WEBINAR VIDEO TRANSCRIPT

DHHS / Health Resources and Services Administration (HRSA)

Replicating Innovative HIV Care Strategies in the Ryan White HIV/AIDS Program

23 June 2022

ANGEL JOHNSON: So good afternoon or good morning, depending on where you are. Welcome to the Integrating HIV Innovative Practices Webinar on replicating innovative HIV care strategies in the Ryan White HIV/AIDS program. Today's webinar features two interventions focused on the unstably housed population. I'm Angel Johnson with the MayaTech Corporation, and I'll be managing and moderating this webinar series.

Our agenda-- before we hear from our speakers, Shelly will give a brief overview about the SPNS IHIP project, then I'm going to speak briefly about the CE credits being offered. Next, our presenters will talk about their interventions. And we like to hold off on responding to questions until both interventions have been presented. Then we'll do a Q&A. And then finally, I'll share some details on how to request CE credits and how to give your feedback on today's presentation.

SHELLY KOWALCZYK: All right. Thank you, Angel. Hi, everyone. Again, I'm Shelly Kowalczyk with MayaTech Corporation, and I am the project director for the Integrating HIV Innovative Practices Project. This is funded through the Ryan White HIV/AIDS Program Special Projects of National Significance. We are led by Melinda Tinsley and Adan Cajina.

In addition to MayaTech, we collaborate with Impact Marketing Communications. They are partner of ours on this project, which was funded this past September. And the purpose really is to support the coordination, dissemination, replication of innovative HIV care strategies in the Ryan White HIV/AIDS Program.

So the SPNS framework of integrating HIV innovative practices does fall within this last part of the SPNS framework. As we are, in fact, developing implementation tools and resources, coordinating the delivery of technical assistance on these tools and resources, and then supporting the uptake and integration of these interventions by Ryan White and other HIV providers.

Also, this project is meant to align with HRSA's best practices compilation by supporting the development of tools and resources for interventions that are already included as part of that compilation, but also by helping providers develop tools and resources that can then be submitted for potential inclusion in the compilation. There are some enhancements to the integrating into the Innovative Practices or IHIP Project. This year the project does now feature not only SPNS interventions, but innovative models developed and implemented by Ryan White grant recipients and subrecipients.

Again, we do align with the best practices compilation, so many of the interventions featured here can be found in the compilation. And in some instances, we're helping providers develop tools and resources and helping them prepare for potential submission to that compilation.

We're also supporting the delivery of individual technical assistance on the featured intervention. So not just these webinars, but also people can request individual TA if you're interested in replicating an intervention that we're featuring. We're also providing technical assistance on the development and dissemination of your own tools and resources for interventions that you've developed and/or implemented. And then lastly, we are offering continuing education credits this year.

And then just lastly, I want to go through some of the key support that we are providing as part of this project. So we're developing implementation guides, fact sheets, and in some cases, video spotlights on the interventions that we're featuring. And once these tools are approved and cleared by HRSA, they will be posted to the Target HIV website. So we'll be sure to share that information via lots of platforms-- HRSA's e-newsletters, Listservs, AETCs, the IHIP Listserv. So we will make sure that you're aware once the tools and resources associated with the interventions today, as well as those moving forward that you'll be made aware of all of those.

The capacity building TA webinars, such as this one, to feature intervention implementers presenting their experiences and lessons learned on the interventions. And then the peer-to-peer TA, as I said, there's an opportunity to request some assistance on the interventions being featured.

We have the support to develop your own tools and resources, coordinating webinars on best practices, and the latest strategies and creating implementation manuals and other tools as well as disseminating them. And then you can also request one-on-one TA. And all of that can be done by sending an email to ihiphelpdesk@mayatech.com for information on the project, TA requests, more information on the interventions being featured. And that's all. Thank you very much, Angel.

ANGEL JOHNSON: Thank you, Shelly. So now I'm going to give a little bit of information on continuing education credits. So we're excited to be offering continuing education units for our live webinar Series. CE units are being jointly provided by the Postgraduate Institute of Medicine, PIM, and the MayaTech Corporation.

Credits are being offered for physicians, nurses, physician assistants, dentists, dietitians, health education specialists, social workers, and pharmacists. So as a little side note, we haven't yet gotten approval from CHES regarding the social work credit for, and this is because the timeline for the materials to be approved took longer than we anticipated. So once we have--

SHELLY KOWALCZYK: Angel, I'm sorry. It's for the health education specialists, not the social.

ANGEL JOHNSON: Oh, I'm sorry. That's health education specialists. So once we have approval, we will send notification to the attendees looking for this credit, and they can request that at that time. Thanks, Shelly.

Please note that the opinions expressed during this presentation are those of the presenters and do not necessarily represent the views of the webinar sponsors and planners, and information presented is not meant to serve as a guideline for patient management. Additionally, our presenters have nothing to disclose and no conflicts of interest.

So now it's time to meet our presenters. Our first presenter is Jamie Shank, a consultant for Organizational Empowerment LLC, who will be presenting on behalf of KC Life 360. Jamie is an experienced public health professional with expertise in federal grant management, quality improvement, system thinking, HIV care, treatment, and housing-related service provision.

She served five years as a quality and housing program manager for the Kansas City, Missouri Health Department, managing the HIV housing program portfolio, including multiple SPNS initiatives. In April 2020, Jamie relocated to Atlanta, Georgia and launched Organizational Empowerment LLC. She believes people working in the fields of public health and social services are the best people.

Following Jamie, we will hear from Robert Arnold, associate director of HIV Services with the San Francisco Community Health Center and Dr. Deborah Borne, medical director with the San Francisco Department of Health San Francisco Community Health Center, who will be presenting on behalf of Homeless HIV Health Outreach and Mobile Engagement, referred to as at HHOME.

Robert and Deborah will also be joined by Martina Travis, a case manager with the San Francisco Community Health Center, who will offer a consumer perspective on the HHOME intervention. Robert Arnold, who worked as a nurse for 12 years. He worked as a substance use substance use nurse manager at a methadone clinic for six years, where he established a system to help clients with poor medication adherence receive direct observed therapy every day without fear of their meds being stolen or lost because of being unsafely housed.

Robert credits Dr. Borne with his coming to the San Francisco Community Health Center, where he has been working with the Getting To Zero and HHOME programs for five years. For the last two years, Robert has been the associate director of HHOME services and oversees three separate HIV mobile care teams, including HHOME.

Dr. Deborah Borne has worked in the homeless and HIV services for the last 29 years as a social worker, researcher, educator, administrator, and provider. Currently, she serves as the medical director for the San Francisco Department of Public Health Care Coordination Transition Division, principal investigator, and provider for the federal SPNS grant HHOME mobile integrated primary care for the homeless dual diagnosis and HIV patients. As both a social worker and a physician, she has worked with highly marginalized communities, including homeless person, drug users, and incarcerated and recently released individuals.

Martina is excited for the opportunity to share her personal and professional journey. She is admittedly HIV-positive and has been positive for 30 plus years. Martina was homeless for two years until, in her own words, "Deb and her crew rescued me from myself." She is a product of the HHOME program she will be speaking about today and currently works as a medical case manager for the San Francisco Community Health Center. According to Martina, she is simply giving back to the community in which she lives and works. Jaime?

JAMIE SHANK: Thanks, Angel. And thanks, everybody for joining. I'm really excited to be here with Dr. Borne and Robert and Martina, so let's just dive in while we have this time together. And I want to share a little bit about our SPNS funded project we titled KC Life 360.

