

HIV Housing Care Continuum Webinar 2 August 3, 2016

Rusty Bennett: Welcome to the HIV Housing Care Continuum planning webinar series. This is webinar two. The impact of housing on health and using your HIV Housing Care Continuum. I'm Rusty Bennett with Collaborative Solutions and I'm joined with Christine Campbell from the National AIDS Housing Coalition.

Christine Campbell: Good afternoon, Rusty. How are you?

Rusty Bennett: Glad you're here. Excited about this next topic. So this webinar is going to be focused on, again, helping you to build your HIV Housing Care Continuum as part of our series of working in your own community, taking some of the lessons learned from our regional meetings and the partnership with the Office of HIV/AIDS Housing at HUD, Collaborative Solutions and the National AIDS Housing Coalition. So certainly by now, hopefully, you have your team established. You're working your process of developing your HIV Housing Care Continuum.

And this webinar is really going to be focused on a couple things. One is the critical connection I think between housing and health and really hammering that home, if you will and looking at some of the research and trying to illustrate that connection that hopefully you can use in galvanizing your community and also your team on building your care continuum. It's also a second part which is using a -- an example from one of our community partners, the New York City Department of Health & Mental Hygiene with John Rojas. He participated with us in the regional meeting and was very instrumental in providing this community level example.

And so we kind of want to walk through that in today's webinars. Well, you have an example of what you can use in your own community in making some

decision points. So we're going to turn it over to Christine and let her walk us through some of the critical connections between housing and health.

Christine Campbell: Thank you, Rusty. So I'm not going to really go into detail as to what the HIV Housing Healthcare -- Housing Continuum is, but what we want to do now is really connect health outcomes and housing and how the -- how important it is to really look at how we can improve our outcomes by providing affordable decent housing.

So at the National AIDS Housing Coalition, one of our mantras is housing is healthcare. We have a strong body of research findings including an analysis conducted by the CDC that shows that housing status is a stronger predictor of HIV health outcomes than individual characteristics such as gender, race, age, drug and alcohol use, mental health issues, and access to supportive services. Additional details regarding this research can be found in your workbook. We had been truly honored to have the benefit of many researchers over the course of the last few years since 2005 to work with us to really show the connections between housing and improved health outcomes.

From the multiple research studies, we know that housing instability and homelessness is going to delay in diagnosis, increased risk of acquiring and transmitting HIV infection, delayed entry into care, lack of regular visits to primary care, delayed use of antiretrovirals and you're less likely to be virally suppressed. We also know that housing stability leads to better health outcomes. So conversely if someone is stably housed they will have reduced risky behaviors, increased rates of care visits, more likely to return to care, more likely to receive antiretroviral therapy, more likely to be virally suppressed and reduced use of ER and other public uses.

So we know that people with HIV/AIDS need the housing support. They're vulnerable to housing instability and as such are often at risk of becoming homeless. An example in the Ryan White HIV/AIDS program, data shows that of all clients in the United States in 2012, 19,702 were unstably housed, with 62,468 temporarily housed. HOPWA performance profiles in 2014 and '15 indicate that for all clients receiving short term rental, mortgage, utility assistance, two percent were unstably housed and 55 percent were only

temporarily stable. Across both programs, we consistently see high level of housing need amongst people living with HIV and AIDS.

We also know that collecting housing data is difficult at best. In HUD's HOPWA program, as reported in the HOPWA consolidated annual performance and evaluation report, housing stability for people living with HIV/AIDS is defined by the type of housing situation a client is enduring or upon exit from the program. Permanent housing includes ownership or rental of a unit, whether subsidized or not and other housing is expected to be ongoing such as where a lease or other agreement gives them a right to stay indefinitely.

Using the current HUD HMIS and Continuum Care Program definitions for unstably housed and at risk of losing their houses, housing instability maybe evidenced by frequent moves because of economic reasons, living in the home of another because of economic hardship, being evicted from a private dwelling unit, living in a hotel or motel not paid for by a charitable organization, being discharged from a hospital or other situation, or otherwise living in housing that has characteristics associated with instability and an increased risk of homelessness. Unstable housing for people living with HIV/AIDS may often be overlooked if program assessments do not include more robust information on the relative stability of clients currently living in a situation that is judged to be permanent and therefore stable by definition.

