KATE BRIDDELL: Good afternoon, everyone, and welcome to today's webinar, titled Holistic Delivery of HIV and Behavioral Health Services with HOPWA and SAMHSA Resources. My name is Kate Briddell, and I work in the Office of HIV/AIDS Housing at HUD. This webinar will feature Harbor Care from New Hampshire, an organization funded through both HOPWA and SAMHSA grants. Harbor Care will discuss how they will use the funding from both sources to coordinate housing and behavioral health services for their clients with HIV.

In addition, we'll hear brief remarks from Rita Harcrow, the Director of the Office of HIV/AIDS at HUD, and Dr. Jim Gandotra, the Chief Medical Officer at SAMHSA. We're also joined by the Director of the White House Office of National AIDS Policy, Harold Phillips.

Just a little housekeeping. If you have questions, please put them in the Q&A. And if you have logistical issues, please also put that in the Q&A, and we will respond to them as soon as we're able. So now I'd like to turn it over to Rita Harcrow.

RITA HARCROW: Hi. Hi, everyone, and welcome. And thank you for joining us for today's webinar about the Holistic Delivery of HIV and Mental Health Services with HOPWA and SAMHSA Resources. My name is Rita Harcrow. I'm the Director of the Office of HIV/AIDS Housing at HUD. And in that role, I oversee the HOPWA program.

At HUD, we understand that homelessness and housing instability lead to poor physical and mental health outcomes. The stress associated with the experience of homelessness or the threat of eviction take their toll on health and well-being. And if a person experiencing a housing crisis is also living with HIV, then the negative impact on their physical and mental health can be even greater.

Research shows that people living with HIV are more likely to experience homelessness or housing instability, and are also prone to depression and other mental health challenges caused by the presence of, and the continuing stigma of HIV. Stable and secure housing, coupled with supportive services, can greatly reduce those stressors and provide a platform from which people can access medical care, and the mental health, and substance use services needed to improve their overall health and well-being.

We recognize that federal funding for housing, and mental health, and substance use services is limited, and it can't always address all the needs of people living with HIV in a community. And, therefore, it's important for communities to understand these funding sources that are available, and to work to ensure resources are used in a non-duplicative manner, and that they're integrated and maximized to have the most impact.

I want to thank Dr. Neeraj Gandotra from SAMHSA for their partnership on this webinar, which aims to highlight how HUD and SAMHSA funding can be used in an integrated manner to deliver HIV, and mental health, and substance use services to low-income people with HIV.

I also want to thank Harold Phillips from the White House Office of National AIDS Policy for joining us today to discuss how the National HIV/AIDS Strategy addresses intersecting factors of HIV, including mental health, substance use, and homelessness and housing instability.

Finally, I'd like to thank Jessica Lorento and Wendy LeBlanc from Harbor Care. Today they will share information about their model for integrating care and housing for people living with HIV with substance use disorder in Southern New Hampshire. And now, I'd like to turn it over to Dr. Gandotra, Chief Medical Officer at SAMHSA, for his remarks. Thank you, all.

NEERAJ GANDOTRA: Thank you, Rita, for the warm welcome. And it is my pleasure to welcome all of you attending this informative webinar. On behalf of SAMHSA, we would like to thank our federal partners at HUD, as well as at the White House and stakeholders who are attending today. I'd also like to thank our grantees, who are going to deliver vital information about the services they provide.

Investing in integrated care and addressing social determinants of health is aligned with SAMHSA's administrative and strategic plan to address outcomes within the lens of equity.

As an addiction psychiatrist, I trained in Washington, DC and practiced in Baltimore. I saw firsthand the impact of addressing social determinants of health within the treatment plan when we were trying to address both behavioral health conditions of mental illness and substance use disorder. I also saw the impact when those social determinants of health were not addressed.

Obviously, basic needs, when they're not met, it's next to impossible to achieve the health outcomes we seek as they relate to HIV, suppression, and elimination. We also know that simultaneous or concurrent treatment is far more effective than sequential treatment when we try to address behavioral health and HIV.

I remember in particular visiting a patient's home, and I'm using the term home generously. It was living quarters that really made me realize just how difficult it must have been to simply get to the clinic to receive treatment, let alone remain compliant with the treatment plan. This would involve both antiretroviral treatment, as well as substance use disorder treatment and mental health care.

Having all of those services under one roof would have been ideal because we know the gaps of unsafe living conditions, limited resources for food and transportation, not only affect access to care and basic needs, but take a psychological toll. We need to address these, as they represent the major barriers to actually having a healthy community that can be supportive of others around them.

Those with substance use disorder and mental illness represent an important group that must be at the table if we are to end the HIV epidemic. SAMHSA will continue to support these initiatives that will be highlighted today through our Minority AIDS Initiative grants, as well as our technical assistance and educational initiatives. We're going to focus today on service integration, but we have several other initiatives that I'd encourage anyone to come and look at our web pages and access.

We'd also like to thank Harbor Care for their willingness to share insights into their program. And we'd also would like to thank all of our federal partners, as we can only do this together. I'd like to now introduce my good friend, and it's my pleasure to introduce Dr. Harold Phillips, the Director of White House Office of National AIDS Policy, for further comments.

HAROLD PHILLIPS: Thank you, Dr. Gandotra, and thank you, Rita. Thank you, both, to the teams at HUD, and also at SAMHSA, for pulling together this webinar today. And also, thank you to Harbor Care for your willingness to share some insights and some innovations into how you approach your work in Southern New Hampshire.

I think if I find a share screen button I am going to share just a couple of slides with you all to talk about the National HIV/AIDS Strategy and how this connects to the work that you're doing on the ground, but also connects to the work that other programs are engaged in across our country, as we work to bring an end to the HIV epidemic.

So I don't see a shared button thing on my slides, but that is OK. I can go ahead and talk about all this and share this good news with you. And the good news is that on World AIDS Day of last year, President Biden released a new National HIV/AIDS Strategy. And that strategy was based on both community input, but also included a vision for our country for the HIV epidemic.

The strategy includes four goals, 21 objectives, and 78 strategies, and identifies eight priority populations based on the rates of HIV in our country. And these are the groups and populations that we need to focus on in order to end the HIV epidemic.

