THE HIV, HOUSING & EMPLOYMENT PROJECT

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INSTRUCTIONS FOR CONFERENCE CALL & ZOOM

- This webinar is being recorded. The recording will be uploaded to the HIV, Housing & Employment Project website, https://targethiv.org/housing-and-employment
- To minimize background noise, all attendees will be muted for the duration of the webinar.
- To ask a question or comment, please use the chat box. Presenters will answer questions at the end of the presentation.

PRESENTERS

Amy Palilonis, U.S. Department of Housing and Urban Development

Kristen Lascoe, Fenway Health

Tanya Khalfan Mendez, Bexar County Hospital District

Jessica Flaherty, Boston University School of Social Work

LEARNING OBJECTIVES

1. Describe how housing instability affects people with HIV (PWH) in the US and the role HOPWA has in supporting PWH with housing opportunities.
2. Learn strategies to leverage HUD and other public resources to provide housing and employment services to PWH.
3. Share methods for integrating HOPWA measurements for tracking housing stability and housing outcomes for PWH.
4. Learn how the initiative's models of care coordination affected clients' HIV health outcomes, housing stability, and employment statuses.

HOPWA PROGRAM OVERVIEW

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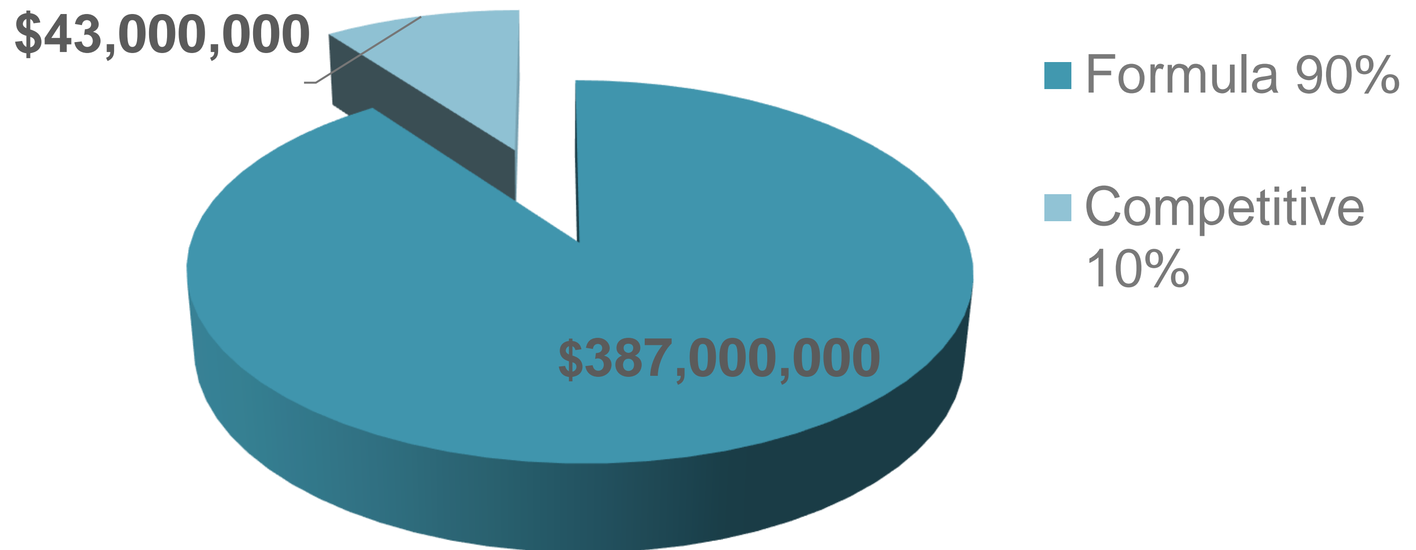
WHAT IS HOPWA?

- HOPWA is the only Federal program dedicated to the housing needs of low-income persons living with HIV/AIDS
- Under the HOPWA program, HUD makes grants to eligible cities, states, and nonprofit organizations to provide housing assistance and supportive services to low-income persons living with HIV/AIDS and their families
- By providing housing assistance and supportive services , the HOPWA program helps persons living with HIV/AIDS enter and remain in housing, access and maintain medical care, and adhere to HIV treatment regimens

HOPWA STRUCTURE

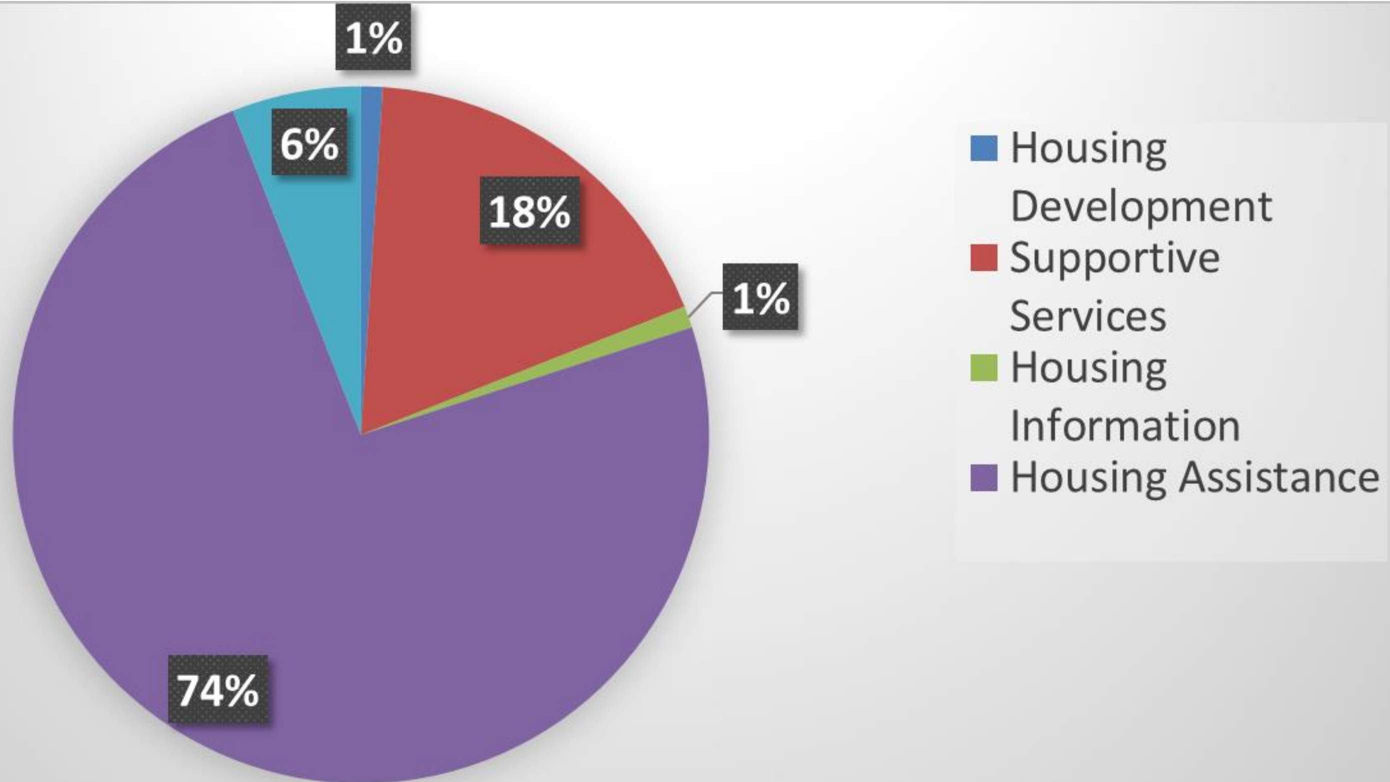
FY21
Appropriation
$430,000,000



ELIGIBLE HOPWA ACTIVITIES

- Facility-based and scattered-site emergency, transitional, and permanent housing
- Short-term rent, mortgage, and utility assistance to prevent homelessness
- Permanent housing placement
- Housing information services
- Supportive services
- Resource identification
- Administration

EXPENDITURES BY HOPWA ACTIVITY



WHO HOPWA SERVES

- Over 100,000 households receive HOPWA housing assistance and/or supportive services annually
- 77% HOPWA beneficiaries are extremely low income
- Among new clients served last year, approximately 3,456 (16%) were experiencing homelessness at program entry
- Over 60% of the HOPWA-eligible individuals served under the program are male
- 43% are between the ages of 31 and 50; and 45% are 51 or older
- 54% are Black or African American, 37% identify are White, and 19% have Hispanic/Latino ethnicity

SPNS INITIATIVE:

IMPROVING HIV HEALTH OUTCOMES THROUGH THE COORDINATION OF SUPPORTIVE EMPLOYMENT AND HOUSING SERVICES

2017-2020

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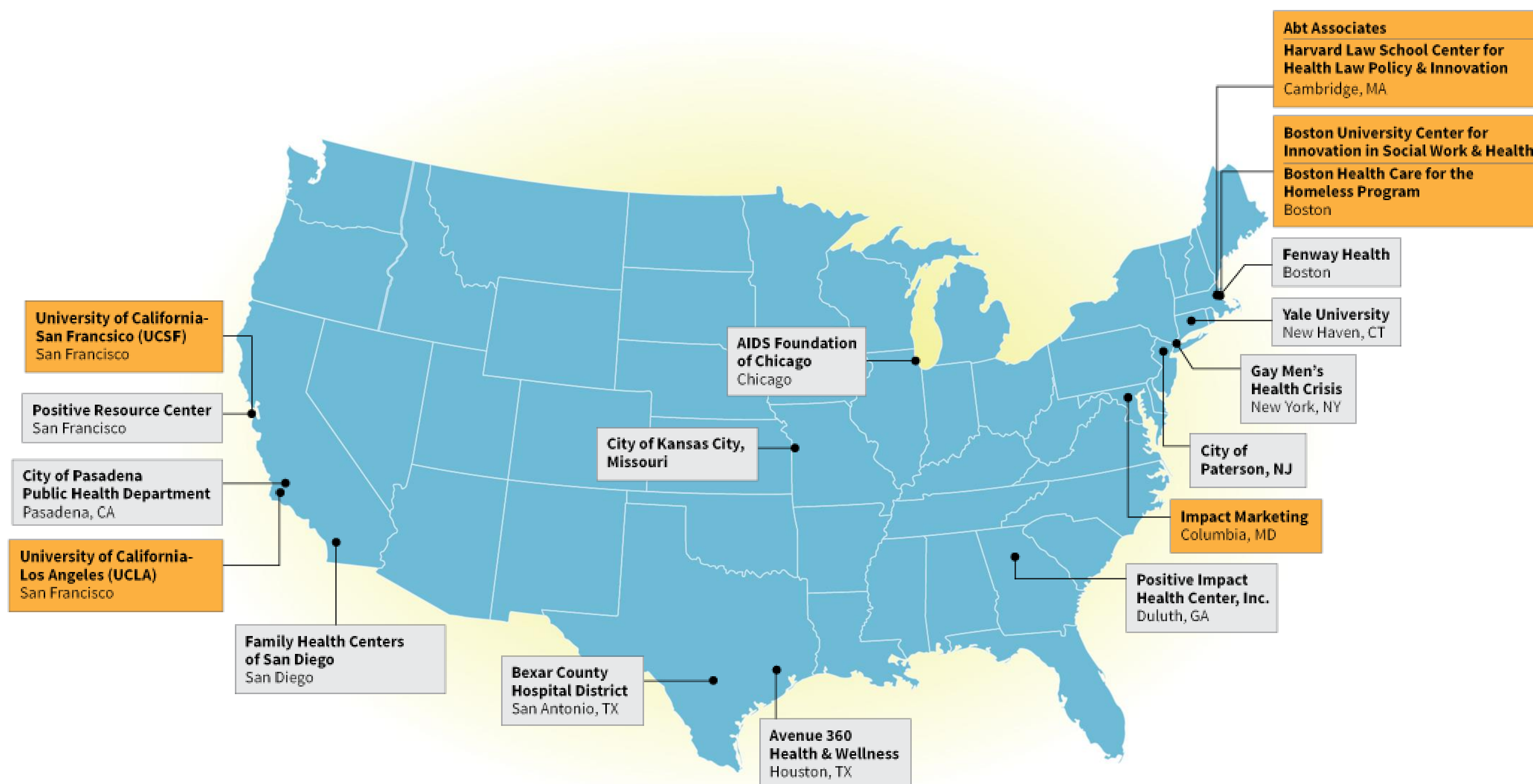
- Special Projects of National Significance (SPNS) initiative supported through the U.S. Department of Health and Human Services (HHS) Minority HIV/AIDS Fund (MHAF) and the SPNS Program under the Health Resources and Services Administration, HIV/AIDS Bureau.

- Conducted in partnership with the U.S. Department of Housing and Urban Development Office of HIV/AIDS Housing and the U.S. Department of Labor

- The initiative supported one Evaluation and Technical Assistance Provider (ETAP) and 12 demonstration sites across the U.S.

12 DEMONSTRATION SITES & 1 EVALUATION CENTER

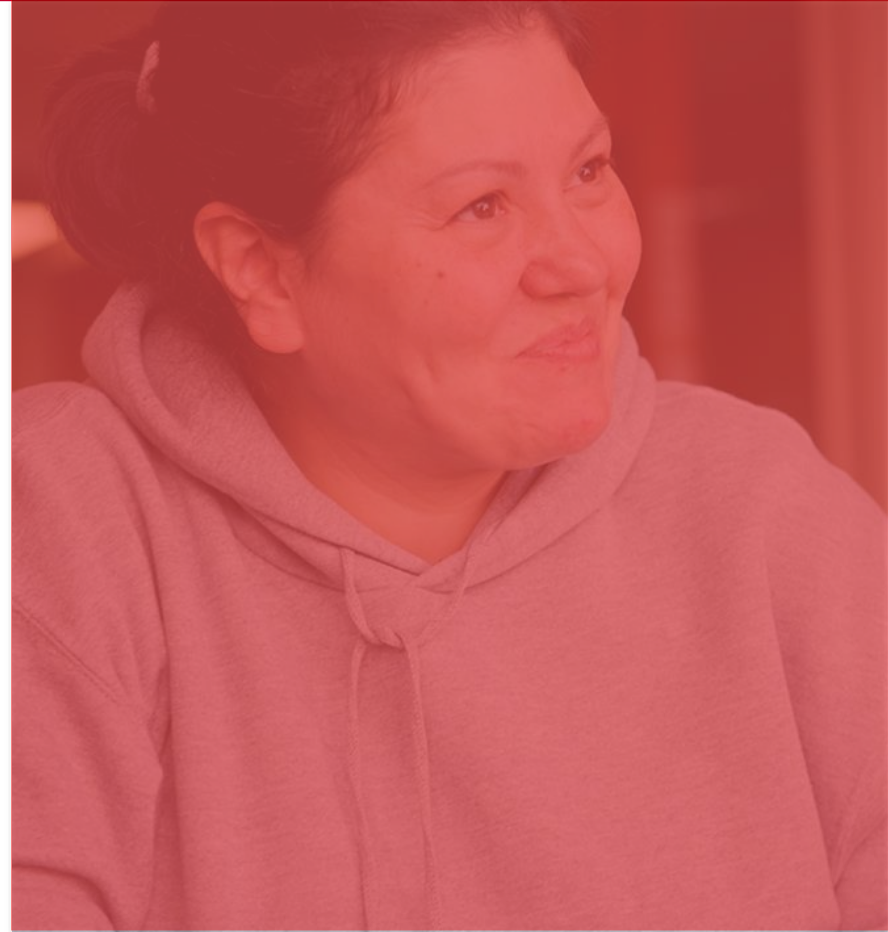


- **4** City/County Health Department
- **4** HRSA Health Centers
- **4** AIDS Service Organizations or HIV Comprehensive Care Agencies

INITIATIVE GOALS

- **Design, implement & evaluate innovative models of coordinated care service delivery** across 3 sectors:
  - HIV care services
  - Housing
  - Employment

- **Improve engagement & retention in HIV care & supportive services** for people with HIV impacted by housing and/or employment instability in racial/ethnic minority communities



SITE INTERVENTIONS & PARTNERSHIPS

12 Care Coordination/Navigation

3 System Wide Case management training

3 Streamlining referrals

2 Expanding IT Capacity/Data Integration

8 Ryan White-HUD/HOPWA partnership

3 partnership with DOL agency

ELIGIBILITY CRITERIA

1. 18 years or older
2. HIV-positive *(and one of the following criteria)*
   - Newly Diagnosed (within 12 months)
   - Not engaged in HIV primary care
   - At risk of falling out of care
   - Not virally suppressed
3. Homeless or unstably housed
4. Unemployed or underemployed

FENWAY COMMUNITY HEALTH CENTER

Kristen Lascoe, Director of Housing Services
klascoe@fenwayhealth.org

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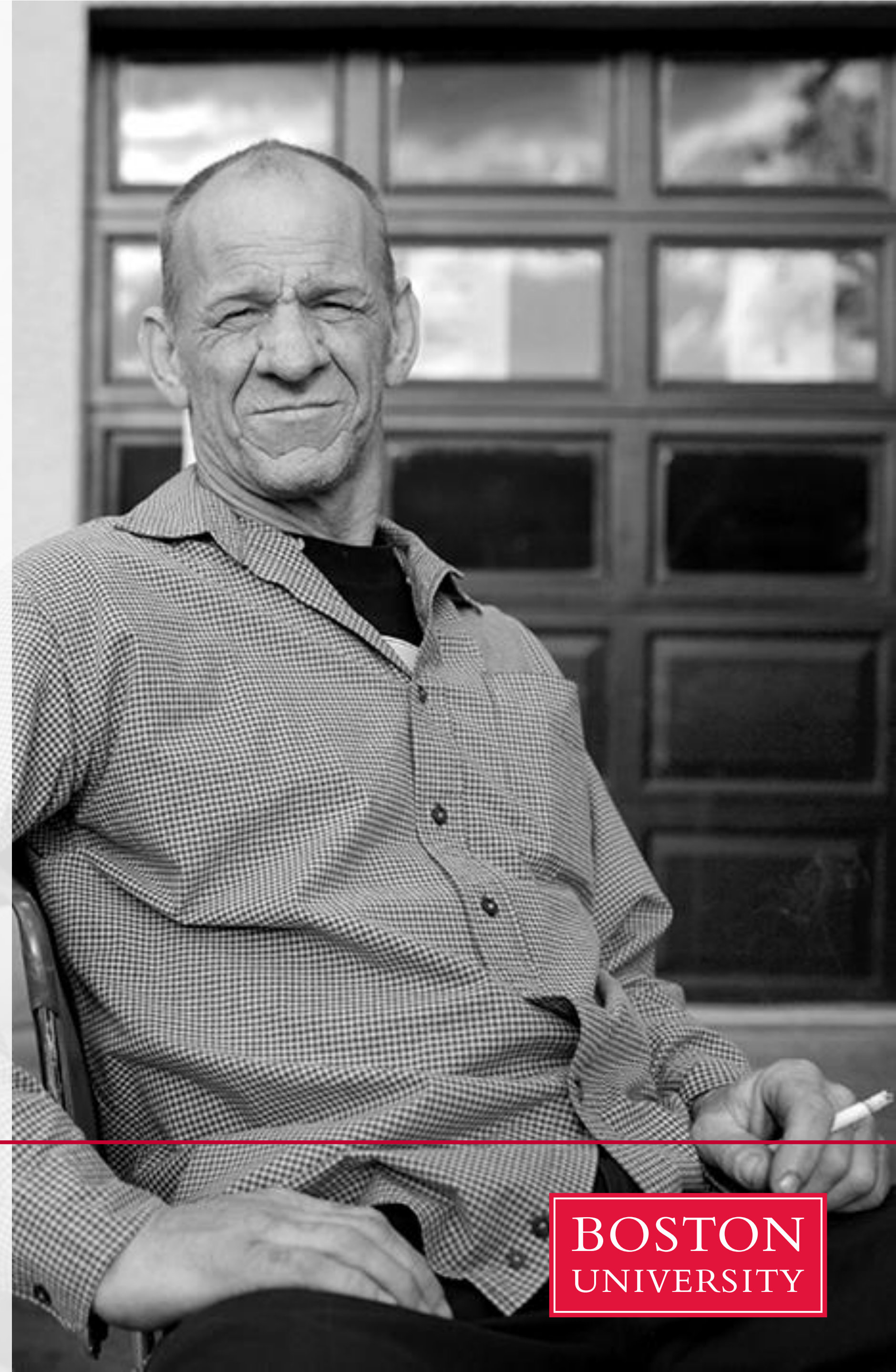
FENWAY HEALTH HOUSING AND EMPLOYMENT PROJECT