For instance, including a measure of housing burden in an assessment can provide important information about the affordability of the housing. If a household is spending more 30 percent or even above 50 percent, that can be an indication that they may not be able to sustain that housing in the future. This type of assessment is among -- along with case management visits, budgeting and additional tools are recommended elements for most HOPWA programs.

Unfortunately, nuance issues about the housing stability over the HIV/AIDS, if missed can become high-risk and lead to episodes of homelessness. This illustrates the importance of not only collecting the proper information but

also developing ways to share it between systems including the Ryan White HIV/AIDS program, HOPWA and the homeless CoC providers.

So we've talked a little bit about why we should build an HIV/AIDS Housing Care Continuum, but here we want to talk about the specific ways that this HIV/AIDS Housing Care Continuum could be used as a tool. So when we -- when -- you'll see that when you go about building a HIV/AIDS Housing Care Continuum, that is going to take a lot of time and it's going to take a lot of resources. So it's worth having a few minutes of discussion as to why it's important to take that time and invest the resources into building an HIV Housing Care Continuum.

So the HIV Housing Care Continuum can be used as a tool to illustrate the overall engagement in care and treatment to people living with HIV/AIDS receiving HIV housing assistance, identify success and gaps in care and treatment experienced by people living with HIV/AIDS -- experience HIV housing assistance -- receiving housing assistance. And then for policymakers on program development, by tracking the proportion of people living with HIV/AIDS that if you can touch by your HOPWA program through the four steps or maybe five steps, depending on which methodology you use, diagnosed, engaged in care, retained in care, prescribed to antiretrovirals and virally suppressed, along with an HIV care continuum, you can identify the gaps and over time pinpoint where and how and when to intervene to improve health outcomes along that continuum.

Ultimately, this will help you reduce -- help reduce HIV transmission and infections as well as improve people living with HIV/AIDS at the individual level. On the national level, the HIV care continuum has been -- and will be used to make decisions about priority resources and populations as well as monitor progress on a national level. We know that housing is healthcare. Once you overlay housing on top of your local HIV care continuum, you can use this model to support themes of surveillance data to identify people out of care and link them and engage them in care. You can use it as a tool for sharing progress towards addressing the epidemic in your community. You can use it as, for research new approaches tell people stay in care and adhere to their medication through structural interventions such as housing.

You can employ this tool as a program planning tool to determine where improvements need to be made and how to target your resources in your agency. You can also develop an education campaign to help healthcare providers integrate simple prevention approaches into routine care for people living with HIV/AIDS, as well as advocate for increased HIV testing. And you can also utilize it as a community planning to galvanize the community to address the gaps and needs of people living with HIV/AIDS.

So as you can see, this is a real important tool for you to be able to use in your community to actually get to a level of viral suppression both at the community level as well as the individual level. So where we're going to go right now is really kind of delve into the New York City methodology, so you can kind of see what it takes to actually build this tool, and then we'll -- before we move into actually doing the step by step process. So with that, I'm going to turn it over to Rusty for him to kind of take that deep dive into the New York City methodology.

Rusty Bennett: Great. Thank you, Christine. I think that overview really helps us as we're thinking about this and I hope you find it helpful, especially now that I'm going to dig a little bit deeper to this example. If you want to follow along in your workbook, you can -- we kind of discuss the New York model a couple different places throughout the book, throughout the workload so you'll see it referenced several times, starting on page 13, 14, 15, it really gives some more detail in some of the things that we're going to be looking at. And as Christine says -- said that the New York model and what they went through will also be prompting us -- you to look at some of the discussion questions later on and especially in the next webinar, we'll cover some of those. So I'm going to try to point out some of those nuances as we go through the model.

