

HIV Housing Care Continuum Webinar 1 August 3, 2016

Rita Flegel: Hello and welcome. I'm Rita Flegel, the Director of HUD's Office of HIV/AIDS Housing. And presenting with me today is Amy Palilonis also from HUD's Office of HIV/AIDS Housing and Dr. Rusty Bennett from Collaborative Solutions. We're glad you're here today.

The purpose of this webinar is to review the structure and purpose of the HIV Housing Care Continuum regional meetings with a goal to develop an action plan to construct, implement and use a local HIV Housing Care Continuum. This is the first in a series of webinars that are intended to walk you through the HIV Housing Care Continuum implementation workbook. And it looks like this.

If you have not already gone online and downloaded this workbook, please take a minute to just pause this webinar and do that now because we will be asking you to refer to this throughout the webinar today. This implementation workbook was developed for the four regional meetings that the Office of HIV/AIDS Housing, National AIDS Housing Coalition and Collaborative Solutions provided together.

The meetings took place in Chicago, Washington D.C., Atlanta and Portland, Oregon. And these meetings brought together teams of HOPWA grantees and providers, HIV surveillance and Ryan White program representatives to identify strategies and develop action plans that would work in their own community for developing HIV Housing Care Continuums locally.

The goal of our webinars is to share that information that we learned from those regional meetings to a broader audience. So, HOPWA grantees and project sponsors that weren't able to participate directly in those regional

meetings can still develop their own plans and build an HIV Housing Care Continuum in their own community.

We expect this to be an interactive experience for you, these webinars. And throughout the webinars, we'll be referring to the workbook for times of discussion and developing your action plan together. So, we hope you're all at the table together and can have the workbook open and work on this together so you can have an actionable plan for your community.

The first webinar will review what is an HIV Care Continuum and why HUD is encouraging our HOPWA grantees to create a local HIV Housing Care Continuum. As you move through this webinar and through pages one through 14 of your coordinator workbook, you should begin to think about who you need to partner with locally inside and outside your organization in order to develop your own HIV Housing Care Continuum, and why is that HIV Housing Care Continuum valuable and important for your own community.

So, again, welcome and now I'm going to ask Amy Palilonis to speak to you about how your work in developing your HIV Housing Care Continuum meets the goals of the National HIV/AIDS Strategy. So, thanks, Amy.

Amy Palilonis: Thanks, Rita. I'll now talk about the National HIV/AIDS Strategy and HUD's work in implementing its goals. More information on the National HIV/AIDS Strategy can be found on page four of your workbook.

So, recent advances have shown that antiretroviral therapy not only improves the health of people living with HIV/AIDS but also reduces the risk of transmitting HIV to others by reducing the amount of virus in the body. By ensuring that people living with HIV/AIDS are aware of their diagnosis and engaged in care, new infections can be dramatically reduced.

In the United States, this is central to the White House's roadmap to address HIV, the National HIV/AIDS Strategy, which was originally released in 2010 and was updated in 2015. There are four primary goals of the National HIV/AIDS Strategy. They are to reduce new HIV infections; increase access to care and improve health outcomes for people living with HIV; reduce HIV-

related health disparities and health inequities and achieve a more coordinated national response to the HIV epidemic.

HUD has a responsibility for carrying out activities to help meet each of the four goals of the National HIV/AIDS Strategy. In particular, the HIV Housing Care Continuum initiatives contributes to goal four which tasks departments and agencies with achieving a more coordinated national response to the HIV epidemic by increasing the coordination of HIV programs across the federal government and between federal agencies and state, territorial, tribal and local governments, and developing improved mechanisms to monitor and report on the progress towards achieving the national goals of the National HIV/AIDS Strategy.

So, back in 2013, President Obama established the HIV Care Continuum Initiative and a federal HIV Care Continuum interagency work group was created and tasked with developing recommendations and action steps to help move our nation forward in meeting the goals of the National HIV/AIDS Strategy, by focusing on improving rates of diagnosis and care for people living with HIV.