- Fenway Community Health Center: Ryan White Part A funded case management
- AIDS Action: housing services funded by HOPWA, Ryan White and state funds, assisting clients to access HUD-funded housing opportunities
- JVS/ MassHire Downtown Boston: Department of Labor funded employment services partner

- Project goals:
  - Integration of employment services into existing clinical and housing services through partnership with external agency
  - Internal systems strengthening: connection and coordination between Medical Case Management and Housing programs

FENWAY HEALTH

- Federally Qualified Health Center (FQHC)
- Longtime recipient of Ryan White CARE Act funding under Parts A and C
- Largest non-hospital provider of HIV/AIDS medical and behavioral health services in Massachusetts, treating more than twice as many people with HIV as all of Boston's other community health centers combined
- Provides Medical Case Management services to patients with HIV



AIDS ACTION

Oldest and largest AIDS Service Organization in New England

Fenway Health and AIDS Action merged in 2018 after a 5-year strategic partnership

AIDS Action is the public health division of Fenway Health

- **Housing**
- Prevention Programs
- Linkage to Care and Short-term Navigation
- Legal

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AIDS ACTION – HOUSING PROGRAMS

Housing Search and Advocacy

- Serves households experiencing homelessness or housing instability

Rental Assistance Programs

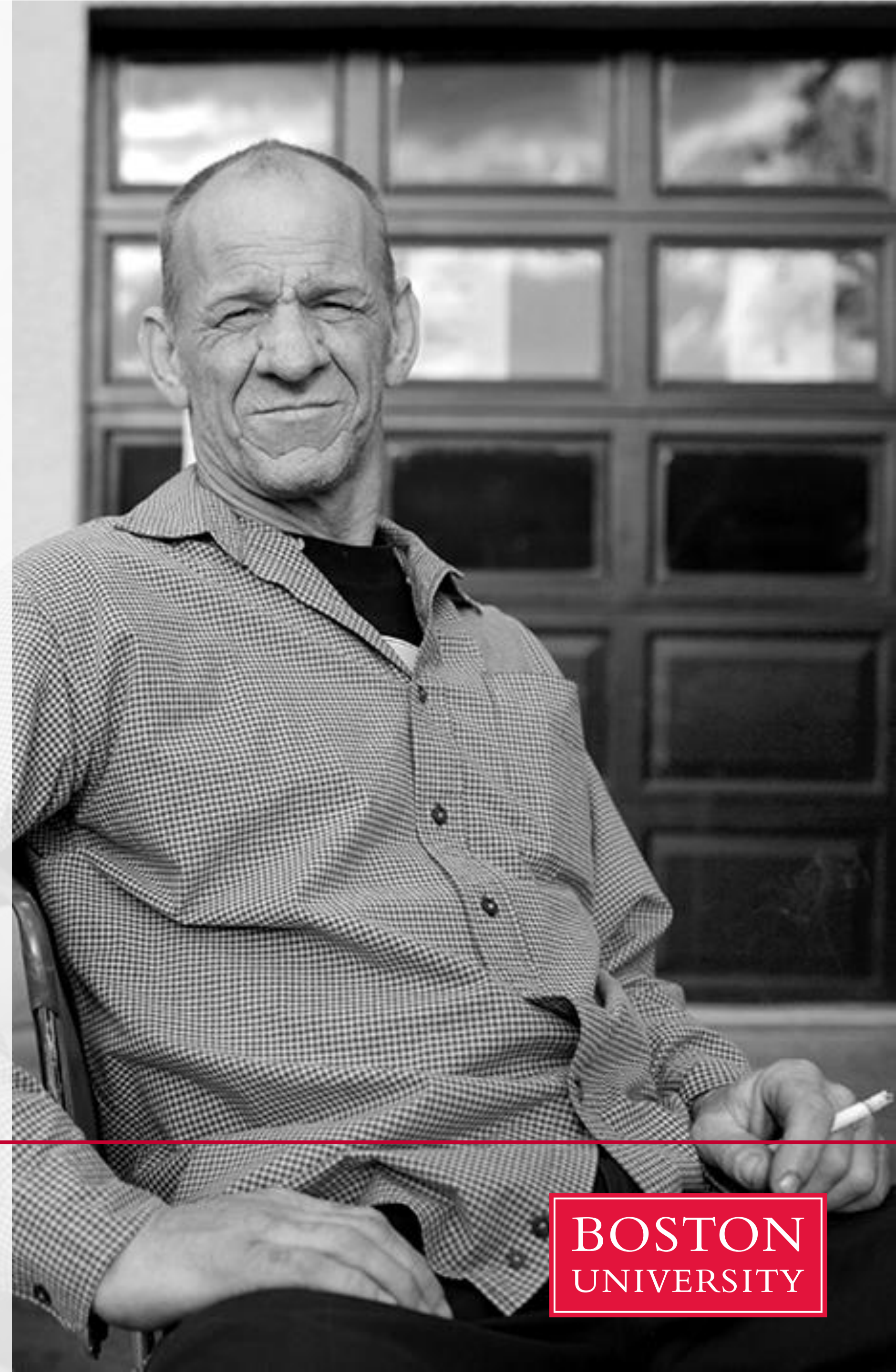
- Assists with back rent, short term ongoing assistance, start-up costs, and emergency utility payments
- Administers ongoing rental assistance for two HOPWA TBRA programs and two CoC programs: PSH and RRH

Supportive Services, including housing stabilization

- Provides community case management and housing stabilization
- Serves households in supportive housing programs, project-based and tenant-based subsidies
- Subsidies administered by AIDS Action and by external partner agencies

LEVERAGING FUNDS FOR CLIENT ACCESS

- HRSA-funded case management partners with HUD-funded housing assistance and services
- Housing programs serve clients who are Fenway patients and those who receive care elsewhere
  - 103 Fenway patients and 994 patients of external providers
- Housing program rely on partnerships with dozens of health centers, hospitals and community organizations across Massachusetts
- MOAs detailing referral process and ongoing coordination
- Strongest partnerships with agencies with Ryan White case management services
- Case Managers identify client need for rental assistance and housing search services, submit referrals, and partner with AIDS Action housing staff for ongoing coordination



LEVERAGING FUNDS FOR PROGRAM COHESION

Example: Rental Assistance Programs

- Rental Assistance Programs: short term financial assistance
- 744 households served
- Four funding sources
  - MA Department of Public Health – state funds
  - City of Boston, Suffolk/Norfolk/Plymouth Counties – HOPWA STRMU and PHP
  - Middlesex/Essex Counties – HOPWA STRMU and PHP
  - Boston Public Health Commission, Boston EMA – Ryan White Part A
- Create a cohesive program, with one set of eligibility criteria and single application for all
- Serve clients throughout Massachusetts
- Gather data to satisfy highest level of reporting requirements
- Matrix funding to meet client needs

INTEGRATING EMPLOYMENT SERVICES: PROGRAM MODEL

An intentional partnership with a Department of Labor funded site to provide coordinated employment services to clients accessing existing medical case management and housing services.

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ESTABLISHING EMPLOYMENT SERVICES PARTNERSHIP

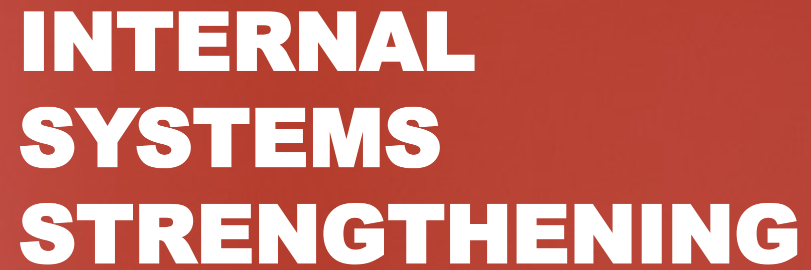
- DOL funded partner site – **MassHire Downtown Boston**
- Robust services including career center, job readiness, immigration support, adult education, job training, ESOL classes
- Liaison, funded through SPNS initiative, dedicated to project with Spanish language capacity
- Experience building programs through partnerships

SYSTEMS LEVEL COLLABORATION

- Cross-training between Fenway staff and MassHire – initially and ongoing to create familiarity and trust
- **Onsite trainings and tours of office allows for increased understanding of services provided, barriers that may affect clients, location, and logistics of accessing services**
- Introductory materials created specifically for clients in program
- **Established consistent practice around outreach attempts**
- Partnership led to staff familiarity with assessment of need for and referrals to employment services

CLIENT LEVEL COORDINATION

- Introduction of co-located services on site at AIDS Action
- Consistent coordination between project coordinator and MassHire liaison – weekly calls, continuous email coordination, data sharing
- Flexible practices around scheduling client appointments
- Ongoing communication between project coordinator and providers regarding progress and challenges in employment services



INTERNAL SYSTEMS STRENGTHENING

SPNS project coincided with merger between Fenway Health and AIDS Action

Barriers:

- Lack of communication between Medical Case Management and Housing programs
- Multiple locations
- Use of two different data systems

STRATEGIES TO ADDRESS BARRIERS TO SYSTEMS INTEGRATION

Project Coordinator position

Works full time on Housing and Employment project

Staff access to data systems

Key staff granted access to both data systems

Biweekly Project Meetings

Includes staff from Housing and MCM programs

QI Projects

Quality Improvement Program Manager facilitates identification of needs and action items

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BIWEEKLY PROJECT MEETINGS

- Includes intervention and evaluation staff
- Dedicated space for case coordination, project development and QI work
- Strengthened relationships between Housing and MCM managers
- Planning for coordination and connection between teams: interviewing and introducing new staff, facilitating cases coordination and information sharing

QUALITY IMPROVEMENT PROJECTS

- Process mapping: identification of barriers
- Housing Search and Advocacy waitlist
- Housing note in electronic health record
- Engagement dashboards: support from Program Evaluation

ACCESS TO DATA SYSTEMS

- Project Coordinator access to CPS – electronic health record
- Flags vs. emails
- MCM Manager access to ETO – AIDS Action database
- MRNs recorded in ETO for cross-reference
- In development: reports used for case coordination

SUSTAINABILITY

Project Coordinator:

Use of HOPWA Supportive Services funds to continue this position short term:

- Pilot outreach to clients
- Build referral guide
- Facilitate meetings and case coordination

Biweekly Project Meetings:

Broaden scope and become Integrated HIV SDoH Clinical Team meetings

QI and Data Access:

Integrate these components into team meetings

University Health

Thinking beyond

Bexar County Hospital District
Over 100 Years of Service
San Antonio, Texas

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About us

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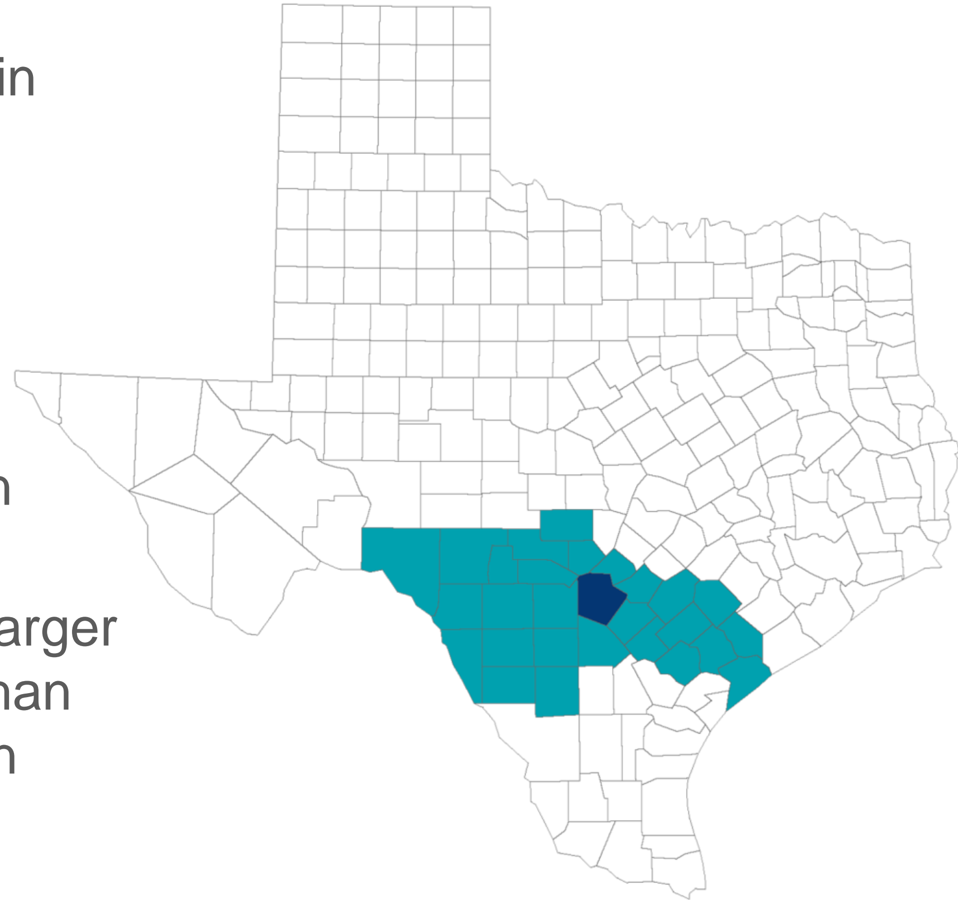
BEXAR COUNTY HOSPITAL DISTRICT DBA UNIVERSITY HEALTH

- South Texas' only safety net health system
- Level 1 Trauma Center
- 28 County Service Region across South Texas
- Over 900 Physicians and Residents
- More than 9,000 employees

UNIVERSITY HEALTH

- San Antonio is the 7th largest city in the United States
- Bexar County, the fourth most populous county in Texas, slightly larger than Rhode Island
- 94% of the region's PWH (People With HIV) can be found in the San Antonio metropolitan region
- Bexar County has a significantly larger proportion of Hispanics (60.7%) than both Texas (39.7%) and the nation (18.5%)

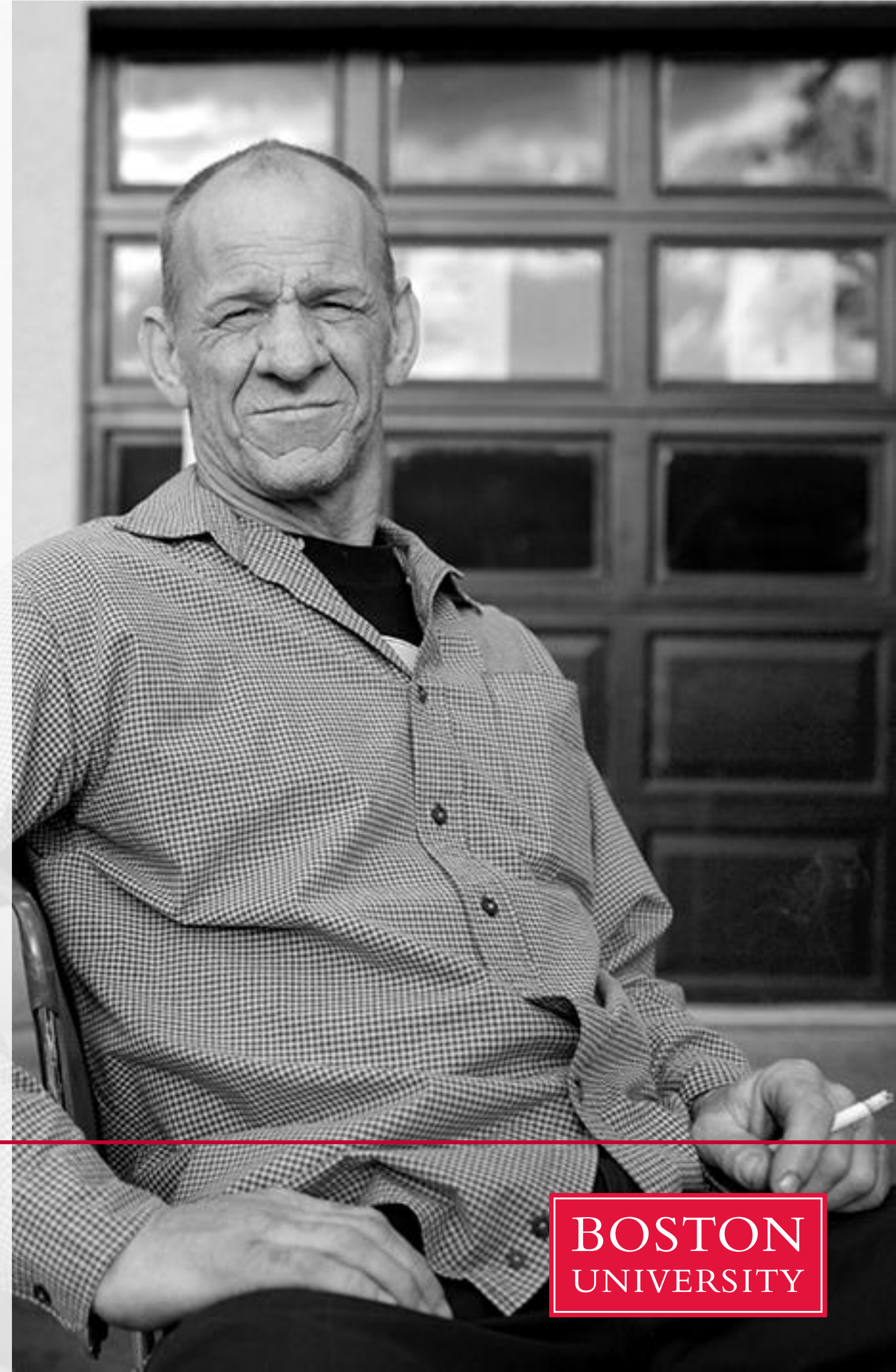


UNIVERSITY HEALTH

Mission - The mission of University Health System is to improve the good health of the community through high quality compassionate patient care, innovation, education and discovery.

Vision - We are leading the way to be one of the nation's most trusted health institutions.

Values - Our patient care will be high quality and compassionate above all, attentive, kind and helpful without exception, and wise in the use of resources.



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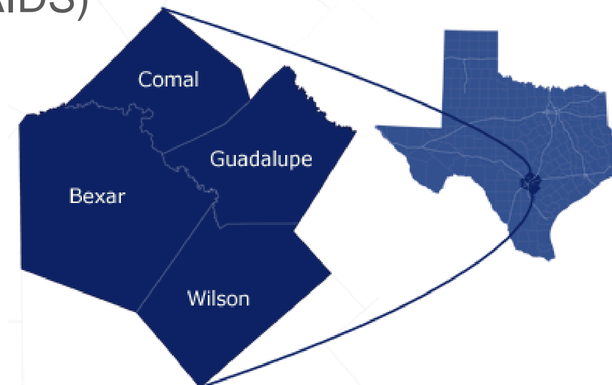
Ryan White Administrative Agency for Parts A, B, D, HOPWA, and Ending the HIV Epidemic

- Serves the San Antonio Transitional Grant Area (SATGA) 4 county area
  - Bexar, Comal, Guadalupe, and Wilson
  - ~2.4 million people

Specialty Community Partners within the SATGA's

- Family Focused AIDS Clinical Treatment Services clinic (FFACTS)
- Black Effort Against the Threat of AIDS (BEATAIDS)
- San Antonio AIDS Foundation (SAAF)
- Alamo Area Resource Center (AARC)
- El Centro del Barrio (CentroMed)



SPECIAL PROJECTS OF NATIONAL SIGNIFICANCE

- BCHD first SPNS program
  - September 2017
- Project Investigator
- Program Manager
- Administrative Manager
- Program Coordinator
- Three Member Advocates
- Data Manager
- Data Coordinator

SPNS/CASE TEAM

- New to HRSA/SPNS
- Diverse experience
- Skills Sets
- Desired to Help
- Onboard Training

SPECIAL PROJECT NATIONAL SIGNIFICANCE

- Enrolled 106 clients (Goal 100)
- 25 Services only clients
- Enrolled clients completed 89 times