Yeah, we have the disclaimer information. You got to hear my bio, so we can skip through. I do want to give a shout out because none of this work would be possible if it weren't for the entire team at the Kansas City Health Department, so this is our KCHD team, so this project was possible with Travis Barnhart, Debbie Adams, Joey Lightner, and Mary Jo Hoyt. We can go to the next slide.

And we have some polling questions to get this webinar going with some interaction. And I think someone's going to post so soon, and I'll read them. Awesome. All right, so we see the first two questions here.

So feel free to select a single choice answer. My organization offers housing support services. This helps us get a read for who's in the room. So yes, we provide robust housing services. Maybe, it's yes, but we're somewhat limited. No, but we are exploring it, or maybe no, not at this time.

The second question, also single choice. We want to know how many folks are working with individuals who are experiencing difficulty finding or maintaining stable housing. Yes, most of the folks I work with. Yes, some of the folks. Not really, or no.

And while I see the questions, I don't quite see the percentage of respondents, but I will trust the other hosts or panelists operating it, once you think we've gotten to a good response rate, we can go to the next ones or post results from these first two. All right, let's see how the crowd shakes out.

So it looks like a majority of folks-- let's see here-- it's interesting. So offering housing support services. So fairly close between yeah and a limited capacity or no not at this time. So good news, we've got some amazing programs and some funding source tips and tricks to help bring those to where you envision them.

We can go to the second question. In terms of working with folks, it's difficult finding or maintaining stable housing. Because finding is one thing. Maintaining is a whole other.

And it looks like a huge majority has some of the individuals or some or most. Awesome. I'm going to close that, and then I think we maybe have two more questions. Awesome.

So now let's talk about employment, because that earned income helps with the housing stability, right? So my organization offers employment and/or job readiness services. Again, this could be yes, we provide robust employment or job readiness services. Could be yes, but we're somewhat limited. No, maybe this is something you want to explore, which is why you're on today, or no, not at this time.

Second question, also single choice. Let's talk about folks that wish to find work but they cannot. Yes, most of the folks I work with wish to find work but can't. Some of the individuals I work with, not really, or no. Thank you for voting.

So in terms of offering employment and/or job readiness services, I am so glad you are on the call today because that's one of the things KC Life 360 is going to specifically talk about. So a majority of folks responded, no, not at this time. But let's look at the need.

We have kind of an interesting spread here, where some of the individuals I work with do want to find work, but for some reason or another, it seems that that's not possible. And then some folks, maybe not the folks you work with, but who knows, maybe some folks you supervise or other members of the care team you're on would be representative of those who do. So we can go to the next slide. Thanks for sending your votes in.

And we will show how featuring Kansas City-- Kansas City, we're talking about Kansas City, Missouri Health Department. Kansas City is an interesting area because it's actually a bi-state jurisdiction. So this is just some context, a little bit about who the health department is and what they do. Special to this is they are the Ryan White Part A recipient and the HOPWA grantee in that area.

You can sort of see in terms of how many folks are accessing Ryan White and/or housing services, but the name of the game, and unlike many places. I've seen outside of Kansas City, is what a strongly

coordinated system of care we are and that's a huge key to the success, and you'll see that coordination of care reflected later on. What we're sharing with you today is part of a journey, so be kind and be compassionate towards yourself and realizing housing and/or employment service goals, because this represents an intensive effort over the course of multiple SPNS projects in different work to get where we are.

This is our philosophy in Kansas City. We operated under the belief that housing is a necessary structural intervention to end the epidemic, and this is what sort of held our vision and our forward trajectory throughout. So KC Life 360, what is it? It was a SPNS-funded grant. We love SPNS dollars. We love that SPNS support. Folks like Adan, [INAUDIBLE], Corliss, Melinda, everyone there.

And the intention of this was to address the intersectionality of living with HIV, experiencing some form of housing instability, and unemployment or underemployment, looking at the interrelated nature of all of those pieces. We partnered with Catholic Charities, who is sort of an employment job readiness expert in the community there, and then we also partnered with reStart, who we had a longstanding continuum of care, CoC, and/or HOPWA-funded funded housing relationship.

And we actually work with them. They secured a 22-unit mass-release building, where half of that was for Ryan White transitional housing and half of it was for HOPWA-funded transitional housing, and some of these SPNS dollars also floating for the support services and other pieces. There was a multi-site research component to this project, as there are with many SPNS.

So what was our purpose? We wanted to be able to address the desire for folks in our community that were living with, that wanted to increase their income or get different certifications, CNA, mechanic, different pieces like that, large equipment operators. We wanted to meet that need because folks are living longer, living fuller lives, happier lives, and we were really just sort of housing people, but not at the greatest quality way, to be honest. We were just sort of providing a place.

So we wanted to address their desires to go to work. We wanted to bust the myth about how much people can work without losing benefits. Also through that relationship, that intersectionality, improve housing stability and then also improve our key health indicators like engagement, retention, and care, and viral load suppression.

So how do we climb that mountain? We had sort of four main goals through KC Life 360. We wanted to vocationalize and address housing needs. What on earth do I mean by that? I mean, make it normal. Make it a normal part of our portfolio, a normal part of our housing conversation, regardless of your funding source, regardless of what agency you work at, regardless if you're a housing case manager or a Ryan White medical case manager. We wanted to make that normal.

So we embedded with dedicated staff. You see they're second. The Health Department created a position through the SPNS grant called the Employment Support Specialists. We then sustained it by adjusting our formula HOPWA grant to include support for that position.

So we had dedicated staff there, as well as partnering with Catholic Charities and reStart, and the SPNS grant supported some FTE as well within those partner agencies. Then we started baking in this assessment of clients at intake. This had to do with what are your employment or workforce or continuing education goals? Going beyond like a psychosocial assessment-- that's pretty standard in our service delivery-- and asking about employment, asking about income, job history. What are your interests? What are your talents?

And also, what are your knowledge of benefits? Are you just not-- are you deterred from looking for work because you're afraid of losing benefits? And then finally, we also had that collaborative coordinated system of care reflected in our interagency collaboration, as I mentioned, and we'll go into more detail.

So our intervention model, so these are the actual folks who help make that work happen. So if you're thinking about how do I staff this, how do I put a program like this into place, here's an example. And on some of this, we built on over time because the SPNS program was a three-year initiative.

So we have a program manager, a data manager housed at the health department, representative myself and Travis Barnhart. Debbie Adams, who you saw, she was the employment support specialist. Interestingly, she had been a medical case manager at a funded clinic for many years, a youth case manager, and then a family case manager, so she brought a lot of wonderful skills into this position.

We also had a clinical evaluator-- that was Dr. Joey Lightner-- to do the IRB pieces and help with dissemination and publication of papers. He was the evaluator, pardon me. Mary Jo Hoyt was a nurse, and she was our clinical evaluator, again, to check in on those key health indicators and different screenings that we might find in EMR.

At reStart, we had two partially supported housing case managers to work with clients when they entered transitional housing. What are your employment goals? What are your earned income goals? Is it job search? Is it resume building? But what are you interested in, and how do we make that happen? As well as a program manager. And at Catholic Charities, a similar structure. We have the employment specialist to do a lot of the one-on-one client level interaction and then the program manager to also support the grant.

So let's talk challenges and solutions at a very macro view, and we can play through these. So this was a new program. We had never done anything like this. We realized employment-earned income support was totally missing from our housing conversation. Huge gap, so we did extensive planning.

