HRSA
Health Resources & Services Administration

Promoting Improved HIV Health Outcomes in Clients Experiencing Unstable Housing

2020 National Ryan White Conference on HIV Care and Treatment

August 13, 2020

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Vision: Healthy Communities, Healthy People

Health Resources and Services Administration (HRSA) Overview

- Supports more than 90 programs that provide health care to people who are geographically isolated, economically or medically vulnerable through grants and cooperative agreements to more than 3,000 awardees, including community and faith-based organizations, colleges and universities, hospitals, state, local, and tribal governments, and private entities

- Every year, HRSA programs serve tens of millions of people, including people with HIV/AIDS, pregnant women, mothers and their families, and those otherwise unable to access quality health care

HRSA's HIV/AIDS Bureau (HAB) Vision and Mission

Vision

Optimal HIV/AIDS care and treatment for all.

Mission

Provide leadership and resources to assure access to and retention in high quality, integrated care, and treatment services for vulnerable people with HIV/AIDS and their families.

HRSA's Ryan White HIV/AIDS Program

- Provides comprehensive system of HIV primary medical care, medications, and essential support services for low-income people with HIV
  - More than half of people with diagnosed HIV in the United States – nearly 519,000 people – receive care through the Ryan White HIV/AIDS Program (RWHAP)
- Funds grants to states, cities/counties, and local community based organizations
  - Recipients determine service delivery and funding priorities based on local needs and planning process
- Payor of last resort statutory provision: RWHAP funds may not be used for services if another state or federal payer is available
- 87.1% of Ryan White HIV/AIDS Program clients were virally suppressed in 2018, exceeding national average of 62.7%

Source: HRSA. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2018; CDC. HIV Surveillance Supplemental Report 2018;21(No. 4)

HRSA Ryan White HIV/AIDS Program

Promoting Improved HIV Health Outcomes in Clients Experiencing Unstable Housing

- **Who is unstably housed in the RWHAP**?
  - Amy Griffin, Public Health Analyst, Homeless and Housing Workgroup Member (HHWG)
- **How does unstable housing impact HIV Health Outcomes in the RWHAP?**
  - Amy Griffin, Public Health Analyst, HHWG
- **How can the RWHAP address housing needs?**
  - Amy Griffin, Public Health Analyst, HHWG
- **Bailey-Boushay House, Seattle, Washington**
  - Linda Coomas, RWHAP Part A director Seattle-King Co., Washington
  - Brian Knowles, Director, Bailey Boushay House
- **Wesley Health Centers JWCH Institute, Los Angeles, California**
  - Hilda Sandoval, PhD. LMFT, Director Behavioral Health
  - Sandra Valdivia, Program Manager, MCC Program, Medical Care Coordination

Learning Objectives

- Improve RWHAP Parts A-F recipients' understanding of how unstable housing impacts HIV health outcomes.
- Highlight innovative strategies to improve viral suppression rates in clients experiencing homelessness.
- Highlight which portfolio of services can work to improve HIV health outcomes in clients experiencing unstable housing.

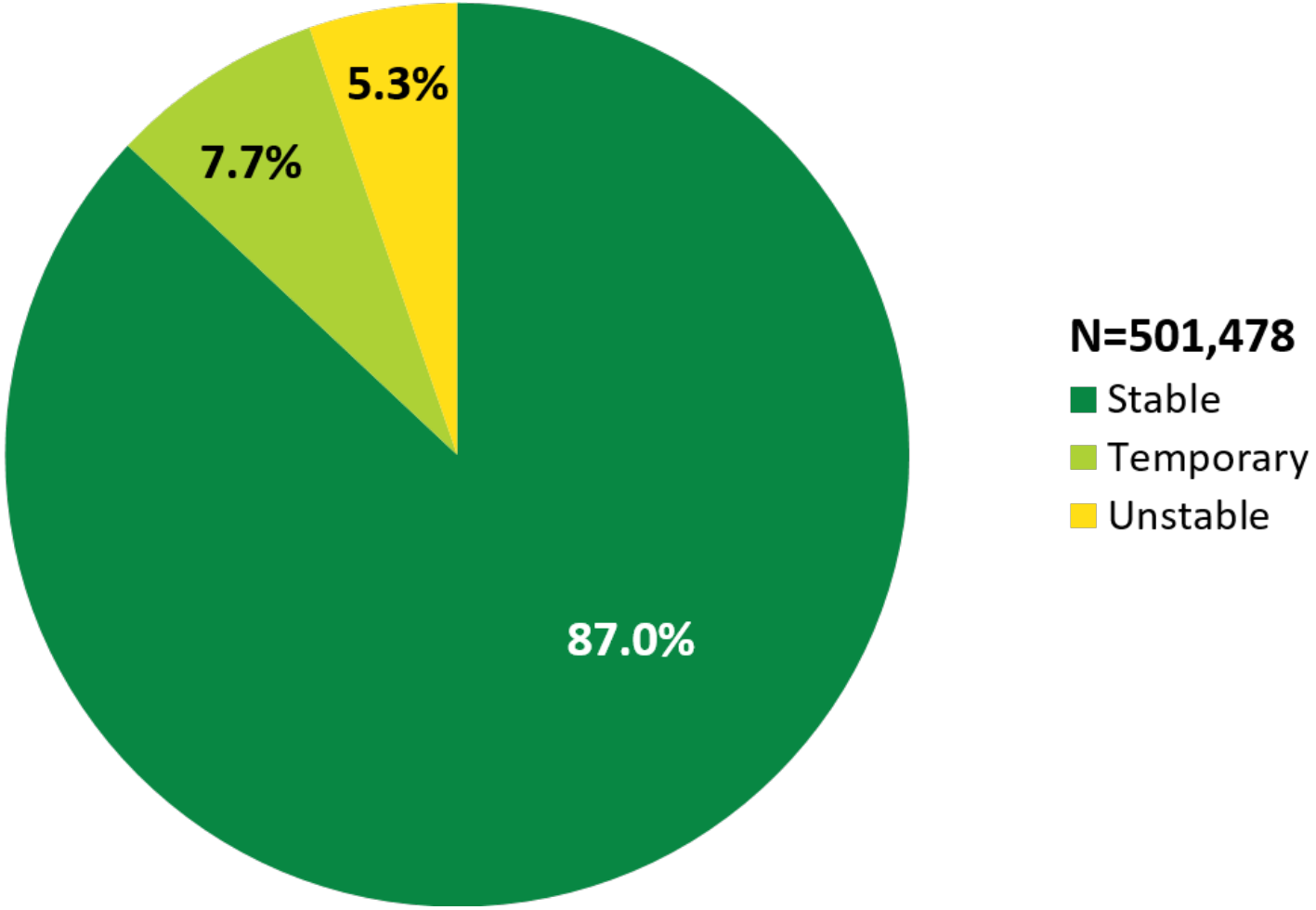
Who is unstably housed in the RWHAP?

Why are Housing Concerns Important to the RWHAP?

- For persons who lack a safe, stable place to live, housing assistance is a proven cost-effective health care intervention.
- Stable housing has a direct, independent, and powerful impact on HIV incidence, health outcomes, and health disparities.
- Housing status is a more significant predictor of health care access and HIV outcomes than individual characteristics, behavioral health issues, or access to other services.

Taken from the US. Housing and Urban Development Publication, *HIV CARE CONTINUUM The Connection Between Housing And Improved Outcomes Along The HIV Care Continuum (2013).* Available for download at https://www.hudexchange.info/resources/documents/The-Connection-Between-Housing-and-Improved-Outcomes-Along-the-HIV-Care-Continuum.pdf

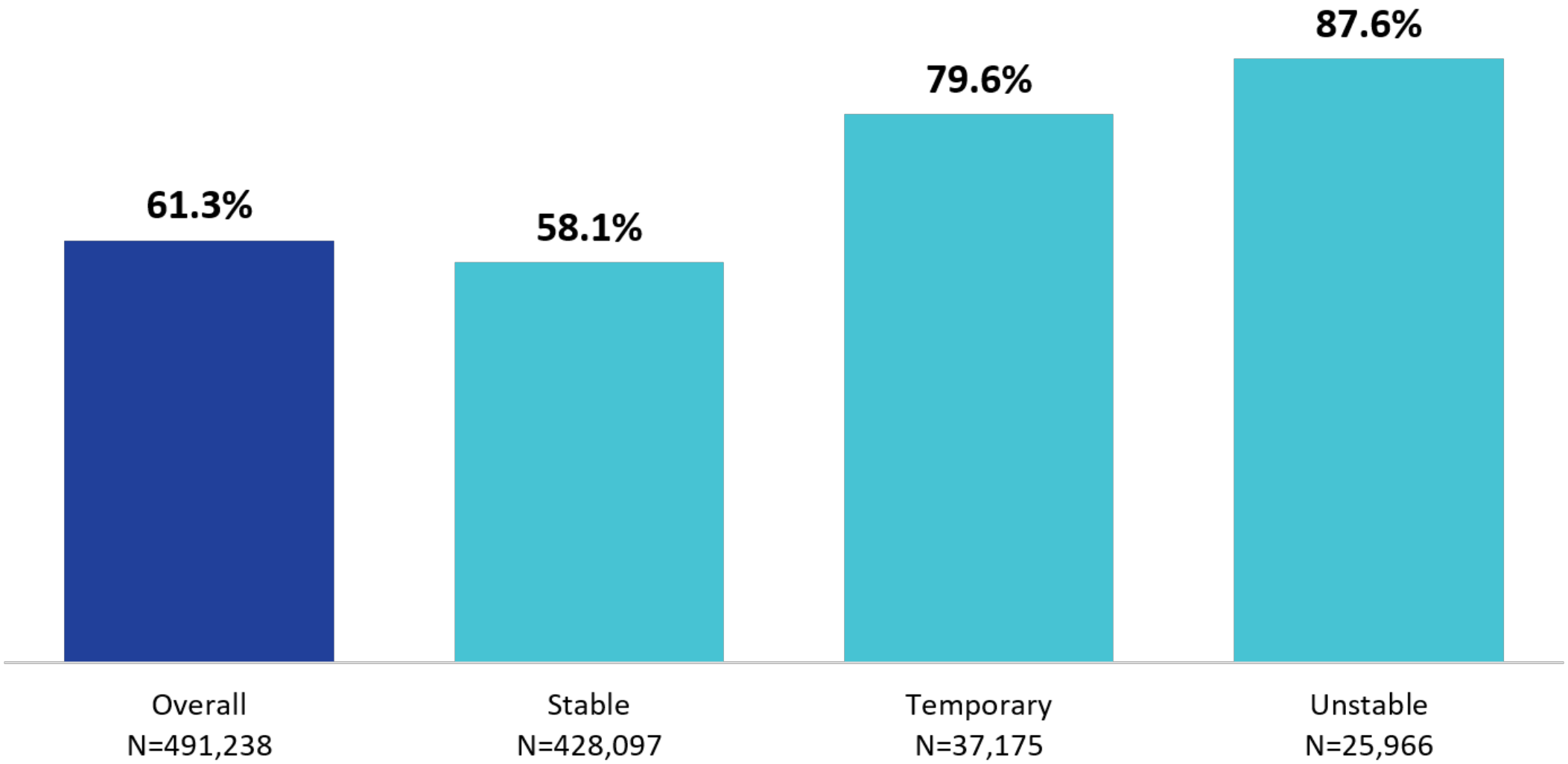
Clients Served by the Ryan White HIV/AIDS Program, by Housing Status, 2018—United States and 3 Territories[a]



[a] Guam, Puerto Rico, and the U.S. Virgin Islands.