REFERRAL SOURCES

Partner agencies

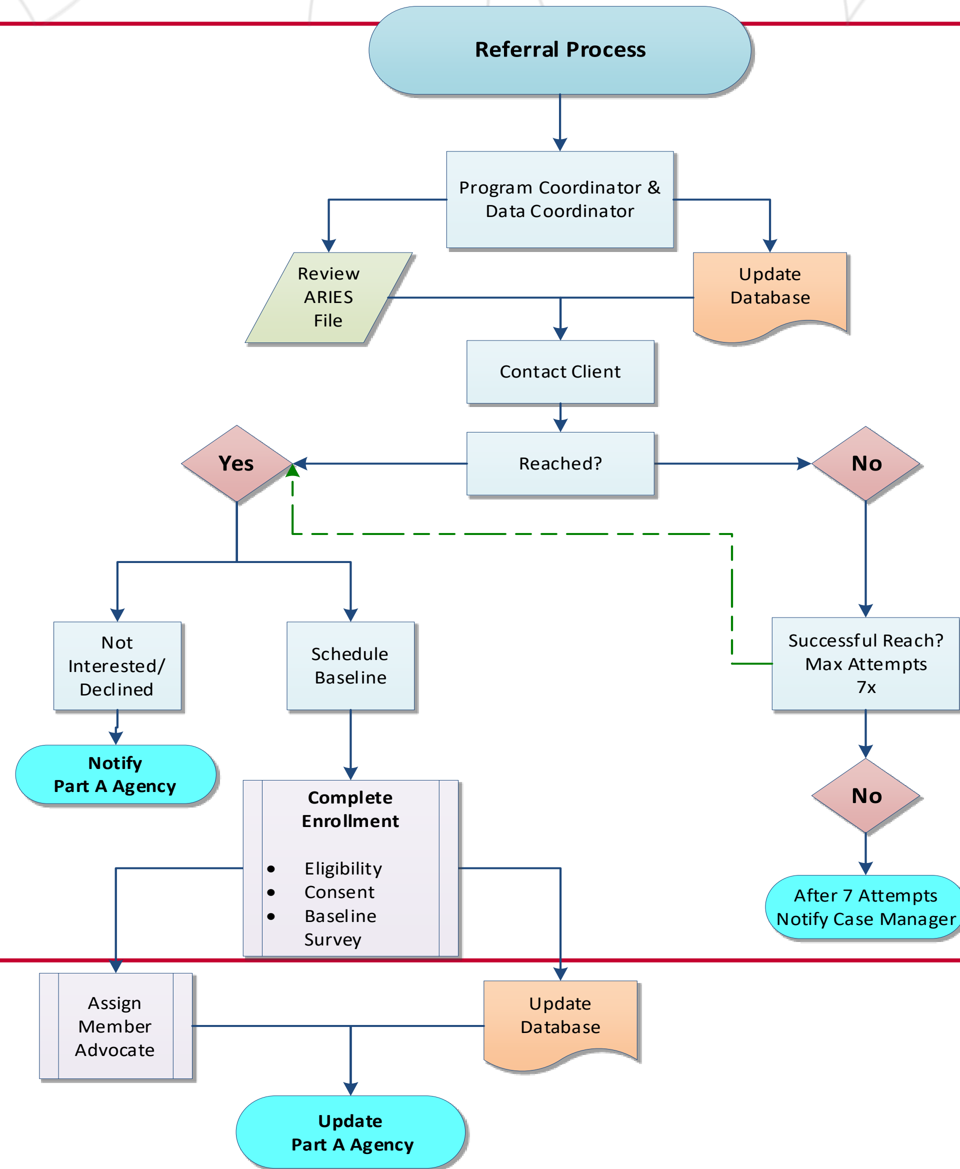
- AARC
- BEAT AIDS
- CentroMed
- FFACTS
- SAAF

Other grant programs

Self referrals

ARIES

REFERRAL PROCESS



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HOUSING STUDY

- Over 90% indicated had been homeless at some point within past 3 years
- 2/3 reported didn't have a support network to remain housed
- 1/3 reported having difficulty paying rent/mortgage within previous 3 months
- Over 17% indicated having no household income from any source
- Most common barriers to obtaining housing:
  - Poor credit history
  - Insufficient income
  - Lack of employment

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HOUSING SUPPORT

- HOPWA
    - TBRA, STRMU, PHP*
    - Wait list
- Carson House
- SARAH – South Alamo Regional Alliance for the Homeless
- Haven4Hope
- San Antonio Housing Authority
- St. Vincent de Paul

*PHP was funded after the project period ended

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HONDURAN FEMALE

- Honduran undocumented female
- Husband passed away (AIDS related illness)
- Widowed leaving her as head of household
- Facing foreclosure
- Transmitted HIV to children

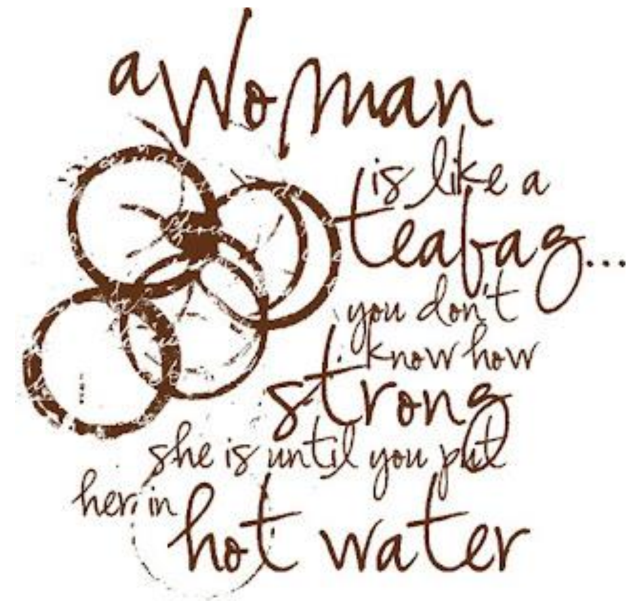
Source: https://www.disabilitysecrets.com/page5-13.html

CHALLENGE

- About to lose home
- Mourning loss of husband
- No formal work experience
- Provide for her four children
- No family support

STRATEGIES

- Empower client
- Discuss importance of appointments
- Apply for financial assistance programs
- Address housing situation
- Identify present skills



Source: https://www.disabilitysecrets.com/page5-13.html

OUTCOMES

- Joy for cooking identified
- Magnified her natural entrepreneur spirit
- Promoted plate sales and grew to catering
- Generated income to support family

BEST PRACTICES / LESSONS LEARNED

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BEST PRACTICES/LESSONS LEARNED

Best Practices

- Meet client where they are at
- Second chance housing
- Continuous communication
- Monthly Task Force Meetings
- Quarterly housing meetings

Lessons Learned

- Mental Health needs
- Neighbor gentrification

PROGRAM SUSTAINABILITY

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SUSTAINABILITY EFFORTS

- Ending the HIV Epidemic funding
- Integrated SPNS into activities
- Expanded on SPNS
- Housing program – Leverage existing programs

HHS funds communities to design and implement local programs to:

Diagnose

Diagnose all people with HIV as early as possible after infection.

Treat

Treat the infection rapidly and effectively to achieve sustained viral suppression.

Prevent

Prevent new HIV transmissions by using proven interventions, including pre- exposure prophylaxis (PrEP) and syringe services programs (SSPs).

Respond

Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

RESULTS FROM HRSA SPNS INITIATIVE:

IMPROVING HIV HEALTH OUTCOMES THROUGH THE COORDINATION OF SUPPORTIVE EMPLOYMENT AND HOUSING SERVICES

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STUDY QUESTIONS

1. Are there differences in health outcomes over time for people with HIV (PWH) by housing status and employment status?

2. What factors are associated with improved employment over time for PWH?

3. What factors are associated with improved housing over time for PWH?

EVALUATION FRAMEWORK & METHODS

- Mittler's Consumer Engagement Framework
- Data collection (May 2018-August 2020)
  - Client outcomes

    Longitudinal observational study
    - Interview (baseline, post 6 & 12 months)
    - Medical Chart review (baseline, post 6, 12 months, subsample of 18-24 months)
  - Implementation activities and process
    - Daily encounter forms
    - Qualitative study with client participants

ANALYSIS & LIMITATIONS

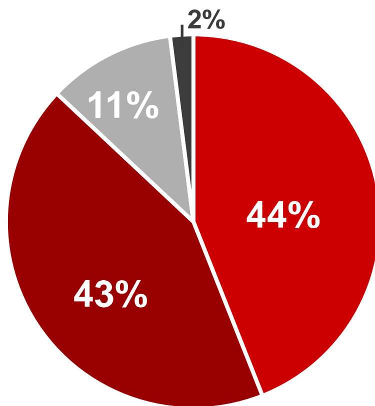
- Analysis
  - Descriptive data on clients served
  - Bivariate and multivariate analysis to assess factors associated with HIV health outcomes, employment and housing status

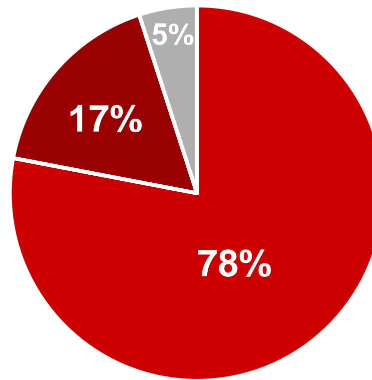
- 106 participants excluded due to never seeking employment

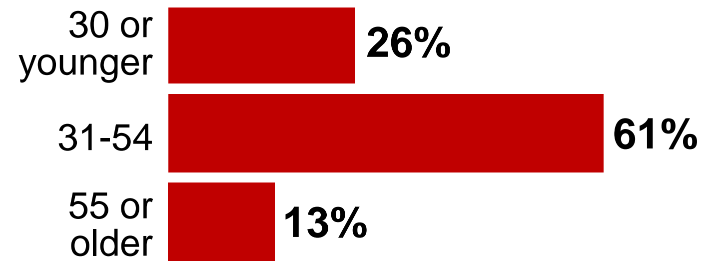
- Missing data: COVID-19 restrictions
  - Delays or inability to conduct medical record chart review
  - Client lost to follow up due to no phone access

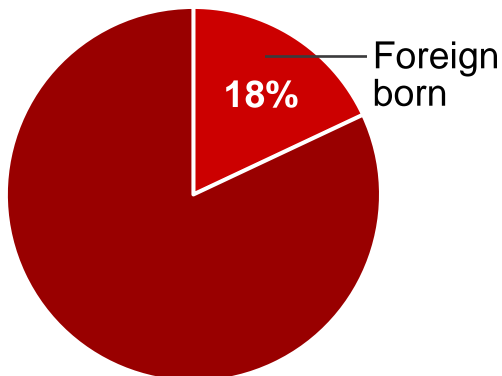
HIV HOUSING & EMPLOYMENT SPNS PARTICIPANTS

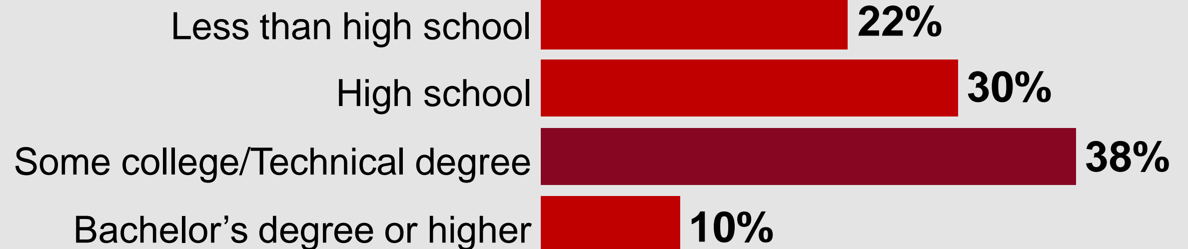
1,261 Clients Served **1,082** Enrolled in multisite evaluation









