Housing First to Treat and Prevent HIV

Intervention Implementation Guide

HRSA
Ryan White HIV/AIDS Program

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This publication lists non-federal resources in order to provide additional information to those considering replication. The views and content in these resources have not been formally approved by HHS or HRSA. Neither HHS nor HRSA endorses the products or services of the listed resources.

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Housing First to Treat and Prevent HIV

This guide examines the Housing First to Treat and Prevent HIV (HFTPH) intervention, launched by Caracole, an AIDS Service Organization (ASO) in Cincinnati, OH. This intervention was initially funded through the U.S. Department of Housing and Urban Development (HUD) including Housing Opportunities for People with AIDS (HOPWA) grants, and funds allocated towards this project from the State of Ohio through the Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program (RWHAP) Part B.

Ending the HIV Epidemic in the U.S. Pillar: Treat

HIV Care Continuum Stage: Linkage and Retention

Priority Population: People Experiencing Unstable Housing

Setting: ASO

Homelessness and housing instability are major threats to HIV management. A safe, affordable home is a necessary platform for rest, nutrition, medical engagement, and medication adherence. Caracole's approach connects individuals to housing and addresses barriers they may face in maintaining housing. The intervention uses three interconnected approaches to improve retention in HIV care: housing first, harm reduction, and Motivational Interviewing.

This guide includes key components of the HFTPH intervention, outlines the capacity required by organizations/clinics to conduct this work, and includes replication steps to support others in their implementation efforts. Finding replicable interventions that meet Ending the HIV Epidemic in the U. S. (EHE) initiative goals and support clients along the stages of the HIV care continuum are key to future programmatic and client success in HIV care.[1]

Achievements

In 2021, 94 percent of HFTPH clients stayed in the program or graduated to a positive, long-term housing option, such as renting without a subsidy; and 84 percent were virally suppressed.

About SPNS

The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services (HHS), is the primary federal agency for improving healthcare to people who are geographically isolated, economically or medically vulnerable. The Ryan White HIV/AIDS Program (RWHAP) Part F: Special Projects of National Significance (SPNS) Program is administered by HRSA's HIV/AIDS Bureau (HAB). The RWHAP SPNS Program supports the development of innovative models of HIV care and treatment to quickly respond to emerging needs of clients served by the RWHAP. RWHAP SPNS advances knowledge and skills in the delivery of healthcare and support services for people with HIV who have not been successfully maintained in care. Through its demonstration projects, RWHAP SPNS evaluates the design, implementation, utilization, cost, and health-related outcomes of treatment models while promoting the dissemination and replication of successful interventions.

Funding Source

The featured intervention was initially funded through the U.S. Department of Housing and Urban Development (HUD) including Housing Opportunities for People with AIDS (HOPWA) grants and Continuum of Care funds for permanent supportive housing; and funds allocated towards this project from the State of Ohio through the Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program (RWHAP) Part B. Caracole also receives funds from the United Way, the City of Cincinnati, and the Ohio Development Services Agency.

To learn more about the RWHAP, visit: **ryanwhite.hrsa.gov**

Getting Started

This table provides a general overview of the HFTPH intervention so readers can assess the necessary steps required for replication.

INTERVENTION AT-A-GLANCE	
Step 1	**Assess Community and Organizational Resources** Assess your service offerings and strengths along with the needs of the community, prioritizing clients most at risk. Identify key partnerships to fill in any gaps.
Step 2	**Bring Partners Together** Develop relationships within the community on both the medical and housing side. Coordinate stakeholder meetings to provide details on the intervention and secure buy-in from referral agencies. Include details on how key partners and referral agencies will work together, track, and coordinate activities.
Step 3	**Hire and Train Staff** Hire key staff and conduct trainings on Motivational Interviewing, harm reduction, trauma-informed care, and cultural competency.
Step 4	**Set up a Collaborative Care Model** Provide for a collaborative work environment where a housing team and clinical case management team will work together to meet client needs.
Step 5	**Review and Engage Client Referrals from Community Partners** Review and accept referrals or be matched with eligible clients based on funding requirements and program structure.
Step 6	**Enroll Clients and Conduct Assessments** Explain intervention activities, explain confidentiality components, screen for eligibility, and enlist clients into the intervention. Conduct an initial assessment and build rapport with each client.
Step 7	**Develop Care Plan** Talk to clients about where they have been, where they are now, and what is next. Develop individualized goals in anticipation of graduation.
Step 8	**Secure Housing and Provide Independent Living Skills Training** Identify appropriate housing for clients and work with both clients and systems to secure housing and support clients in the transition by providing independent living skills training.