We did planning around what does our database have in terms of how can someone make a referral, electronic referral? How can someone add case notes? All of those little particular pieces.

So we did multiple presentations to our entire system of housing providers and medical case managers. We created a FAQ sheet. We created a program brief, and we kept that reoccurring so that new staff are onboarded appropriately, and then that refresher learning is in place.

The next animation you'll see talks about that we needed employment expertise, especially that this was new. We needed to educate ourselves on benefits. We needed to educate ourselves on many of those pieces. So we secured that employment partner in our community. That expertise came through Catholic Charities. Next animation.

We also had a massive lack of short-term immediate housing, and this didn't come on until probably year two of the grant. So being a SPNS network, right, SPNS grants connect us with wonderful colleagues across the country. So there were two other sites in San Diego and in Atlanta that use the SPNS grant to support emergency hotel, kind of a gap lodging.

So we learned they were doing that with these dollars, and we said, how the heck do we do the same thing? And then they shared their program resources, the administrative tracking, the how do you de-

escalate a situation at a hotel between client and hotel staff. And then we were able to get some approval for shifting our budget and use some carryover dollars, and then we piloted an emergency hotel gap lodging program through the SPNS initiative, which we were then able to sustain through formula HOPWA dollars. We'll talk about that a little bit more.

As I mentioned, we needed our database to hang with us in terms of case notes, referral, tracking employment. And again, recognizing this is a big want, and need, and desire, we received so many referrals, it was almost like turning on a fire hose because so many folks were interested in this. So we needed our database to be compatible with that, so we did a lot of modifications there and then obviously a ton of training.

We wanted to focus on holistic care, and this was really successful through the co-location. Between our three partners, we had co-location agreements MOU between everybody. So the housing case manager could be at the health department at the same time, or the employment support specialist could be at the housing agency. So if an individual was there because that's where they live, that's where they're at, they could still do warm hand-offs. They could do care coordination. But we really solidified a lot with co-location MOU agreements.

So challenges in depth. It took a lot of time for this program launch. I have never been a part of a team that dedicated so much to program planning, but it really was a major secret to success. Even still, that's a lot of time and that's a lot of effort.

Client motivation, which is a phrase we hear, so I think there's always a lot more into that. But it's really discouraging, I think, to all humans to apply for jobs and apply for jobs and not get callbacks or to get interviews and not be selected. So rolling through that situation and those experiences is also something you need to anticipate.

I mentioned the insufficient stock of permanent safe, decent housing, which we were able to mitigate with our emergency hotel. Cell phones, baby, boy, did that come up, so let's use our budgets wisely. Folks need those cell phones, so purchasing phones, data plans, things like that became a necessity. And then we learned a lot through legal name change for new IDs for folks of trans experience, especially within the employment, providing your ID, how do you present an interview versus how do you present on the job. And sometimes client follow-up was a challenge, but I think we run into that fairly often.

We see our facilitators here. Again, the gap lodging, the employment partnerships, and coordinated system of care. Here is information in detail if you are interested in adding this type of housing service to your portfolio.

You see we've broken this down into steps one and steps two, with a nod to the Family Health Centers of San Diego and Positive Impact in Atlanta. Here are more details, again, in terms of breaking into concrete steps how you can add hotel lodging. And then we were able to use the HOPWA formula funds to add those line items.

Here are outcomes, and we're almost finished. We had nearly 94% of folks in this program achieve or maintain viral load suppression, which is huge. 67% increasing their earned income through some form of employment. We also got 78% to receive permanent housing assistance and nearly 98% engaged in care.

And here we have, at the very end, we have the voice from folks as well. So here we have one of our KC Life 360 clients. She was an awesome woman, and she says, "I'm thankful for the support of the employment staff assisting me with finding out the process for the name change in another state. This is important for me to get done so that I feel better about myself."

So this woman actually was hired multiple times. She relocated to Kansas City, Missouri, and she was able to get jobs and nail the interview. Challenges arise when she presented by the identity that she identifies as, which was sometimes different than in the interview session. Or once coworkers found out she was the woman of trans experience, that created some trouble.

So she was getting jobs and losing jobs, getting jobs and losing jobs. And what a just awful experience. So once she identified like, hey, you know, I really do want to go through with the legal name change, let's make that happen.

So this is another woman, and she says, "We are stable, safe, and together. We are in a good spot." This was a single mother of three who moved from Texas to Missouri. She was fleeing domestic violence. So this woman was taking on that power and control dynamic we see in domestic intimate partner violent relationships.

So for her, it was getting her and her three children together. She was able to get a job at a KC's gas station that she loved in more northern suburb outside of the metro area. So she was able to get her kids in a school district that she was happy with, and there were just so many things for her kind of coming together and that holistic approach.

Here we have a gentleman who said, "The peer educators and staff helped me and my family understand how to handle my HIV better." So this individual went through KC Life 360. So working with our employment support specialists at the health department, really, really care coordinate with the medical case managers and the housing folks.

And he was more newly diagnosed, and he was really wanting to work through disclosure with his family, who ended up being very supportive, but that was a huge deal. So as we were working on employment goals, we were also able to assist with this because the peer educators were actually a major source of referral into our program. And so there was a strong relationship with peer educators across different sites in Kansas City.

So how do we think about sustaining the gains? When you want to look at the intersection of employment, earned income, and living with different care markers. What we hear from one person, "I'm just so thankful for the opportunity to be out of the winter weather and in a safe place."

Hearing these client stories I think it is the motivation to go through the challenges you go through or also just to have the perseverance for how long sometimes things can take. The power of handing someone a key or the power of someone starting work is really, really meaningful. So again, we found a way, and it's kind of bureaucratic, it's kind of tedious, but you can make changes to your HOPWA formula award.

Lots of folks have had these for 30 years or more, and they just kind of stayed the same year after year after year. But you can do things like emergency hotel gap lodging. You can do things like support and employment support specialists through your HOPWA formula. It's just a matter of going through the

steps in which to do that, but that's how we were able to sustain that position permanently and to sustain that type of housing service in our housing portfolio.

You also want to make sure your database stays with it, so we created an employment log. Because employment is very fluid, and so we really sort of needed the work history and all the pieces. So made those adjustments, which is now permanently part of our data system. And again, continuing those relationships with your key community partners.

Here are our lessons learned and recommendations. I think we've talked about many of these. Co-location is a powerful tool. Definitely budget for cell phones-- that one was huge.

Also think about exploring things like alternative transportation. You'll see on the Resources slide that we got bikes donated, and then a ton of clients got bikes, which is really fun and exciting, and it was fun to have bikes at the health department. A little bit of levity and fun in work is also allowed.

And so individuals would maybe ride their bike to the bus stop rather than walk two miles to get on the bus to go to the job. But being innovative is also something that SPNS is so supportive of. So explore alternative transportation, and you can see the bike spotlight on the Resources page toward the end.

As I mentioned employment, there's some fluidity there, so keep that in mind. Leverage your related care systems. We had to really work with our safety net hospital and other are two largest providers to get access. We did HIPAA training. We did all this stuff so that we could see how our individuals in our program, how is their health and not just care continuum indicators but others.

The other most important thing is that no matter what any time in this program, while it looked at the intersection of housing and earned income and care, housing was always the prime need. So that was something-- sometimes that takes longer than, say, the job piece, but that was 100% the prime need.

Here we are toward the end. I want to say thank you so much for my time, and thank you for the support of this group at the SPNS office and highlighting this innovative practice. If you click on these slides after they're sent out, it's direct links.