That strategy is a national strategy in scope, in that it just doesn't include the work of the federal agencies. It's a strategy where community-based organizations, faith-based organizations, and even those who aren't doing HIV-specific work can see themselves and see a role that they can play in helping to end the HIV epidemic in the United States. Excuse me.

It does include actions. And we also have released a Federal Implementation Plan that came out this summer, which details over 380 action items that the federal partners will undertake to help lead to an end of the HIV epidemic. Our partners at SAMHSA, our partners at HUD, as well as HHS, and the other departments were all part of developing that implementation plan.

And while it does contain 380 actions, that doesn't represent everything that we're doing to end the HIV epidemic. But those are the 380 actions that my office deemed as being transformative and important enough to include as part of this implementation plan.

The other thing that we did, in addition to the implementation plan this summer, was also include a set of five new indicators, which are our quality of life indicators for people living with HIV. What we heard from the HIV community is that they are more than just those lab values that are collected on a quarterly basis. There are aspects and domains of quality of life for people living with HIV that need to be measured and that our programs need to be responsive to.

And when we took a step back and thought about it, these are the aspects that make access to prevention, care, and treatment services difficult. So a set of five new quality of life indicators include self-reporting on good or better health, unmet needs for mental health services, those who report being hungry or not having eaten because there wasn't enough money for food. So we're looking into the issues of food insecurity.

Those people with diagnosed HIV who report being out of work, as well as those who are unstably housed or homeless. So again, the intersectionality of those issues and their impact on care and treatment, we will now be able to measure as federal programs and also steer our federal programs, policies, and resources in a direction that helps us deal with those quality of life measures.

The Ending the HIV Epidemic Initiative, which started in 2019, has been fully embraced by the Biden-Harris administration and as part of a health equity approach, where we are looking to address the HIV related disparities which impact our community and disproportionately impact certain populations more than others.

The initiative has a goal of a 75% reduction in HIV infections within five years and a 90 [AUDIO OUT]

MARIE HERB: Hi, everyone. Just wait as Mr. Phillips is connecting back to audio. Apologies for the interruption. And we'll also make sure the slides he's referencing will get published on the HUD Exchange after this webinar.

HAROLD PHILLIPS: And, hopefully, I'm back. Sorry about that.

MARIE HERB: You are back.

HAROLD PHILLIPS: We're going to blame Verizon. We're going to blame Verizon for that one because the cell phone service just dropped out completely. So sorry about that, my apologies. So the initiative for EHE has a 90% reduction by the year 2030 for new infections. The initiative itself focuses on those areas of the country with the greatest HIV disparities. So there are 57 jurisdictions that we are including that also include non-rural states.

The initiative itself focuses on diagnosing all people with HIV as early as possible, treating those rapidly who test positive, and helping them achieve and maintain viral suppression, preventing new HIV infections through proven and effective methods, such as access to PrEP and syringe services programs, and our response pillar, being able to respond to-- detect and respond to clusters of infection.

Our work also includes, really and truly, I think working with you all to help address not only those living with HIV, those 1.2 million people in the United States, where we have persistent disparities among gay and bisexual men, African-American persons, and Hispanic and Latinx persons, and closing the gap both on PrEP coverage and working to lower viral suppression rates, which really means dealing in a real syndemic way with not only HIV testing, but also the mental and behavioral health issues that get in the way of both care and treatment and HIV prevention.

So I want to stop there and turn it back over to-- am I turning it back over to Rita? Am I turning it back over to Jim?

KATE BRIDDELL: You're turning it to Kate, Harold.

HAROLD PHILLIPS: I am turning it to Kate. So Kate, here you go. And, again, I apologize for the technical difficulties. I want to congratulate you all and really encourage you to help us as we think outside the box and be innovative and creative in our approach to ending the HIV epidemic. Thank you.

KATE BRIDDELL: Great. Thank you, Harold. I am-- sorry. Again, I am Kate Briddell, and I am with the Office of HIV/AIDS at HUD. I'm going to give you a brief overview of the HOPWA Program. So HOPWA was established in 1992. And this year marks 30 years of the HOPWA Program. In 1992, the National Commission on AIDS recognized that housing is critical to the national response. And then that next year, HOPWA was included in the appropriations.

In those early days, HOPWA programs were often hospice or end of life housing, a safety net that ensured communities could offer a safe and stable place for people at the end stage of AIDS to have a place to die with dignity. And the purpose of the program has evolved since then.

So why HOPWA? And we get this question sometimes-- why do we need a housing program specifically for people living with HIV? And as you know, and as you've heard, HIV remains a significant public health issue. Between 40% and 70% of all people with HIV in the US will experience a housing crisis at some point following their diagnosis. And among all people with HIV in the US, the CDC identifies that about 9% are homeless.

People living with HIV who do not have stable housing are less likely to seek and maintain care or return to care after disengaging. And they're also more likely to use the ER and other public resources, rather than getting into regular medical care and, thus, maintaining a care and medication routine. And so doing that actually can be challenging for many people, even those with strong social and economic supports. But those challenges are magnified for someone who's also experiencing housing instability.

And as I said, people living with HIV need stable housing in order to access care in order to achieve and maintain viral suppression. And viral suppression means a level of the virus in the bloodstream that is so low that it's undetectable during routine labs. And viral suppression is widely recognized as the key to ending the HIV epidemic.

I just wanted to share a little timeline view of HIV viral suppression. A person with HIV must engage in medical care and follow a routine of medications that slow the replication of the virus, leading to viral suppression. And after six months of undetectable labs, closely followed by-- by closely following medication regimens that suppress the virus, a person can no longer spread HIV. Undetectable means untransmittable.

And so, as medications and treatment have evolved to get us to the point of U equals U, so has HOPWA evolved. As I mentioned before, HOPWA's purpose in the beginning was to provide a place of dignity for people to die. Today it's recognized that housing is a structural intervention to end the AIDS epidemic.

So we've answered the why of HOPWA, now let's look at the what. What is HOPWA? HOPWA is the only federal program dedicated to the housing needs of low income people living with HIV and AIDS. And under the program, HUD makes grants to eligible cities, states, and nonprofit organizations to provide housing assistance and supportive services to those same folks and their families. And by providing housing assistance and supportive services, the HOPWA program helps people living with HIV and AIDS enter and remain in housing, access and maintain medical care, and adhere to HIV treatment regimens.

