed household needs, viewed the presenting issues, and communicated with the HOPWA team.

#### **Improve Data Collection and Analysis to Streamline Service Delivery**

FPC focused on collecting the correct data in the appropriate method to target resources to improve household outcomes. FPC analyzed client data to identify a small group of chronically homeless clients that were requiring the most time and resources. FPC shifted caseloads so that one case manager took on the chronically homeless persons and those who constantly faced housing insecurity. Within several weeks, most of those households had secured non-HOPWA housing assistance and supportive services to keep them housed. Additionally, FPC identified gaps in client data regarding housing, finances, and criminal activity and created a housing screening tool. Through this screening tool, FPC assessed program eligibility, identified needed case management and supportive services, determined which housing programs clients should apply to, and identified key components of a client's HOPWA program exit strategy or transition plan. This tool streamlined the case management process and allowed front-line workers to begin planning for client self-sufficiency at intake.

*"The data we collected changed how we did business, an important shift in our way of thinking – one of the greatest successes of the IHHP grant."*

## OUTCOMES

Frannie Peabody Center’s project, the Maine Integrated HIV/AIDS Housing Plan, provided housing assistance and supportive services to a total of 116 individuals living with HIV/AIDS. Of those 116 individuals, 61.0% were between the ages of 31-50 years old and 32.1% were 51 and older. A total of 54.7% were Male, 47.8% were White, 45.9% were Black, and 3.1% identified as Hispanic. All of the Maine Integrated Housing Plan program participants were low income, with 70.2% of clients having incomes at or below 30% of the area median income (AMI), which means they were *extremely* low income. While the majority of the clients lived alone, 41.5% of clients had additional beneficiaries in the household. All the clients were reported as having consistent contact with a case manager (100.0%). A few of the beneficiaries identified as homeless veterans (0.6%), as chronically homeless (5.0%), or as literally homeless at the time of program entry (5.7%). See Table 5 below.

Table 5. Maine Integrated Housing Plan Demographics & Additional Client Characteristics					
n=116					
Age		Race & Ethnicity		Additional Characteristics	
Younger than 18	2.6%	Black	39.5%	Consistent Contact with Case Manager	100.0%
18-30	6.1%	White	52.6%	Household included additional beneficiaries	36.8%
31-50	56.2%	Other/Multi	7.9%	Consistent Contact with Health Care Provider	98.0%
51 & older	35.1%	Hispanic/Latino	3.5%	Stably Housed at HOPWA Program Exit (n=84)	87.0%
Gender		Household Income		Homelessness	
Female	39.5%	0-30% AMI	70.2%	Homeless Veteran	0.6%
Male	59.6%	31-50% AMI	20.2%	Chronically Homeless	5.0%
Transgender	0.9%	51-80% AMI	9.6%	Literally Homeless Prior to Enrollment	5.7%

The Maine Integrated Housing Plan provided Permanent Housing Placement (PHP); Short-Term Rent, Mortgage and Utility (STRMU) Assistance; Tenant-Based Rental Assistance (TBRA); and Employment Services. Table 6A shows the health outcomes for clients receiving TBRA. Approximately 79% of individuals saw their Viral Load (VL) decrease and/or maintain viral suppression, and were considered to have positive or improved health. 17.5% of individuals maintained their VL (not suppressed) value and were considered to have maintained their level of health. Approximately 4% of individuals saw an increase in their VL, denoting a decline in health. Of those with health data collected, there is a high percentage with improved health outcomes associated with positive HOPWA measures. See Table 6A and 6B below.

Table 6A. Health Outcomes by Assistance Type					
HOPWA Service Provided	Health Improved	Health Maintained	Health Declined	Virally Suppressed	Undetectable Viral Load
TBRA (n=103)	78.6%	17.5%	3.9%	74.8%	33.0%

Table 6B. 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 are 13 clients without entry and exit health data which is needed for this analysis.</i>
Housing Stability Outcome	80.3% of those Stably Housed had improved VL	
Access to Care <sup>3</sup>	78.6% of those with high Access to Care had improved VL	
Obtained Income-Producing Job	78.6% of those obtaining employment had improved VL	

<sup>3</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)

## JRI HEALTH YOUTH HOUSING INITIATIVE

JUSTICE RESOURCE INSTITUTE

### Service Area

Greater Boston, MA

### Grant Term

1/1/2012-12/31/2015

### Grant Funded HOPWA Eligible Activities Include:

- Tenant Based Rental Assistance
- Case Management
- Resource Identification

JRI was awarded \$1,223,377 to provide Tenant-Based Rental Assistance and supportive services to 20 homeless youth living with HIV in the Boston area. JRI partnered with two local project sponsors: the Metropolitan Boston Housing Partnership to provide housing support and the Boston Medical Center to coordinate supportive services.

## STRATEGIES

### Implemented a Client-Centered Approach to Build Rapport and Maintain Youth Engagement over Time

Working with runaway and homeless youth, JRI employed several strategies to create a comfortable, nonjudgmental space where youth could open up about difficult topics such as addiction, sex work, the dangers of living on the street, symptoms of emerging mental illness, and substance use issues. Through their case management process, JRI incorporated motivational interviewing to tap into clients' own source of motivation. Rather than offering standardized services, JRI tailored the program to meet each client's specific interests and priorities. By maintaining their engagement in the program, 75% of the youth clients reached viral suppression by the third year of the program.

### Strengthen Existing and Create New Partnerships for PLWHA Youth Self-Sufficiency

JRI worked closely with the Metropolitan Boston Housing Partnership (MBHP) to house each program participant. The project manager and a MBHP point person worked one-on-one to talk through any tenancy issues or concerns to prevent eviction. In spite of a tight rental market with increasing rents, 22 youth found and leased an apartment within Greater Boston. Once in housing, many stated they wanted to begin or continue working towards a college degree. JRI developed a partnership with a Bunker Hill Community College recruiter who had an interest in working with PLWHA youth and became invested in their success. The recruiter streamlined the application process for youth, acted as a mentor, and offered support on campus as a way to respond to clients' goals of attaining higher education. Three clients completed an associate degree and two began community college.