Christine Campbell: And just as a little bit of history, New York City, John Rojas actually brought the model to us. He had a meeting with the National AIDS Housing Coalition board and he did this presentation of what they were doing in New York City and he saw that final bar graph and realized, that's the money shot. That is the evidence that we've been looking for that says when you overlay housing on top of the HIV care continuum, you improve health outcomes. Of

course there's a lot of details which we'll get to that kind of breaks out those numbers. But when you just look at the profound difference that housing makes, it's a wonder to see.

Rusty Bennett: And we did invite John to be here, unfortunately, his schedule didn't allow it. He did participate with us in the regional meetings.

(CROSSTALK)

Rusty Bennett: So we had a great time and I think communities really benefited from hearing directly from him as a grantee, HOPWA grantee, that really looked at this information, so let's walk through that, some of the nuances what he did and what they did as his team and kind of illustrate, I think, what you can do in your own local community. So just a little bit of background. The New York City Department of Health & Mental Hygiene oversees the HOPWA program within New York City. It serves about 36,000 individuals annually and targets low-income persons living with HIV who are homeless or unstably housed. Certainly also look at within people living with HIV conditions of mental illness, people with substance abuse problems, families with children, senior adults, really taking a look through at this intersect of those that are marginally housed and unstably housed.

So that program really becomes the basis, if you will, of their sample population. We're going to ask you later in the next webinar to think about your population and what you're going to be looking at. But what the New York City did, what their team did, looking at the sample population really being anybody who was touched by HOPWA in the given year in 2014 in this example. So any HOPWA dollar that really went into to a household really became the -- those individuals were the ones that were going to be used within the sample, and that sample and building the HIV Housing Care Continuum is going to be compared to New York City's overall HIV care continuum that they developed. So it's good comparison point. It's something you'll want to look at when you start having those discussions.

They also came up with very specific definitions to define their own HIV care continuum. So this would be very similar to what the CDC did with the

national analysis, but you'll notice some tweaks or slight differences and later in the workbook you'll see that comparison and we'll be walking you through that in the next webinar.

But let's just take a look at how New York defines some of their steps along the HIV care continuum. So you kind of have a sense of what they were looking at. So as Christine said, we're going from diagnosis all the way down to the viral suppression. So let's look at each of those steps along with the definitions they use. So first of all, diagnose, they took anybody diagnosed and reported to New York City HIV surveillance registry person to be living in 2013, became part of that diagnosed number. Linked to care was defined as any viral load or CD4 test since 2001 at least eight days after the date of HIV diagnosis, so really looking how quickly somebody was tested, so that was kind of the proxy for being linked into care. Retained in care in 2013 was any viral load CD4 test in 2013, and then if they initiated antiretroviral therapy was a viral suppression at any point since 2001 so it's presumed that -- again a proxy of that initiated antiretroviral therapy.

Achieving viral suppression was really a last viral load 2013 that was less than 200 copies, so that became again that proxy along the care continuum. So these are the definitions they used, again it was pulling from their surveillance data so it's going to be dependent here. That gives you an example of how they use their data and those definitions and those indicators to be able to build their own analysis and then they're going to overlay their HOPWA information into this.

So let's talk a little bit how they matched the two data sets being the surveillance and also the HOPWA data. So they have the benefit of, I will give that caveat in New York City of having both of these data sets in one house, if you will. So they had the access to the client level data of those that are being served by the HOPWA program as well as the surveillance data, and that's not going to be true for all of you, as you look at your own communities. You may not have direct access; you may have indirect access. And so some of the questions that you're going to be working through in the discussion is who has that information and how do you get that information and pull it together for your community.

So in this case, what New York City did, they had a HOPWA program database that really included everybody enrolled in the program, the services that were provided, and the housing history. Then they had the New York City HIV surveillance registry which included everybody that had been diagnosed with AIDS or HIV, as well as laboratory testing, test results including the CD4 counts and viral loads, as well as any other demographics they would need in order to fill out, if you will, the HIV care continuum.