HRSA Ryan White HIV/AIDS Program

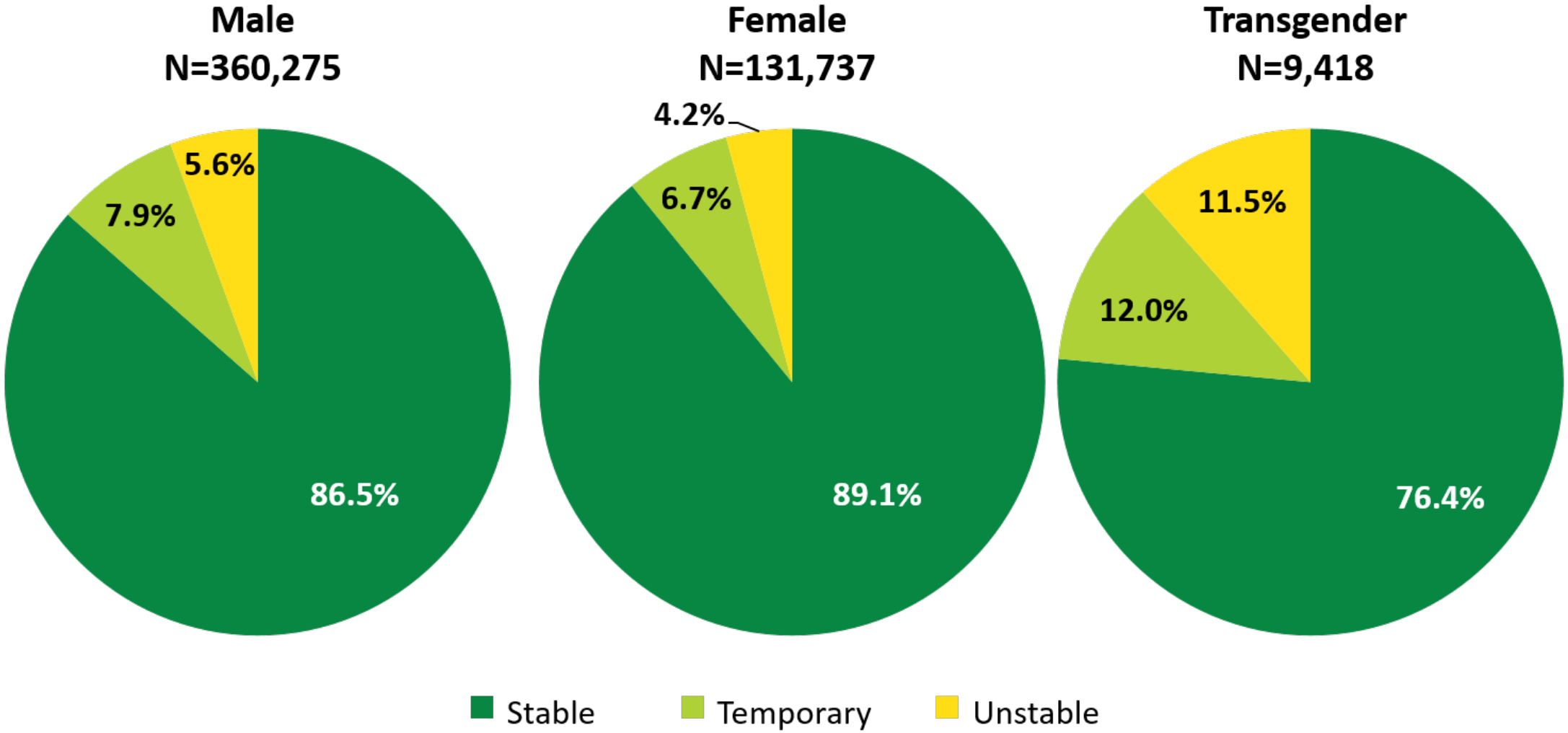
Clients Served by the Ryan White HIV/AIDS Program Living ≤100% of the Federal Poverty Level, by Housing Status, 2018—United States and 3 Territories[a]



[a] Guam, Puerto Rico, and the U.S. Virgin Islands.

HRSA Ryan White HIV/AIDS Program

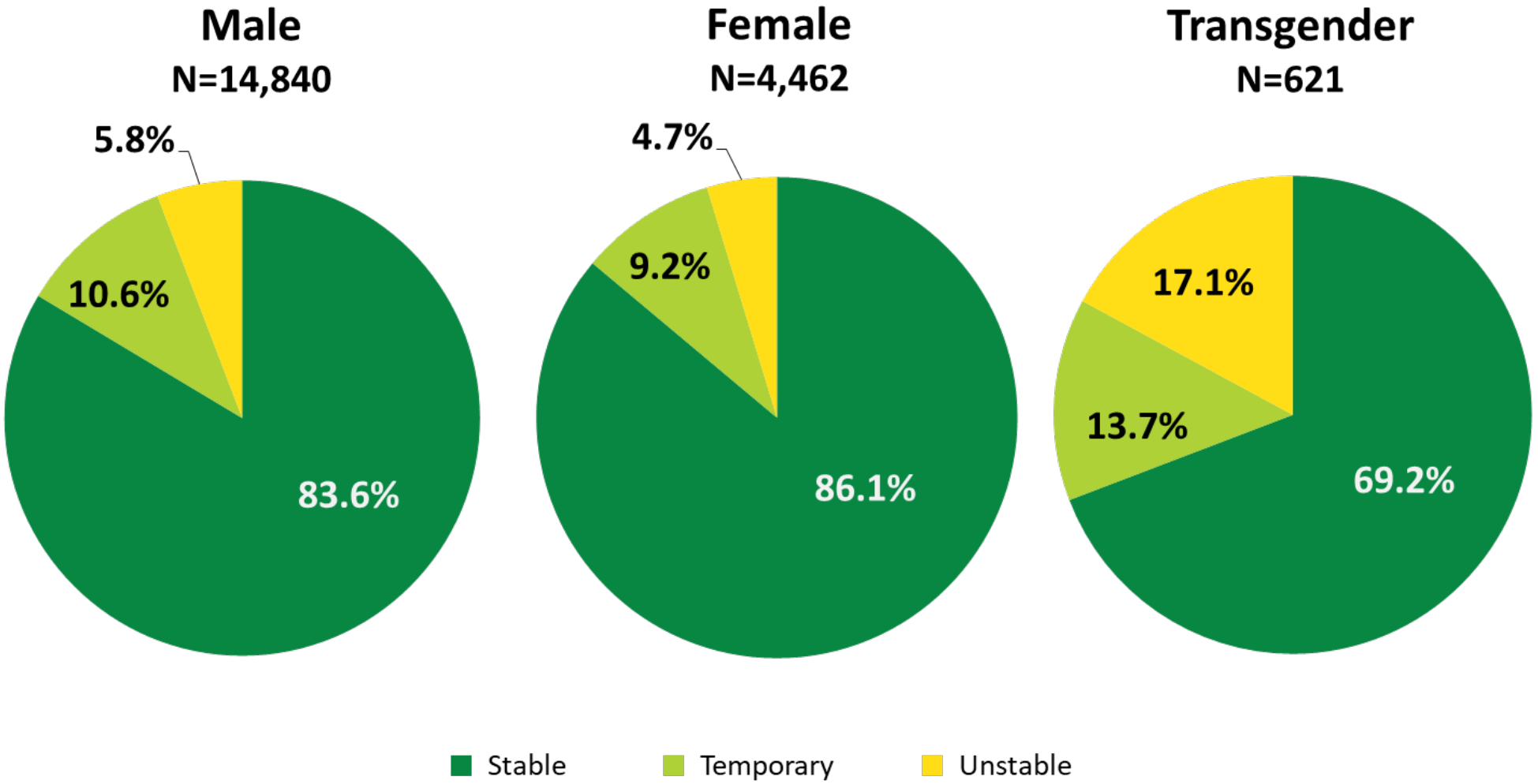
Clients Served by the Ryan White HIV/AIDS Program, by Gender and Housing Status, 2018—United States and 3 Territories[a]



[a] Guam, Puerto Rico, and the U.S. Virgin Islands.

HRSA Ryan White HIV/AIDS Program

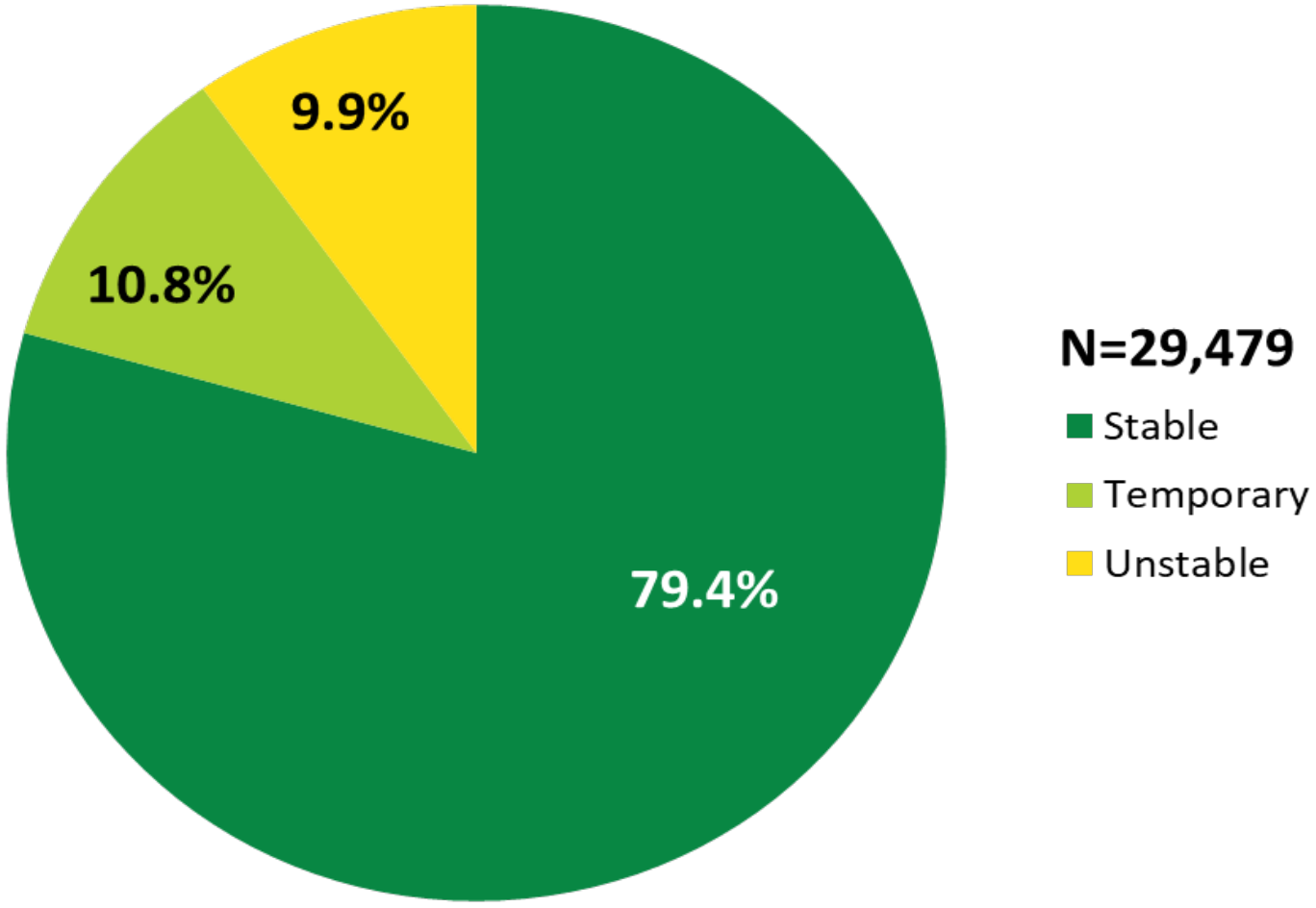
Youth and Young Adults Aged 13–24 Years Served by the Ryan White HIV/AIDS Program, by Gender and Housing Status, 2018—United States and 3 Territories[a]



[a] Guam, Puerto Rico, and the U.S. Virgin Islands.