As a member of the working group, HUD was responsible for carrying out action steps to implement this HIV Care Continuum initiative. One of the action steps included 5.4 which said that HUD and HHS will provide technical assistance and trainings to better coordinate and align the provision of housing services with medical care for people living with HIV.

So, based on this 5.4 action step, HUD did a couple of things. The first one was that a white paper was developed by the Office of HIV/AIDS Housing and Collaborative Solutions to highlight key findings and research studies to demonstrate the impact that stable housing has on each step of the HIV Care Continuum.

The white paper promotes stable housing as a critical component of effective HIV system – of effective systems of HIV care and supports improved collaborations between HIV housing providers and medical care providers. It was released in the fall of 2014 and was jointly promoted by HUD's Office of

HIV/AIDS Housing and the Health Services and Research Administration's HIV/AIDS Bureau. That white paper can be accessed online on the HOPWA page on the HUD Exchange.

So also, in response to action step 5.4, the Office of HIV/AIDS Housing collaborated with the National AIDS Housing Coalition and Collaborative Solutions to carry out a series of regional meetings focused on the connection between stable housing and improved outcomes along the HIV care Continuum.

As Rita mentioned earlier, this TA effort was designed to increase the capacity of HOPWA grantees to measure health outcomes and to understand how stable housing impacts access to health care and health status for people living with HIV/AIDS. In this series of webinars, we'll cover the information that was shared in those regional meetings.

So, before we get any further, we should talk about what the HIV Care Continuum is. The HIV Care Continuum, which is sometimes also referred to as the HIV treatment cascade, is the model that outlines the sequential steps of stages in HIV medical care from the initial HIV diagnosis to achieving the goal of viral suppression. And it shows the proportion of individuals living with HIV that are engaged in each step of care.

The HIV Care Continuum begins with the diagnosis of HIV infection. The only way to know for sure that you're infected by the HIV virus is to get an HIV test. People that don't know their status and don't know that they're infected are not accessing care and treatment that they need to stay healthy.

They could also unknowingly pass the virus along to others if they don't know their status. CDC recommends that all adolescents and adults be tested for HIV infection at least once, and that persons at increased risk for HIV infection be tested at least annually. According to the CDC in 2012, approximately 87 percent of all people living with HIV in the United States had an HIV diagnosis.

The next step in the Care Continuum is accessing and staying in medical care. Once you know you're infected with the HIV virus, it's important to be

connected to an HIV health care provider who can offer you treatment and preventive counselling to help you stay as healthy as possible and prevent passing HIV on to others.

Because there's no cure for HIV at this time, treatment is a lifelong process. To stay healthy, you need to receive regular HIV medical care. According to the CDC, in 2012, approximately 39 percent of all people living with HIV in the U.S. were connected to HIV care.

The next step is about antiretroviral therapy. Antiretrovirals are drugs that are used to prevent a retrovirus such as HIV from making more copies of itself. Antiretroviral therapy is the recommended treatment for HIV infection. It involves using a combination of three or more antiretroviral drugs from at least two different classes of drugs every day to control the virus.

U.S. clinical guidelines recommend that everyone that's diagnosed with HIV receive treatment regardless of their CD4 count or viral load. Treatment with antiretrovirals can help people with HIV live longer, healthier lives and has been shown to reduce sexual transmission by 96 percent. According to the CDC in 2012, approximately 36 percent of all people living with HIV in the U.S. had been prescribed antiretrovirals.

So, the next and last step is achieving viral suppression. So, by taking the antiretrovirals regularly, you can achieve viral suppression, which basically means that you have a very low level of HIV in your blood. You aren't cured, there is still some HIV in the body but lowering the amount of virus in your body with medicines can help you stay healthy, live longer and greatly reduce your chances of passing HIV on to others.

According to the CDC, approximately 30 percent of all people living with HIV have reached viral suppression. So, what that means is that only 3 out of 10 people living with HIV in the U.S. have their virus under control.

So, for more information on the HIV Care Continuum, please see pages six to seven of the workbook. And I'll now turn things over to Dr. Rusty Bennett to tell you more about how the HIV Care Continuum is being used.