INTERVENTION AT-A-GLANCE	
Step 9 	**Provide Clinical Case Management** Provide case management services; help reduce barriers to care; and support access to applicable HIV care, substance use treatment, mental health treatment, adherence counseling, benefits programs, and health insurance.
Step 10 	**Graduate Clients** As clients progress through their care plan and develop increased autonomy, support their "step down" to a lower-intensity level program.

RESOURCE ASSESSMENT CHECKLIST

Prior to implementing the intervention, organizations should walk through the following Resource Assessment (or Readiness) Checklist to assess their ability to conduct this work. If organizations do not have the recommended readiness, they are encouraged to develop their capacity so that they can successfully implement this intervention. Questions to consider include:

- ❑ Does your organization offer housing services?
- ❑ Does your organization have experience working with people with HIV?
- ❑ Is staff culturally responsive, compassionate, and interested in working with those experiencing unstable housing? Substance use disorder? Mental health issues?
- ❑ Are your services accessible to people experiencing unstable housing? Consider proximity to public transit, appointment times, modes of communication, required verification documents, etc.
- ❑ What services can you offer to build trust with clients experiencing unstable housing (e.g., food and transit vouchers, toiletries, comfortable waiting area, linkage to supportive services)?
- ❑ Does your organization offer harm reduction services and, if not, are you able to partner with an organization who does?
- ❑ Is staff trained in HIV, mental health, harm reduction, trauma-informed care, and Motivational Interviewing and, if not, are you able to provide trainings on these topics?

Setting the Stage

In 2018, approximately 9.5 percent of people with HIV in the U.S. experienced homelessness.[2] People with HIV experiencing homelessness and housing instability continue to disproportionately face challenges in accessing care and achieving improved health outcomes.[3] They tend to have lower CD4 cell counts and higher viral loads at diagnosis (which is a predictor of mortality) and higher rates of comorbid infections such as tuberculosis, hepatitis and pneumonia than those who are stably housed.[4] Due to immediate needs such as food and shelter not being met, people with HIV experiencing homelessness and housing instability have poorer retention in care, lower adherence to antiretroviral treatment (ART), and a higher viral load.[5,6,7,8]

Tenants of Housing First

- Housing is a human right.
- Human rights are not "carrots and sticks" to change behavior.
- People cannot address other needs well while experiencing homelessness or housing instability.
- Safe, affordable housing is a platform for best possible health and wellbeing.

Studies have demonstrated the strong association between access to stable, secure, and adequate housing and improved engagement and retention in HIV prevention, treatment, and care; viral suppression; and long-term survival.[5,6,9,10] Despite this evidence, approximately one-half of the estimated 1.18 million people with HIV nationwide[11] are expected to experience homelessness at one point in their lifetime.[12]

Description of Intervention Model

CHALLENGE ACCEPTED

The Challenge: Connect individuals to housing and address barriers they may face in maintaining housing.

The intervention uses three interconnected approaches to improve retention in HIV care: housing first, harm reduction, and Motivational Interviewing.

Housing. Clients pay about 30 percent of their gross income toward housing costs (rent and utilities). For example, if a single individual earns $800 per month, they are responsible for $240 per month in housing costs while the intervention funds the remaining amount. The intervention does not require prerequisites such as consenting to treatment, being employed or engaging in mental health services.

Harm reduction. Intervention services (provided in partnership with Hamilton County Public Health) include providing clients with clean syringes, naloxone, clean cookers and other supplies, Fentanyl test strips, and education on how to use drugs more safely. Caracole staff also refer clients to treatment facilities and link them to additional community resources and benefits. The intervention also provides clients with an onsite primary care clinic and an empowerment group for people who use drugs.

