

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%
Total (n=214)	79.0%	11.7%	9.3%	76.2%	59.3%

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 ⁵	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	

⁵ 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)