HRSA Ryan White HIV/AIDS Program

Clients with HIV Infection Attributed to Injection Drug Use Aged ≥13 Years Served by the Ryan White HIV/AIDS Program, by Housing Status, 2018—United States and 3 Territories[a]

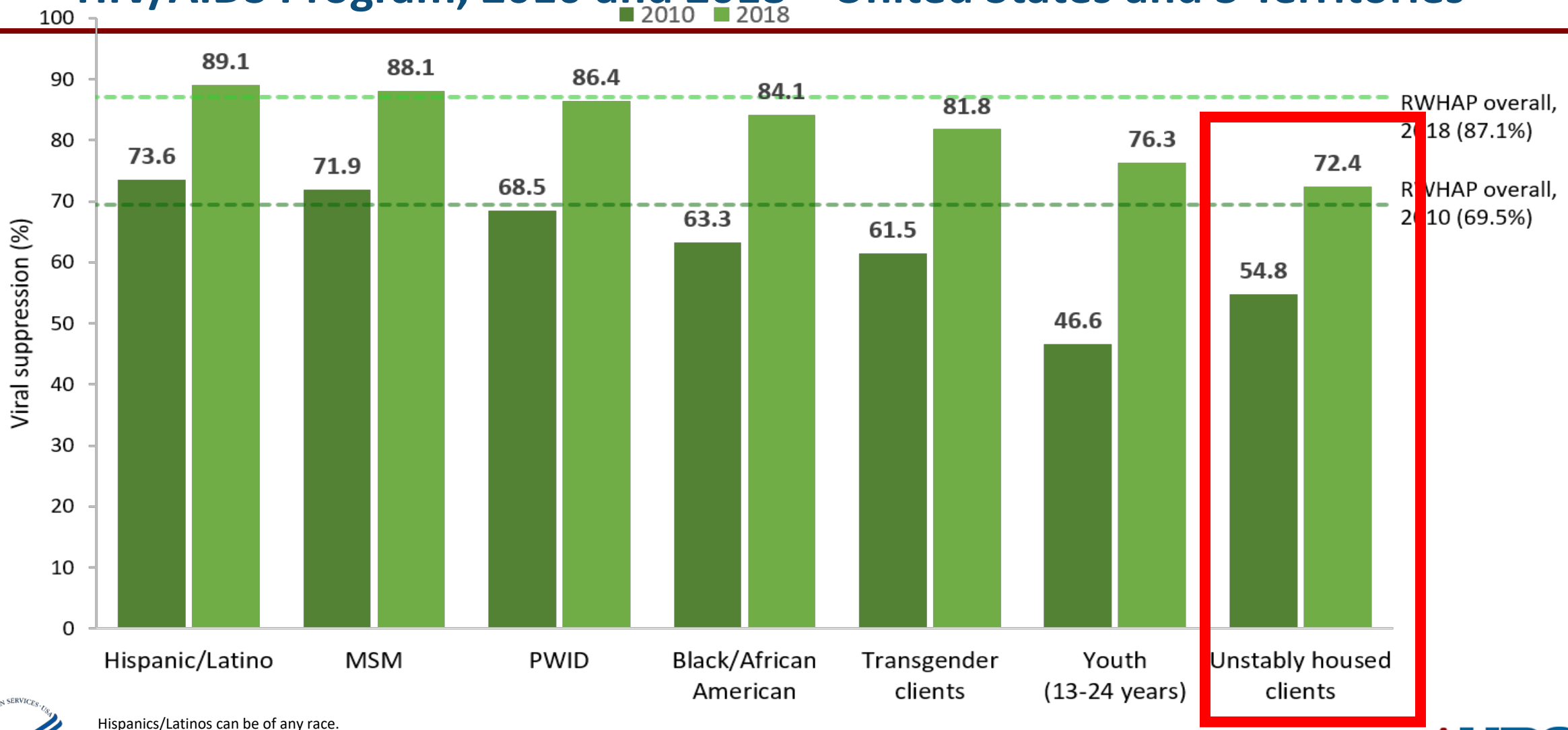


Data represent clients who reported injection drug use as their transmission risk category; data may not reflect current behavior.
Data do not include male-to-male sexual contact *and* injection drug use nor sexual contact *and* injection drug use among transgender clients.
[a] Guam, Puerto Rico, and the U.S. Virgin Islands.

HRSA Ryan White HIV/AIDS Program

Unstable Housing and Viral Suppression

Viral Suppression among Key Populations Served by the Ryan White HIV/AIDS Program, 2010 and 2018—United States and 3 Territories[a]



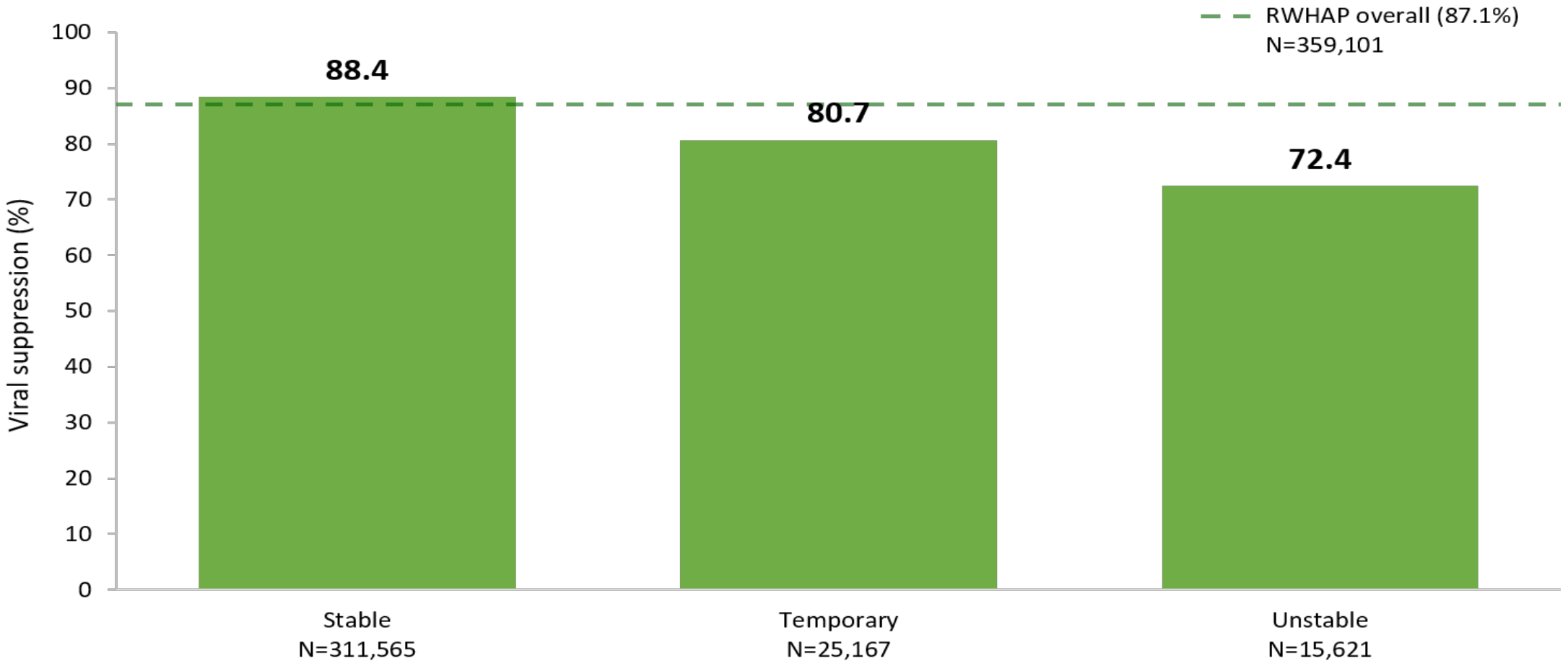
Hispanics/Latinos can be of any race.

Viral suppression: ≥1 OAHS visit during the calendar year and ≥1 viral load reported, with the last viral load result <200 copies/mL.

[a] Guam, Puerto Rico, and the U.S. Virgin Islands.

HRSA Ryan White HIV/AIDS Program

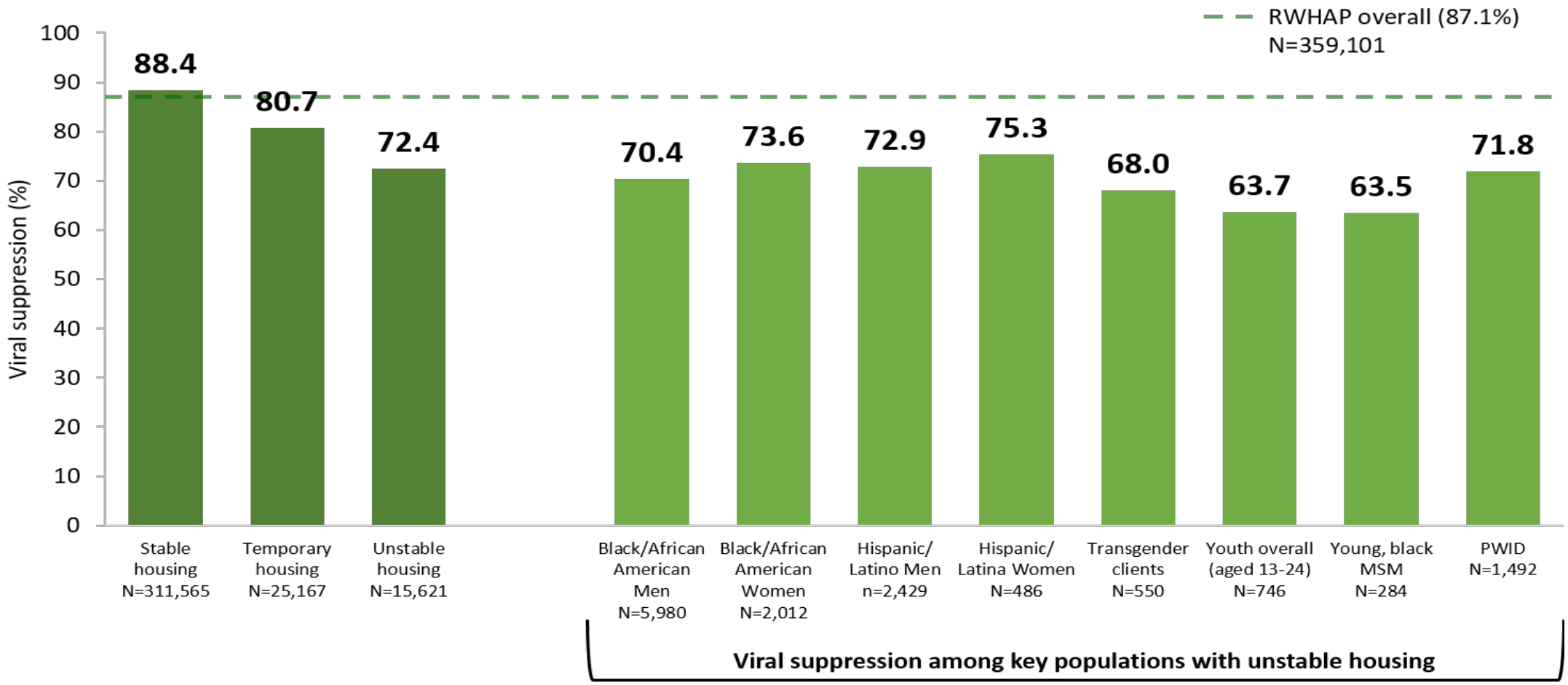
Viral Suppression among Clients Served by the Ryan White HIV/AIDS Program, by Housing Status, 2018—United States and 3 Territories[a]



N represents the total number of clients in the specific population.
Viral suppression: ≥1 OAHS visit during the calendar year and ≥1 viral load reported, with the last viral load result <200 copies/mL.
[a] Guam, Puerto Rico, and the U.S. Virgin Islands.

HRSA Ryan White HIV/AIDS Program

Viral Suppression among RWHAP Clients, by Housing Status and among Key Populations with Unstable Housing, 2018—United States and 3 Territories[a]



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HRSA Ryan White HIV/AIDS Program

How can the RWHAP address housing needs?

Housing Provision: Allowable Services

Flexibility allowed to address the housing needs of youth. These service categories are listed on the HAB webpage in Policy Clarification Notice (PCN) 16-02: Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds

- **Housing Services:** transitional, short-term, or emergency housing assistance as well as housing referral services (assessment, search and placement) and housing advocacy services for clients.
  - ✓ Individualized housing plan updated annually
  - ✓ Can be incorporated within another core or support service
- **Emergency Financial Assistance:** limited one-time or short-term payments to assist with an urgent need for essential items or services necessary to improve health outcomes, including utilities and housing

Leveraging Housing Services

- U.S. Department of Housing and Urban Development (HUD)
  - Housing Opportunities for Persons with AIDS (HOPWA): https://www.hudexchange.info/programs/hopwa/
  - Homeless Assistance Program Locator: https://www.hudexchange.info/homelessness-assistance/
- U.S Department of Agriculture (USDA), Rural Housing Services:
  - programs to build or improve housing and essential facilities in rural areas
  - https://www.rd.usda.gov/about-rd/agencies/rural-housing-service
- U.S. Department of Health and Human Services (HHS)
  - Substance Abuse and Mental Health Services Administration (SAMHSA) Projects for Assistance in Transition from Homelessness (PATH)
    - ✓ Formula grant to address the needs of clients experiencing both serious mental illness and homelessness
    - ✓ https://www.samhsa.gov/homelessness-programs-resources/grant-programs-services/path