Our site, Kansas City, as well as the other 11 funded sites through this project with support from Impact Marketing, who's on the call today, created a manual. So there's all kinds of details to supplement what I talked about. We have our one pagers when you just need like the short and sweet of stuff, tip sheets, the spotlight I mentioned in posters. This program we did borrow a lot from HUD's Getting To Work, and so we have that curriculum and training as a resource for you there as well.

So I want to say thanks. I'm going to turn it over to Dr. Borne, and you have my contact info there if you like. Thank you so much.

DEBORAH BORNE: Thank you, Jamie. I'm going to ask Martina and Robert to hop on too. That was a brilliant presentation. I think it's going to be interesting and very to partner our SPNS program, which is actually all the steps for a different population before the training for when people get housed.

And I can't highlight enough how important some of the things Jamie said, which is about whole person care and looking at the whole person and their ability to have the life that they envision and dream of, and that's really where we came and started from with this SPNS grant. I cannot thank the folks at HRSA

enough. Melinda, who is our-- and all the people at [INAUDIBLE] in Boston who helped all of the programs for the SPNS grant.

But really, this has been one of the most impactful programs in the last 30 years that I've had the privilege of working with. HHOME stands for-- and sometimes we think it changes-- Homeless HIV Health Outreach and Mobile Engagement. And really what we looked at is the system. It's a system, a program, and a client-level intervention, and that's really what we looked at. And our final conclusion was that systems are the failures and not the humans that we're serving.

So this is our grant and our disclaimer. We love Wonder Woman. I hope Robert brought his mug. We don't get to wear the breastplate in our meetings, but I would if I could. Sometimes I envisioned her when I went out in the street.

But really, the first thing that we started with was looking at the system and where we were blaming and looking at each other and getting that together so that the amazing human beings that were living with HIV living on the street and using drugs and living with mental health challenges didn't have to wrangle our confusing system. Many of your cities probably have similar challenges.

So many different people came together in 2014, and we're constantly upping this list. This is the original group that came together and said, what are the gaps in our system? All the way from the hospital to jail to nonprofit programs like a program called Project Homeless Connect. And I recommend you Google that and look to see if there's a Project Homeless Connect in your community. It's a volunteer program. SF Community Health Center and some other community programs.

I do want to correct that I work for the Department of Public Health and not for the non-profit. And right now, I oversee health policy for people experiencing homelessness and vulnerable populations. Because this grant really helped us realize in San Francisco that we had to keep and look at this high level and have that be as organized as our on the ground programs.

But really what we looked at is those times when you get phone calls, you're like I can't believe that hospital. I can't believe that program. They did this and they did that. We realized we weren't working together. We were blaming each other for the gaps in the system.

So we got together and said, what can we do? What do we want to do? And used a real collective impact model and continued to meet during the time of the SPNS grant with these groups. They're still meeting together in other iterations. One of the things Robert and I talked about just yesterday is we need to get back to these basics of making sure that everyone is aligned.

So this is first take-home, get everyone together. The next take-home that I hope you can start today-- and if you're saying to yourself, we don't have all of-- we can't do a multi-agency, multidisciplinary mobile team and leave our health centers. That's fine. We're hoping that in our next 20 minutes, you're going to take away some really key concepts.

One is get everyone together, like Jamie said. Who's there working with folks and get them together? The next is that stigma really is the thing that's driving people not accessing care and not fully embracing their health goals.

So making sure that we have programs that are not a one size fits all, and Martina is going to talk more about her experience and the different kinds of programs. She's now working in one of our programs

now that's a low-barrier social service program. But how different sizes meet different people at different times in their life.

I want to also have another visual for you to think about what our health centers look like. There are four-walls health centers that people need to get to. And for someone living with so much stigmatizing illnesses and many social determinants of health challenges, going to a four walls health center can feel like they're going to the Himalayas with oxygen.

So if you were someone who had lung disease and you had a health center that was up here on the top of high mountains, high altitude, it wouldn't serve you. You could not fit there. But that's what the equivalent is of many of our four-walls health centers.

So in order to improve the lives of people living with HIV, in order to decrease the trauma to the staff that's serving them, we need to understand that four-walls typical health centers are not the place, and they just cause more and more trauma, which is called sanctuary trauma. It's a trauma someone experiences when they go to get and receive care and they just find failure.

Even asking someone, are you ready-- I'd like to start you with HIV meds when they're not ready or able to do it is stigmatizing and can cause more trauma. So we really want to think about, how do we make everything as accessible as possible to where someone's at.

So when we all got together and what we still look at now is there's five areas that people living with HIV who are experiencing homelessness or unstabley housed might need. The first is starting at the left. Everyone needs a safe place to live, and Jamie really highlighted the importance of that. What's not on here is their own goals of support and work and life goals.

The folks that we were working with-- and Robert will talk a little more about this-- really starting to work was not the first step. It was really getting them somewhere safe. So that includes three different things. Anyone experiencing homelessness or marginally housed needs the first on the left.

Most people with any health illness, just like in cancer, we know people need navigation. They need to know where the resources are. They need some social support. We need to understand their health literacy. These are two basics.

What we found with HHOME is that no matter what, even if we gave them all five of these interventions, people still need those first two. The next, some folks might need case management, behavioral health, and all the way to medical care that would be able to support them on the street.

So we designed something called an acuity scale that we used in San Francisco, all these groups, to say not everyone is the same size. How do we actually systematically-- and just like you check viral load and/or CD4 count, we can get actual data to understand what the level of complexity is. Because sometimes someone comes and you think they need full on support and care, but they might just need med adherence.

So we broke everything down into these six different groups-- medical care, physical care, medication adherence, navigation, case management, substance use, mental health. I'm not going to go into the details for time's sake, but all of this is available to you if you want to look at this acuity scale a little deeper.

I'm going to show a couple of slides of what it looked like. It was not completely animated. It's in a PDF. We've actually shared this with some jurisdictions who took this and actually made it part of their other system, so we love when people steal what we have and use it for your jurisdictions.

But it's pretty detailed. This is just the short version of a medical page, and so it helps the care coordination person know and use actual data which programs. And we divide our programs into 0, 1, 2, and 3. I'll go into detail about what those are to understand what they need for medical, housing, what their functional needs, what their behavioral health needs, case management, and navigation.

So we have programs that fit into each of these models. If your health center could do any of these, even starting with 0, our positive health program, Ward 86, for UCSF actually has developed a level 0 program, 0 to 1 program that's in the health center but it's a low-barrier. People have open access, anyone experiencing homelessness. They've completely revamped their care to ensure that they're really serving folks in the four-walls health center.

Level 1, then level 2, another program that Rob is working on. Level 1 is in programs in social service agencies, where actually I do my care where Martina is the case manager. It's a social program where people go, they have lunch. They can pick up their meds, their breakfast, they can pick up their meds, and do art, et cetera. We have other low-barrier options for folks.

Level 2 is half inside of health center, half outside. And what level 3, which is the HHOME, we're going to talk about is most of the service-- 75% of the services are fully mobile. And we try at all points to get people as much as possible to a four-walls program. I'm going to hand it over to Robert, who's going to talk a little more.

One more thing, Barbara, before we go. Who's the gatekeeper of the program? Who makes the decisions is going to be different in every location.

But one of the things that the group has done is there are gatekeepers, which is a LINCS program, does our linkage through our disease investigation, and then we have another program at the hospital. When they encounter someone living with HIV that's not in care, they go through this assessment process and decide which program someone should be in. And then they place that person in that level of care and the referral, and that level of organization is really critical. They also have a once a week Monday meeting where they go through complicated patients to try to decide which program that person should be in. OK, Robert, I'm going to hand it over to you.