So who does HOPWA serve? HOPWA served over 100,000 households in the past year with housing assistance and supportive services. Last year, 77% of households served were extremely low income, which is between 0% to 30% of the area median income.

Among new clients entering the HOPWA program last year, approximately 16% were homeless at entry. 63% of HOPWA eligible individuals last year were cisgender male. 43% were between the ages of 31 and 50, and 48% were 51 or older. I'm sorry, 45% were 51 or older. 54% of clients were Black or African-American. 37% were white. And 19% had Hispanic or Latino ethnicity.

So now let's talk about how, how the program is structured, and how it can serve eligible people. 90% of the budget goes to formula grantees and 10% goes to competitive grantees. In FY22 that appropriation was $450 million. And let's take a deeper dive into that. The HOPWA appropriation has increased every year since 2015, up to $450 million in 2022.

The program assists about 50,000 households each year with housing assistance, including tenant-based rental assistance and facility-based housing, and another 50,000 with supportive services aimed at ensuring housing stability, which can mean linking people to other housing while they're on a HOPWA waitlist or providing supportive services to someone on a Housing Choice Voucher or Section 8, for example. And while this appropriation has been increasing, the estimate for the number of people eligible for HOPWA assistance who are not receiving it is over 380,000 folks.

Very briefly, this slide shows the main categories of HOPWA eligible activities. HOPWA statute and regulations lay out a menu of eligible activities. From this menu, grantees can choose to fund a range of activities in their communities based on their local planning decisions and with HUD approval. Grantees can provide these activities directly or contract with project sponsors, often nonprofit agencies. And those will carry out those activities.

And this pie chart shows how our grantees are choosing to spend HOPWA funds. So HOPWA housing assistance, that big purple slice, includes tenant-based rental assistance, like vouchers, facility-based housing, like apartments or other residences in the community that are owned by a funded organization.

And HOPWA supportive services, that second largest slice, are quite flexible. And they can be used for a range of services, including case management, nutritional services, transportation, and child care, and behavioral health services, mental health and treatments. While mental health and substance use treatment services are eligible under HOPWA, we encourage grantees to braid SAMHSA funding with their HOPWA funds or to form strong community partnerships with SAMHSA funded organizations for these services where possible.

That was a rather brief overview of the HOPWA program. So for those of you who want to learn more, we've pulled together some resources. The first link will take you to the HOPWA regulations. The next one will take you to HOPWA web page on the hud.gov website. The third to will take you to the program data for each of our grantees. And the last one is a link to the white paper showing the connection between housing and health outcomes for people living with HIV.

And with that, I'm going to turn it over to Lieutenant Commander Katie Hager with SAMHSA, who will introduce you to their programs. Katie.

KATIE HAGER: Hello, everyone. Thank you very much. Let me share my slides real quick and we will start. So good afternoon. Thank you very much for joining this webinar. My name is Lieutenant Commander Katie Hager. I am a SAMHSA Government Project Officer in the Center for Mental Health Services. And I work specifically on the Minority AIDS Initiative Service Integration grants and the Treatment for Individuals Experiencing Homelessness grants within SAMHSA.

So the four grant programs that I'm going to talk about today, so SAMHSA is organized into three different centers. We have a Center for Substance Abuse Prevention. We have a Center for Substance Abuse Treatment. And we have a Center for Mental Health Services. And within two of these centers, the Center for Treatment and the Center for Mental Health, we have HIV-related programming as well as homelessness-related programming.

So these four programs make up what is our HIV and homeless services programs. Two of these programs just had, in FY22, starting September 30, new cohorts of grantees.

The other-- and then for FY23, please keep an eye on grants.gov. We do have a new cohort of the CSAT Minority AIDS Initiative High Risk Populations grant, forecasted, a new cohort for the Grants for the Benefit of Homeless Individuals within CSAT, and also the Treatment for Individuals Experiencing Homelessness within Mental Health Services are all forecasted for new cohorts this fiscal year.

So I want to talk a little bit about the substance abuse treatments-- Substance Use Disorder Treatment for Racial and Ethnic Minority Populations with High Risk for HIV. And the purpose of this grant is to provide-- program is to increase care for racial and ethnic minority individuals with co-occurring substance use and mental health challenges who are at risk for or are living with HIV and AIDS and receive HIV primary care and other services.

It is a five-year grant program awarded to 61 grant recipients, or up to $500,000 per year. And eligible applicants include domestic public, private nonprofit entities, including federally recognized tribes and tribal organizations.

And then in the Center for Mental Health Services, we have the Minority AIDS Initiative Service Integration grant. And the purpose of this grant program is to reduce the co-occurring epidemics of HIV, hepatitis, and mental health challenges through accessible, evidence-based, culturally appropriate treatment that is integrated with HIV primary care and prevention services.

This is a four-year grant program with 18 grantees at up to $485,000. And again, eligible applicants were domestic public and private nonprofit entities, states, political subdivisions of states and federally recognized American-Indian, and Alaska Native tribes, and tribal serving organizations.

And within these two grant programs, we incorporated the National HIV and AIDS Strategy to ensure that we were providing easily accessible HIV and hepatitis prevention services, screening risk assessment, prevention counseling, HIV and hepatitis testing, referral to PrEP, hepatitis vaccination within behavioral health care or substance use treatment settings.

We also ensure that across both the CSAT and CMHS program the case management services to coordinate all aspects of care, including behavioral health, primary care, HIV and hepatitis treatment, and other supportive services, to include housing, benefits, and employment, and transitions to the community.

Also new in this FY22 was to develop across both programs, CSAT and CMHS, to develop Memorandums of Agreement with primary HIV treatment and care providers, including Ryan White providers, to strengthen integration of care through case management, treatment providers for referral and linkage to follow-up care and treatment for individuals with viral hepatitis, both B or C, and care providers for referrals and linkages to PrEP, as well as care providers for referrals and linkage to primary care services.

In addition to the HIV-specific grant programs SAMHSA also has two homelessness-related grant programs. The grant to Benefit Homeless Individuals program is a competitive grant program to help communities expand and strengthen recovery support services for individuals, including youth and families, who are experiencing homelessness, who have substance use disorders or co-occurring disorders.