### Increase Collaboration to Address Disconnected Mental Health and Substance Abuse Treatment

In working with youth, JRI identified a major disconnect in mental health and substance abuse treatment for youth with emerging mental illness. Navigating these siloed systems was a major barrier to youth seeking treatment. To address this barrier, JRI staff accompanied clients to counseling sessions and accompanied service providers to the apartments of clients that were severely depressed and/or experiencing other mental health challenges. JRI also partnered with a Boston Medical Center psychologist that met clients at JRI offices for initial counseling sessions. JRI understood that traditional therapy does not always work for homeless youth who are highly mobile and living in chaos. JRI worked with a social worker at the Mt. Sinai Adolescent Clinic to advocate for opportunities for youth to meet with a clinician for a few minutes for focused sessions on problem-solving or crisis management. JRI also worked with clinicians to use texting and cell phones to follow up with clients who were often on the move and relied on the tools of technology to stay connected.

*"Through efforts to address mental health and substance abuse issues, many clients achieved stable housing and worked towards greater self-sufficiency through employment and higher education."*

## OUTCOMES

The Justice Resource Institute’s Health Youth Housing Initiative provided housing assistance and supportive services to a total of 22 individuals living with HIV/AIDS. Of those 22 individuals, 100.0% were between the ages of 18-30 years old. A total of 68.2% were Male, 59.1% were Black, and 40.9% identified as Hispanic. All of the JRI Health Youth Housing Initiative participants were low income, with 100.0% of client incomes at or below 30% of the area median income (AMI), which means they were *extremely* low income. While the majority of the clients lived alone, 40.9% had additional beneficiaries in the household. The majority of clients had consistent contact with a case manager (90.9%) and a health care provider (81.8%), with 81.8% documented as receiving ART therapy for HIV. None of the beneficiaries identified as homeless veterans or as chronically homeless; however, 22.7% reported they were literally homeless at program entry. See Table 7 below.

Table 7. JRI Health Youth Housing Initiative Demographics & Additional Client Characteristics					
n=22					
Age		Race & Ethnicity		Additional Characteristics	
Younger than 18	0.0%	Black	59.1%	Consistent Contact with Case Manager	90.9%
18-30	100.0%	White	22.7%	Household included additional beneficiaries	40.9%
31-50	0.0%	Other/Multi	18.2%	Consistent Contact with Health Care Provider	81.8%
51 & older	0.0%	Hispanic/Latino	40.9%	Receiving ART therapy	81.8%
Gender		Household Income		Homelessness	
Female	18.2%	0-30% AMI	100.0%	Homeless Veteran	0.0%
Male	68.2%	31-50% AMI	0.0%	Chronically Homeless	0.0%
Transgender	13.6%	51-80% AMI	0.0%	Literally Homeless Prior to Enrollment	22.7%

The Justice Resource Institute’s Health Youth Housing Initiative provided Tenant-Based Rental Assistance (TBRA) to program clients. Table 8A shows the health outcomes for clients receiving TBRA. Of those clients with CD4 counts reported, 68.4% saw improvement in CD4 counts during participation in the program. Approximately 95% of clients saw their Viral Load (VL) decrease and/or maintain viral suppression, and were considered to have positive or improved health outcomes. Approximately 5% of individuals saw their VL increase during the time they were in the program and are considered to have negative or declined health outcomes. All 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 measures. See Table 8A and 8B below.

Table 8A. Health Outcomes by Assistance Type					
HOPWA Service Provided	Health Improved	Health Maintained	Health Declined	Virally Suppressed	Undetectable Viral Load
TBRA (n=19)	94.7%	0.0%	5.3%	89.5%	73.7%

Table 8B. 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 Health Outcomes Analysis
Length of Time in Program	Positive relationship between length of time and improved VL	3 clients excluded: no health data at exit (n=2); death (n=1)
Housing Stability Outcome	94.1% of those Stably Housed had improved VL	
Access to Care <sup>4</sup>	79.3% of those with high Access to Care had improved VL	
Obtained Income-Producing Job	92.3% of those obtaining employment had improved VL	

<sup>4</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)

## STRATEGIES

### *SPRINGBOARD TO STABILITY, SELF- SUFFICIENCY AND HEALTH PROGRAM (S4H)*

PORTLAND HOUSING  
BUREAU (PHB)

#### Service Area

Portland, OR Metro Area

#### Grant Term

1/1/2012-12/31/2015

#### Grant Funded HOPWA Eligible Activities Include:

- Permanent Housing Placement
- Short-Term Rental Assistance
- Supportive Services
- Resource Identification

Portland Housing Bureau (PHB) was awarded \$1,365,900 to serve people living with HIV/AIDS who are homeless or at risk of being homeless in Portland, OR. PHB utilized the HOPWA “Other” line item to combine emergency and short-term housing assistance into one pooled fund to provide a continuum of eviction prevention, rapid re-housing and housing retention services.

#### **Increase Client Self-Sufficiency Through the use of HOPWA Funding to Expand a Locally-funded Flexible Short- and Medium-term Rental Assistance Program**

The Portland Housing Bureau (PHB) partnered with Cascade AIDS Project (CAP), the Portland Metro Area’s leading HIV housing, services and prevention agency, and Home Forward (the local housing authority) to use IHHP grant funding to expand a locally-funded, flexible short- and medium-term rental assistance program for homelessness prevention and rapid rehousing. The expansion demonstrated the effectiveness of HOPWA as a rapid rehousing tool for people experiencing homelessness, especially when coupled with assertive case management services focused on employment and self-sufficiency. Beyond the IHHP grant award period, CAP continues to access locally-funded rapid rehousing and homelessness prevention programs through Home Forward’s Short-Term Rent Assistance program and is committed to this housing model based on proven client success.