Motivational Interviewing. Motivational Interviewing has been an effective strategy with Caracole's high-needs clients. Through a series of open-ended questions, staff gain a better understanding of, and express empathy toward client challenges and help clients identify what they want to accomplish in a set period of time. Motivational Interviewing respects the client as the expert and author of their own journey and provides a reflective framework for change rather than dictating requirements.

"We believe that housing is a human right. It is not a carrot or a stick to change people's behavior, but instead something that people are entitled to and something that's essential as a foundation for better health."

— Carolyn Yorio, LISW, MPH
Director of Housing, Caracole

Housing First uses an approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment or service participation requirements.

All households served by Caracole housing include an HIV+ household member and were previously homeless or unstably housed. The most vulnerable households are prioritized for assistance. Eligible individuals may reflect any of the following criteria: CD4 < 200, medically vulnerable (undergoing treatment for cancer, recent stroke or heart attack, transplant recipient, amputation, sickle cell anemia, liver or kidney disease, etc.), pregnant or parenting, mental illness, substance use disorder.

Intervention Steps:

1. *Prioritize clients most at risk.* Provide permanent supportive housing services to individuals with the greatest needs, taking into consideration the individual's mental health, substance use, chronic co-occurring conditions, legal history, length of time experiencing housing instability, and viral load. In Caracole's Continuum of Care—funded housing program, staff work with the region's Coordinated Entry System to use the federal Vulnerability Index—Service Prioritization Decision Assistance Tool (VI-SDAT) to identify individuals who are of greatest need and eligible for the intervention.

2. *Train staff.* Conduct trainings with staff on Motivational Interviewing, harm reduction, trauma-informed care, and cultural competency.

3. *Set up a Collaborative Care Model.* Provide a collaborative work environment where a housing team and clinical case management team will work together to meet client needs.

4. *Review and engage client referrals from community partners.* Programs may review and accept referrals or be matched with eligible clients based on funding requirements and program structure.

5. *Enroll clients, conduct assessments, and develop an individualized care plan.* Once a client is located, the HFTPH

team conducts an initial assessment, seeks to build rapport, explains confidentiality components of the intervention, and has the client sign basic intake paperwork. The team works with the client to identify goals related to medical care and housing. Part of this process includes educating the client about available resources. The clinical case manager and housing specialist work together with the client to develop a care plan, which includes short- and long-term goals, and what is needed to graduate to more independent housing.

6 *Connect individuals to housing.* Intervention housing specialists identify a housing unit that accepts the subsidy. This process can be challenging given the:

- Limited supply of apartments considered "rent reasonable" (HUD's criteria for how much total rent can be charged for a unit), and
- Number of landlords willing to accept the subsidy.

To encourage uptake of the subsidy, HFTPH educates landlords about the support it provides clients to make the housing placement successful and its willingness to step in to resolve disputes or mitigate issues. Over the years, HFTPH has developed a list of landlords who are willing to rent to their clients based on good experiences and mutual trust.

7 *Provide clinical case management.* Provide case management services; help reduce barriers to care; and support access to applicable HIV care, substance use treatment, mental health treatment, adherence counseling, benefits programs, and health insurance.

8 *Support placement success.* Staff offer coaching and supports to help clients stay in their homes. For example, Caracole leverages private funds to fill gaps when clients are unable to pay their rent (approximately 30% of their income) or other necessities due to extenuating circumstances. Housing specialists may suggest other strategies to improve placement success, such as installing punch code door locks if clients tend to lose their keys. One housing specialist hosts a monthly tenant meeting to encourage behaviors that keep people housed. Caracole also provides "Welcome Home Kits" with basics like linens, kitchenware and cleaning supplies.

9 *Address longer-term challenges.* HFTPH's integrated team of housing specialists and medical case managers must build trust with clients to help mitigate issues that might jeopardize long-term housing stability. This relationship often starts with home visits. If staff see concerning behaviors that could lead to eviction, they engage the client in honest conversation about what needs to happen based on what is important to the client: preserving

Harm Reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.

housing. Staff do not assign blame for client behavior. Instead, they look to what can change. For instance, they would not chide a client for allowing a family member to move into the home. They would instead present options of formally adding the family member to the lease or setting a timeline for the family member to move on. Clients who are stable in their housing can then work on larger goals: engagement in healthcare, education, employment, addressing legal history, etc. Through this technique, staff "build a map" with clients to help them reach their long-term goals, starting with their most immediate concerns.