These grants are for five years and up to $400,000. And there were 85 grants across 33 states. Services under this grant program include outreach and engagement for the population of focus, mental and substance use screening and assessment, direct treatment for substance use and co-occurring disorders, assistance in accessing permanent housing, case management and recovery support services, enrollment for health insurance, Medicaid, SSI, SSDI, and other mainstream benefits, and access to recovery support services.

The Center for Mental Health Services Homelessness grant, the Treatment for Individuals Experiencing Homelessness, and this purpose is to support the development or expansion of local infrastructure, behavioral-- and here we go-- this is the Treatment for Individuals Experiencing Homelessness. These grants are for five years, up to $1 million for states and territories, and $500,000 for tribes and community-based organizations.

There are 48 grantees across 26 states. And there have been several cohorts of these grants that have been funded. And the required activities for this program include outreach, screening, treatment, peer support, connection to sustainable, permanent housing, case management, recovery support services, and assistance and enrollment in mainstream benefits.

So thank you very much. And with that, I'm going to pass it over to Wendy LeBlanc and Jessica Lorento with Harbor Care.

WENDY LEBLANC: Good afternoon. Thank you so much. My name is Wendy LeBlanc. And we'll be presenting on integrated care for persons living with HIV and substance use disorder in Southern New Hampshire. Here we go.

So as I said, my name is Wendy LeBlanc. I've been involved with the HIV community since 1991, when my best friend was diagnosed with AIDS. And at the time, the only service offered in our area was a support group in the basement of the local hospital. I got involved and began volunteering. And eight years later was hired as the agency's first respite care coordinator. Almost 24 years later, I'm still here, proudly providing quality services to people living with HIV/AIDS through Ryan White and HOPWA funding.

JESSICA LORENTO: And hi, my name is Jessica Lorento. I oversee one of our SAMHSA funded grants at Harbor Care. My education and experience is in mental health counseling and clinical work with individuals who are living with substance use.

Today, we're here to share about Harbor Care's approach to serving those who are living with HIV. And to give you a brief overview of the agenda for our portion of today's presentation, we're going to chat about Harbor Care and provide an organizational overview, as well as overview the SAMHSA funded programs that we have, and HIV services, and HOPWA.

Wendy and I are going to also share two client stories with you and then discuss some of the approaches we have to serving this population. So that includes trauma-informed care, Housing First, harm reduction, and our Integrated Care Model. We're also going to talk about some community collaborations we have, as well as discuss some lessons learned and best practices. We're going to end the presentation with some future recommendations and chat about next steps.

WENDY LEBLANC: So I'd love to share with you the very unique and interesting story of the history of Harbor Care. For over 40 years, six separate organizations with six distinct missions and finances, budgets, 501(c)(3) designations have been working to provide services to vulnerable populations.

Harbor Homes is the oldest and largest of our organizations. It was founded in 1982 to serve nine individuals with mental illness in a group home and has grown over the years to provide multiple housing solutions for folks with mental illness, substance use disorder, homeless veterans, people living with HIV/AIDS, and chronically homeless individuals and families.

Harbor Homes has always been driven to provide supports and create opportunities that enrich well-being and help individuals to realize their potential. In its second decade, Harbor Homes featured the launch of new initiatives and soft mergers, as well as strategic partnerships. And these efforts expanded its mental health services, launched home health services, and created affordable housing for a variety of populations, as I just mentioned.

Keystone Hall, also known as the Greater Nashua Council on Alcoholism, has been providing substance use disorder treatment in our area for decades. And about 20 years ago joined the Harbor Homes family.

Milford Regional Counseling was a small, independent counseling organization that partnered with Harbor Homes many, many years ago and is now-- those therapists are now working at the Harbor Care Health and Wellness Center. The Southern New Hampshire HIV/AIDS Task Force was founded in 1991 to provide supportive services to people living with HIV/AIDS. And in 2006, we joined the Harbor Home's family.

Healthy at Home is a visiting nurse organization that was founded by Harbor Homes to meet the gap in our community of providing home care services to people with severe and persistent mental illness. And our home care agency also specializes in providing home care services to those who are experiencing homelessness.

The Welcoming Light Training Institute was also created out of Harbor Homes to give an opportunity for community-wide training, staff, clients, and we have a lot of community events that take place at our training institute as well.

Named to the Partnership for Successful Living, for over a decade these six organizations worked under a unique nonprofit model. As I mentioned, we still maintained our own separate mission statements, 501(c)(3) designations and funding sources, but we shared a lot of back-end resources, such as our board of directors, president and CEO, human resources, IT, development, marketing, et cetera. And this was really beneficial to the smaller agencies that didn't have a lot of unrestricted funding for those important back-end resources.

In 2009, Harbor Homes launched the Harbor Care Health and Wellness Center, which is a Federally Qualified Health Center focused on serving people experiencing or at risk of homelessness. Integrating health care services with stable housing and other necessary supports was key to its efforts to address homelessness and improve the well-being of vulnerable community members. Today our Community Health Center serves nearly 3,000 individuals each year.

In October of 2020, after years of being known as the Partnership for Successful Living, we formally merged all six organizations and now operate as Harbor Care. So what began in 1982 as a group home serving nine people is now an organization that serves more than 5,000 individuals and families each year. Today Harbor Care is the largest supportive housing provider for those who are homeless, for veterans, people living with HIV/AIDS, and it is the only standalone Federally Qualified Health Center in New Hampshire that prioritizes homeless patients.

Our Federally Qualified Health Center, as I mentioned, is known as Harbor Care Health and Wellness Center. We provide primary medical care, as well as a range of behavioral health services, from therapy, psychology, psychiatry. We have a multitude of substance use treatment programs. We offer medication-assisted treatment. We offer the only residential program in the state of New Hampshire for pregnant and parenting women and children.

We provide intensive outpatient programs and individual counseling with a licensed alcohol and drug counselor. We have dental services on site, as well as a 340B pharmacy, HIV support services, and community health workers, and homeless outreach staff.

JESSICA LORENTO: So most recently, we've been the recipient of four SAMHSA grants. And the next couple of slides are a snapshot into each level of funding that is received by Harbor Care, and really how we've utilize all the different funding opportunities to support continued integration.

So listed first here is the Targeted Capacity Expansion, or TCE, grant. And this previously funded our MERIT Program. MERIT stands for Motivating and Empowering Recovery through Integrated Treatment program. We received that funding in 2019 as a three-year grant through September of 2022. And this is primarily a methamphetamine treatment program, specifically serving homeless or at-risk of homeless adults and adults receiving MAT in Hillsborough County, New Hampshire. They had a project goal of serving 165 clients in three years.