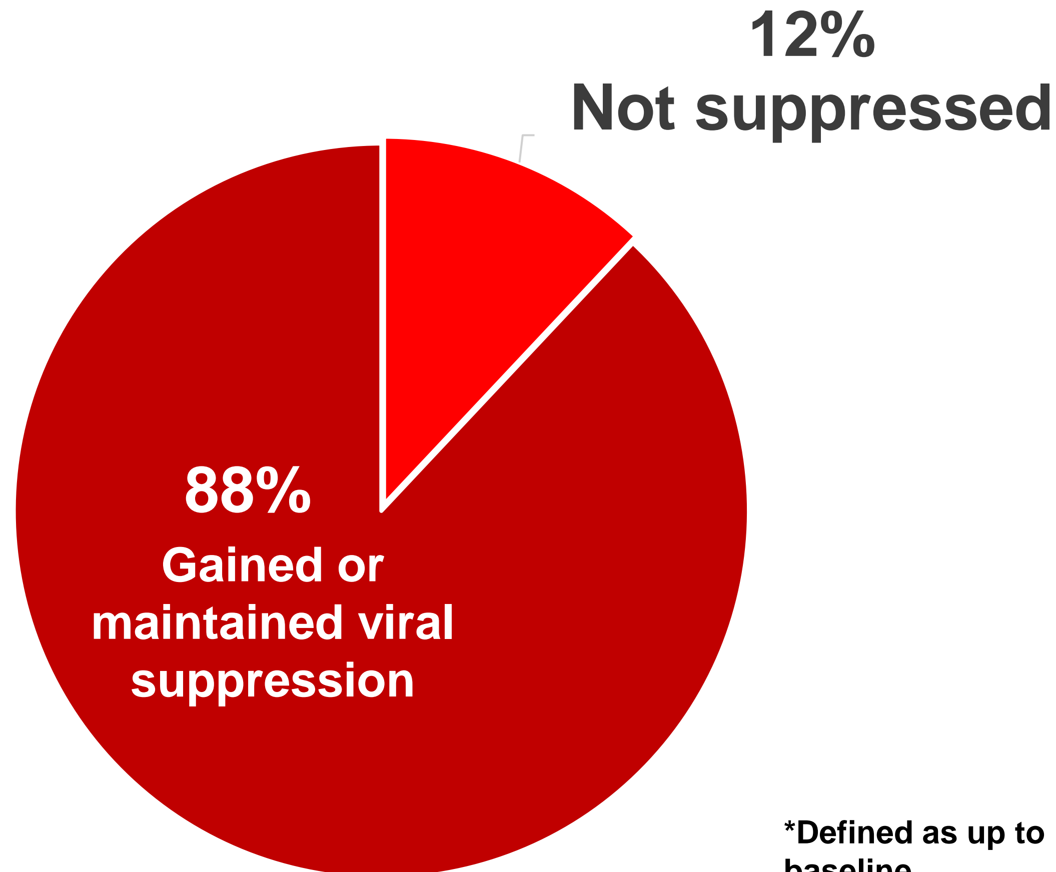


HIV HOUSING EMPLOYMENT INITIATIVE SPNS PARTICIPANTS (N=1,082)

Characteristics	%
Incarceration history	67%
Mental health-Moderate/high risk Depression Anxiety	 70% 53%
Trauma history	40%
Substance use risk High risk (dependence)/ Moderate risk (problem) Tobacco Alcohol Cocaine Opioid	 63% 46% 21% 11%
Food insecure, Very high risk past 30 days	68%

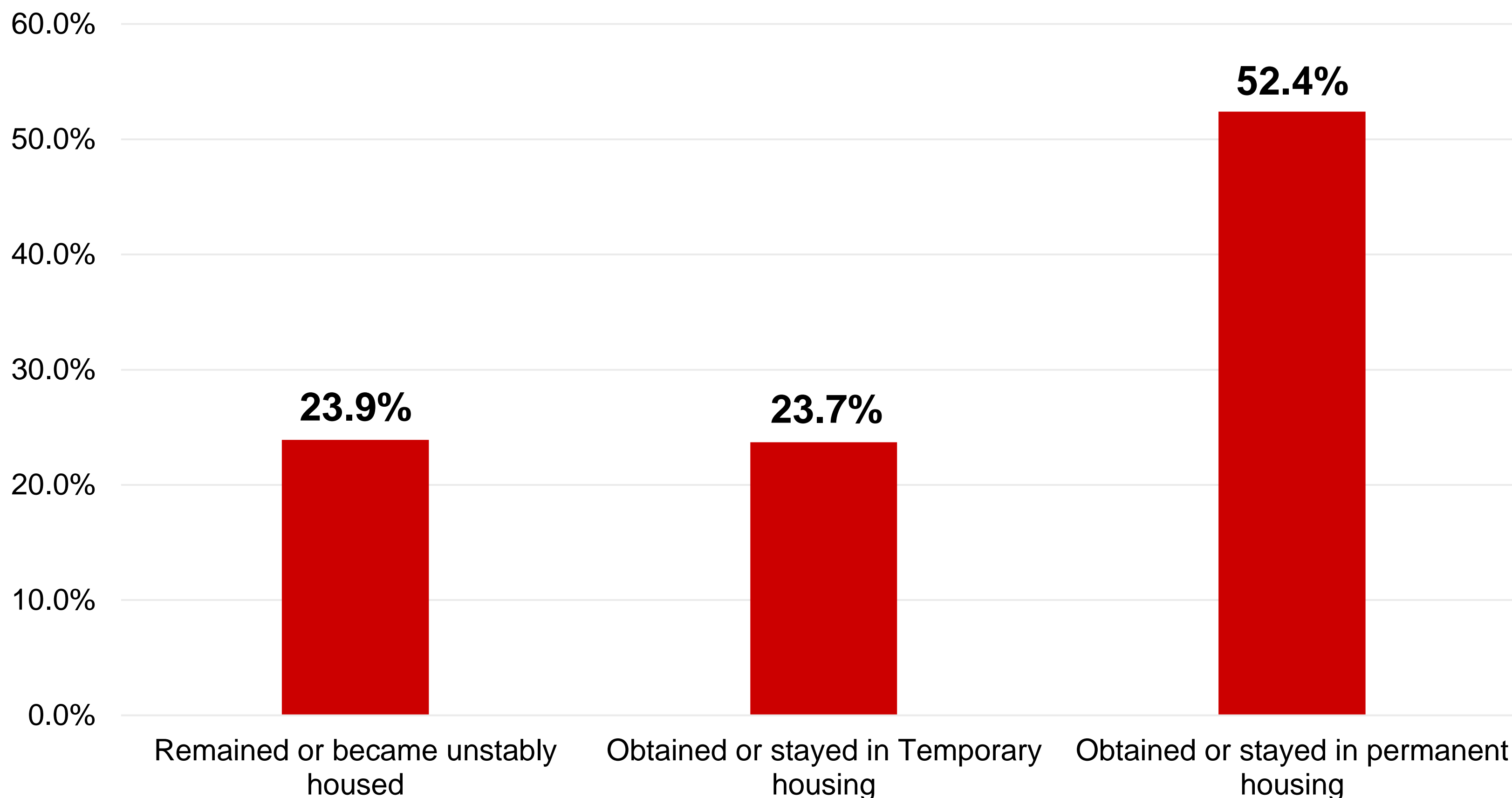
Data not for quotation or publication

VIRAL SUPPRESSION POST INTERVENTION* (N=472)

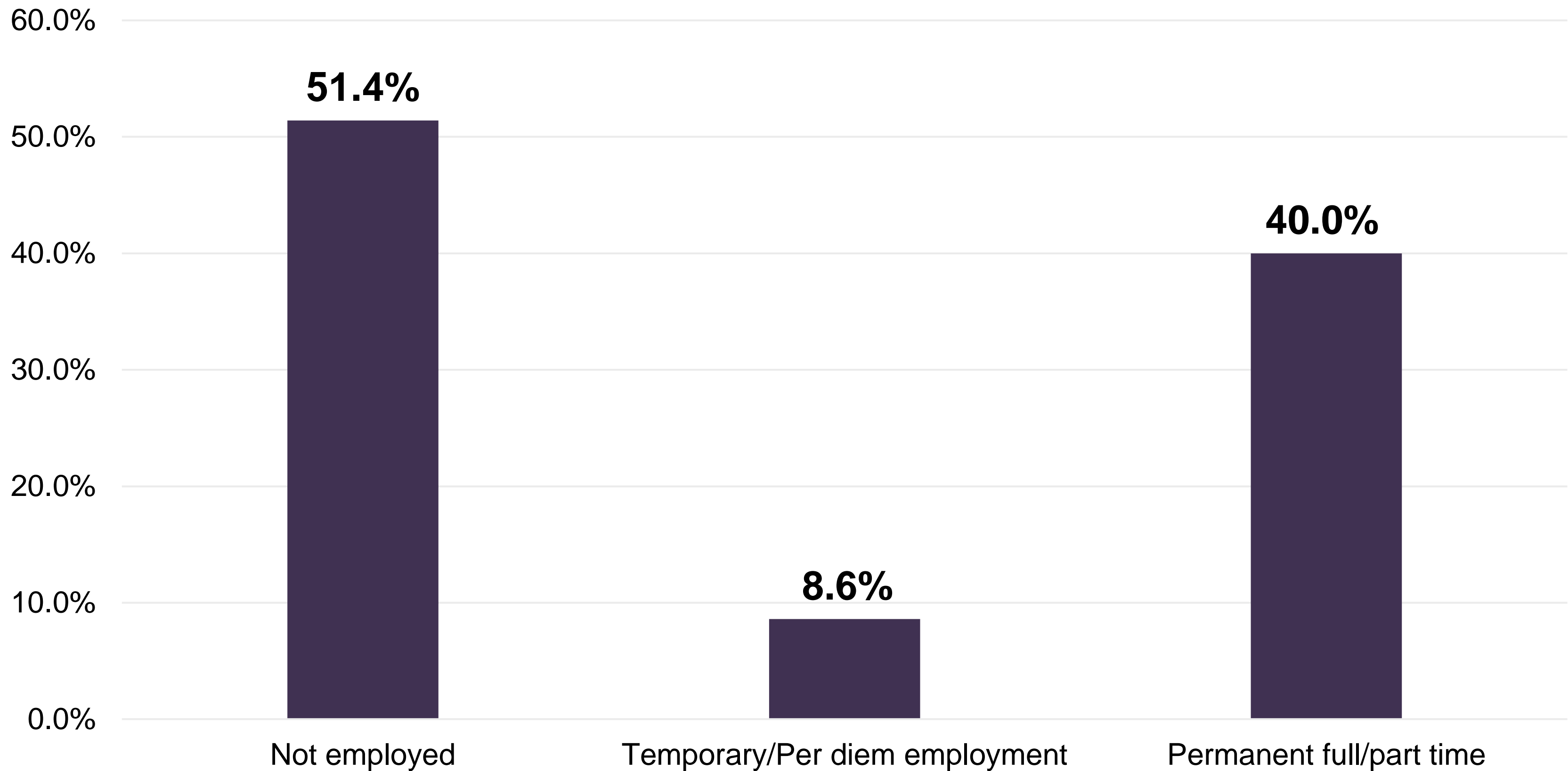


*Defined as up to 12 months post baseline

CHANGES IN HOUSING STATUS (N=472)