10 *Provide harm reduction services.* Many people in need of supportive housing are also dealing with substance use. Harm reduction is an approach that engages the client and encourages them to be as safe and healthy as they can while continuing to use, reducing use, or stopping their use altogether based on the client's priorities. In addition, through these services, the intervention builds trust with individuals and connects them to other support services and medical care. Harm reduction services help improve housing stability by reducing behaviors that cause problems for property management. Caracole partners with Hamilton County Public Health to provide syringe services, Naloxone, clean works, safer sex and safer use kits, pregnancy tests, Fentanyl test strips, and other products that protect health. Caracole staff can connect clients with addiction treatment, including medication assisted treatment for opioid addiction.

11 *Graduate clients.* As clients progress through their care plan and develop increased autonomy, HFTPH staff support their "step down" to a lower-intensity level program.

Meetings

There are a series of meetings to help keep team members and partners coordinated. This includes a monthly meeting between the medical case managers and the housing specialists for case discussion and how they can support one another.

STAFFING REQUIREMENTS & CONSIDERATIONS FOR REPLICATION

Staffing/Organizational Capacity

HFTPH uses a collaborative care model that includes two dedicated staff people—one housing specialist and one medical case manager—for every single household. Staff requirements and competencies needed to successfully implement HFTPH include the following:

- *Project Manager:* Provides oversight of the HFTPH intervention and oversees quality improvement efforts. Builds and implements project management tools; creates and implements intervention protocols; and organizes and convenes administrative and community stakeholder meetings.
- *Clinical Case Managers:* Work in tandem with the housing specialist to develop a collaborative care plan for each client. Promote HIV medication and care adherence and provide support to obtaining health insurance. Accompany clients to medical appointments; advocate for clients with other service providers; conduct field-based assessments of client needs; conduct psychosocial and cognitive assessments; provide referrals to health and psychosocial service resources and programs; and provide informal, field-based, short-term psychosocial counseling to address immediate client barriers to care (including mental health and substance use issues). Each clinical case manager should have no more than 30–40 cases at one time.
- *Housing Specialists:* Work in tandem with clinical case managers to develop a collaborative care plan for each client. Work with the client and landlords to find, lease, and maintain appropriate housing. Engage participants to increase independent living skills and/or income as participants work toward program graduation. Build and maintain positive working relationships with landlords, advocates, and other community providers. Each housing specialist should have no more than 30–40 cases at one time.
- *Housing Property Relations Coordinator:* Pursues and maintains relationships with community property owners and managers in order to secure and maintain safe and affordable housing. Maintains current lists of available units. Mediates issues with landlords in collaboration with housing staff and clients. Assists program participants in building independent living/tenancy skills.
- *Housing Quality Coordinator:* Ensures clean, safe, secure living environments for housing clients. Conducts inspections, tracks and communicates needed maintenance to property management, clients and staff. Maintains relationship with property owners to ensure maintenance, unit turnover, and a positive living environment. Supports clients in maintaining clean/safe housing and in knowing their rights as tenants.
- *Clinical Supervisor:* Supervises the clinical case management team members. Provides training and guidance on HIV-related health issues, mental health, substance use, and medical benefits issues.

Staff Characteristics

Core competencies include:

- Cultural responsiveness, compassion, and humility
- Familiarity with housing instability and homelessness, HIV, mental health, harm reduction, trauma-informed care, and substance use disorders
- Communication and teamwork skills

Replication Tips for Intervention Procedures and Client Engagement

This section provides tips for readers interested in replicating the intervention and, where applicable, examples for further context. Successful replication of the HFTPH intervention involves the following:

Hire the right staff. Hire team members with good instincts who know the community, its resources, businesses, and people. Recognize that this work necessitates a team approach. Housing specialists and medical case managers must work together to develop a collaborative care plan for each client. These client teams meet once a month to review caseloads and talk about client needs, so hiring staff that values teamwork is critical.