This program really allowed us to train internal and external partners on methamphetamine use disorder, best practices, and different approaches to encourage recovery from meth, including contingency management. This expanded our client access to treatment and recovery housing, which was offered to clients who are living with HIV.

The second level of funding listed you just heard a lot about, and it's the GBHI funding. And that funds our homeless outreach services. And that program is often referred to as HOP. We received that funding in 2018 as a five-year grant and will have the funds through September of 2023. The grant serves adults who are simultaneously living with homelessness and substance use disorders. And we're on track for our project goal of serving 270 clients in five years.

IDDT, which is written on the screen, stands for Integrated Dual Disorder Treatment. And it's an evidence-based practice that encourages treatment of mental health and substance use at the same time. This funding has increased communication and shared goals between departments. And it's further allowed integrated clinical services throughout Harbor Care. HOP also expanded outreach and community support, which really allows us to re-engage people with HIV who might be homeless again or previously disengaged from services.

Slide.

Our Medication Assisted Treatment, Prescription Drug and Opioid Addiction, or MAT-PDOA grant, funds our Integrated Recovery Support Services Program. We received that funding in fall of 2021. And we'll have it for five years, through September of 2026. This supports homeless or at-risk of homeless adults with prescription drug or opioid use who are residing in Hillsborough County, New Hampshire.

We have a goal to serve 600 clients in five years. This allows us to provide intensive wraparound services for any client identified as high risk. And this includes adults living with HIV. This is helping us move forward with integrating clinical services and additional training for providers.

The Residential Treatment for Pregnant and Postpartum Women, or PPW, grant, supports programming at the Cynthia Day Family Center, or CDFC. This is a residential treatment program at Keystone Hall, and it provides substance use treatment services. Wendy had just referenced this earlier on as part of the Harbor Care merger in 2020 as well.

PPW was awarded this year, in 2022, and we've begun utilizing it as of October 1. The program will continue to support pregnant, postpartum, and parenting women who are accessing high or low intensity SUD treatment. And also who are facing homelessness, as well as providing child care to children who are living in the residential facility as well.

We have a project goal to serve 250 women and 150 children within five years. This funding will also increase children and families' access to services, including additional community education for harm reduction. And a portion of these funds are going to be used for continued training opportunities. Slide.

WENDY LEBLANC: Thanks, Jess. And now I'd like to talk about our HIV support services here at Harbor Care. It's important to know that New Hampshire is a low prevalence and low incidence state for HIV. So last fiscal year, we served 175 clients in our Nashua office and 41 at our satellite office in Keene, which is a small community in Western New Hampshire.

We provide medical case management, which as you know, focuses on health outcomes, such as viral suppression. I'm very proud to share that among all of our clients at Harbor Care, we're experiencing 96% viral suppression rate. We also provide non-medical case management services to provide access to care.

And in New Hampshire, in order for an individual living with HIV to access the AIDS Drug Assistance Program, or Ryan White Part B funds, the individual must apply through an HIV case manager at an AIDS service organization. They're not able to apply individually to the-- independently to the program. And so each person that needs that AIDS Drug Assistance Program assistance needs to apply through us.

Because of this, our clients are rarely discharged. Even though we can help them reach a really great level of self-sufficiency, folks are always going to want to take advantage of the opportunity to have help with their medication or medical costs.

We also provide peer support services. We have a gentleman living with HIV who provides one-on-one counseling sessions for those who wish to participate. And then we also have support groups. We have a support group for both English-speaking individuals and Spanish-speaking individuals.

We have a food pantry, which is like a little, free grocery store. People can come in and choose the items they want and put them in their own bags. We like to feel that this lends them a bit of dignity, so they can choose the things that they'll use, as opposed to getting a pre-packaged bag, depending on their household size, which is often the case in other food pantries.

We offer transportation. Not only do case managers sometimes help their clients get to appointments when there's support needed as well, whether it's linguistic support or comprehensive support at a medical or social service appointment, we also have an agreement with our local taxi company, where we can pay for rides for medical and social service appointments. We also have a variety of housing solutions through Ryan White Part B and primarily through HOPWA.

Our organization has long been known for our one-stop shopping for people living with HIV, including all these services at one location, whereas in larger cities you may need to go to a different agency for case management, housing, a different one for food, or peer support. Now that we've integrated with the Harbor Care Health and Wellness Center, even medical services, behavioral health, dental, and pharmacy are all available under one roof. And this can really go a long way in easing the comfort of clients, especially those dealing with stigma.

And as I mentioned, because we are a low prevalence state, we are able to have smaller caseloads, giving our case managers an opportunity for more one-on-one support. We each have a caseload of about 35 to 40 clients.

Moving on to HOPWA, Housing Opportunities for Persons with AIDS, the eligibility is basically the same, an HIV positive resident of the state of New Hampshire with a household income of at or below 80% of the area median income.

We have two HOPWA grants that serve greater Nashua. The first was received in 1999 and was originally set up to provide short-term rent mortgage and utility assistance, permanent housing placement and support services. But in 2017, HUD encouraged us to make a shift in our program because we recognized that the same households were accessing the short-term funding year after year, indicating that there really was a need for more long-term solutions.

And so with HUD's support, we moved the bulk of our short-term funding into tenant-based rental assistance or long-term subsidies, and now we're able to serve six to seven additional households each year with long-term subsidies. And we have many fewer requests for short-term assistance. Through that grant, we generally serve about 30 folks a year with supportive services, in addition to those receiving the short-term and long-term assistance.

Our second housing-- our second HOPWA grant was applied for in 2005, when funding was made available to be applied to by cities and municipalities. The city of Nashua is the grantee and then the housing program at Harbor Care, which is also the lead entity for our continuum of care. The housing program provides the rental calculations, the housing inspections, landlord communications. And then the HIV Services department provides the supportive services, some of which we've already talked about-- case management, transportation, linguistics, et cetera.

Because we're funded, fortunately, by HRSA and HUD for the same support services, all of our clients receive the same services regardless of which funding stream we need to pull from to meet those needs.