VIRTUAL
2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

SEATTLE TGA

HOUSING STRATEGIES, FUNDING & SERVICES

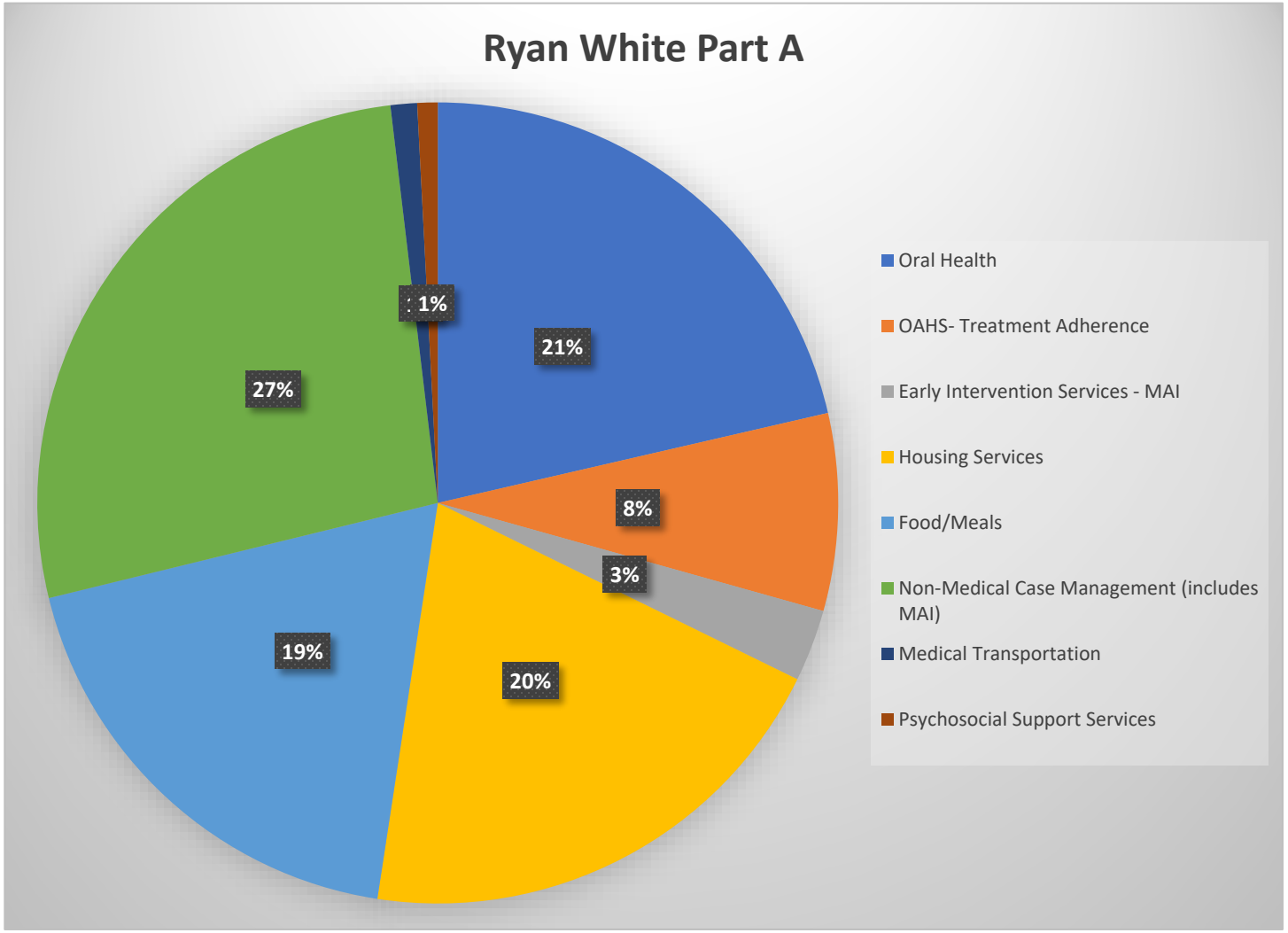
SEATTLE TGA HOUSING CRISIS

- The One Night Count for 2019 estimated that more than 11,000 people in King County are experiencing homelessness.
- Data available for King County estimate that 11%, or about 600-800 people with HIV, are also experiencing homelessness.
- In Snohomish County, the count identified over 1,000 persons experiencing homelessness, including those living unsheltered and in emergency and transitional housing. We do not have an estimate on the number of people with HIV also experiencing homelessness.

Barriers to Housing

- 2019 average rents in Seattle are over $2,000 per month so are unaffordable for most PLWH.
- Not enough housing stock & low vacancy rates.
- Insufficient supply of subsidized housing to meet need. Shortage of Section-8 rental assistance vouchers and other rental subsidy programs.

SEATTLE TGA – FUNDED SERVICES



- 2020 HRSA award was ~$7 million; ~$6.1 distributed to sub-recipient agencies
- 20% allocated to Housing
- 27% ($1,465,000) allocated to Non-Medical Case Management; 65% ($950,000) of NMCM allocation sub-prioritized for Housing

GOAL	ACCOMPLISHMENTS	CHALLENGES
• <5% homeless/unstably housed persons with HIV	• 2017 was the first year we developed a joint RFA with HOPWA to maximize funding. • HOPWA pays for permanent housing and RWPA for transitional and emergency housing, as well as supportive services (NMCM). • In FY 2019 1,180 eligible clients received Housing and/or NMCM - Housing Services	• Still striving to reach our ultimate goal of <5 %. 2019 Epi Report indicates 11% homeless/unstably housed persons with HIV. • Housing costs make it difficult to find affordable units for clients. Clients have to move further away from service providers. • Mental health and substance use issues (particularly crystal meth use) contribute to difficulties finding appropriate housing, and staying connected to services.

Bailey-Boushay House
Virginia Mason™

Bailey-Boushay House (BBH) outpatient programs assisting to lower HIV viral load and increase housing stability.

Services Offered at Bailey-Boushay House Outpatient Programs

- 24 hour day center
- Medication management – DOT, daily, weekly
- Emergency Homeless Shelter
- Rental Assistance Program
- 3 meals and multiple snacks per day
- Individual and group counseling
- Escorts to appointments
- Psychiatry
- Occupational and Physical Therapy
- Chemical Dependency counseling
- Community activities: movies, BINGO, bowling, field trips
- Off site storage
- Free access to needles

Bailey-Boushay House Inpatient

- Bailey-Boushay House is most known for being the first nursing home designed and built from the ground up to serve people with HIV at end of life
- Half of the individuals that died of HIV/AIDS in King County have died at Bailey-Boushay House.

People served

- Individuals referred due to homelessness, inability to successfully take HIV medications, drug/alcohol use, and/or disabling mental illness.
- Homelessness over the last 10 years has moved from 10% to 45%. Currently about 30%.
- People of color: 51%
- Women: 13 %

Adherence to HIV Medications and provider appointments

- 91% adherent to medical appointments.
- 78% with confirmed undetectable HIV viral load.
- Identified individuals and their roadblocks to viral suppression:
  - Refusal of treatment
  - Refusal of labs
  - Acute crystal meth use
- No disparity due to race, gender, or housing status.

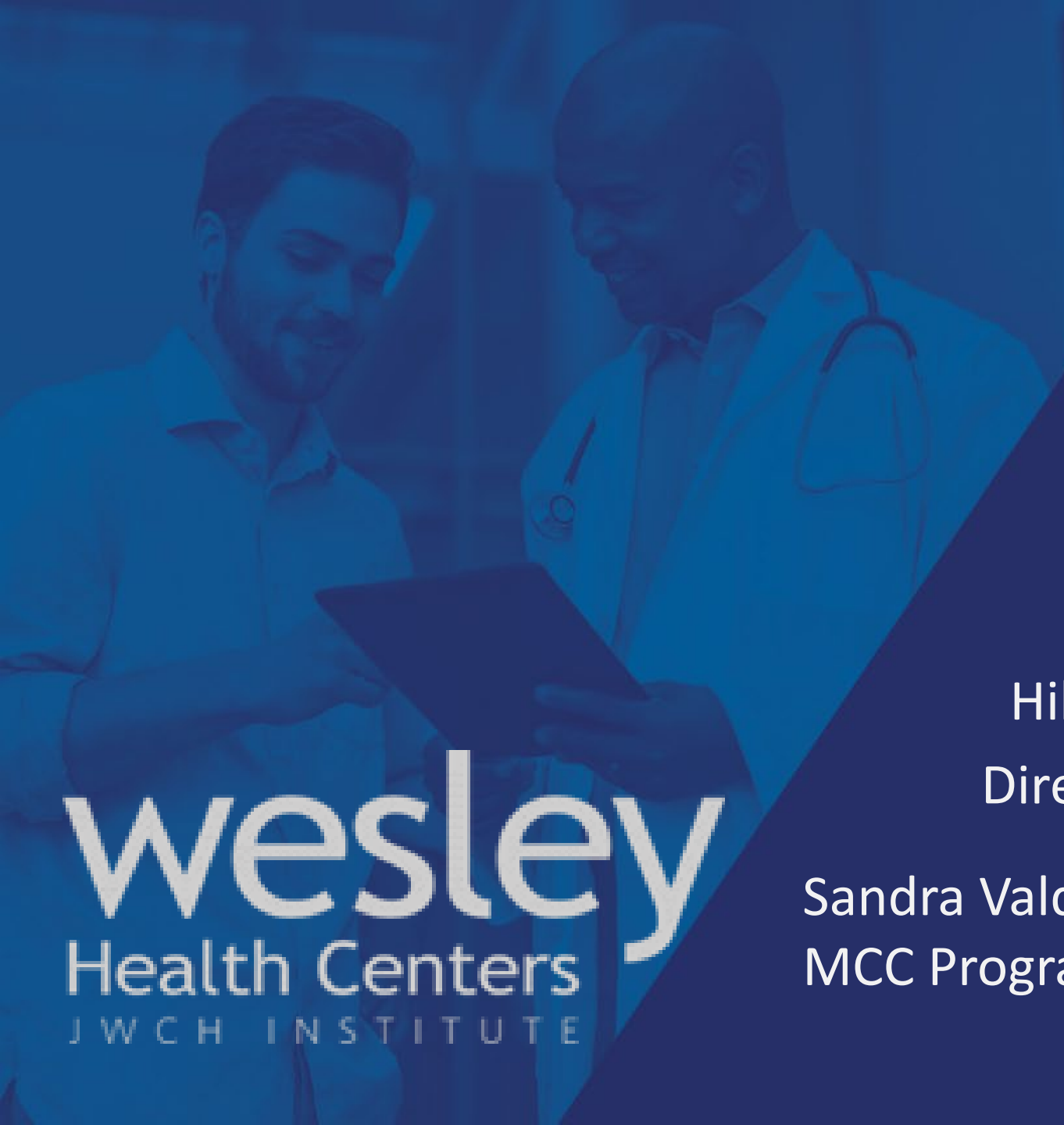
Program Funding Sources – you need to find the pieces and make it work!

- Emergency Homeless Shelter
  - City
  - State
  - County thru Ryan White (NMCM – Housing)
- Outpatient Services: Daytime shelter, nurses, clinicians
  - City
  - State
  - County thru Ryan White (OAHS, NMCM, MAI, Transportation)
- Rental Assistance
  - City
  - HUD

COVID-19

- Programs being reimagined since they are based on group model – not unusual for 100+ people to attend for lunch.
- Most individuals who are using crystal meth daily are unable to be successful in limiting exposure or taking even the smallest precautions.
- Those with homes experiencing isolation and increased mental health issues.

Questions



VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

30 YEARS

Los Angeles

Hilda Sandoval, PhD. LMFT

Director of Behavioral Health

Sandra Valdivia, Program Manager

MCC Program - Medical Care Coordination

wesley Health Centers

JWCH INSTITUTE

Services Provision

Provide a full continuum of care to decrease health disparities among at-risk populations. Services include:

- Primary Health Care
- Behavioral Health Care
- Homeless Health Care
- HIV Services
- Oral Health Care
- Pharmacy Services
- Vision Care

Supportive Services

- Chronic Disease Case Management
- Youth Services
- Housing Assistance
- Health Education
- Nutritional Assistance

Overview of HIV Programs

National	**HAB** – HIV/AIDS Bureau
	HRSA – Health Resources & Services Administration
	RWHAP – Ryan White HIV/AIDS Program
	CDC – Centers for Disease Control and Prevention
State	**CDPH** – California Department of Public Health
	OA – Office of AIDS
	CARG – California Regional Quality Group
Local	**DPH** – Los Angeles County Department of Public Health
	DHSP – Division of HIV and STD Programs
	COH – Los Angeles County Commission on HIV
	RQG – Los Angeles Regional Quality Group

Source: H Glenn San Agustin, MD (DODO

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HIV Care & Prevention

VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

HIV Testing

HIV Case Management

Transitional Case Management

- Services to incarcerated individuals who are living with HIV and are transiting back to the community.