#### **Expand and Integrate Employment Services**

CAP employs an HIV employment specialist through its Working Choices program. WorkSystems, Inc. (the local Workforce Investment Board) hired a “boundary spanner” to help overcome access barriers and guide the success of PLWHA jobseekers. The “boundary spanner” was charged with assisting system integration of housing and employment activities. Rent assistance and supportive case management were used to help people achieve the stability necessary for successful employment by reducing barriers to accessing and maintaining stable housing. Clients involved in the Working Choices program, and those who indicated they were interested and able to work, were prioritized for rent assistance. By the third year of the grant, Working Choices had nearly doubled both its participation and its success rate: 125 participants with a 35% education and employment placement rate. The expanded expertise and access to mainstream resources achieved through S4H’s partnership between CAP and WorkSystems, Inc. was crucial to client success.

#### **Improve Linkage between Housing and Primary Care Services to Enhance Client-, Program-, and Community-level Outcomes**

Collaboration increased beyond the already solid partnership with the Ryan White Part A grantee, particularly regarding cross-system planning. Coordination efforts with the Multnomah County HIV Health Services Center included the successful joint application and granting of a five-year HRSA Special Projects of National Significance award to implement a “medical home” model of integrated behavioral health, physical health, case management and such ancillary services as housing support for PLWHA.

*“Those partnerships have increased staff-level collaboration to improve housing stability and engagement in primary and behavioral health care, have informed cross-system needs assessment and planning, and are working toward better data systems integration for care coordination and program evaluation.”*

## OUTCOMES

Portland Housing Bureau’s S4H Program provided housing assistance and supportive services to a total of 356 individuals living with HIV/AIDS. Of those 356 individuals, 61.5% were between the ages of 31-50 years old, and 29.8% were over the age of 50. A total of 88.2% were Male, 73.3% were White, and 17.7% identified as Hispanic. All of the S4H participants were low income, with 80.6% of client incomes at or below 30% of the area median income (AMI), which means they were *extremely* low income. While the majority of the clients lived alone, a small percentage (7.3%) had additional beneficiaries in the household. Two-thirds of clients had consistent contact with a case manager (66.0%) and health care provider (66.6%). A few of the beneficiaries identified as homeless veterans (1.7%), chronically homeless (13.2%), or as literally homeless at time of program entry (6.5%). See Table 9 below.

**Table 9. Portland Housing Bureau Demographics & Additional Client Characteristics  
n=356**

Age		Race & Ethnicity		Additional Characteristics	
Younger than 18	0.0%	Black	13.2%	Consistent Contact with Case Manager	66.0%
18-30	8.7%	White	73.3%	Household included additional beneficiaries	7.3%
31-50	61.5%	Other/Multi	13.5%	Consistent Contact with Health Care Provider	66.6%
51 & older	29.8%	Hispanic/Latino	17.7%		
Gender		Household Income		Homelessness	
Female	9.8%	0-30% AMI	80.6%	Homeless Veteran	1.7%
Male	88.2%	31-50% AMI	13.5%	Chronically Homeless	13.2%
Transgender	2.0%	51-80% AMI	5.9%	Literally Homeless Prior to Enrollment	6.5%

Portland Housing Bureau utilized the “Other” line item to innovatively provide modified forms of Short-term Rent, Mortgage, and Utility Assistance (STRMU), Tenant-Based Rental Assistance, and Employment Services. Table 10A shows the health outcomes for clients receiving these services. Of those clients with CD4 counts reported, 39.4% saw improvement and 39.8% saw maintained CD4 counts during participation in the program. If an individual saw their Viral Load (VL) decrease and/or maintain viral suppression (79.0%), they are considered to have improved health. If an individual saw their VL remain the same (not suppressed) (11.7%), they are considered to have maintained their health. If an individual saw their VL increase (9.3%), they are considered to have declined health. All 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 under each service type and associated with positive HOPWA measures. See Table 10A and 10B below.

**Table 10A. Health Outcomes by Assistance Type**

HOPWA Service Provided	Health Improved	Health Maintained	Health Declined	Virally Suppressed	Undetectable Viral Load
STRMU/Rental Assistance Program (n=84)	72.6%	15.5%	11.9%	71.4%	57.1%
Employment Services (n=130)	83.1%	9.2%	7.7%	79.2%	60.8%
<b>Total (n=214)</b>	<b>79.0%</b>	<b>11.7%</b>	<b>9.3%</b>	<b>76.2%</b>	<b>59.3%</b>

**Table 10B. 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	A total of 142 clients did not have entry and exit health data reported which is needed for this analysis.
Housing Stability Outcome	72.6% of those Stably Housed had improved VL	
Access to Care <sup>5</sup>	76.8% of those with high Access to Care had improved VL	
Obtained Income-Producing Job	80.3% of those obtaining employment had improved VL	

<sup>5</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)

***FORGING USEFUL  
SYSTEMS TO EMPOWER  
(FUSE) PROJECT***

RIVER REGION HUMAN  
SERVICES, INC.

**Service Area**

Jacksonville, FL, Duval  
County

**Grant Term**

11/1/2011-10/31/2015

**Grant Funded HOPWA  
Eligible Activities Include:**

- Tenant Based Rental Assistance
- Supportive Services
- Resource Identification

RRHS was awarded \$1,353,743 to provide tenant based rental assistance and coordinated linkages to comprehensive supportive services for 40 households headed by homeless persons living with HIV/AIDS in the Jacksonville, FL, metropolitan area. The project provided housing assistance and service coordination through a partnership with Ability Housing of Northeast Florida, Inc.

## STRATEGIES

### **Increase Involvement with the local Homeless Continuum of Care (CoC) to Improve Understanding of the Needs of PLWHA**

RRHS participated in the 100 Homes project (known nationally as 100,000 Homes) to house the 100 most medically vulnerable homeless persons in Jacksonville. This project provided an opportunity to directly work with the local CoC and strengthen the relationship. Leveraging the 100 Homes project, RRHS partnered with other homeless and housing service providers to pilot the Northeast Florida CoC Coordinated Intake process. In conjunction with the development of the CoC Coordinated Intake and Assessment process and oversight committee, RRHS engaged in the establishment of a CoC Planning Board, on which RRHS now serves and co-chairs. Strengthening this relationship with the CoC and being involved in the Coordinated Intake process was critical to ensure that PLWHA were considered in its development and implementation.