Rusty Bennett: Thank you, Amy. That's a great overview of the HIV care cascade or the HIV Care Continuum that we're going to be talking about today. And just before I move on to some things I'll be talking about, I think just sitting with the fact that 30 percent had achieved viral suppression nationally, it's a pretty sobering number.

And I think it's part of what has driven the White House to begin looking at this initiative also from HUD's implementation of this initiative to say what can we do differently, how can we work within our communities to change that along each step of the care continuum.

And so, that's really what this initiative is about, is how do we use the information, the data we have available to us in trying to create system-level solutions that really changes the direction along the care continuum. So, why is it important? That's why it's important, we want to see that along the care continuum that individuals living with HIV and AIDS do achieve the optimal health benefits of being engaged in treatment and care and also engaged in medical treatment.

So, part of this, I think, becomes a tool in many ways. So, what we're looking at and I think many of you that are looking at your own community and looking at the HIV Care Continuum you are seeing this is an effective tool to look all the way across the care cascade about where those gaps in your own service system are.

And so, looking at where people are engaged in care, are maintaining their care, that are on treatment, and then finally are achieving viral suppression. And it becomes an opportunity and a tool, I believe, to begin looking at your system of care and really seeing how can we improve it and who do we need at the table to be partnering together.

And so, as part of what we're working toward and what Rita and Amy have been talking about is a strategy to really pull off HOPWA providers, Ryan White providers, your surveillance data to being coming together to the table to basically look at how communities are using the HIV Care Continuum to one, further their HIV prevention and care efforts, to look at where those gaps

are, to look a little bit deeper within their community to say how are those gaps occurring, and what we're learning and what I think is very clear in the National HIV/AIDS Strategy is that we're really not going to make a difference in this care continuum unless we start looking at the social determinants of health.

Obviously, housing and housing as an intervention is a proven intervention and throughout the webinar and in the workbook, you'll see those connections. We're going to talk a little bit about that. But new approaches have to be employed. And so, how do we make sure that we're looking at that across that care cascade or across that continuum.

And so, state and local health departments, community organizations, health care providers, everybody is starting to look at the care cascade, as a possible benchmarking but also to kind of measure their progress and using it as a tool to really think about how they're having progress within their own community.

Now, as I said, as a structural intervention and what this initiative is really focused on, is to move beyond just the broader HIV Care Continuum and begin to look at well, how can we show housing as a structural intervention. We know that the research and what's happening here is that we now have an opportunity to use this care cascade or this continuum in our own communities to be able to document how housing is truly that structural intervention, use it to benchmark how successful we are, where we need improvement, where those gaps are, to bring it – to bring the community in collaboration and really create a system of care that works effectively, to ultimately see higher than 30 percent viral suppression. We want to see 100 percent viral suppression.

So, let's talk a little bit about this connection between housing and the HIV Care Continuum. So, a couple of things that we want to make clear, when we talk about housing continuum in this case, we're not talking about the array of housing resources that are available in the community even though that becomes – that is important.

What we're talking about is building an HIV care cascade but having housing and looking at individuals that are engaged in housing and doing that comparison between – when people are in housing compared to those that are not or those that are unstably housed and stably housed and where we see the differences along the care cascade, and using this as a tool to really demonstrate as I said that housing is an effective structural intervention.

Why would we do this? Well, here is some of the connections. I just want to put a plug in for the National AIDS Housing Coalition that really has been the impetus I think behind all the research, pulling together that through their national summits and other things that have really helped to demonstrate that housing as a structural intervention. A lot of researchers are working on this, they have come to those summits and being able to present on that.

So, what we know is that homelessness is a major risk factor of HIV infection. So, rates of HIV infection are 3 to 16 times higher among persons who are homeless or unstably housed compared to those that are in stable housing. HIV is also a major risk factor of homelessness. So, we estimate that at least half of Americans living with HIV will experience homelessness or some type of housing instability in their lifetime.

As we think about this and we think about this connection of housing to HIV, we have to think about it in two different ways. One, HIV – housing [omit HIV] being HIV prevention so, it's the prevention of HIV infection when people are stably housed. They're less likely to be engaged in risky behaviors, more likely to be engaged into care.