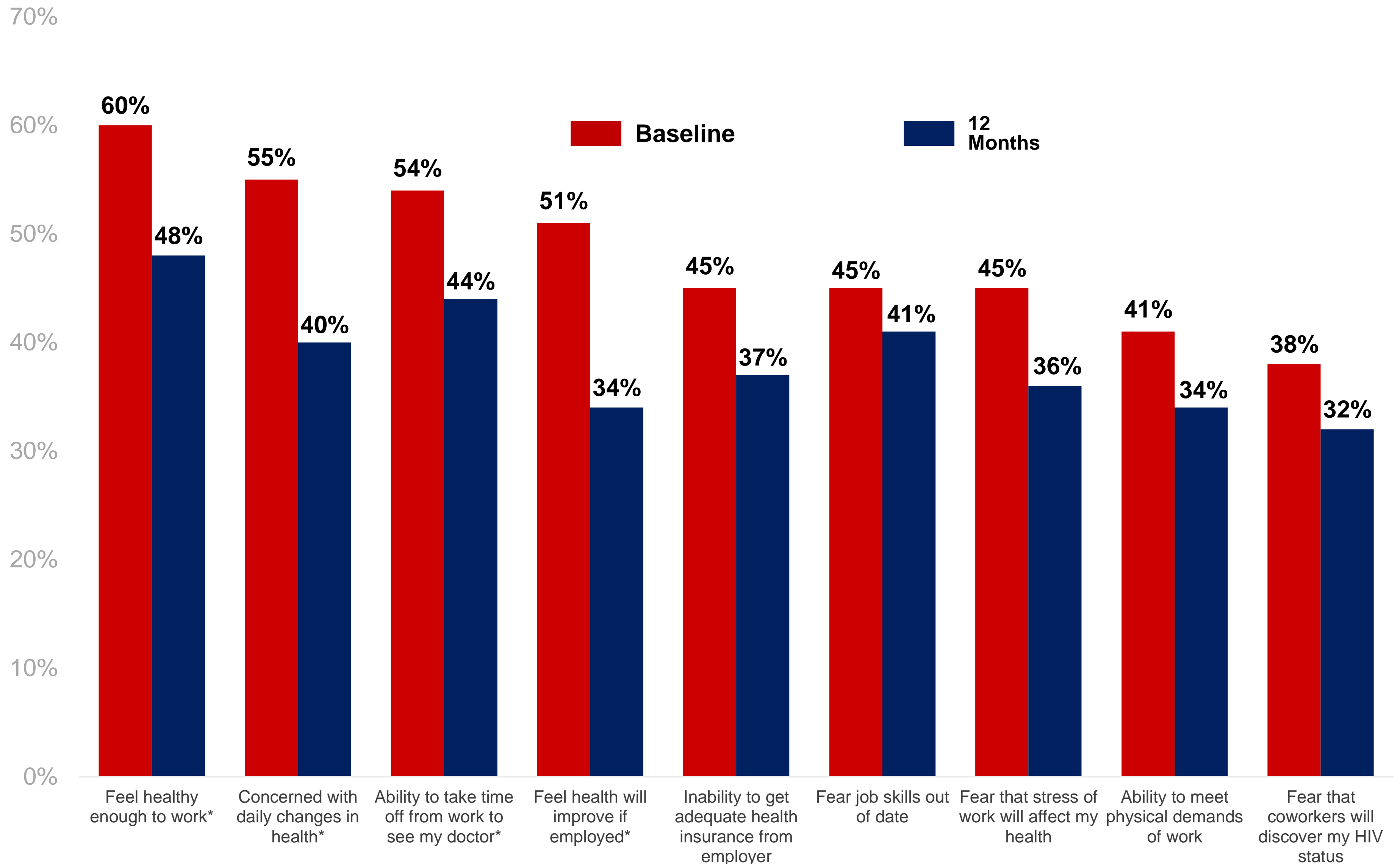


CHANGES IN EMPLOYMENT STATUS (N=472)

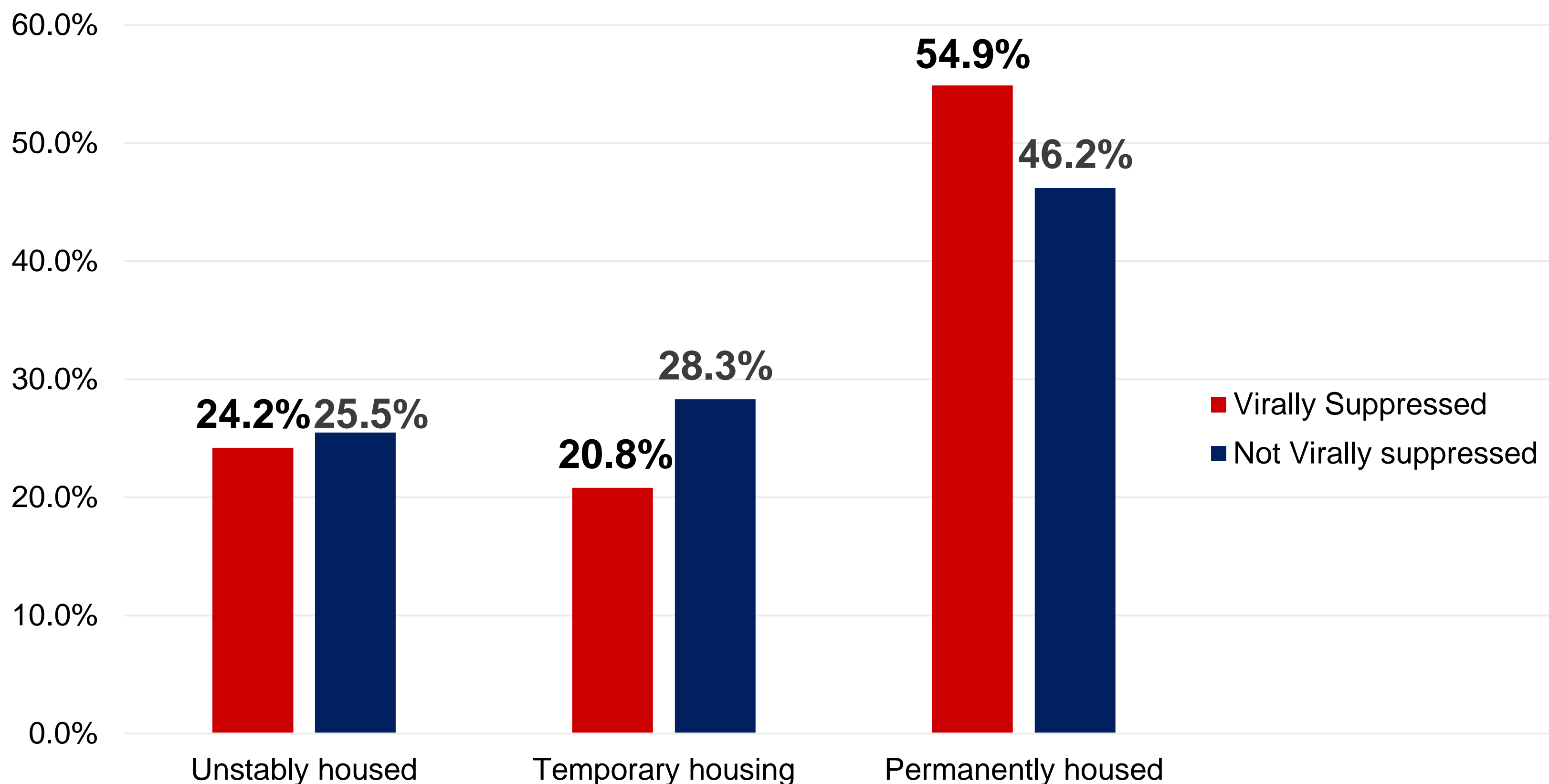


EMPLOYMENT BARRIERS

Percent of participant that noted barriers to employment, *p<0.05



HOUSING & VIRAL SUPPRESSION (N=472)