Complete Motivational Interviewing training curriculum. Proper training of staff is essential to successful implementation of the intervention. Motivational Interviewing is a focused, client-centered approach to counseling that helps clients identify, explore, and deal with ambivalence.

Collaborate. Caracole has maintained strong relationships with partner agencies that provide housing, mental healthcare, and other social supports throughout the area by being generous with time and resources. Staff participate in workgroups and collaboratives and share policies and procedures with partner organizations. Caracole also established liaisons to lead communications with each area infectious disease provider to ensure responsiveness. As a result, Caracole has a comprehensive network of service partners for client referrals. Cincinnati's Continuum of Care for the Homeless also partners with the Cincinnati Metropolitan Housing Authority which enables them to graduate clients with housing choice vouchers sooner as many times they have the skills to live independently but it takes longer to acquire the finances.

Use a trauma-informed approach. A cornerstone of replicating this intervention is ensuring that leadership is devoted to trauma-informed management—both at the system and client level—and that team members are trained in a trauma-informed approach.

Provide incentives. Bus passes, gift cards to local food establishments, protein bars, and hygiene supplies go a long way in meeting clients' basic needs. They also encourage clients to engage in the services offered through the intervention. When moving into an apartment, Caracole provides "welcome home" kits for clients with items such as cooking tools, linens, cleaning supplies, and other items they may need. In addition, clients also receive a $60 gift card when they become virally suppressed and graduate from the Viral Load Suppression for HIV Program. HFTPH uses a combination of RWHAP funds and state and private grants to fund these client incentives.

Leverage funding streams. Flexible funding streams can help ensure that the range of a client's needs are met including from federal rent subsidy programs and private grants for supportive services such as cleaning supplies or application fees.

Share resources and information. Regularly scheduled meetings are important to discuss intervention logistics, protocols, as well as case conferencing for more complex clients. Case managers participate in monthly group supervision, during which they discuss different client situations and share advice on how to talk to and motivate their clients.

Securing Buy-in

Securing the support of leadership, staff, and other relevant stakeholders is an important step when implementing an intervention. The following strategies may help to secure buy-in for the HFTPH intervention:

- ***Highlight the gap*** this intervention seeks to address which other entities are either failing to meet or are ill-equipped to implement.
- ***Ensure all key players are at the table*** including funding partners and other community organizations, such as city linkage programs and referral agencies. Discuss how referrals will be handled and tracked.
- ***Employ a collaborative approach*** to intervention planning and implementation, and schedule regular meetings to keep partners informed and involved.

Overcoming Implementation Challenges

There are often challenges implementing a new intervention. Caracole experienced several challenges and addressed them in the following ways:

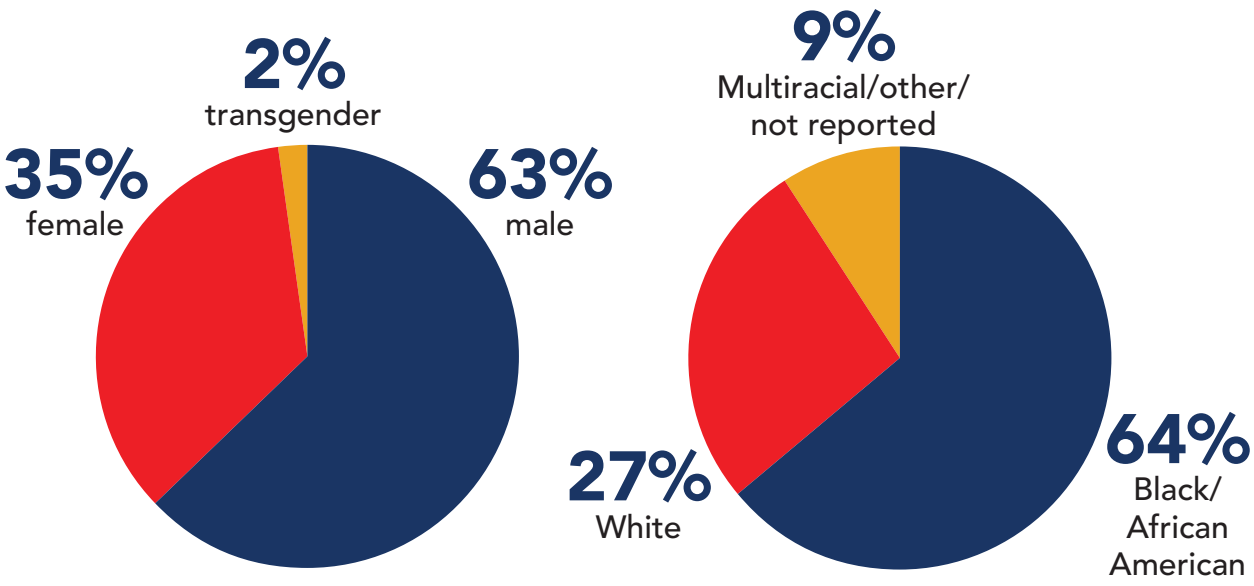
- ***Difficulty maintaining independent housing.*** Caracole coordinates a monthly tenant meeting to improve housing outcomes, which focuses on topics such as paying rent, understanding the terms of a lease, making a maintenance request, and conflict resolution, among others.
- ***Limited amount of available housing.*** Some landlords are hesitant to work with subsidies, and some landlords are hesitant to take clients with experience of incarceration or substance use. Facilitating relationships with landlords and finding enough available housing for clients may be a challenge. Caracole has addressed that through paying double deposits at times, and recently hiring a Property Relations Coordinator to work with landlords.
- ***High staff turnover.*** High staff turnover for an intervention of this nature is common. Anticipating turnover at a management level, and planning for additional training to help new staff have less of a learning curve, can help mitigate disruption of the intervention.
- ***Working in a collaborative care model.*** Many organizations are siloed between departments and many offer staff the flexibility to work remotely some of the time, necessitating a great deal of collaboration to offer wraparound services between two departments. Requiring team members be in the same location one to two days a week has helped Caracole staff develop strong working relationships and have the space to collaborate with each other.
- ***Limited staff time.*** As with many intensive interventions, key staff's time is typically spread thin. Intervention developers have found that when staff are busier, they tend to spend less time collaborating. Providing smaller caseloads by leveraging additional funding streams will help promote collaboration as well as providing the structure for a collaborative care model.

Promoting Sustainability

Caracole relies on steady HUD funding for housing subsidies including HOPWA grants and Continuum of Care funds for permanent supportive housing. Caracole also receives funds from the United Way, the City of Cincinnati, and Ohio Development Services Agency. In order to be sustainable, programs need to invest in staff retention through education, compensation, and support to consistently accomplish a recognizably difficult job. Programs also need strong community relationships with property managers. When behavioral issues lead to lease violations, Housing Specialists with strong relationships with the property managers can help the parties involved find a solution rather than resorting to eviction.

CARACOLE HOUSING: BY THE NUMBERS

In 2021, Caracole housing served **216** people in **167** households.



Within 12 months:

84 percent percent achieved viral load suppression

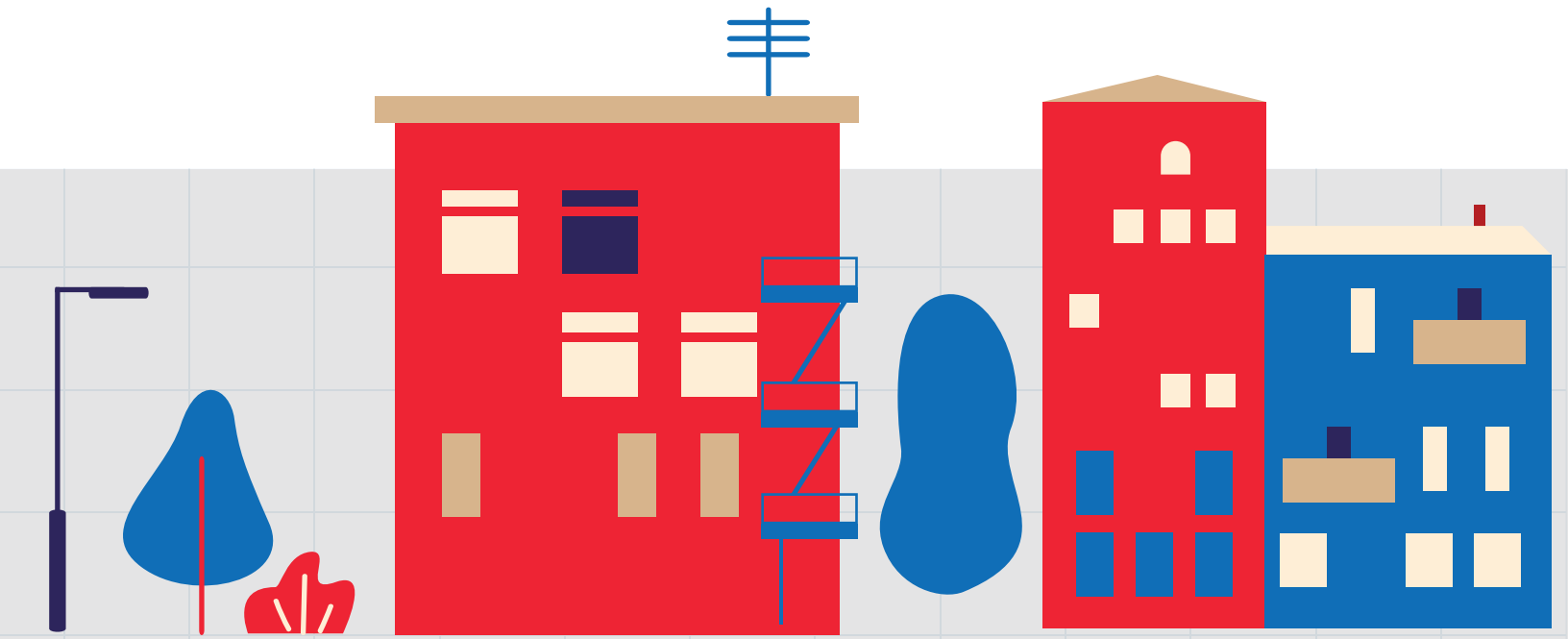
94 percent remained in permanent supportive housing or exited to permanent housing

98 percent established a relationship with a healthcare setting

Conclusion

HFTPH represents an innovative, holistic, and promising intervention model to connect individuals with HIV experiencing homelessness or housing instability to permanent supportive housing. The intervention targets the most vulnerable community members—those who have been chronically homeless, and those with co-occurring mental illness, substance use disorder, multiple health conditions, multiple evictions and past incarceration, which can be barriers to maintaining housing.

The intervention uses three interconnected approaches to improve retention in HIV care—housing first, harm reduction, and Motivational Interviewing—and provides wraparound services in a collaborative care model to reduce the impact of those barriers. By improving independent living skills, and providing a safe, stable foundation for housing access, HFTPH clients showed improved engagement and retention in HIV prevention, treatment, and care, and viral suppression.



OTHER AVAILABLE RESOURCES

HFTPH Resources

Permanent Supportive Housing and Viral Load Suppression Presentation
https://targethiv.org/sites/default/files/media/documents/2021-08/Permanent_Supportive_Housing_and_Viral_Load_Suppression_9.2020_508.pdf

Additional Replication Resources

Integrating HIV Innovative Practices (IHIP):
https://targethiv.org/ihip

Best Practices Compilation:
https://targethiv.org/bestpractices/search

HIV Care Innovations:
https://targethiv.org/library/hiv-care-innovations-replication-resources

Finding Home: Tips and Tools for Guiding People Living with HIV Toward Stable Housing Toolkit:
https://ciswh.org/wp-content/uploads/2017/09/Housing-Toolkit.pdf

Need Help Getting Started?

If you are interested in learning more about this intervention or other interventions featured through the Integrating HIV Innovative Practices project or want to request technical assistance, please email: **ihiphelpdesk@mayatech.com**

Subscribe to our Listserv

To receive notifications of when other evidence-informed and evidence-based intervention materials, trainings, webinars, and TA are available through the Integrating HIV Innovative Practices project, subscribe to our listserv at: **https://targethiv.org/ihip**

Tell Us Your Replication Story!

Are you planning to implement this intervention? Have you already started or know someone who has? We want to hear from you. Please reach out to **SPNS@hrsa.gov** and let us know about your replication story.

Endnotes

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