ROBERT ARNOLD: OK, so come as you are wherever you are. Perfect for that whole model. It's mostly mobile care to gain our client's trust who do not trust our four-walls clinics or have a lot of trauma from visiting hospitals and outpatient clinics and stuff. Meeting them where they're at is extremely important to gain that trust. You're there every day. If they don't need something today, they might need something tomorrow.

So HHOME target population, it's the highest level acuity from the scale that we showed before. Considered the hardest to serve, and that's based on the clinic models that we have going right now. They're not so hard to serve if you can meet them at their level.

So some of the qualifications to become a HHOME client, you must have a detectable viral load, CD4 less than 200, AIDS status, active substance abuse, must be experiencing homeless, usually dual diagnosis,

has severe mental illness or behavioral health issues. One of the key things that HHOME does do is the special populations. Working with HIV-positive pregnant women.

If one of our positive HHOME clients also has a partner that does not positive, is negative but still is homeless or has substance use, it's very important to bring them in because, one, you can offer them PrEP and you can prevent them from experiencing HIV. Also it encourages the other client to come in. They're working together for both their healths. Transitional age youth ages 18 to 25, newly diagnosed people with HIV, and people that are imminent risk of eviction. So we help with eviction prevention or at least getting them to who can help them with that.

HHOME couldn't have started or been possible without coordination with other programs throughout the city. Street Medicine is a safety net for the city. It's drop in for emergent or urgent care also for our homeless population here in SF, and they provided the medical provider, Dr. Borne, et cetera, nurse, medical supplies. We have a drop in clinic with them once a week for our clients to be navigated to.

SF Homeless Outreach Team, which they provide a dedicated housing case manager. They also provide a clinical social worker, and they give us access to stabilization rooms. They help guide the clients to being housing-ready, getting their ID, et cetera.

SF Community Health Center, so they provided the culture, the social work, the navigation, the program manager. We also have an open access drop in clinic. We have a drop in every morning from 9:00 AM to 12:00, where HHOME clients and other clients that are HIV-positive clients can come and get breakfast, get coffee, socialize, watch TV, check in with their case managers, kind of get used to being inside of the clinic.

And our client intervention philosophy. So harm reduction, very important. Come at it with love and care. The interdisciplinary model, when we meet at HHOME, we have our case management meetings, et cetera, we do not-- everyone is sitting at the table. The doctor, the social worker, the program manager, the case managers, the navigators. They're all sitting there with the client as the lead.

So every one is coming together with client. There's no doctor over nurse. There's no program manager over case management. You're all coming in for the betterment of that HHOME client. And I feel like that's very important because it kind of lets other case managers and stuff feel more free to advocate for their client a bit more staunchly.

So yes, also remembering that stigma is the disease. So letting the client lead you is very important. Letting them know where they want to be. If they're not ready for meds, if they are-- do they need to take a break from meds? And letting them know that these things are OK and help guiding them the proper way to do it.

Client intervention basic techniques. We can quickly go through these. So drop in service programs. Mobile care is very important. So we have our open area where clients can come and drop in anytime they need something, but the majority of the time, the nurse is going in the field, doing phlebotomy in the field, case managers meeting them wherever they may be. Getting down to all the appointments that they need to get to or just checking in make sure they're fine.

DEBORAH BORNE: I'm just going to go over some of the data high level from our study. It was published in American Journal of Public Health and walk you through. The data has changed since 2017, but you'll

see blue lines and orange lines. The blue lines for people that were in the study. The orange were the number of people in the three years that actually participated in HHOME.

And that difference in number-- 40 clients were too psychotic at the time of meeting us to be able to be in the study. We couldn't do an interview with them within the first two weeks. We needed to spend the first month or two help stabilizing them to be able to participate. They could consent, but they couldn't do a one or two-hour interview. But so that's why the numbers look different.

But it is important, we like to show that you start where the person is, and you can still get to very similar outcomes, even if people are the ones that-- we had one client naked on the street. And we used to go out there, they would be getting 5150. They wanted to conserve that person, and they are now actually work at San Francisco Community Health Center and started their own nonprofit. So this is the opportunity to just understand that the person presented in front of you-- is one of the take-homes from this slide-- is not necessarily the person that is inside waiting to emerge.

So the data that we looked at was the ability to achieve viral suppression, and the majority of people, 79%, were virally suppressed and most of them before they were even in a four-walls clinic. So that was because case managers, nurses, peer navigators were part of the adherence and it wasn't just about the doctor or the nurse doing the work. Permanently housed, 83% of the people in the city and 62% were in inside and signed a lease at some point.

The numbers who have deceased are actually larger since 2017, and that's on Robert's and my to-do list is actually publish what we know about five years later and where this cohort is. Discharged to standard care, we stepped people up to different levels of care so that they could go from either a 4 or a 3 program, and they actually going into a 1 or a 0 program. And a small percentage of people were lost to follow-up, which with this particular population is quite stunning.

I'm going to hand it over to Martina, if you can change the slide, to talk to us about some of the policies that even if you're not going to go out on the street doing things, there's lots of things you could do tomorrow that had huge impact for her and a little bit about her story. Martina?

MARTINA TRAVIS: Good afternoon. I want to talk about the policies that improve the outcomes of people experiencing homelessness. I did experience a short time being homeless; about two years.

I had no access to the clinics, and I had no access to the case management and things like that I deem necessary in order to continue my life. Of course, they would bring pills to you, but already I was non-adhering to the medication. I've taken so much for such a long time that my numbers just would not go up.

The incentives that they provided were food, clothing, and gift cards. That's actually how I sustained my life for that two years. I really was out on the street and unable to make decisions that would help me to move forward. The housing support that I got was from the home team. The home team actually came and got me, picked me up from a couch surfing situation and tried to point me in the right direction.

I think it wasn't just one or two people that came to visit me. Dr. Borne came in droves with as many individuals that she deemed necessary for the different avenues that I had to travel in order to get my life straight. The mobile teams that came out, that would have Dr. Borne as well, and I'm doing labs in the field, coming out and trying to get me to motivate myself in order to go to these places and get the help that I needed.

I communicate a lot with them, and I communicate a lot with Robert here in the office. I was able to get things straightened out with my medication. Right now, we're still having a small problem, and I don't mind sharing this, that the medications that I'm on currently are not bringing my viral load all the way down to where it needs to be. It's hanging out around 20, 25. And although that's still considered undetectable, I'm not comfortable with doing a few things that we do in life.

I do have a partner. My partner is negative, and my partner has been negative for eight years, and that's not because of using condoms and things of that nature. It is because of the medication finally getting to where it needs to be and protecting him as well.

I am a trans experience, and I actually would not come out on my own. It took all of these guys to help me get to where I am today. I'm comfortable in my skin. I'm comfortable being a trans experience, and all of these resources that brought me together.

Starting out in just the standard hotel room, sometimes I had to move from one hotel room to the other constant. It was like two weeks here, one week there. But the team, the home team made sure that I was inside, and being inside, I was able to start to control things in my life myself without having other people tell me to do so.

I was hooked on drugs out there. Methamphetamines was my best friend. I didn't have any other friends, but I did have methamphetamines, so that would actually sustain me for a short period of time.