HIV/AIDS Residential Housing

- Emergency and transitional housing services to people living with HIV/AIDS with 15 beds nightly

Young Men's Connection Program

HIV Education Risk Reduction

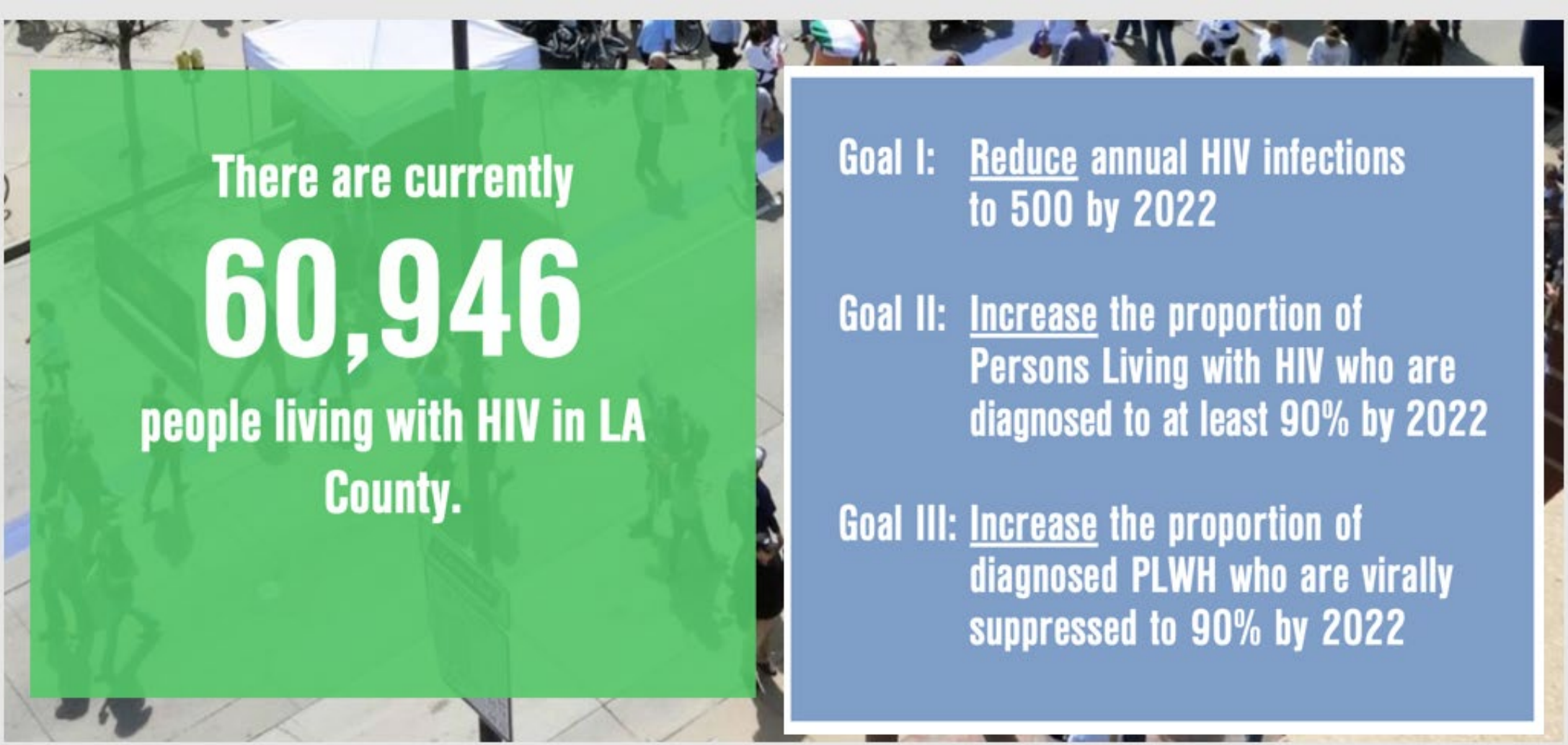
- Healthy Alternatives for Reducing the Risk of HIV Infection HARRP men and women at sexual risk who may be dual diagnosed, at risk for HIV or STDs, or experience substance abuse.

Mobile Testing Unit

Services Provider Network (SPN)

- Collaborative of over 30 agencies responsible for the coordination of HIV prevention and care services in and around downtown Los Angeles to increase access to healthcare services for homeless and medically indigent persons who are at risk of and/or affected by HIV/AIDS

LA County HIV/AIDS Strategy



LACHA Strategy 2020

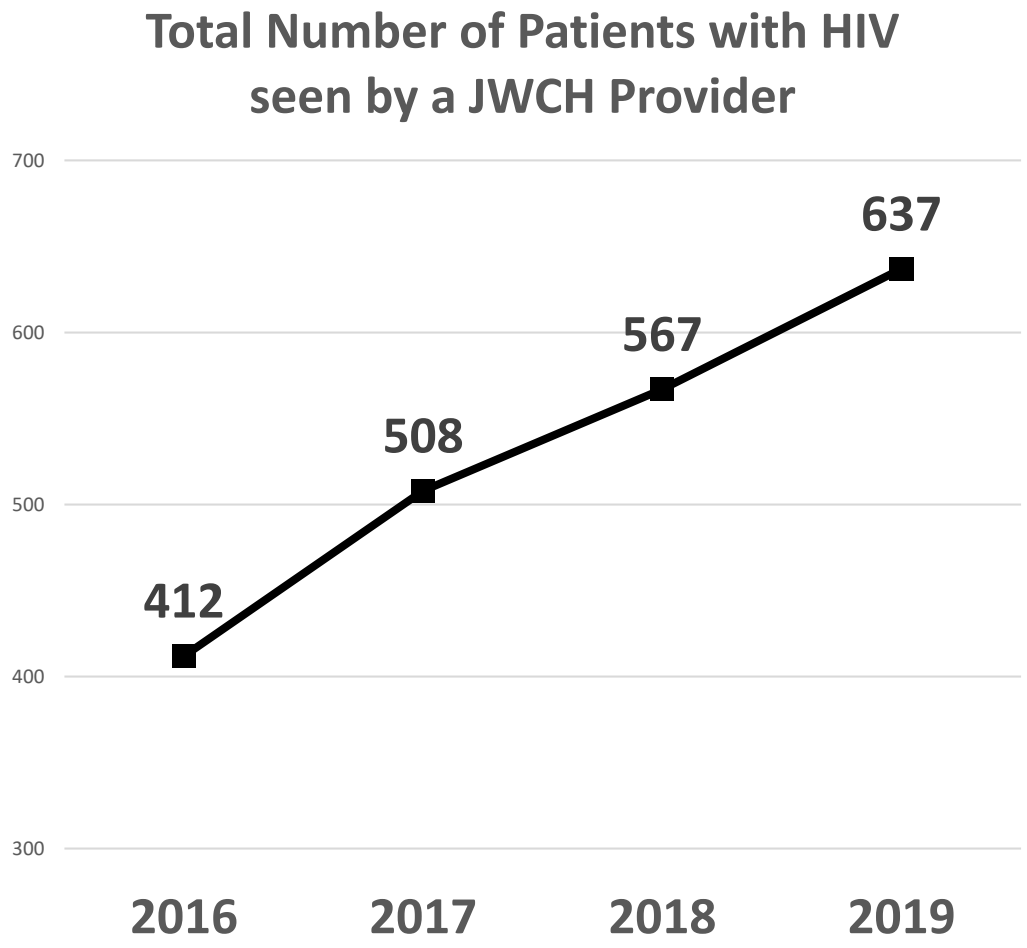
Transmission and viral suppression of HIV are closely associated with a multitude of inequities among LAC's communities:

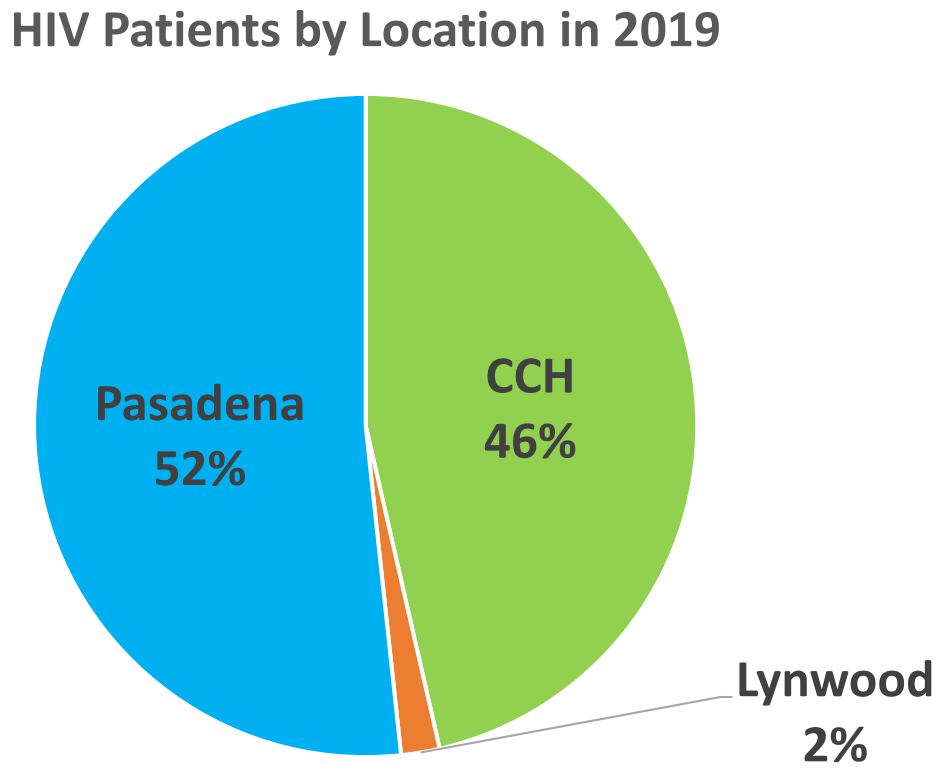
- Structural racism, ongoing lack of social support, exposure to environmental hazards; residential segregation; inequities in access to medical care and treatment; and chronic stress. These all play a role in an individual's ability to thrive

- SOCIAL DETERMINANTS TO CONSIDER
  - Stigma
  - Violence
  - Homophobia, Transphobia
  - Fear of rejection
  - Discrimination and racism

(LACHA Strategy 2020)

HIV Patient Population





Source: H Glenn San Agustin, MD (2020)

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Core Measures by Location

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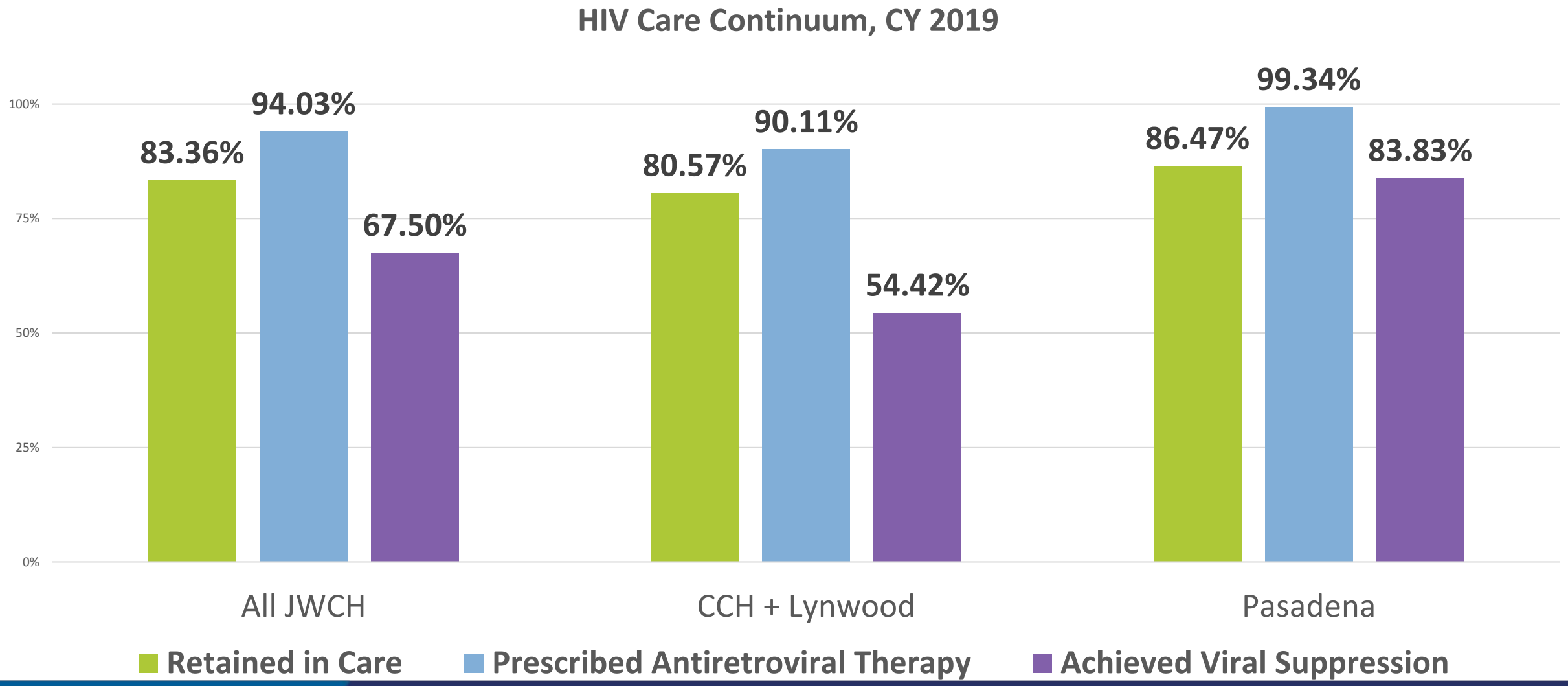