### **Improve Service Delivery and Coordination by Constructing a Databridge between CAREWare and HMIS**

PLWHA may have more than one case manager, including a medical case manager, housing case manager, service coordinators, and peer navigators. Medical case managers as well as other Ryan White service providers are required to enter client characteristics, service and health data into CAREWare, while housing case managers and service coordinators as well as other homeless service providers are required to enter client characteristics, housing and homeless service data into HMIS. RRHS saw an opportunity for data system integration to streamline data entry and thereby streamline service delivery and case planning. The Database Managers for CAREWare and HMIS collaborated with the staff of the HMIS software provider (ClientTrack) to build a databridge that enabled more than 50 fields of client-level data in CAREWare to be accessed, processed and managed in the HMIS.

### **Enhance Coordination and Integration of Housing and Primary and Behavioral Health Services**

RRHS saw that many of their clients needed not only primary health services, but behavioral health services. To improve that connection, RRHS developed an integrated case management system that assessed and linked clients to primary and behavioral health services. Additionally, RRHS partnered with Ability Housing of Northeast Florida and University of Florida Center for HIV/AIDS Research, Education and Service on a successful joint application for a five-year HRSA Special Projects of National Significance grant to implement a “medical home” model of integrated behavioral health, physical health, case management and such ancillary services as housing support for PLWHA. The coordination and integration of housing and services occurred on a planning level, as well as within and between service coordinators and peer specialists/navigators in each of the programs.

*“Active participation, collaboration and building of partnerships among healthcare, housing, homeless service providers contributed substantially to FUSE successes in its service coordination and integration efforts.”*

## OUTCOMES

River Region Human Services' FUSE Project provided housing assistance and supportive services to a total of 50 individuals living with HIV/AIDS. Of those 50 individuals, 60.0% were between the ages of 31-50 years old, and 34.0% were between the ages of 18-30 years old. All were Female, 84.0% were Black, and 2.0% identified as Hispanic. All of the FUSE Project participants were low income, with 82.0% having incomes at or below 30% of the area median income (AMI), which means they were *extremely* low income. While some clients lived alone, the majority of clients (80.0%) had additional beneficiaries in the household. All clients were reported as having consistent contact with a case manager (100.0%) and health care provider (100.0%), with 84.0% documented as receiving ART therapy for HIV. A total of 72% of clients stated being "literally homeless" at the time of program entry, with 2.0% identifying as chronically homeless. See Table 11 below.

Table 11. FUSE Project Demographics & Additional Client Characteristics					
n=50					
Age		Race & Ethnicity		Additional Characteristics	
Younger than 18	0.0%	Black	84.0%	Consistent Contact with Case Manager	100.0%
18-30	34.0%	White	12.0%	Household included additional beneficiaries	80.0%
31-50	60.0%	Other/Multi	4.0%	Consistent Contact with Health Care Provider	100.0%
51 & older	6.0%	Hispanic/Latino	2.0%	Receiving ART therapy	84.0%
Gender		Household Income		Homelessness	
Female	100.0%	0-30% AMI	82.0%	Homeless Veteran	0.0%
Male	0.0%	31-50% AMI	18.0%	Chronically Homeless	2.0%
Transgender	0.0%	51-80% AMI	0.0%	Literally Homeless Prior to Enrollment	72.0%

The River Region Human Services, Inc. FUSE project provided Tenant-Based Rental Assistance (TBRA). Table 12 provides information on Viral Load at program entry across the 50 clients. Of those clients with CD4 counts reported, 52% saw improved or maintained CD4 counts during participation in the program. If an individual saw their Viral Load (VL) decrease and/or maintain viral suppression (71.4%), they are considered to have improved health. If an individual saw their VL remain the same (not suppressed) (4.8%), they are considered to have maintained their health. If an individual saw their VL increase (23.8%), they are considered to have declined health. All 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 under each service type and associated with positive HOPWA measures. See Table 12A and 12B below.

Table 12A. Health Outcomes by Assistance Type					
HOPWA Service Provided	Health Improved	Health Maintained	Health Declined	Virally Suppressed	Undetectable Viral Load
TBRA (n=21)	71.4%	4.8%	23.8%	61.9%	52.4%

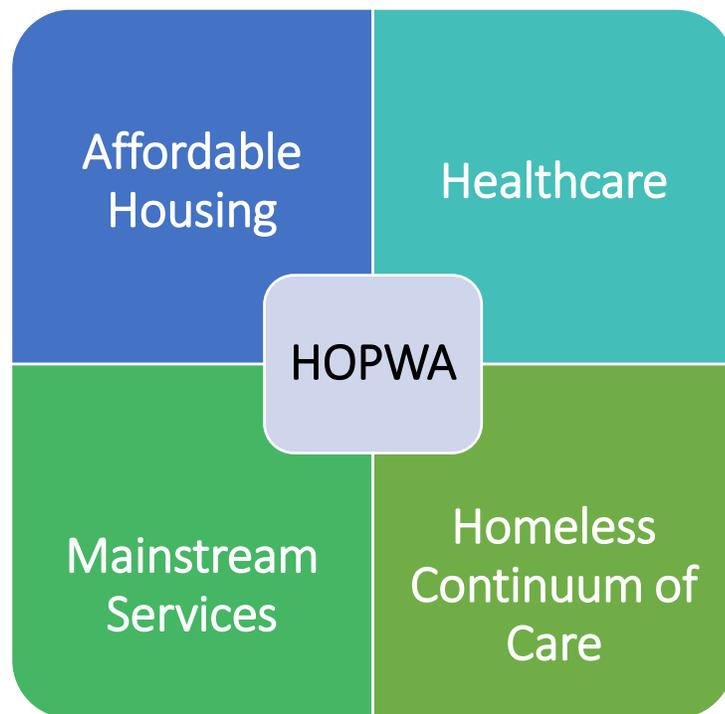
  

Table 12B. Correlation between Health Outcomes & HOPWA Program and Accomplishment Measures		
HOPWA Measures	There is a Positive Relationship between these Measures and Improved Health Outcomes	Limitations of Health Outcomes Analysis
Length of Time in Program	Positive relationship between length of time and improved VL	29 clients excluded due to no health data at exit
Housing Stability Outcome	63% of those Stably Housed had improved VL	
Access to Care <sup>6</sup>	71% of those with high Access to Care had improved VL	
Obtained Income-Producing Job	70% of those obtaining employment had improved VL	