One of the things that I'm really proud of is to share that our former CEO, who just retired last month after 40 years of service, early on recognized the need for specialized housing for people living with HIV, and particularly that there needed to be supports connected.

So long before HOPWA competitive funds were available in New Hampshire, he designated some of the CoC application funds for our permanent supportive housing to be set asides for people living with HIV and was the first in New Hampshire to recognize this need and put it into action. Once those HOPWA funds became available in the community, he worked with the HIV Task Force to bring those funds to Nashua.

So there are obvious differences for HOPWA subsidies, as many of you know. One of the most important is that undocumented individuals can be served with this funding. HOPWA has really been the only housing solution for several of our immigrant clients. But the biggest difference to me is the wraparound services that come with housing, unlike Section 8 or mainstream housing vouchers. We have case management supports and those other support services I mentioned, like transportation and so forth.

We have a handful of landlords who enjoy working with our clients because they know that we're there for support. And these landlords will even let us know when they have openings in case we have anyone looking for an apartment.

JESSICA LORENTO: So we have a couple of client stories to share with all of you today. And I just want to remind you that HOP and MERIT are two of the programs internally at Harbor Care that were funded through SAMHSA. And for the purpose of this story, all identifiable information has been changed.

Client A will be called Monica. And in the story, I do reference Safe Stations, which was a program that was created in response to the opioid crisis in New Hampshire. Any person who wanted access to substance use treatment services could walk into any fire station 24/7, 365 to be assessed and referred to treatment.

So HOP program staff met Monica when she was receiving substance use treatment at Keystone Hall about three years ago. At the time, Monica was connected with the HIV service agency in Manchester, New Hampshire, but not in Nashua. Monica was living in an emergency homeless shelter. And HOP would frequently visit her in Manchester.

One day, she relapsed and began using drugs heavily. HOP drove to Manchester and walked her into a safe station to connect with detox and treatment. From there, the client went to Brattleboro Retreat in Vermont for dual diagnosis mental health and substance use treatment for two weeks. She detoxed off methadone and began MAT treatment for Suboxone.

Afterwards, Monica began another residential SUD treatment program, followed by transitional living for approximately eight months' time. During this, HOP remained supportive to Monica. As she furthered her treatment and stabilization, she was requesting transitioning all care to Nashua so her providers would be in the same system.

At that point, we connected her with HIV services and Wendy's team, and helped her apply for the HOPWA housing voucher program. Monica was approved relatively quickly, which was extremely encouraging to her, given her commitment to sobriety and turning her life around.

Monica was housed in May of 2020 in her own apartment. From that point on, HOP has met with the client regularly and is in contact with HIV service's case management team to collaborate. The client is now deeply connected over at our Federally Qualified Health Center and is engaged in MAT and behavioral health services. The client has maintained housing, is connected to her community, has been sober for several months, and is a true success story.

She's had her struggle along the way, but she always knows she can reach out and does. And on the screen, you'll see a direct quote from Monica. "I never in a million years thought I would get to this point in my life. I have done a lot of work on my own, but without the support of my team at Harbor Care, I would not be here. I am beyond grateful and beyond blessed."

WENDY LEBLANC: Thank you, Jessica. Now I'm going to read a story to you about Joey, also not his real name. Joey connected with the HIV services team at Harbor Care in February of 2020. He was in active addiction with methamphetamine. It was very difficult to work with him, as his attention span was incredibly short, and he was unable to sit still long enough to complete documents. For example, at one point during his intake, he started doing cartwheels in his case manager's office.

Less than a month after his intake, he became homeless, and his HIV case manager connected him to HOPWA and the MERIT program. Due to his inability to keep appointments or return phone calls, these referrals took a bit longer than usual, but by September of 2020, he was connected with MERIT. And his MERIT case manager and his HIV case manager worked together diligently to try to reach the client and meet his needs, despite his inability to follow up.

The team was finally successful in connecting with him and finding him an apartment. And he moved in January of 2021. According to the MERIT program manager, he was connected with them from September of 2021 through March of '22 with minimal engagement. But he kept popping back up, which we saw as a good thing.

A couple of goals were outlined, including connecting with a behavioral health therapist, as well as finding employment. And it did not appear that during his time receiving supports he secured employment, but he did connect with a therapist. And he seemed to feel connected with that individual.

The MERIT program did ultimately have to put him on an inactive status, per their policy of no contact for more than 90 days. But his HIV case manager reports that while he is still actively using meth, he is stably housed and back in medical care. When he first connected with us, he refused a referral to HIV specialty care because he told us he was in a study in Boston for elite controllers and he didn't need the meds. But that study has now concluded. And although his CD4 count is very high, he was not virally suppressed. So he has accepted a referral to a local HIV provider and is now on HIV medication.

JESSICA LORENTO: So we wanted to highlight a few principles and practices that really influence the quality of care that we're providing all of our clients, but specifically the ones who are living with HIV and substance use. If we look into the research, the essential qualities for positive client outcomes are listed on this slide. And this really can be used to discuss all kinds of staff support, so to include case managers, community support, workers and so on.

About 40% of outcomes are factors related to what the client brings to the situation. So really, that means their life experience before we met them and everything that that encompasses. The therapeutic relationship is approximately 30% expectancy, and hope, 15%, and the therapy model or approach used in the clinical setting is also about 15%.

So really what that's saying is that 60% of whether or not somebody responds to treatment hinges on the people who are delivering that treatment. Better relationships lead to better outcomes. And so for us, that really means being flexible, responsive, and following through with scheduled appointments. And all of those different pieces can help develop trust between the client and a staff person.

As staff, if we're focusing on being positive, empathetic, and supportive, we can help people feel that progress is actually possible, and we can help instill hope. And over time, what that does is it empowers the person to help themselves. Next slide.

So now to discuss trauma-induced treatment. Although we don't like to acknowledge it, it's entirely possible for a traumatization to occur during clinical treatment. And the best way to avoid that is to create an environment of safety. So keep in mind that every relationship happens in the context of connection, disconnection, and re-connection. And all of the services that we provide in these various grant funded programs are essential to re-connection.

So really, when we're talking about the environment that we work in, we have to identify potential triggers that could lead to somebody's emotional distress. So a couple of examples here. Some folks are triggered by institutionalized settings. So white walls, less inviting office spaces, all of that can be very uncomfortable. And this is why we've found too that community settings can help build rapport.