Housing is also HIV health care; it makes a difference along that care continuum. And research is showing that individuals that are stably housed are more likely to be engaged into care. They're more likely to maintain that care. They're more likely to be compliant with their ARV therapy. They're also more likely to have viral suppression.

Those are the things that we're looking for along the care continuum. So, the research bears this out and the white paper I think does a great job of illustrating this, so if you really want the research studies, I refer you to the

white paper. And also we've referenced those in the workbook for your own community and so, you can think about those.

So, how does this look from an example standpoint? We were fortunate in the regional meetings to partner with the New York Department of Health and John Rojas was a part of our meetings, and really it was through their work at the Department of Health that we began to get an illustration of what local communities are using their data and in this case the city of New York where they developed first their own care continuum very similar to what Amy went through.

So, really looking across that continuum from diagnosis all the way to viral suppression on the right hand side, this is illustrated in page three of the workbook. And I just want to highlight a couple of different things of why when we saw this and HUD saw this, that we all said this is something we want to be able to show other communities how to develop and use it really as a tool to assess – not only assess their programs but also to improve programs.

So, on page three on your workbook, you can see that there are two bars. One represents the HOPWA enrollees which is the dark blue line on the left hand side throughout, and those compared to persons living with HIV in New York in total. And so, what you will see – let's first look at the persons living with HIV in New York City which kind of mimics the national numbers, again, it's ever HIV-diagnosed then linkage to care.

So, we had diagnosis at 100 percent, linkage to care drops to 86 percent for the overall population, retained in care drops to 62 percent; presumed ever started therapy 60 percent and then to suppressed viral load at 51 percent.

Now, looking at that, pretty good numbers when compared to the national average, 51 percent viral suppression where we want to get to, certainly higher than the national average of 30 to 36 percent.

So, now let's look at those individuals that are engaged in housing as what New York City did. Looking across that same thing, 99 percent ever linked to care. So, greater linkage to care when people are engaged in housing, retained in care 95 percent when housing is provided for, or when people are housing

secure; on ART, 92 percent and then ultimately viral suppression 73 percent. Those are great outcomes when we think about being housing – with being housing-stable.

And that's what makes the difference is in New York City what they're looking at is anybody touched by a HOPWA dollar, that is what we're looking for in each community. So, when we're talking about developing your own HIV Care Continuum, it's really developing this illustration of here's the effectiveness of our own housing programs. And it's that critical connection that we're trying to make between housing stability and positive health outcomes.

Increasingly I think this is important to HUD. I think it was certainly important within the National HIV/AIDS Strategy. It's been the conversation of this initiative and certainly important to the overall work of the National AIDS Housing Coalition as we think about really demonstrating the effectiveness of housing as a structural intervention.

So, let's talk a little bit about how you now can go through the process of developing this care continuum in your own community. So, what we've done through the workbook is basically highlighted each of these components so you can use the workbook as a tool and follow through the workbook to help you in your own community.

One thing we'll point out as you are looking at the workbook, there's key discussion questions that we have prompted you with that we're encouraging you as a community to talk through. Now, what does that community look like? What we learned through the regional meetings, we actually wanted communities to come together with a team of folks.

And so, I'm going to encourage you that as you're working through this, if you don't have your team set up yet, pause the webinar and go get the team and come back and start over again. So, let's talk a little bit about what we want that team to look like as you develop this.

One, honestly we want a HOPWA grantee in the room. HOPWA grantees, I want you to be in there and committed and bring some of your strongest

HOPWA project sponsors to the table, too, those that really understand the HOPWA system of care, the HIV housing system of care.

We also want the Ryan White provider in the room. So, who's doing the case management and that connection to medical care is critical because we're trying to connect the health outcomes and the housing outcomes so, let's bring those two together.

We also want to see your HIV surveillance person, the people that are responsible for the overall surveillance for your own community, so we could begin connecting, one, to the broader HIV Care Continuum community and begin to look at that in comparison to those individuals that are in housing.

So, that becomes routine. You may want to have other people, great. But those are the core people that we want you to have in the team. Why is that critical? Because we realized for the first time through all these regional meetings, people did a much better job and it was much easier to develop their action plan which is what we're hoping to create through this, is an action plan to develop your care continuum that that process became a lot easier when you had all the right people at the table.