Now I've been clean for over nine years and without any methamphetamines, without any drugs to cover up what's going on with me. And I know that in any situation, I can come to the center here where I can access them, I can access Robert if I need anything to help me continue my life and my development here at work as well as the development in my home, which I can actually call a home now because all the people around me are there to make me feel at home. They're there to help me get through the hardships in life.

I just have become creative with my own communications, using phones not Facebook. I do not participate in any social media, and the bracelets that are down here, Deb is going to have to tell you what those are because I don't have them.

DEBORAH BORNE: Thanks, Martina. I do want to point out some things. I think it's hysterical when you call me Dr. Borne. We all go by our first names, and that's part of what it is. We all show up as who we are, not our titles or not even our dead names. We're here as who we are and who we want to be authentically.

And I do want to-- if you don't mind me sharing-- Martina asked the other day, she's like, did you ever think I'd be a case manager? I was like, absolutely. I always thought I just see you, and that's who we were always talking to, and you were the center of what your health goals are.

HHOME home bracelets, where the name-- you saw one on the little puppy's neck. Robert is showing you one right now. They have the name of our program, the telephone number, and we've had people show up six months later and said, you told me I could jump in here when you met me on the street and here I am. So it's just a way that people can wear them and remind them. It was an idea of one of our patients whose past said that if I could just remember that someone really cared and loved me when I was out there, it would be really great. So it was his idea, and we hold it for him.

So we're going to go-- Robert, I'm just going to take this away if you don't mind the challenges. Thank you. So there was a lot of challenges here. And just for a time, we're not going to go through everything. One is staying grounded when there's a lot of trauma, either with the team or the client, with the team or in the system, and that requires good communication and mindfulness.

The other is understanding that getting housed is a slow walk to the starting line. It's just the beginning. And with Jamie's program pointed out, really having very rigorous programs for people's full lives once they're housed is really important. Holding onto QI principles also. And again, remaining focused in chaos. If we weren't meditating before, this is certainly what we do now, and I'm actually teaching mindfulness for my department because it's been such an important thing.

Some more challenges that we have is citywide, COVID was really, really challenging. I was actually pulled from the team and overseeing deputy for the COVID response in San Francisco. The team really held a lot of people together during that, but also political and other changes. Even there was four programs that started HHOME. There's now three there. There might get down to two. What's going on, who has funding, and being able to move, it was really a challenge, but very critical and moving with the times.

So I want to talk a little bit about the spin-offs and our successes because it's really important to understand that once you're starting to do this kind of work, it really has potential snowball to really make some differences, and these are programs that are going on now in San Francisco because of our work. One of them is getting to 0. One of the programs that Robert oversees, it's a level 2 program that helps people. There's two agencies that are doing intensive case management, half in clinics and half outside.

There's a life skills program that we started to develop in getting back to, something called encampment health, which is a huge part of what San Francisco is doing now. And we got CDC Foundation funding to expand that and some other funding from the CDC and something called opt-in, where we do low-barrier PrEP, STI, in other kinds of testing in encampments and with syringe exchanges, and I still work two or three evenings a week at some of these programs.

We have a pregnant woman mobile program that actually works with women that use drugs or experiencing mental health challenges. And we've had a congenital syphilis issue with a lot of women that are using drugs experiencing homelessness, and the HHOME program has actually been the model that we've been using to help and support these women.

The last program is something called Social Medicine. It's a social determinant of health consult service in our safety net hospital that now is funded with eight doctors. It used to just be me and another provider. A full multidisciplinary team looks a lot like HHOME, where they support folks in the emergency room and help consult on social determinants of health. Really huge successes, and now there's actually a mobile palliative care program that is part of street medicine, looking a lot like what we did for people that are not just living with HIV.

We hope that you really take home for us is that you really encourage all of you to think about what you can do on a systems level. Get together with all the programs that are working and just sit down and see what you can all share together. Coming together and incorporating any of the policies that Martina reviewed with you.

But at the end of the day, everything needs to come from the consumer. The people who are serving have health goals. They might not be looking like the ones that we have to check off in our boxes and our electronic medical record.

So understanding that their health goal might be taking a vitamin. Their health goal might be that they want to come in and see you once a week. Their health goal might not be taking a pill. You start from where they are.

Trauma-informed leadership with great leaders like Robert. Really understanding that we can work together in multidisciplinary teams. Take the onus away from the doctors and really have community health workers and peers rise to the forefront of the work. And then keeping the system aligned as we move forward.

Lots of resources you can move forward that will be available to you that we use. Healthcare for the Homeless. We would love to help and support any organization that wants to learn and even all the way from any level 2, 3, and 4 type program. Robert actually oversees all three of those at his center, and we just wish you the best, and thank you for doing this work. Over to you, Angel.

ANGEL JOHNSON: Thank you, Deborah and thank you Robert, Martina, and Jamie for wonderful presentations. So we're now going to open the floor and take questions for our presenters. There were a few questions that were placed in the group chat earlier.

Eric wanted to know if there are articles about these programs. Have they been published? And if so, if there's a list that they can get.

JAMIE SHANK: Yes, publishing does take some time, so I know we have some that are still under review in a couple of different open journals from the KC Life 360 side. I want to double-check the link to the manual. There might be some of the publications there, and then I'm also going to check before we get off, I might be able to share some additional links.

ANGEL JOHNSON: Thank you, Jamie. Deborah?

DEBORAH BORNE: I'm just getting for our, the PubMed citation for HHOME that we did publish, and we did publish in American Journal of Public Health. I'll put that in the chat in a second, from the entire SPNS with all the different-- there was eight programs that really did look at-- some of them were just level 0, level 1 program, level 2 looking at homelessness.

But ours was with some of the more complicated, so I will put that in the chat as well the link. But this is just a citation for our mobile program. And there's what you will put together, which is a great tool kit that people can take and use.

ANGEL JOHNSON: OK, thank you. And Eric also wanted to know, are clients present at the HHOME case conferences?

ROBERT ARNOLD: Yeah, we can both answer from experience. Historically, no. They aren't present. They are advocated represented by the case managers, but we do have a community, like community access boards, where clients from HHOME and other programs meet once a month to give feedback on things they'd like to see different at our agency or at the program they are part of, and we usually try to fold

that into our policy. But generally, they're not there unless we're having an individual case conference, where, of course, we want them to be a part.

DEBORAH BORNE: Yeah, Robert, I'm just going to jump in for one minute. One of the things that was really critical is actually to help support people at their points of transition. So if someone was in the hospital, if someone was in a skilled nursing facility, if someone is in jail, if someone was in hospice programs, we would actually meet every time with the client, speak with them first. Make sure that we knew what their goals and would meet with the whole organization.

Sometimes someone could be in three different places in one week, but that was a huge and important part. And so any care and conferencing that we had on someone's individual needs, that the participant, the person that we were working with always was at those meetings. Just because of HIPAA, they weren't in the meetings we were talking about other clients.

But if people had phones, there were times that we would call them in and say, we want to do X, Y, and Z and have some questions because we used to give out phones is a huge part of what we did. So conferencing with a person, having them be part of their treatment is really critical. And we didn't do it-- we don't do it for the HHOME meetings where we're talking about everyone, but we did have participants be a part of their treatment plans wherever they were. And we would also do conferencing, obviously, on the street.

One of the things we didn't cover is that we go out, always have two different disciplines at the very least. So Martina said, we have a ton of people coming out, but we would have a case manager and the provider, a nurse, and the navigator in different forms. And if the other person that needed to be in the conversation was there, we would call and just all talk and touch base. OK, all five of us are in this communication right now. So we would have mini little conferencing with the guest with a person like when that person we visited them in their tent.