So things like going for a walk or asking somebody where they feel comfortable meeting with you, if that's possible, can be very, very helpful. Things like lighting, temperature of the space, how much privacy you have when you're meeting with somebody is also important. And especially working with underserved populations, more casual dress can be less intimidating to the client compared to business attire or suits. Next slide.

And so specifically with this population, there are many layers caring for somebody who's diagnosed with HIV, as most of you are very aware of. There's still a lot of stigma related to the LGBTQ+ population, and all of that increases vulnerabilities for these community members. Elevated levels of trauma are linked to immune suppression and treatment failure. So for somebody who's already immunocompromised addressing the causes of trauma as part of the care model in place is really important to their treatment.

A holistic approach is best, really trying to acknowledge all needs of the person. And to do this, we recommend a wraparound care team from a multidisciplinary approach. Slide.

So housing first, an evidence-based practice, most of you know well, this really recognizes permanent housing as a necessary precursor to receiving support services. So like many of you in your organizations, it's really that concept of housing is health care. And this concept, as well, is intended to serve chronically homeless individuals who have co-occurring mental illness and substance use, but really this can apply to all vulnerable populations.

Barrier-free housing means that folks deserve housing regardless of active substance use or untreated mental illness. So for us, either situation would not put somebody at risk for immediate loss of housing. And then support services advocacy in connection with things like primary medical care and other resources are incredibly important to ensure that somebody's success in a housing placement. Slide.

So with any practice, there's always challenges. And we know that chronically homeless by definition means this person has been literally homeless for 12 or more months. So when we think about a move to housing, that is a massive transition for many people. And several folks really lack basic skills for tenancy. And they might continue to struggle with active substance use and untreated mental illness once they're in housing.

So thinking about client engagement challenges, several of our clients will pull back from services once they're in a housing placement. And supports can be voluntary, meaning that we can't force anybody to continue meeting with us once they're housed. So additionally, this is a high-needs population, and we have some challenges engaging with new landlords, but do continue working with our community partners to try and find new landlords.

When we say low vacancy rates in Southern New Hampshire, we're talking less than 1%. So landlords have the ability right now to be choosing from a large applicant pool. And our clients can often be overlooked. Slide.

WENDY LEBLANC: So as Jessica was just talking about, we all have heard the slogan, "Housing is Health Care." At Harbor Care, we also know that implementing a housing first model is also an effective harm-reduction tool. And we really try to execute this concept throughout all of our housing programs, including HOPWA.

As I shared in my client's story, even though access to permanent supportive housing doesn't mean immediate and long-term recovery, it can be an important step in harm reduction, allowing the individual to have a source of stability and pride.

We also like to talk about contingency management, which was used a lot in our MERIT program. Contingency management is just always positively rewarding a target behavior. It really could be anything. So an intervention can be set up to target behaviors-- for example, abstinence, or treatment engagement. The target behavior is always immediately rewarded when the behavior happens.

So in this example, if a contingency management intervention is set up for patients where they are rewarded for abstinence from stimulants, they would provide a urine sample every so many days to capture if any use has occurred. And if each and every urine sample is negative for stimulants, they would be rewarded with a tangible prize. This is an evidence-based practice that has been quite successful here at Harbor Care.

Syringe service programs are an obvious example of harm reduction. In June of 2017, the state of New Hampshire finally legalized syringe service programs. Harbor Care took the lead in organizing the Syringe Service Alliance of the Nashua Area, also known as SANA. This was a group of dedicated public health workers, substance use treatment providers, the HIV services, and the local Substance Use Peer Recovery Support Center.

And in February of 2018, we began providing mobile syringe services in this community. About two years ago we turned over the leadership of this program to Revive Recovery, the local peer recovery support agency in our community. And they're still active providing mobile services six days a week. And I'm just super proud of them.

And then, of course, we have to acknowledge the difference between harm reduction and behavioral management. Behavioral management, it simply means that we try to meet our clients where they are and provide support based on their goals, not on our own goals for them.

I can share that as an HIV case manager for over 20 years, this has been incredibly difficult for me. And it's taken a lot of training and personal development to try to change my processes. Because I want to work with clients to create goals that help them decide how they want to live life on their own terms, not on my terms.

Regarding integrated care, we really have seen that model here at Harbor Care to effectively serve persons living with HIV as a coordination of care. Our HIV services team has recently moved locations. And so now we are co-located in the same building as our Federally Qualified Health Center. This makes it much easier for us to encourage clients to come for behavioral health or dental services.

They know the facility. We know that they know that we're here to greet them and help make sure they get to the right place in the building. We also can walk with them to the receptionist to schedule these types of appointments.

Obviously, we talked about housing and HOPWA. Harbor Care, or Harbor Homes, as it was formerly known, as I mentioned, has a variety of housing solutions, including mainstream housing vouchers, and has a lot of experience in this area. Medical services, obviously, have a lot to do with persons living with HIV. Our long-term goal is to have an ID specialist on our Harbor Care clinic team.

Prior to the Federally Qualified Health Center coming online a Ryan White Part C clinic was designated in our community. So the bulk of our clients had been receiving their care there before our health center opened. But many of our clients are receiving care here now.

As I mentioned, we have a really great behavioral health team. We have dental services. And in New Hampshire, the Medicaid benefit for oral health is practically nonexistent, but for people living with HIV they can access the Ryan White Part B services through the state. And Harbor Care is a contracted dental provider, so our folks living with HIV can get free dental services here as well.

And then, of course, we have ongoing community support to work towards re-engagement for folks who we have lost to care. And again, as we always say, meeting people where they're at.

In community, collaborations are important as well. The three that I'd like to highlight for our program here regarding HIV services, as I mentioned Dartmouth-Hitchcock is a large medical provider here in our state. And they hold the Ryan White Part C and Ryan White Part D grants in our state. And we've long worked with them to coordinate care. We meet regularly and talk regularly with the providers there to make sure that we're taking care of all of the needs of our folks.

And as I mentioned, Harbor Care is the lead entity of the Greater Nashua Continuum of Care. And many of you know that the Continuum of Care exists in order to bring funding into the community through their CoC application process each year. But in addition to that, it's a great opportunity for networking and relationship building.