<sup>6</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)

## Breaking Down Silos

As illustrated by each of the case studies, the IHHP grantees not only provided housing assistance and supportive services, but engaged in comprehensive planning to make community-wide system changes to service delivery for low-income PLWHA and their families. To improve access to care, engagement in care, and health outcomes among PLWHA, grantees actively increased coordination with their local healthcare systems. Through efforts to integrate with local Homeless Continuums of Care (CoC), the grantees worked to increase the identification of homeless PLWHA and increase their linkage to and engagement in care. To address the lack of available housing units for PLWHA, grantees strengthened their relationships with mainstream housing providers through coordination and education efforts. Lastly, IHHP grantees targeted partnerships with mainstream resource providers to increase PLWHA self-sufficiency. Below is a summary of how grantees made these connections to better address the needs of PLWHA and improve the systems of care in their communities.



### Increasing Self-Sufficiency through Mainstream Services

All of the IHHP projects focused on increasing client self-sufficiency through employment and education. Portland Housing Bureau found that employment services were essential to the success of their S4H program. Portland Housing Bureau found that as the affordable housing market tightens and federal funding requires more participant documentation, housing case managers need to focus on engaging their clients and understanding available housing options. They are not able to take on the additional role of job coach or employment expert. Portland's S4H Program was a success in part because clients had access to the devoted staff time and employment services of Cascade AIDS Project's Working Choices program.

The Corporation for AIDS Research, Education, and Services, Inc.'s (CARES) IHHP project originally had a focus on job-placement for clients ready, willing and able to work. The focus changed to job readiness and benefits counseling for clients considering work when they found that many clients feared that they would lose their benefits if they worked, including their housing. To address this fear, CARES conducted workshops for PLWHA and case managers on benefits counseling and job readiness activities – emphasizing the point that one can work, continue to receive benefits, and be financially better off.

While working with youth, Justice Resource Institute in Boston, MA, found great success in developing a working partnership with a local community college. As attaining higher education was a top stated goal of the

*“29% of the participants had their housing subsidy decrease. This decrease is one of the most significant outcomes in regards to housing because it demonstrates that PLWHA who are encouraged to consider pursuing employment and successfully engage in employment/vocational services are more likely to reduce their reliance on continued housing assistance which will serve to not only improve the quality of life — who are experiencing longer, and healthier lives due to advancements in medical care—but to also retain essential funding which has been systemically decreasing for those PLWHA who are in the most need.” - CARES*

youth, JRI nurtured a relationship with the local community college to streamline the application process, assist in completing the Free Application for Federal Student Aid (FAFSA) and identify a point-person/mentor on campus that could provide support and guidance.

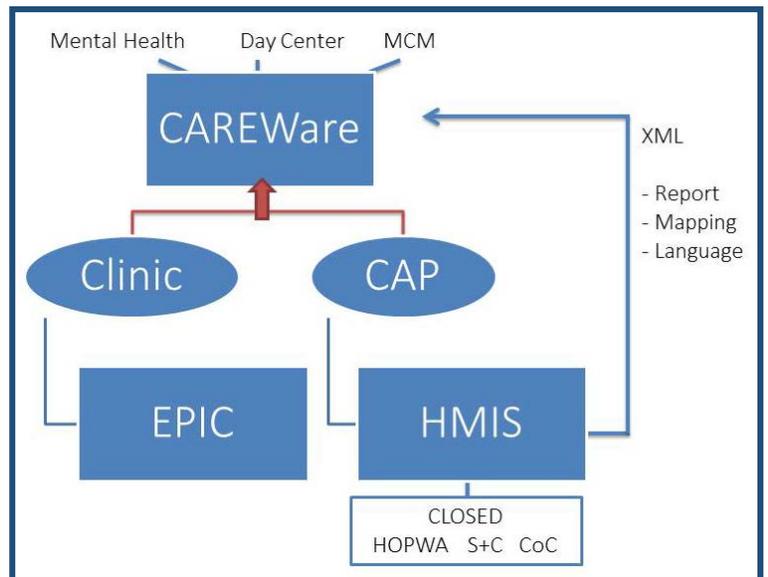
Meeting the clients where they were in their employment, education, and income goals was the overall strategy for all the IHHP projects as they worked to increase self-sufficiency. HUD, in partnership with the U.S. Department of Labor (DOL), launched *Getting to Work: A Training Curriculum for HIV/AIDS Service Providers and Housing Providers*. *Getting to Work* provides an overview of the reasons why employment services for PLWHA are essential, describes successful approaches to incorporating employment into HIV/AIDS service provision, and highlights promising programs. The training curriculum is available online at: <https://www.hudexchange.info/training-events/dol-hud-getting-to-work-curriculum-for-hiv-aids-providers/>

### Increasing Coordination and Collaboration through Data Collection and Integration

The IHHP grantees were expected to participate in client-level information systems [i.e. Homeless Management Information System (HMIS), CAREWare, or equivalent system]. HMIS is a locally administered, electronic data collection system that stores client-level information about persons who access the homeless service system. While HMIS is HUD's local homeless client-level information technology system, many Ryan White-funded agencies use CAREWare, which is an electronic data collection system for managing and monitoring HIV clinical and supportive care. As many HOPWA providers receive HUD and Ryan White funding, they often use one or both of these systems to track their services and outcomes on a client-level. HMIS and CAREWare were integral tools in planning and reporting on the activities funded under the IHHP grants. Grantees were expected to assess the needs of persons and families living with HIV/AIDS who were homeless or unstably housed, track the housing and service patterns of program beneficiaries, and report results on households served. The IHHP grantees represented a range of system usage before they received the grant funding, from utilizing Excel spreadsheets for data collection to acting as the system administrator of a local HMIS.