ROBERT ARNOLD: Yes, thanks for clarification. That's right.

ANGEL JOHNSON: OK, thank you. Sharon asks, how do you fund and manage the distribution of incentives and other necessary items such as gift cards, clothing, and food?

DEBORAH BORNE: I want to talk about contingency management first, which we kind of skipped over, so contingency management is one of the few interventions that's been shown to help improve people's outcomes around methamphetamine. That's when they come and then for a year-- and I don't like to use the word "clean" because you're clean when you're in a shower, but if there's a year in that does not have drugs in it, they get a reimbursement.

So we used contingency management to help decrease dopamine. Sometimes it looked like a gift card. Sometimes people wanted tiaras. Sometimes people just wanted food. It was their goals, and we would bring it. Robert can talk about how they use incentives and both the levels 0, 1, 2, and 3 programs because it's a great point to go over.

ROBERT ARNOLD: Yes, with HHOME, it's important to be more creative and allow the client to tell you what they really need or want and what it would take to get them where they want. But as far as the incentives of gift cards, clothing, and food, well, the gift cards are gift cards for our programs come from Department of Public Health, HHS, and we are allotted so many per year. And how we divide those out,

the program managers work with the case managers to use the incentive accordingly. Like some people need more incentives to do other things than others, but it's very important to track all of that.

Clothing, food, it's all just was in part of the grants that we've gotten since the SPNS contract. Also too, our agency just puts in for food and stuff like that. I don't know how else to do it. Yeah, most of it comes from DPH. It's very tightly tracked, but it's very important to incentivize people to do labs, incentivize people to whatever it is their goal is. If a client has a goal to reach, we can say, OK, I'll help you get there. And if you get there, is this something that you like, or is there something else that would help motivate you to get there?

JAMIE SHANK: Yeah, I would agree. It's similar. So really learning how to maximize your funds. It really it humbled me quite a lot in this four-year SPNS journey, whether it was my SPNS dollars or my HOPWA dollars what I was still sort of persistently unaware was eligible. So I think that's just something for everyone to always keep in mind.

But through SPNS dollars, especially as it's related, we could get clothing. You know, hey, we did a lot of stuff. Hey, you're going to start a construction job. We're going to get your boots, we're going to get your belt, we're going to get your tools. Really supporting a lot of different things.

Kansas City gets a lot of snow and ice. We're a cold weather place, and we also get very hot. So we ended up at the health department having a little closet for things like toothbrushes, socks, gloves, backpacks. But so some of this came through donation. We maximized Third and Long Foundation, which ties to the Kansas City Chiefs. So they donated food around Thanksgiving time. They donate stuff around winter holidays like Christmas, Hanukkah, things like that.

So maximizing some of the community partners who want-- let's be honest-- the tax write-off for certain things. I'm just channeling that to your organization. But we were able to do a lot of clothing eligible through the employment support line in our budget and then continue that through formula HOPWA as well.

And what we did with gift cards is we also learned a little bit about client choice. And we initially just started with one of the same thing, but then we would get a variety of stuff because some people wanted the gas card because they were living in their car to stay warm, and they were driving themselves to work, so the gas card was more helpful. And then for other folks, it was food-related. Was it a grocery store? Was it Subway or something else close by?

So we also made sure when folks could receive a gift card, which was based on different appointments that they came in just to have conversations with their employment support specialist that they also had choice in terms of what they wanted for that time frame. Again, not one size fits all.

ANGEL JOHNSON: And Jamie, did you mention anything-- someone wanted to know about the cell phones and how they were paid for.

JAMIE SHANK: Yeah, again that was a line item that we were eligible to use within our SPNS dollars. I have to think-- I mean, I think we literally just budgeted it as cell phones. So for some of this was-- some people we bought like a prepaid monthly phone. For some people, they had a phone, but we helped them buy the plan. We helped them with their minutes. You can also do things like hotspots.

Something that I did learn over time though is different folks prefer a phone to a tablet. So also keeping in mind like the tech wants, desires, and needs is something to explore. But we started doing cell phones right after year one because we learned that they were so central, and that was eligible expense.

So our employment support partner, Catholic Charities , that was something-- they subcontracted with us as the health department. So it was just a line item in their budget, and the employment support specialist would go with somebody to get the prepaid phone and/or get a better minutes plan, and it was just a very straightforward line item actually.

DEBORAH BORNE: Jamie, we had a line item in our SPNS grant too for phones at the very beginning. And by the time Robert came on, which was after the SPNS grant was over, was not something that was budgeted, the rate that people lost it with this particular population. But the Obama phone and helping people get registered for the federally-approved phones.

For Facebook, I work with the Homeless Youth Alliance, and they actually use Facebook as their form of communication because they use-- or other people can actually borrow other people's stuff to get on, and it's a way of actually communicating. So we're looking at other more creative ways just for the consistency that it's not requiring it a particular number, but it requires something that can stay that the person would have, like the email or something. But it was a really wonderful thing to be able to have that with the SPNS dollars, and I look forward to when people understand about the equity needs for communication and the correlation with health.

ANGEL JOHNSON: Thank you. And can you all talk a bit more about options and communities when housing stock is low? It seems like most communities are struggling with housing in general.

DEBORAH BORNE: Jamie, do you want to start that one?

JAMIE SHANK: Yeah, I'll go first. So yes, we feel that. One of the things that we did in Kansas City is we mapped out a housing continuum. We came up with what are the different sort of housing circumstances people find themselves in and then what are the resources or what are the funds that we have or that are gaps so that we could begin to plug in those gaps. So we did some sort of strategic planning.

One big thing was, again, finding funding for the hotels. And housing is resource-intensive. It's very expensive to provide housing for even a small number of people. So that's also part of the challenge. But again, through formula HOPWA dollars, you can fund that.

So we learned that lesson. We went back to our cities consolidated plan, and we switched money in the budget. And yes, sometimes this takes money from other places. So you have to also navigate like, yeah, we're decreasing this, but maybe you've traditionally left some stuff unspent or this, that, and the other. But again, recognizing that collective need. So formally funding it through HOPWA formula.

Also, many housing authorities have what's called moving on. So with local Continuum of Care, CoCs, a lot of different communities are doing an MOU and moving on MOU agreement. So your local housing authority has a certain number of units that they need to keep filled in order to keep those number of units. So for folks who are on programs through your CoC through an ESG, Emergency Solutions, or through HOPWA, or through something else, for folks who've been on a housing voucher where their unit is paid for like 10 years, 8 years, 12 years, very successful.

Having conversations with your housing authority, doing an MOU to basically transition who's paying for that unit. This person doesn't have what we would say is like high acuity, all those different pieces. They've self-managed. They've been there for a long, long time. Let's move them off of our grants and fulfill the need of the housing authority to keep units filled.

The individual never has to move. So if they have established themselves in their neighborhood or they've established himself in their home, that's going to all stay the same. It's just sort of who's footing the bill on the back end. And then that's going to free up housing stock under your current grant awards.

So I would definitely look to explore with your local housing authority and MOU. And in all honesty, the HIV Services Department and the Missouri Department, like a DMH, Department of Mental Health, we initiated that, and later on, the entire CoC came on board. But it kind of created a channel for, again, folks who've been there for a long time to come off some projects, which then opens up-- like it creates resources when you don't have to build new housing or you don't have to wait for these big capital developments and stuff like that. So those are a couple of options.