And one thing I know that they have been doing once they have developed that their overall care continuum which we will share with you is also looking at differences in those kind of different brackets, and so that's kind of the beauty of being able to match some of this and so look, are there nuances based on race, ethnicity, other kind of conditions so that they can look at the differences in the care continuum.

They did match their two data sources so they had an algorithm that kind of matched both the HOPWA data and the surveillance data, so that then they could take the sample now of anybody that was touched by HOPWA and compare that overall to their HIV care continuum. So let's look at that comparison. We shared it early on in the webinar at the first webinar. Let's look at it again because I think it's a great illustration and just a good reminder of where you're headed as a community. And so as Christine said, it's kind of the money shot, we're all excited about and hoping that you're going to develop as a local community and be able to share, not only use it in your local community but I think it really becomes a great tool to illustrate the effectiveness of housing across the country.

So if looking at this slide, again, as a reminder, the right-hand -- the left-hand bars -- excuse me, the dark blue is the HOPWA, those that were engaged in HOPWA program. So again, anybody touch my HOPWA. The light blue is the overall HIV care continuum. So this is New York's care continuum as we would compare to the national perspective. So in this case, going all the way across to the right to virally suppressed, you will notice that New York, over 50 percent. That's compared to the national average that we shared in the first webinar at 30. So already New York in itself is an improvement over the

national numbers. But let's now look what happens when they look specifically at housing and health or in this case, the HOPWA program and it's going to illustrate, I think, exactly what you were saying is that we know that housing is structural intervention it does have a positive impact on retention in care and ultimately viral suppression.

And so in this case going again, all the way to the right-hand side, 73 percent. So 73 percent virally suppressed when you introduce housing as that intervention.

And so that again that comparison between those that were touched by HOPWA against the overall population is pretty incredible, that increase. Going back, looking at those that were retained in care, again, you're seeing improvement across the care continuum when housing is introduced. And so - - I think it's just a perfect illustration and a way to look visually, very quickly what the impact of housing and that connection to health outcomes that you were talking about. And so I hope that when you look at this, this could really become a tool for you to really -- this is your vision, if you will. This is where you're headed in the work that you're doing and I agree with you. It's going to be a commitment of time, resources. It's really -- you creating the space, I think, to work through this process and really thinking through how to pull in the data and the resources to make this happen. But this is what you want to be able to demonstrate. You look like you want to say something.

Christine Campbell: You're doing fine.

Rusty Bennett: So related to this, I think, one of the things we're going to move on this. So we want to use New York as that example, right? So I think there's a lot of, like we said, in the workbook the New York example, I think can really help you as you go through this process. In the next webinar what we're going to do is actually break down some of the steps that we think that New York went through. So from identifying the data sources to really figuring out who's going to be in that sample population that you want to compare to. Also just figuring out who needs to be at the table, what resources do you need, all of those become the conversation pieces that we want you to have. And so this is kind of the basis and kind of the understanding that we want you to know to

begin that discussion, so that as you go on to the third webinar, you really have the space to have those discussions more effectively.

So I think from this, the takeaways, use the New York model. I think it's a great example. I want to do a plug in as we are ending this webinar. There's resources there throughout this process from the work that HUD is doing. We provide the -- HUD is providing technical assistance opportunities. We just want to promote the HUD Exchange that it's available, has resources on there. We've also created a peer portal specifically for the HIV Housing Care Continuum that we're working that we hope that you will join, that link can be found at HUD Exchange and I hope that you would join and be a part of that because what really provides you, I think a link to these resources but also the work that other communities are doing.

And so other communities are developing their action plans, other communities are moving forward on development of the HIV Housing Care Continuums that they're working on. And so this is an opportunity for me to learn from your peers, participate with them, share with them what you're doing but also to be honest about some of the barriers that you're facing and seeing how other communities are addressing those barriers. So we hope that you'll be a part of that learning community and make that a part of this. So with that, Christine, thank you for being a part of this. Thanks for working on the regional teams, NAHC is a great partner and it's really been a pleasure working together with you on this issue. So good luck everybody out there and look forward to working with you through the process. Thank you.

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