As discussed in their case study, CARES focused on customizing their HMIS to integrate housing and health data, while River Region Human Services, Inc. developed a databridge between CAREWare and HMIS. Below is a description of Portland Housing Bureau's process of developing and implementing a databridge as part of their IHHP grant activities.

There are 10 Ryan White Part A providers in Portland, OR, and all are required to enter data into CAREWare. Eight of the providers input their data into CAREWare directly, while two import their data into the system. One of those two providers is a clinic that enters into EPIC, a medical records database, and the other is Cascade AIDS Project (CAP), Portland Housing Bureau's project sponsor under the IHHP grant. Before their data integration efforts, CAP entered data into HMIS and once a month created an export file that was sent to County staff to import into CAREWare.



The IHHP grant provided CAP with an opportunity to impact their data system and work to avoid double entry of data on over 1,200 clients through the creation of a databridge between HMIS and CAREWare. CAP determined the most cost effective process would be to develop a way to have client information in CAREWare rather than HMIS, because all of the other Ryan White Part A providers entered directly or imported into CAREWare, rather than HMIS.

To get CAP's HMIS system ready to directly import into CAREWare, CAP had to:

- Do extensive data mapping for HMIS to CAREWare, particularly housing status and income;
- Update intake, assessment, and exit forms to ensure they were collecting all the correct information;
- Customize HMIS to import into CAREWare; and

- Create policies and procedures to determine how to handle data discrepancies.

With the goal to share client data with all 10 Ryan White Part A providers, CAP was still working to implement the databridge at the end of grant period. Contract amendments were being processed that will allow data sharing to be completely functional. Once completed, providers will be able to see any client that has received Ryan White services, including their demographics, medical visit information, and a shared eligibility system in CAREWare. Documents will be uploaded into the system so that clients do not have to go through the eligibility process multiple times. Not only will this streamline service delivery and allow for greater coordination among providers, CAP hopes that the complete data collection will provide a holistic picture of their community. The shared data will point to service priorities, including how to increase engagement in care, as well as how people access providers (e.g. which clinics people are visiting after diagnosis).

As other communities consider implementing a databridge in their systems of care, CAP offers these recommendations:

- Organizations will need the right IT people from the start. This is not a job for case managers.
- Strong working relationships between Ryan White and HOPWA networks are essential. Additionally, these partners need to have a clear understanding of their responsibilities. CAP says that once you start sharing data, you might lose who it belongs to.
- Since this is sensitive data, there will be several legal issues to consider when developing and implementing a databridge. Each provider will need individual legal advice and data sharing agreements in place.
- This process takes time and resources. Be prepared to make an investment. While CAP coordinated, developed, and is working to implement the databridge “in house”, they greatly recommend, if communities have the resources, to hire an outside consultant to manage this process.

*How can you convince your partners to build a databridge in your community?* CAP suggests the following:

- There will be cost savings through the reduction and elimination of double entry.
- Communities will see greater client engagement through a streamlined and efficient intake process.
- Silos will break down on all levels – data sharing creates a conversation between housing and health case managers and improves service coordination; it builds collaboration among existing and new partners; and it helps create policy and change the epidemic within your community.

## Conclusion

As the HIV epidemic changes with advancements in medical treatment, communities face reductions in funding, and the need for housing assistance and supportive services continues to grow, ASOs must coordinate and collaborate with the affordable housing, healthcare, and mainstream resources systems to expand housing options and improve service delivery for PLWHA. As communities work to improve their systems of care and service delivery, cross-systems planning should be at the center of local efforts to improve housing stability and health outcomes for low-income PLWHA.

## APPENDIX A: METHODOLOGY

### Housing & Demographic Data

Each of the IHHP grantees provided HOPWA housing assistance to low-income persons living with HIV/AIDS and their families. These practices follow the standard of care and were not modified based on the evaluation research component of this project. Under the HOPWA competitive program, grantees are required to submit Annual Progress Reports (APR form HUD-40110-C) to HUD at the end of each program year. The reports provide information on program evaluation and the ability to measure program beneficiary outcomes related to: maintaining housing stability; preventing homelessness; and improving access to care and support. Additionally, demographic information is also collected with this information. The housing and demographic data reported through the standard HOPWA APR provided the basis for the housing measures used in the national analysis. Additional measures capturing data on the service timeframe were also used for analysis, including: entry/exit dates, number of moves during assistance period, and total length of time the client had been in permanent or transitional housing at exit. Grantees used their local client-level data collection systems to report these additional measures.

### Health Data

One of the primary reasons housing is considered an important intervention in improving the lives of individuals living with HIV/AIDS is based on the fact that stable housing has been proven to positively impact health outcomes. On a national level, the IHHP demonstration project has been evaluated to determine if health outcomes improved as housing assistance was provided to clients. Clinical HIV health measures (Viral Load and CD4 Count) and perceived health data were collected, where possible, for analysis. Additionally, grantees tracked the number of clients that were receiving antiretroviral (ART) therapy for HIV treatment. The grantees worked under the appropriate mechanisms in their local provider system to collect and store the required Release of Information documentation necessary to report health and housing measures for national analysis.

### Data Collection

In addition to the HUD-required HOPWA APR reporting form, the IHHP grantees completed the IHHP Client-Level Data Collection Tool in MS Excel format. The data reported through the APR is aggregated and does not allow for inter-variable trend analysis. The Tool allowed evaluators to assess demographics, housing assistance type, HOPWA accomplishment measures, and the level of access to care on a client-level basis. In addition to the client-level APR data, the Tool also collected the requested health measures and allowed for cross-tabulation analysis. Some data elements were collected at a single time point (e.g., Race and Ethnicity), while others were collected at or close to entry and exit from the program (e.g., tracking CD4 Count and Viral Load over time to determine if there was a relationship between housing support and health for the clients involved in the program). Dates associated with the beginning and end of the housing assistance serve as time point markers in the data.