Source: H Glenn San Agustin, MD (2020)

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Medication Adherence

30 YEARS
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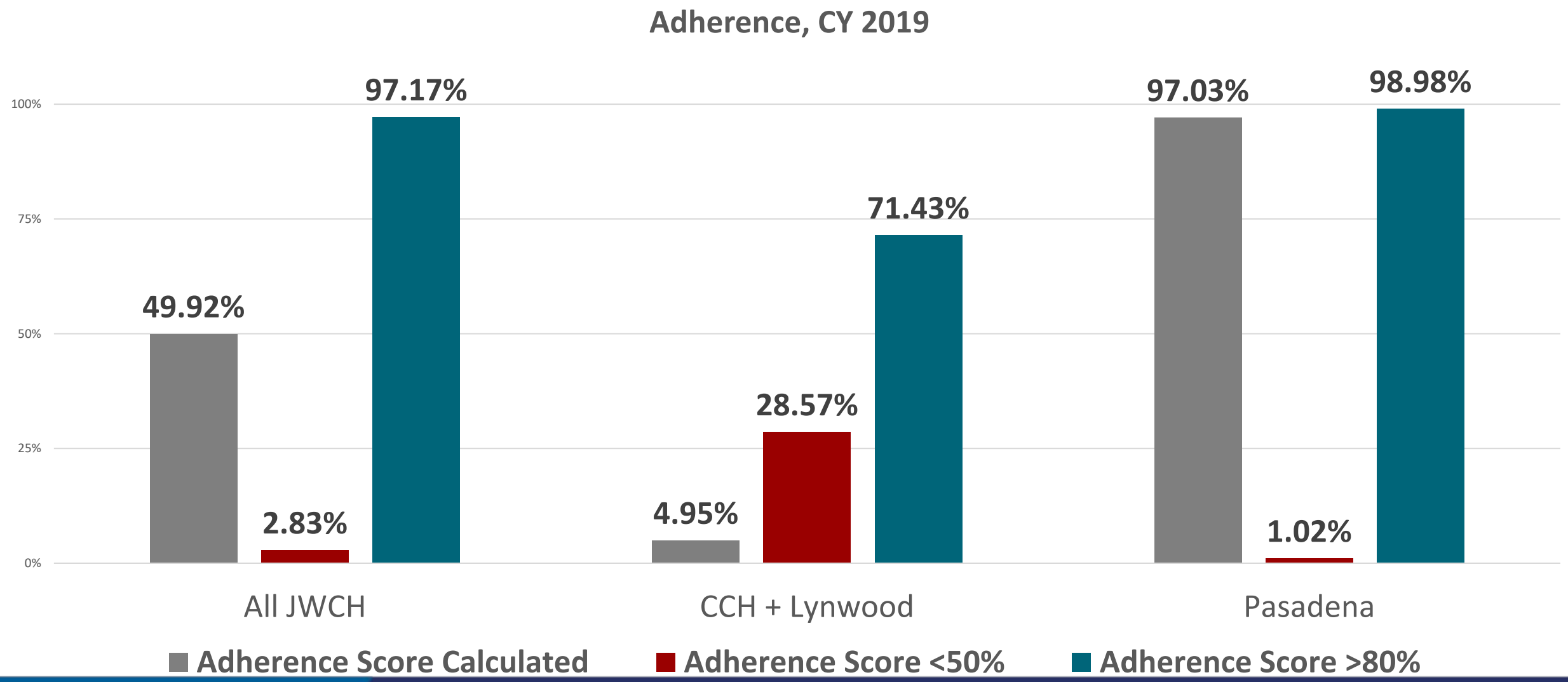
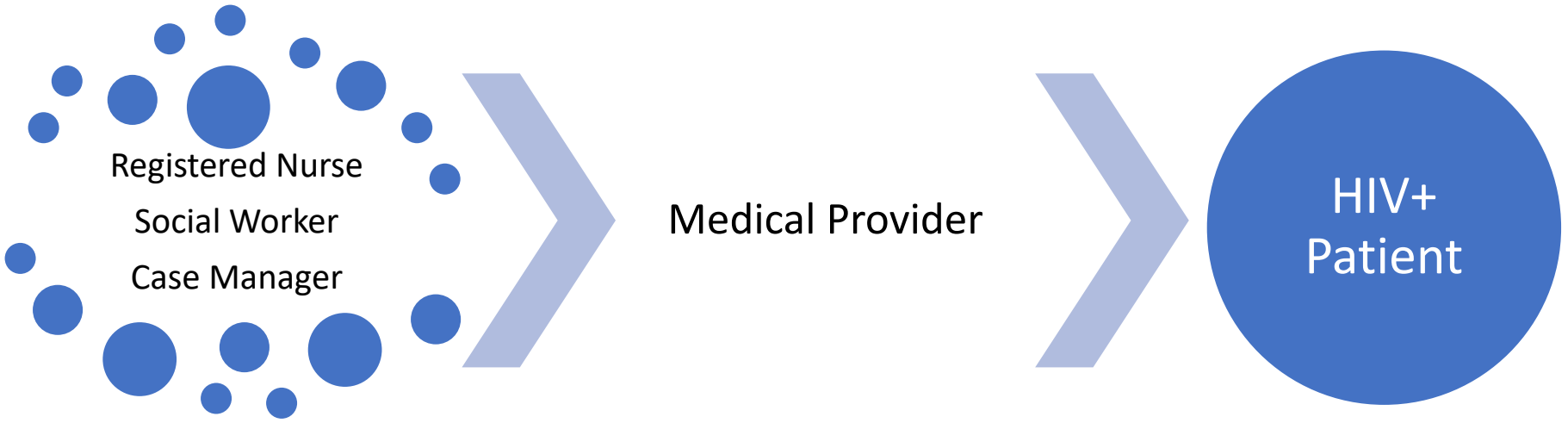


Source: H Glenn San Agustin, MD (2020)

MCC: Program Overview

The Medical Care Coordination (MCC)

- Funded by Los Angeles County Department of Public Health, Division of HIV and STD Programs (DHSP)
- Multi-disciplinary case management team with the goal of becoming self-managed and virally suppressed



Approach to MCC

Protocol

- Grounded in the LAC Commission on HIV MCC Standards of Care
- Informed by evidence-based interventions and best practices
- Supports standardized service delivery

Assessment

- 26 page tool that surveys the patients' needs in an objective manner; administered by the RN and MSW
- Examines 12 Domains of the patient's life- past and active
- Entered in to Casewatch for acuity result

Acuity

- Identified key questions in assessment related to level of need
- Assigned acuity level responses to those questions: **Severe**, **High**, **Moderate**, **Self-Managed**
- Guides service intensity and care planning: ICP, Follow-up, intervention, and Case Conference

- Taken from the County of Los Angeles Public Health Information for DHSP Contracted Providers webpage; *Successful Bidders Conference July 2019.* Available for download at http://publichealth.lacounty.gov/dhsp/Contractors/2019_AOM_MCC_Successful_Bidders_Conference_June2019.pdf

Source: Wendy Garland, Chief Epidemiologist Planning, Development and Research

MCC Flow

VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Referral and Screening

- Patient is referred to MCC via the provider or screened into the program by the Case Worker- Last visit with a HIV specialist, Detectable VL, ART Prescribed, Substance Use interferes with Medical Adherence, Homeless or unstably housed, Recent STI/STD in the past 6 months, Hospitalized or ER visit in the past 6 months, Provider Referral

Assessment

- Patient is assessed using survey tool that measures patients' needs in an objective manner
- 12 Domains: Patient Health Status, ART Access and Adherence, Medical Access and Retention, Housing, Financial, Transportation, Legal/End of Life Needs, Support System and Relationships, Risk Behaviors, Substance Use, Mental Health, and SI Risk Assessment.

Care Plan

- Patient centered and derived from the assessment session
- SMART goals: Specific, Measurable, Achievable/Attainable, Relevant, and based on a realistic time frame
- Patient identifies barriers possible as well as ways to over come the barriers
- Patient signs their Care Plan and we follow-up
- ICP guides brief interventions to help achieve patient goals

Who was served by MCC in 2019?

JWCH Sites & LA County Comparison	Latino/African American	At or Below FPL	Homeless in the past 6 months	History of Incarceration	High	Moderate	Self-managed
County Wide Data	85%	60%	12%	35%	27%	53%	19%
SPA 4- DTLA Skid Row	85%	91%	53%	26%	41%	37%	15%
SPA 3- Pasadena	68.6%	67%	14%	9.3%	22%	43%	34%
JWCH Overall	76.6 %	79%	67%	35.3%	33%	38%	21%

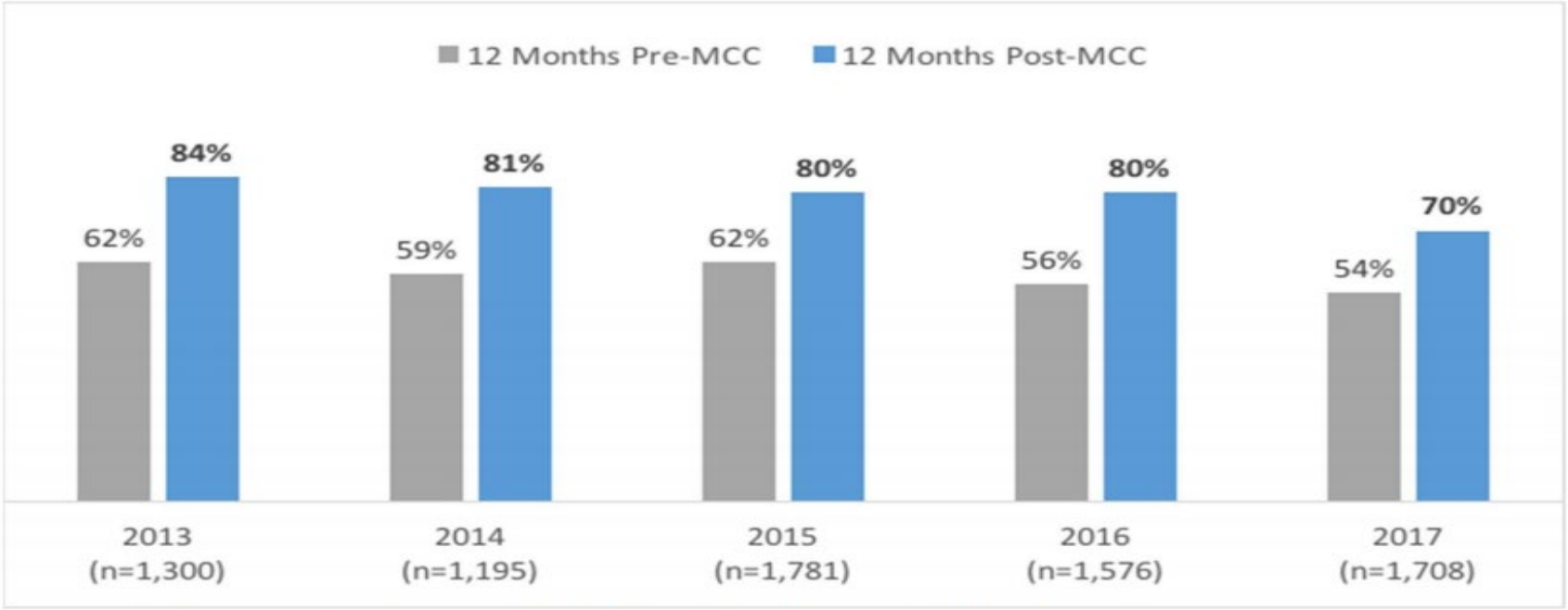
- Taken from the County of Los Angeles Public Health Information for DHSP Contracted Providers webpage; *Successful Bidders Conference July 2019.* Available for download at http://publichealth.lacounty.gov/dhsp/Contractors/2019_AOM_MCC_Successful_Bidders_Conference_June2019.pdf

Source: Wendy Garland, Chief Epidemiologist Planning, Development and Research and JWCH MCC Final Report FY 2019/2020

Los Angeles County Public Health MCC Evaluation- All Sites

MCC Evaluation – Service Effectiveness

On average, retention in care improved by 34% in the 12 months after enrollment in MCC



Source: Ryan White Program Data (HIV Casewatch 2013-2019), HIV Surveillance Data (eHARS as of April 2019).