When you have all the right people at the table for the first time many communities said, we're actually talking about the importance of connecting our data, connecting what we know what is happening with people's lives around housing to their health outcomes and that's critical. So, we want you to have that team as you have those discussions.

So, again, part of the objective here that we're encouraging you to do is to develop an action plan to help you get to the development of an HIV Housing Care Continuum or Care Cascade. And so, to lead you through that process, we have a series of questions, and so, the first two discussion questions that we want you to do after this first webinar are found on pages 8 and also on pages 13 and 14.

The first set of discussion questions on page 8 are really around barriers and strategies for building an HIV Housing Care Continuum. So, again, step back, you're not talking about the continuum of housing services; we're talking

specifically about the development of a care continuum similar to what New York City did.

So, what do you think are going to be some of those barriers for your community in pulling data together and really coming together to think about this base-lining of what's happening. How are people engaged in care? Are they maintaining that care and ultimately that viral suppression? Talk about that honestly. Talk about what those barriers are and think about ways you might come together to mitigate those.

The next piece is how are you going to use the HIV Care Continuum. We're giving you some examples and we're going to give you more as we go through the webinar series. But think about how can we use it as a tool, one, to assess how well your system is working; two, can it be something that helps to bring people together in collaboration and really create that story about housing connected to health care.

Can it be used as a way to measure your own progress against the Care Continuum and help to identify those gaps and really can come together around better retention efforts, ultimately to help people to have better positive health outcomes. Those are the things we'd want you to think about. How can you really use it in the community to help you think through that?

Be honest about those conversations, use the workbook to write that stuff down so that you're capturing your conversations as you go through, and give yourself space. What we found in our regional meetings, people needed a good hour, two hours to really talking through some of this, have those honest conversations.

And from that, begin identifying what do you think are some of your key action steps, mark those, circle those because those things that you want to pull out and put it into your action plan. We have – as Rita said, there's a nice little template at the back of your workbook that you can use to begin capturing some of these. And so, I'd encourage you to each discussion, if you see something that really rises to an action step, take it and put it on to your action plan.

Lastly, as we think about what resources that you might have as you're going through these webinars, we want these webinars to be helpful to you. As Rita mentioned, the workbook is available to you, use the workbook, walk through the workbook. It's one of those tools.

There's the white paper that gives additional information. So, if you need to educate your community or people that are coming to the table, that could be a tool for you to help. We're also developing a couple of things that I think will be helpful.

One is we've made available a HIV Housing Care Continuum portal – a peer portal that's available and the link could be found on HUD Exchange. Link to that and then go through the process, you can become a part of that portal. And what we're doing there is providing this additional information but also trying to give discussion and help those communities that are working on this are available to put their action plans on there, able to put their example care continuums.

And so, there are resources there that you can see what other communities are doing but also connect with those other communities. You can talk to them about how they're doing it. And so, you can talk to somebody that's working with their Ryan White provider that is connected data systems that had really developed it but also maybe address some of the challenges that you may be facing. So, it really becomes a place that you can connect with those other communities in a peer-to-peer learning kind of situation.

So with that, I want to encourage you to get on the portal, close what you're doing, have that discussion, again, use these resources that we're giving as you're going through this. These webinars are tools and we hope you're using them. Now is the time as we end this first webinar for you now to have that discussion as your team.

And then as you have after you have those two discussions and you feel like you've done that well then come back and do the next webinar. So with that, do you have closing comments?

Rita Flegel: Just thanks again for participating and thank you for putting out those resources, Rusty. I think those are valuable. I know that sometimes people look at that New York model and it might be a little intimidating because you might think I'm not New York or I can't match up to this, that's OK.

This is really for your community to come together and to figure out what works for you. So, that's why we think that networking opportunity that's available on the portal and other resources are going to be so important for you. So, you don't have to think just like this. This is an example so really talk through that like Rusty said and think about what will work locally for you.

Rusty Bennett: That's great. Thank you.

Rita Flegel: Thank you.

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