### Data Protection

The data collection protocol and IHHP Client-Level Data Collection Tool were included in program documentation submitted to the Western Institutional Review Board (WIRB) and classified as exempt from the more formal IRB review. Efforts were made to ensure that none of the clients' Protected Health Information (PHI) was requested on the Tool for national evaluation review and analysis.

These efforts included:

- Developing a methodology for creating randomized unique identifiers for each client to be used exclusively (excluding any request for names, DOB, contact information or any other identifying information);
- Using the terms "Before" and "After" to replace the exact clinic visit / lab dates (note: these dates are considered PHI) to determine when the clinical measures were taken in relation to the Entry and Exit dates for the housing program;
- Providing client-level data from providers to the national evaluation team only, grantees did not have access to client-level data from other sites; and
- Reporting all findings to funders and the public in aggregate on a grantee or national levels.

Throughout the grant term, the housing providers submitted the client-level data to the national evaluation team at Collaborative Solutions, Inc. for review and analysis. The unique encryption and password-protection of each Client-Level Data Collection Tool was established prior to any electronic transmission of the data. The file password information was

provided in a separate correspondence - either by phone or email. The national evaluation team stored client-level data on a USB flash drive that is stored under a double-lock system (locked office door & locked file cabinet).

### **Data Analysis and Reporting**

The national evaluation team collected the client-level data from the grantees for analysis and review. The analysis was conducted primarily using SPSS and MS Excel and was intended to describe key variables, as well as explore the relationships between changes in health over time with the introduction of the housing assistance intervention. This analysis did not employ a control group to establish 'causation' between variables or levels of statistical significance, but did assess correlation among data elements. Additional analysis compared subsets of the client group across various demographic characteristics and program outcomes.

- ***Analysis on Demographic and Additional Client Characteristics Data:*** Univariate descriptive analysis was conducted on Age, Gender, Race, Ethnicity, Income, Additional Characteristics, and Homelessness to assess frequencies and percentages.
- ***Analysis on Clinical Measures and Determining 'Levels of Health':*** If an individual saw their Viral Load (VL) decrease and or maintain viral suppression, they are considered to have improved health. If an individual saw their VL remain the same (not suppressed), they are considered to have maintained their health. If an individual saw their VL increase, they are considered to have declined health. Measuring change in health using CD4 Counts is described as improved (increase in CD4 Count), maintained (no change in CD4 Count), or declined (decrease in CD4 Count).
- ***Bivariate Analysis Describing Housing and Health Relationship:*** Bivariate analysis was conducted using cross-tabulation and correlation analysis methods to determine the relationship between HOPWA Assistance Type, Length in Program, Housing Stability Outcomes, Access to Care, and Employment with clinical health measures (CD4 and Viral Load).

## APPENDIX B: GLOSSARY

**Access to Care Measures:** In this report includes tracking the extent to which households utilize the supportive services that are part of the Integrated HIV/AIDS Housing Plan.

**Acquired Immunodeficiency Syndrome (AIDS):** The final stage of HIV. Individuals are considered to progress to AIDS if they have one or more specific opportunistic infections, certain cancers, or a very low number of CD4 cells.

**AIDS Service Organization (ASO):** Community based organizations that provide support for people with HIV and AIDS. They can provide a range of services that include housing assistance, medical care, and supportive services. While their primary function is to provide the needed services to individuals with HIV, they also provide support services for their families and friends and conduct HIV prevention efforts.

**Beneficiary(ies):** All members of a household who received HOPWA assistance during the operating year including the one individual who qualified the household for HOPWA assistance as well as any other members of the household (with or without HIV) who benefitted from the assistance.

**CAREWare:** A Ryan White Management Information System (MIS) for managing and monitoring HIV clinical and supportive care.

**CD4 Cells:** Also known as T-cells, a type of white blood cell that plays a major role in protecting your body from infection.

**CD4 Count:** A lab test that measures the number of CD4 cells in a sample of your blood. The higher the CD4 count, the better the body is able to fight HIV and other infections.

**Chronically Homeless Person:** An individual or family who: (i) Is homeless and lives or resides in a place not meant for human habitation, a safe haven, or in an emergency shelter; (ii) has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least 1 year or on at least 4 separate occasions in the last 3 years; and (iii) has an adult head of household (or a minor head of household if no adult is present in the household) with a diagnosable substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002)), post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability, including the co-occurrence of 2 or more of those conditions. Additionally, the statutory definition includes as chronically homeless a person who currently lives or resides in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital or other similar facility, and has resided there for fewer than 90 days if such person met the other criteria for homeless prior to entering that facility (See 42 U.S.C. 11360(2)). This does not include doubled-up or overcrowding situations.

**The Continuum of Care Program (CoC):** HUD program 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.

**CoC Coordinated Assessment System:** A system to make rapid, effective, and consistent client-to-housing and service matches—regardless of a client’s location within a CoC’s geographic area—by standardizing the access and assessment process and by coordinating referrals across the CoC.

**Collaboration:** In this report involves a mutually beneficial and well-defined relationship between two or more programs, organizations, or organizational units to achieve common goals.

**U.S. Department of Housing and Urban Development (HUD):** An executive branch of the federal government with a mission to create strong, sustainable, inclusive communities and quality affordable homes for all.

**HIV Health Measures:** Data measures that include but are not limited to HIV Viral Load Suppression, Prescription of HIV Antiretroviral Therapy, HIV Medical Visit Frequency, and Gap in HIV Medical Visits.

**HOPWA Eligible Individual:** The one (1) low-income person with HIV/AIDS who qualifies a household for HOPWA assistance. This person may be considered “Head of Household.” When the CAPER asks for information on eligible

individuals, report on this individual person only. Where there is more than one person with HIV/AIDS in the household, the additional PWH/A(s), would be considered a beneficiary(s).