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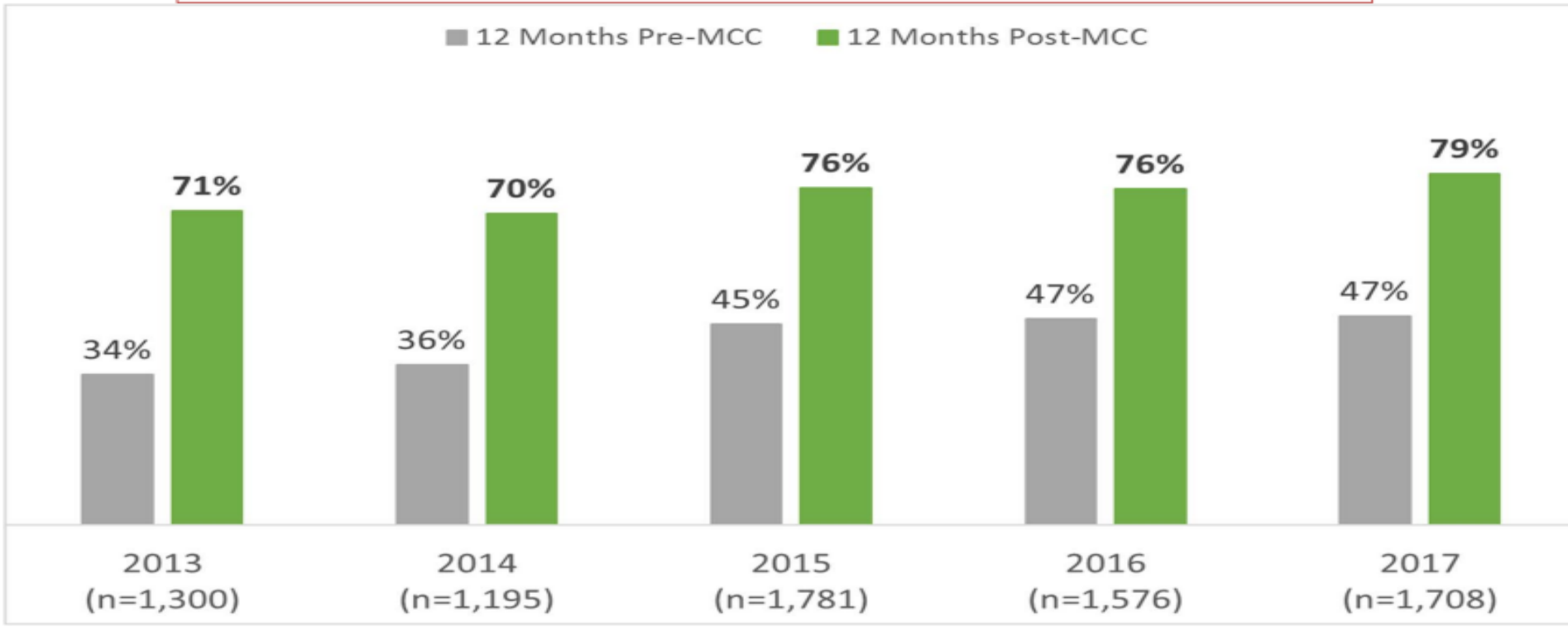
Source: Wendy Garland, Chief Epidemiologist Planning, Development and Research

Los Angeles County Public Health MCC Viral Suppression

MCC Evaluation – Service Effectiveness

On average, viral suppression improved by 80% in the 12 months after enrollment in MCC



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Los Angeles County Public Health MCC Best Practices- All Sites

MCC teams have a critical role to reach 90% viral load suppression:

- Prioritize patients with or at risk of poor health outcomes
- Provide patient-centered clinical and support services based on patient acuity
- Re-engage patients in care who were lost to follow-up from MCC and the clinic
    - Medical
    - Mental Health
    - SA treatment, if needed
    - Housing
    - Dental/Optometry
- Maintain robust communication and conferencing with the patients' medical team and support service providers
- Retention Outreach Specialist (ROS) utilized to find patients who are "lost to care" or "unable to contact"

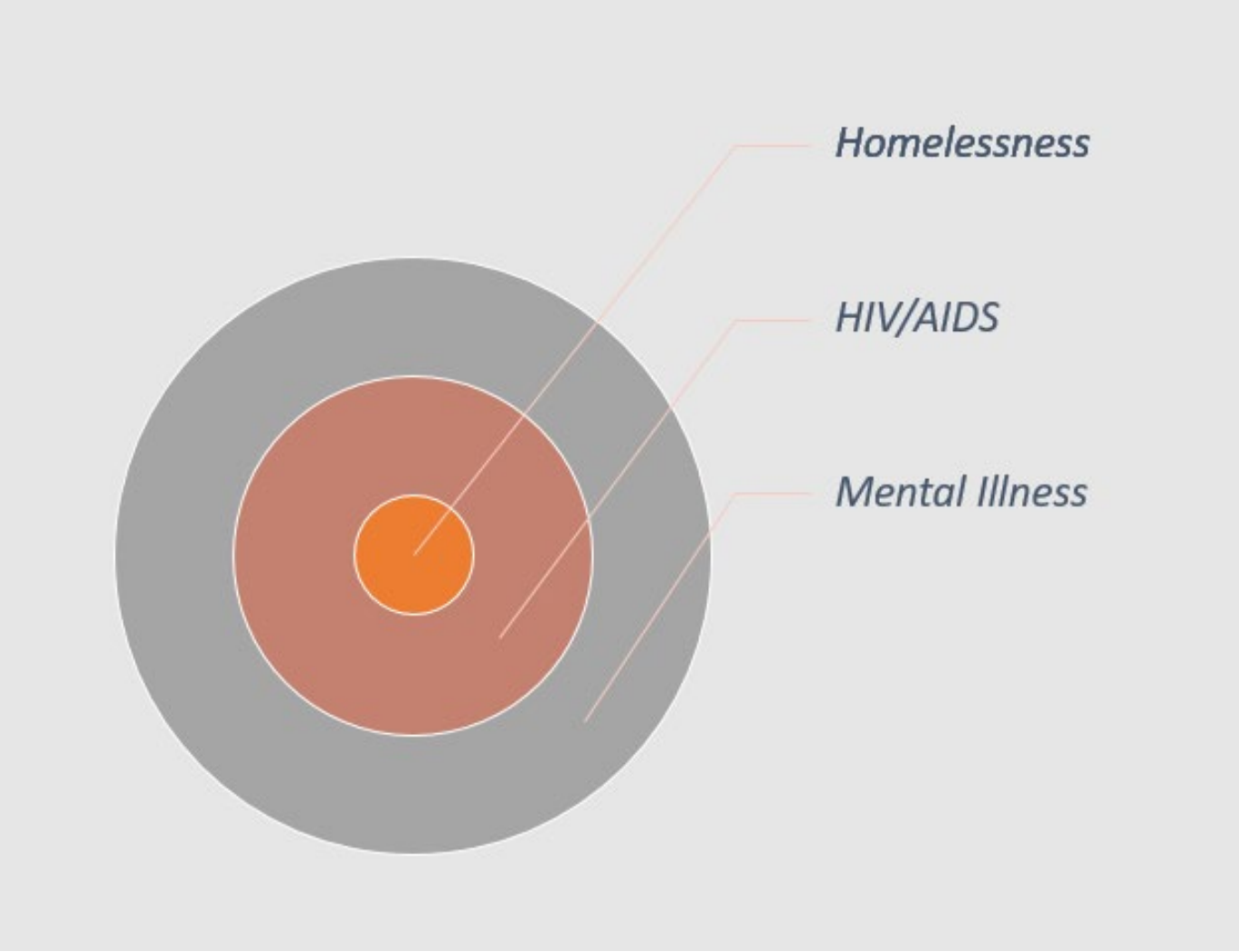
Source: Wendy Garland, Chief Epidemiologist Planning, Development and Research

Breaking Systemic Barriers

For persons experiencing homelessness or unstable housing critical efforts are needed:

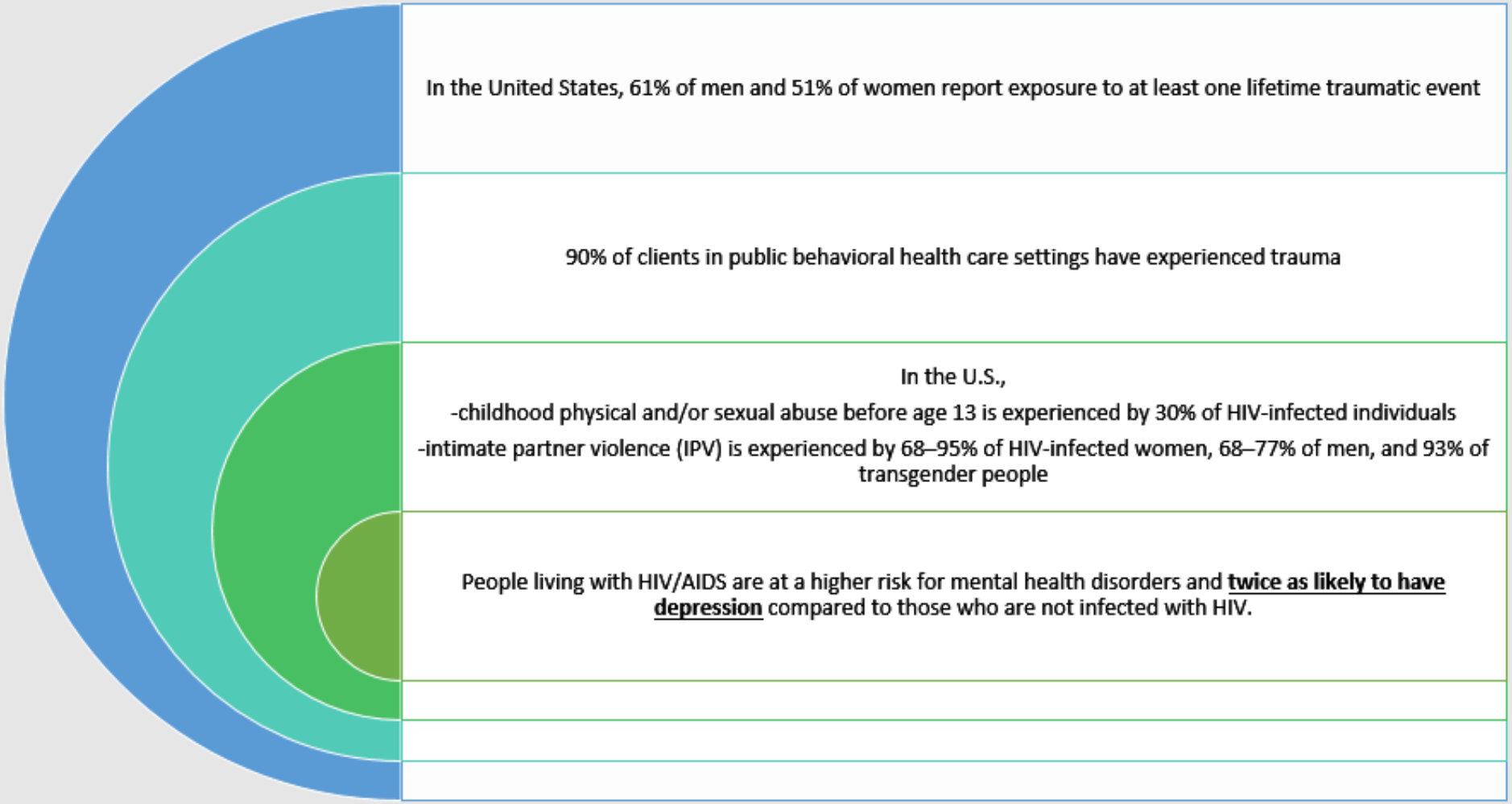
1. Care Coordination: Addressing medical and psychosocial needs
2. Partnership: Coordination of services with service agencies in LA County to stabilize housing inequities for persons living with HIV/AIDS.
    - Housing Opportunities for People with HIV/AIDS (HOPWA) program
    - Substance abuse treatment centers
    - Long-term housing programs for People Living with HIV/AIDS (PLWHA)
    - *During COVID-19 pandemic - Project Room Key (90-day hotel stay).
3. Partnering with client:
    - Acquiring Picture ID, social security card, diagnosis form, TB clearance, and proof of income to access services.
    - Addressing food insecurities
    - Building Community

The Intersections of Homelessness, HIV and Mental Health



- *Structural and Institutional Inequities*
- *Systemic Racism/Discrimination*
  - *Implicit/Explicit by service providers*
  - *Repeated Incarceration*
- *Poverty*
- *Trauma*
- *Stigma*
  - *Mental Illness*
  - *Substance Use*
  - *HIV/AIDS*
  - *LGBTQI+*

Prevalence of Trauma



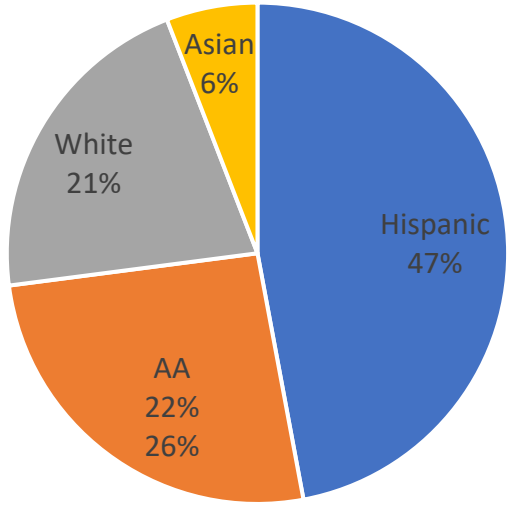
Impact of Trauma

Impact of Trauma

LA County Department of Mental Health

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.