Also raise a little hell, if you will, and support folks who are advocating. There's a group called KC Tenants. So doing a lot of grassroots organizing. Really being present, presenting to your planning counsel, to your mayor to put political pressure on them to make changes. And really working with-- in a city structure, your whole community development and your neighborhood division of your City department is also someone you need to be present with, have conversations with, attend meetings with, build relationships with because that's where other housing stock options lie.

DEBORAH BORNE: Jamie, I'm just going to jump in on some high level, because what happens is you have one social worker who gets and knows the system and can get people housed. That's why I would just encourage everyone. There is not enough housing in the United States for the number of people that are living on the street. That is the truth.

And in your neighborhoods, if we don't get together in your communities and start to create coalitions where health systems are talking to the housing systems, we're not going to make any headway. And the other eight, nine, seven programs that worked on our SPNS grant, some of the most lingering and impactful work with coalitions. We only got $350,000 a year for this program, and we put money into community organizing because we knew that was importance for stabilization.

I put in the chat information on what the HUD Exchange and the CoC is. If you don't know, in your neighborhood and your community, everyone if you get HUD dollars must have a continuum of care program. Go to those meetings. Start to meet the folks and start to tap in.

You have stuff that they want. They want health care information, and so they want to work with you. So start to get relationships. National Health Care for the Homeless, also wonderful. It's funded by HRSA. It's technical assistance for health care providers working with people experiencing homelessness.

There's a lot of programs in your-- they offer TA. There's a lot of 101 to understand a lot of what Jamie was just talking about. So start to meet your partners. They want something from you. You want something for them.

What Robert's program does now in San Francisco, because things have changed in the last seven years that we've been doing this program, just make sure they partner with the person who has the ticket to getting people assessed for housing and we're partnering constantly. The other thing that's really

important is not just permanent housing but for stabilization, because the reality is, we often can't get people directly into care. So working with the folks that are running the shelters if they still are using any funding for stabilization rooms for money for hotels, et cetera.

So we also have something in San Francisco called Problem Solving-- it's part of the continuum of care. And these issues are all-- where they go and they have funding through HUD to be able to actually pay for little bits of dollars to-- a lot of continuum of care funding is actually going for funding that's not just for the housing, but it's for people that they need just like first and last month's rent.

So really get a conversation with your continuum of care. These issues are so important from a health point of view that I'm no longer doing the direct work with HHOME. I actually do health policy for people experiencing homelessness, meeting and making sure that we're aligned on the policy level because this is just as critical.

That social worker in your program, that case manager program struggling to find housing needs us, all of us to get it together and to say that to get to viral suppression, we need to understand that housing is health and we need to work together. So those would be my-- you can do that tomorrow. That doesn't take funding is to start conversations and to start-- Jamie, wouldn't you say just alignment?

JAMIE SHANK: Yes, like 100%. And we are all very, very, very busy, but building those relationships, being part of the committees or the groups with your CoC and other groups really, really is important because we're also burning out staff because you can't move the whole system as a party of one. And also, it's not good for our systems to have those back door channels where you have the veteran person who's like, well, I know so-and-so at this shelter. That's unequitable, and it's toxic to your entire system, and it's harmful for the folks trying to navigate that system.

And it's hard to make a shift from that. We did that in Kansas City in the five years I was there. It takes time. But those relationships are invaluable and that policy, that advocacy at that level is invaluable.

ANGEL JOHNSON: Thank you. Jamie, I have another question for you. How do you assist your transgender clients with navigating transphobia from housing and employment providers, including employers, landlords, hotel staff, and management, Catholic Charities, housing services, et cetera?

JAMIE SHANK: Thank you, Amanda. So a couple of things is a big question is what lots of pieces. A couple of things, one deal-- and we hear this a lot with Catholic Charities-- was what's the perception of partnering with them, and what's that vibe? And there's also trauma from folks' faith experience surrounding that.

So before we even applied for this grant, we had a lot of very frank conversations. How comfortable are you checking their internal biases and things like that? And they were actually very supportive, very open. So really just ensuring that we have a safe partner to refer folks to and doing that vetting ourselves.

Same with the hotel. Where are we building a relationship? What part of town is this in? Very much explaining-- like obviously we did not disclose status by any means. We didn't even disclose health condition. So we learned from our partners in San Diego and PIHC, so how do you navigate like, hi, I'm paying for someone's room without there being a lot of unnecessary questions and nosiness. So we did a lot of partner vetting.

In terms of transphobia with employment, so actually one of the things we focused on was for folks who are experiencing that, obviously if anyone wanted to make a grievance or a complaint, what do they have the right to do, and what are the channels, whether it's landlord or an employer, if they want to follow that process. Most of them didn't opt to take that.

So we talk about de-escalation also and how do you advocate for yourself to your employer. It's not OK for people, your coworkers to treat you X, Y, Z way so folks would just not show up or just quit. But so how do we navigate through that in a way that folks feel empowered, and also how do we approach things like the interview?

How do you want to present at an interview? How are you planning to present on the job? Are there things like your ID or other stuff that you feel like, well, I have to present my gender assigned at birth because that's what all my documentation say. How do we think upstream before any of that stuff happens?

And then with housing, especially it's as a landlord within our system, especially being at the health department, just going to that agency and saying, look, this is what happened. This is unacceptable. What's going to be the couching, coaching, firing, termination, or whatever of these individuals? Really checking people on what do you say your core values are and how are you showing up for them or how are you not, but really being that direct with folks.

So providing a lot of training as well to support folks who acknowledge that their comfort level is maybe low in these spaces so it doesn't turn into discrimination. But we work through our phobias, we work through our biases. The mental modes we carry based on our experiences or our interpretation of the world, how do we sort of crack that so that folks have an affirming environment?

So those are some examples. We only had one person with a landlord want to follow through with discrimination, so we supported them in how do you do that? What are the steps? Because obviously that goes outside of the health department's purview, but we'll go with you to that appointment. We will help you look through that paperwork. What would you like to do, and we're here to support you because you're fully within your right. And then also we're going to find you a better place. I hope that answers it enough.

ANGEL JOHNSON: Thank you all very much. So we only have a few more minutes left to wrap it up. I thank you all for the presentations and for responding to the questions. If you have other questions for our presenters, you can do that through our IHIP help desk, and I'm going to give a little bit of information. But be mindful that IHIP intervention guides will be out soon about these interventions, and we'll also include links to additional resources from these programs. We will send out an update on the IHIP Listserv once they are.

For folks interested in receiving these alerts, they can subscribe on Target HIV website under Subscribe. You'll also note that there is a link on the screen for feedback about this presentation, and we would appreciate if you will provide your feedback. Also when you close out from this webinar, you'll get a thank you email. This link will also be provided in that email.

Now I want to talk a little bit before we go about how to request your continuing education credits. So when requesting CE credits, please go to www.cmeuniversity.com. You'll be prompted to log in or create a new account. You will be prompted to either to enter a web ID, which is 17219 for this webinar, or you can look for it by the date.

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Also to stay connected for capacity-building TA questions, you can email the IHIPhelpdesk@mayatech.com. If you have additional questions for our presenters, you can do that, and we will get those questions to them and get them back to you. And to access the IHIP tools and resources that we talked about earlier and to join the IHIP Listserv, you can go to Target HIV website at targethiv.org/ihip.

Any other comments or questions before we go? We're right at our time here at 2:30. If there are any last minute comments from anyone, now it's time. We thank you all so much for your time, for your participation, and for all the information, and we really, really appreciate it. Thank you.

ROBERT ARNOLD: Thank you.