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P=0.21, adjusted for site

Data not for quotation or publication

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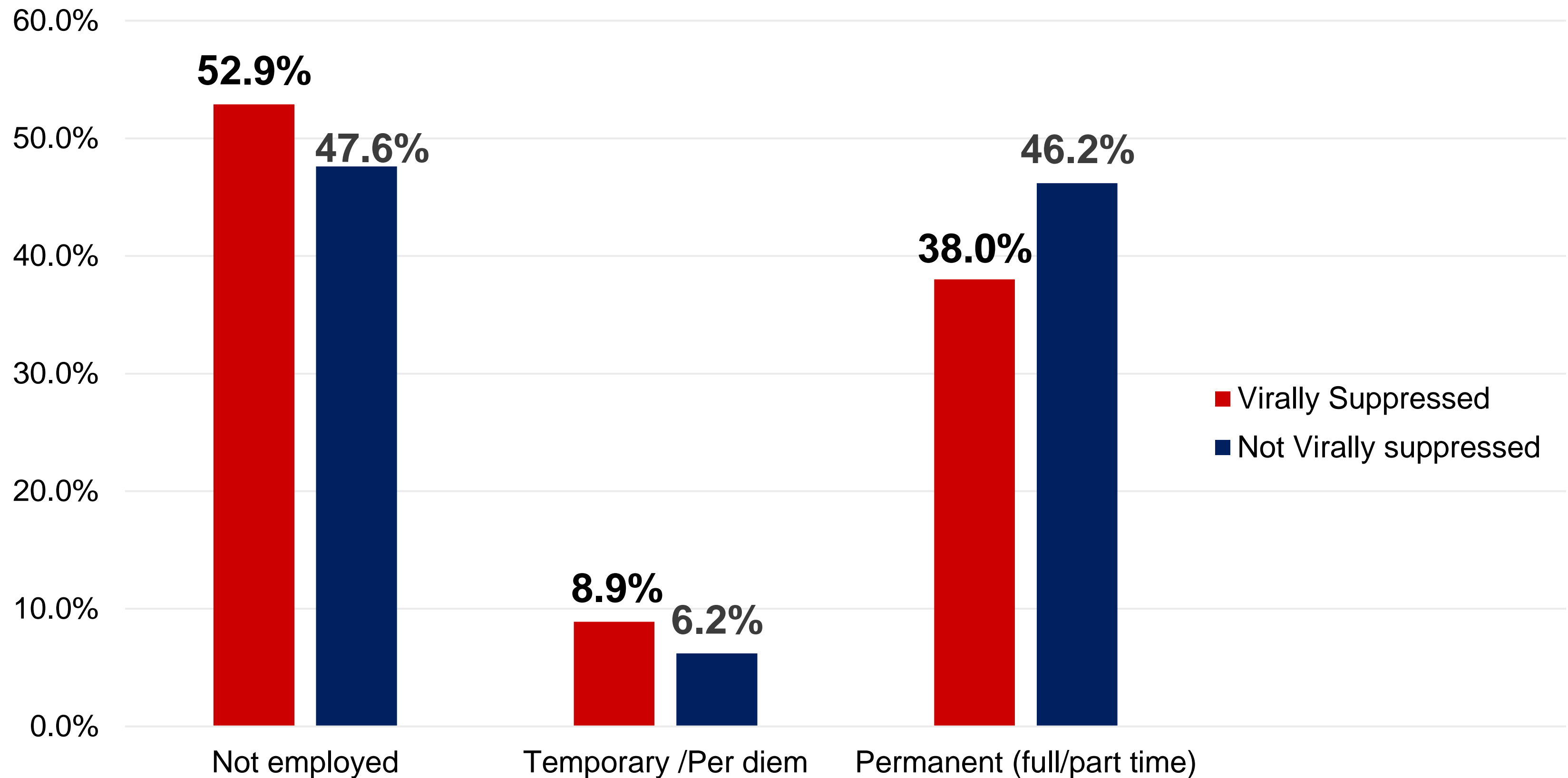
EMPLOYMENT STATUS & VIRAL SUPPRESSION (N=472)



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FACTORS ASSOCIATED WITH IMPROVED HOUSING & EMPLOYMENT STATUS

- ***Higher number of social support networks & no recent history of incarceration*** significantly associated with ***improvements in housing and employment***

- ***Previous employment history & addressing needs for mental health*** treatment significantly associated with ***improved employment***

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SPNS INTERVENTION INTENSITY & TYPES OF ENCOUNTERS POST 6 MONTHS

11, 570 encounter forms

- 9,478 direct client contact
- 2,092 Time spent finding/outreaching to clients
- Of direct client contact:
  - 47% Housing activities
  - 30% Employment activities
  - 15% Medical care support

9 encounters per participant (range 1-80)

- Housing: 5 encounters (range 0-59)
- Employment: 4 (range 0-46)

Average duration per encounter per participant: 38 minutes (range: 0-660)

Average caseload size per interventionist: 32 clients

CLIENT IMPACT

"I became more confident with myself, the stuff I do… I've been trying to or things that I know of, as far as when it comes to HIV, STI, prep, resources, just me being more confident, more of a confident person."

– SPNS client

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EMPLOYMENT SUPPORT FROM SPNS

[SPNS Interventionist] is really great about pointing out job fairs, which are great, because you get to go and meet with so many different prospective employers at the same time...And I have always felt like I've been supported in finding, environments like these, work fairs, or jobs that have been offered to me that fit more of who I am as individual, so I can't praise enough [SPNS Interventionist] for always reaching out to me and saying "Here is this next opportunity"

– SPNS client

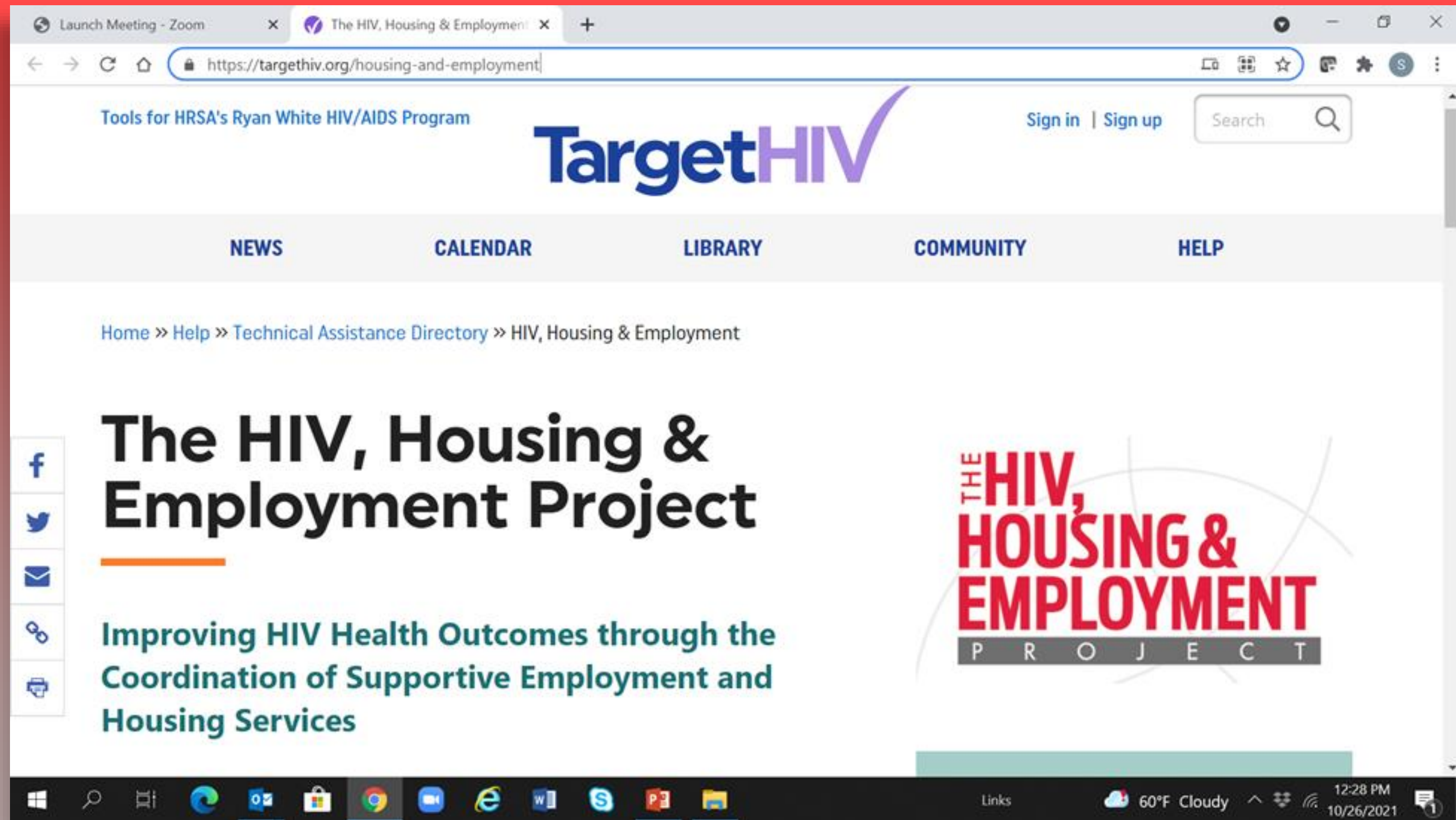
LESSONS LEARNED

- **Housing & Employment stability is not a linear process**
  - Need longer project cycle for stable housing & employment
- **Need a champion and coordinator for consistent community coalition building across sectors**
- **Social support & networks are critical**
- **Dedicated staff for coaching and empowerment**

LESSONS LEARNED

- Role for emergency housing support
- Role of private landlords, business owners
- DOL partnerships were challenging for some SPNS clients

PROJECT RESOURCES



https://targethiv.org/housing-and-employment

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PROJECT RESOURCES

- Intervention implementation manuals
- Site spotlights
- Issue briefs
- Client case studies
- Technical assistance webinars
- Presentation recordings and materials (throughout the initiative)
- Journal articles (coming soon)
- Project monograph (coming soon)

SPOTLIGHT

INTEGRATING HIV CARE, HOUSING, AND EMPLOYMENT SUPPORT IN A FEDERALLY QUALIFIED HEALTH CENTER: A NO WRONG DOOR APPROACH

Lessons learned from Fenway and AIDS Action in building a system between the Medical Case Management (MCM) and Housing programs to meet clients' social and medical needs, including access to HIV care, housing support and employment services.

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WHY THIS SPOTLIGHT?

- **Why:** People with HIV who experience unstable housing may have competing social and medical needs which require multiple interactions with various parts of the care system. This can lead to duplication of effort, confusion between provider and client, or lapses in communication. Staff from each part of the system need to communicate and coordinate to meet multifaceted client needs. We call this the "no wrong door" approach.
- **What:** The spotlight describes Fenway Health's best practices for building a comprehensive system to address medical and social needs for people with HIV through a two-pronged approach:
  - Integrating existing services at a Federally Qualified Health center (FQHC) & AIDS Services Organization (ASO)
  - Identifying and building partnerships to address employment needs

SUMMARY

Fenway Health provides HIV care and treatment, including access to Medical Case Management. AIDS Action Committee (AAC), the public health division of Fenway Health, provides comprehensive housing services, including housing search and rental assistance. With funding from the HRSA HIV/AIDS Bureau (HAB) Ryan White HIV/AIDS Program (RWHAP) Part F, Special Projects of National Significance (SPNS) Initiative "Improving HIV Health Outcomes through Coordinated Housing and Employment Services", Fenway partnered with MassHire Downtown Boston, a division of Jewish

Q&A

Any questions? Ask in the chat box!

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THANK YOU