**HOPWA Housing Information Services:** Services dedicated to helping persons living with HIV/AIDS and their families to identify, locate, and acquire housing. This may also include fair housing counseling for eligible persons who may encounter discrimination based on race, color, religion, sex, age, national origin, familial status, or handicap/disability. .

**HOPWA Housing Subsidy Assistance Total:** The unduplicated number of households receiving housing subsidies and/or residing in units of facilities dedicated to persons living with HIV/AIDS and their families and supported with HOPWA funds during the operating year.

**Household:** A single individual or a family composed of two or more persons for which household incomes are used to determine eligibility and for calculation of the resident rent payment. The term is used for collecting data on changes in income, changes in access to services, receipt of housing information services, and outcomes on achieving housing stability.

**Housing Stability:** The degree to which the HOPWA project assisted beneficiaries to remain in stable housing during the operating year.

**Homeless Management Information System (HMIS):** A local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness.

**Housing Assistance:** In this report includes but is not limited to: tenant-based rental assistance; facility-based permanent housing; transitional housing; short term/emergency assistance with rent and utility expenses; permanent housing placement assistance; and housing information and referral services. For information regarding the types of housing assistance provided under HOPWA, please visit <https://www.hudexchange.info/programs/hopwa/>.

**Housing Choice Vouchers (Section 8):** A voucher program to assist very low-income families, the elderly, and the disabled to afford decent, safe, and sanitary housing in the private market. The participant is free to choose any housing that meets the requirements of the program and is not limited to units located in subsidized housing projects. A housing subsidy is paid to the landlord directly by the PHA on behalf of the participating family.

**Housing First:** An approach to ending homelessness that centers on providing people experiencing homelessness with housing as quickly as possible – and then providing services as needed.

**Housing Opportunities for Persons With AIDS (HOPWA):** The only Federal program dedicated to the housing needs of people living with HIV/AIDS. Under the HOPWA Program, HUD makes grants to local communities, States, and nonprofit organizations for projects that benefit low-income persons living with HIV/AIDS and their families.

**Housing Measures:** In this report, includes measures of housing stability and homelessness prevention at the household and client levels to enable grantees to determine the effectiveness of their Integrated HIV/AIDS Housing Plan model and the extent to which it encouraged long-term stability among clients. Housing outcomes include unstable, temporarily stable, stable/permanent.

**Housing Subsidy:** A form of financial or in kind support extended groups or individuals to reduce the cost of housing.

**Human Immunodeficiency Virus (HIV):** A chronic virus that weakens the immune system by destroying cells that fight diseases and infections.

**Integration:** Provides persons with seamless comprehensive services from multiple programs without repeated registration procedures, waiting periods, or other administrative barriers.

**National HIV/AIDS Strategy (NHAS):** Released by President Obama on July 13, 2010, a five-year plan that details principles, priorities, and actions to guide our collective national response to the HIV epidemic. In July 2015, the White House released the National HIV/AIDS Strategy for the United States: Updated to 2020. This Update reflects the work accomplished and the new scientific developments since 2010 and charts a course for collective action across the Federal government and all sectors of society to move us close to the Strategy's vision.

**Permanent Housing Placement:** A supportive housing service that helps establish the household in the housing unit, including but not limited to reasonable costs for security deposits not to exceed two months of rent costs.

**Person Living With HIV/AIDS (PLWHA):** An individual diagnosed with HIV or AIDS.

**Public Housing:** Established to provide decent and safe rental housing for eligible low-income families, the elderly, and persons with disabilities. Public housing comes in all sizes and types, from scattered single family houses to high rise apartments for elderly families.

**Public Housing Authority (PHA):** A local independent agency that works in conjunction with local governments and agencies to administer public housing dwelling units and housing vouchers.

**Ryan White HIV/AIDS Program (Ryan White):** A federal program that works with cities, states, and local community-based organizations to provide services by providing funds to support primary medical care and essential support services. A smaller but equally critical portion is used to fund technical assistance, clinical training, and the development of innovative models of care.

**Shelter Plus Care (S+C):** A program designed to provide housing and supportive services on a long-term basis for homeless persons who have a serious mental illness, chronic problems with alcohol and/or drugs, or with acquired immunodeficiency syndrome (AIDS or related diseases), or any combination of those disabilities, who are living in places not intended for human habitation (e.g. streets) or in an emergency shelter.

**Single Room Occupancy (SRO):** A residential property that includes multiple single room dwelling units. Each unit is for occupancy by a single eligible individual. The unit need not, but may, contain food preparation or sanitary facilities, or both.

**Short-Term Rent, Mortgage, and Utility (STRMU) Assistance:** A time-limited, housing subsidy assistance designed to prevent homelessness and increase housing stability. Grantees may provide assistance for up to 21 weeks in any 52 week period. The amount of assistance varies per client depending on funds available, tenant need and program guidelines.

**Supportive Services:** In this report can include but is not limited to housing case management and counseling; client legal services with housing; employment services, training and support; and entitlement/benefits research and enrollment.

**Tenant-Based Rental Assistance (TBRA):** TBRA is a rental subsidy program similar to the Housing Choice Voucher program that grantees can provide to help low-income households access affordable housing. The TBRA voucher is not tied to a specific unit, so tenants may move to a different unit without losing their assistance, subject to individual program rules. The subsidy amount is determined in part based on household income and rental costs associated with the tenant's lease.

**Transgender:** Transgender is defined as a person who identifies with, or presents as, a gender that is different from his/her gender at birth.

**Veteran:** A veteran is someone who has served on active duty in the Armed Forces of the United States. This does not include inactive military reserves or the National Guard unless the person was called up to active duty.

**Viral Suppression:** When antiretroviral therapy (ART) reduces a person's viral load (HIV RNA) to <200 copies/ml. Viral suppression does not mean a person is cured; HIV still remains in the body. If ART is discontinued, the person's viral load will likely return to a detectable level.

**Undetectable Viral Load:** Undetectable Viral Load or Optimal viral suppression is defined generally as a viral load persistently below the level of detection (HIV RNA <20 to 75 copies/ml, depending on the assay used).