Estimated 140K Clients Served Annual by LACDMH



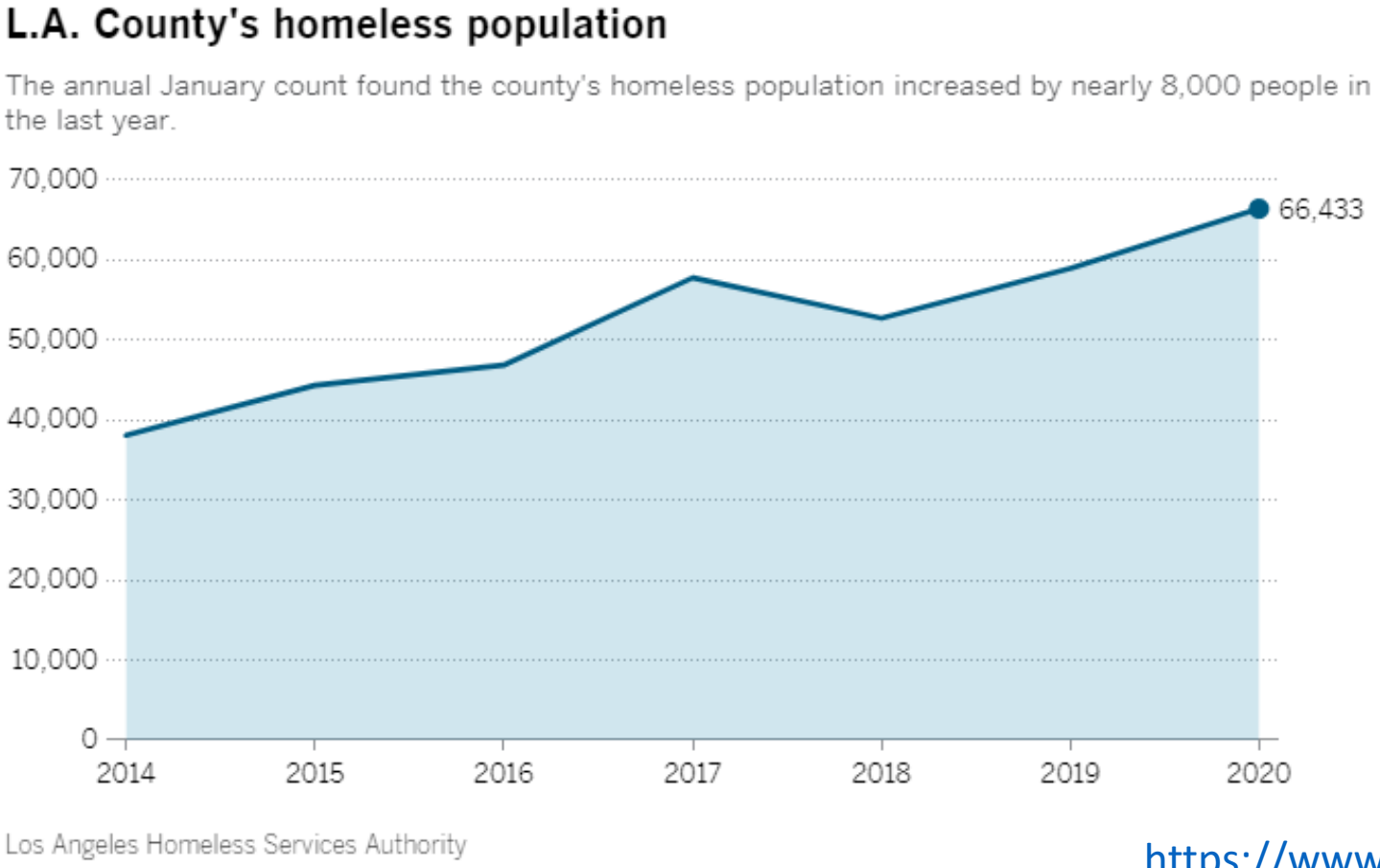
Wesley Health Centers provides long term treatment services through outpatient care in Skid Row area

- FSP (*Full-Service Partnership*)
- RRR *(Recovery, Resilience and Reintegration Services)*

Focus on population with high rates of homelessness, incarceration history, and frequent visits to emergency room

wesley Health Centers JWCH INSTITUTE

Homeless Crisis In LA



- The homeless population continues to be about **two-thirds male**.
- The racial dynamics of homelessness continue to be stark. **Black** residents account for **8%** of the population in Los Angeles County, but **34% of those who are homeless.**
- Structural racism means that Black men and women are **four times** more likely to experience homelessness.

https://www.latimes.com/homeless-housing/story/2020-06-12/la-homelessness-jumped-before-coronavirus-hit

Homeless in California

- 134,278 people are homeless on any given night in CA.
- More than 9,000 people in Los Angeles County became homeless for the first time in the last year.
- **L.A. County has a housing shortage** (565k in affordable housing units for low income renters. (California Housing Partnership Corporation, May 2018)
- **Rent in LA County increased by 32%,** while median household income has decreased 3% when adjusting for inflation. (California Housing Partnership Corporation, May 2017)
- **25% of LA County households live in poverty**

Impact of Living on the Streets

ADAPTIVE SKILLS OF LIVING ON THE STREET OR IN THE SHELTER

- culture of lying low, flying under the radar
- ingratiating to workers
- hyper-dependence or the flipside: lack of trust
- hopelessness
- toughness or threatening behavior to avoid being victimized

- disruptive behavior to get transfer or attention [i.e., starting an altercation to attract a worker's attention]
- hyper-vigilance/anxiety
- avoidance [leaving during the day because required to and to avoid the setting]
- reluctance to change
- passivity

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Housing as a Solution

SUPPORTIVE HOUSING IS THE COST EFFECTIVE SOLUTION TO END HOMELESSNESS

Range of Estimated Costs Per Day	Costs Per Year	Costs Per Day
Supportive Housing (Single Unit)	**$15,330**	$20.54 (Phoenix, AZ) - $42.10 (San Francisco, CA)
Jail	**$60,000**	$45.84 (Phoenix, AZ) $164.57 (New York, NY)
Prison	**$42,705**	$47.49 (Atlanta, GA) $117.08 (Boston, MA)
Shelter	**$19,863**	$11.00 (Atlanta, GA) $54.42 (New York, NY)
Psychiatric Service Hospital	**$466,470**	$280 (Phoenix, AZ) $1278 (San Fran, CA)
Acute Hospital Care	**$797,160**	$1185 (New York, NY) $2184 (Seattle, WA)

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Source: Substance Abuse & Mental Health Services Administration. Tip Sheet retrieved 2018

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Critical Services and Resources

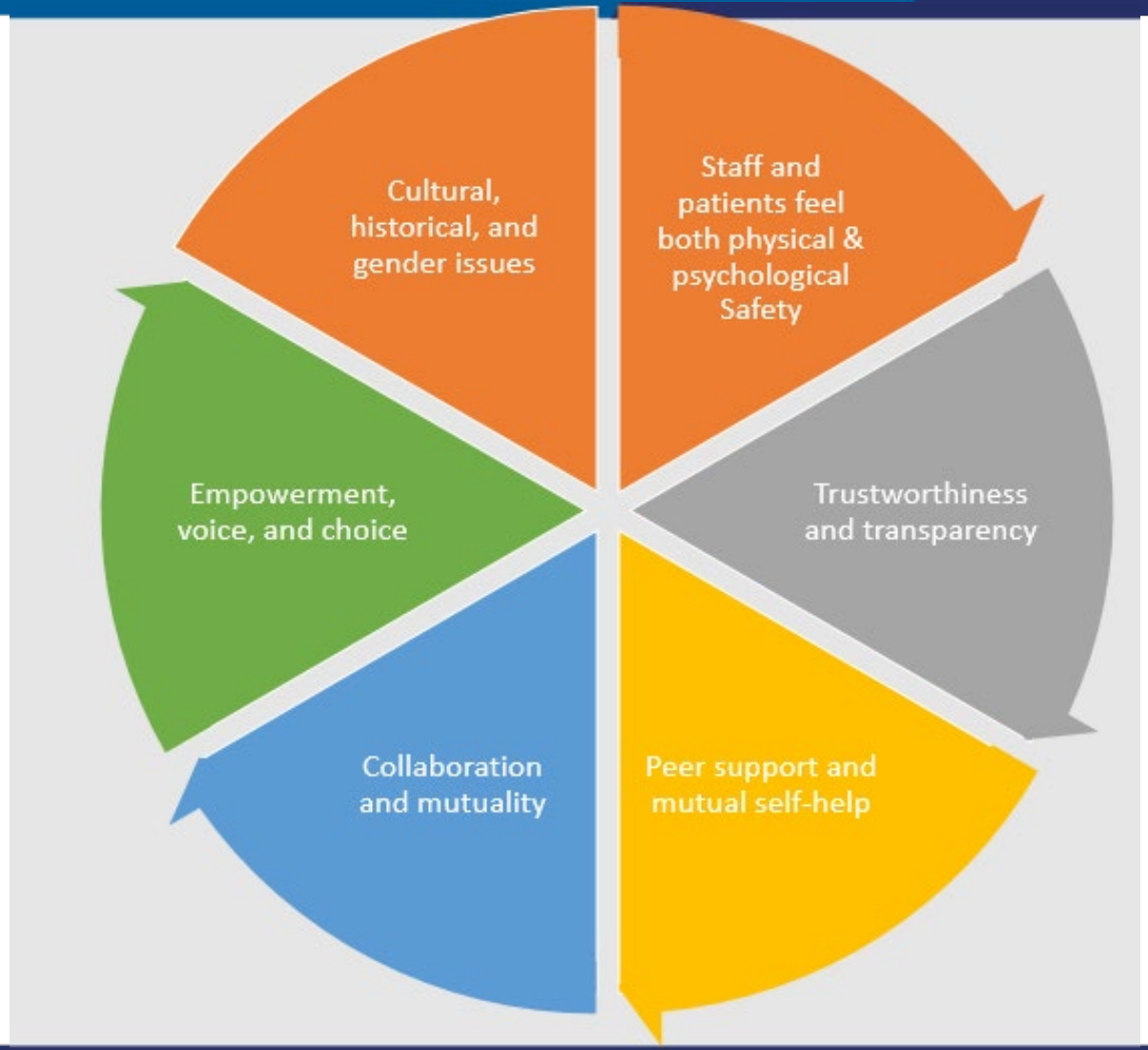
Bridging Gaps

- Linking persons to mental health & medical and community partners
- Prescription drug coverage (ADAP)
- Treatment education
- Advocating for Housing
- Equitable Policies to protect the most vulnerable

Advocate, Engage, Retain in Care

- Weekly check-ins with the provider and MCC teams
- Weekly dispensing of medication
- Condom provision and access to prevention resource
- Hygiene supplies
- Hormone treatment for transgender persons
- Re-engagement for newly released detainees from jail/prison

Following the Guiding Principles of Trauma-Informed Care



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