And my favorite story is how, in 2005, when HUD released additional HOPWA competitive funds that needed to be applied for by a city or a municipality, because of the relationship that I had developed over years at the Continuum of Care with our local welfare office, I was able to ask him to advocate for us with the mayor and the alderman to take on this grant and to apply for these funds, which they did. And so now we have over 30 households successfully housed in long-term vouchers.

And then, of course, we do work with the Veterans Administration. Several of our clients are also veterans, and they do get their medical care. And some are fortunate enough to receive the VASH vouchers, which are also long-term subsidies.

And then when we talk about-- I'm sorry, I'm bouncing around here-- lessons learned, I think informing client care, what we talked about earlier is that smaller caseloads provide opportunities for one-on-one support. And because we're funded through multiple funding streams for case management, medical, non-medical, and HOPWA case management, there is some flexibility there to define the case management services that we're providing.

And certainly, it doesn't hurt that we have a food pantry. So when we have those hard to reach clients that we need them to come in and sign their paperwork for their Medicaid application, we remind them that they can come in and get some food. And we also find that conversations that take place in the food pantry are much less formal. And sometimes we learn important information from our clients that we may not have gleaned in an office setting.

As we mentioned, co-locating support services in the clinic setting makes it easier for our clients to access all of those services under one roof, meeting in a comfortable location, as Jessica was talking about earlier. We have artwork that is diverse and all sorts of things to make people feel comfortable.

And then I'm really proud that we have a diverse staff for being in New Hampshire. There are seven of us on the HIV team, three of whom are Spanish-speaking, bilingual, bicultural staff. Three of our team members are part of the LGBTQ+ community, and two of our staff are HIV positive. So we really do mirror our population. And we work really hard to make sure that we take training very seriously. Making sure that we're using appropriate language, that we have a welcoming environment, and just making it a comfortable place for our folks to come for services.

JESSICA LORENTO: So as well as lessons learned, best practices that we've adopted, this is a common theme you've heard a lot today, but really having all services available under one roof. It's that type of collaborative environment that helps keep our clients engaged.

On the screen here, you'll see red carpet treatment. That's a philosophy we have at Harbor Care that, in essence, means that if anyone were to contact myself, or Wendy from another department on behalf of a client, we'll always do our best to prioritize that request and get the person connected to whichever service they're looking for as soon as possible. As you can imagine, there can still be wait times to see certain providers, but we do try to prioritize our HIV positive clients for behavioral health and dental services.

Trauma-informed treatment, we discussed this earlier. Really, the only way to make that happen is from continued education, discussion, and honesty, really above all else. Because we have to be honest about our approach to how we're treating those who are living with HIV.

We can often support people who come to us, to our building and services, but there are still several people who do not. So another common theme of meeting people where they are, that's where outreach and community engagement efforts are really important to encourage continued engagement in services. Next slide.

And then moving forward, really continuing to participate in joint learning collaboratives, like this opportunity today, is important for all of us in our continued education and growth. Within Harbor Care and in our clinic services we recognize that we are just a piece of the puzzle when it comes to supporting this population. And with only being able to support one or two dimensions of somebody's needs, we can't always get the full picture.

So an example, if we're able to access additional data regarding medical episodes, cost from insurance companies, things like that, we can better determine if our interventions are truly leading to better outcomes. So more resources, more data points are necessary to determine the overall impact that we're making.

And then exploring future funding opportunities for community support to better serve this population and fill gaps in our service delivery. And then lastly, but certainly not least, integrating dual disorder treatment and clinical services across all departments is a more comprehensive way to view somebody from that whole person treatment approach we've been talking about.

So moving forward, really making sure that we're continuing to strive for that level of integration. Thank you.

WENDY LEBLANC: Did anybody have any questions on the presentation from Harbor Care? I see one in the chat. And it says, what roles of your HOPWA, HRSA, and SAMHSA, and VA and other program officers played in supporting our brilliant efforts to blend and braid separately funded services to meet your clients' needs? How often are they able to help you to get to yes when you propose something innovative?

So I can answer that question, certainly for HOPWA. And we're actually-- I think we each program within Harbor Care has individual relationships with their program officers. And then under the leadership of our CEO, Henry Och, who is on the call also, that may want to expand on this question, guides us in working together to come up with those strategies. Henry, do you have anything to add for that question?

OK, oh, there he is.

HENRY OCH: I'm here, Wendy.

WENDY LEBLANC: OK.

HENRY OCH: Sorry about that. I was getting my computer reset here. Can you repeat that again, please?

WENDY LEBLANC: Yeah, so what roles have our program officers played in supporting our efforts to blend and braid separately funded services?

HENRY OCH: So the-- so we have many program officers. And our job as staff is to inform each program officer about the wide array of services that we offer at Harbor Care. And in some cases, we do come across what I would call funder friction, where we have expectations that might not necessarily be aligned between or amongst funders. So we have to be very well versed on what those left and right limits are.

And it is a little bit complicated at times. But as a result of the great partnerships that we have had with SAMHSA, the VA, HRSA, and others, we're able to deliver an integrated service model.

WENDY LEBLANC: Thank you, Henry. The second question in the chat that I see, I'm not sure if maybe somebody else on the call would like to answer it, but it's asking for HOPWA programs that cannot and do not have housing, drug, mental health services under one roof, which SAMHSA grant should we look into? And so perhaps Lieutenant Commander would like to answer that question.

KATIE HAGER: Absolutely. So for coming up, FY23, there are actually three related grant programs that-- recommendation go to grants.gov. Search for SAMHSA grants. Also on the SAMHSA website, if you go to our Grants page, there will be a link at the top for forecasted FY23 grant programs.

Both the Center for Mental Health Services, Treatment for Individuals Experiencing Homelessness grant is forecasted to have a new cohort. For CSAT, both their Minority AIDS Initiative High Risk Populations grant will have an FY23 cohort, as well as also in CSAT the grant to Benefit Homeless individuals. So those are three funding opportunities that will be coming out in the near future.

WENDY LEBLANC: All right I'm going to turn it back over to Kate Briddell.

KATE BRIDDELL: Well, thank you. And thank you very much for your presentation, Wendy and Jessica. It was so tremendous hearing about the work-- the important work that you all do every day. And thank you to our SAMHSA colleagues, and to Harold Philips for your partnership. And thank you to everyone who attended today to learn more about these resources.

Just so you know, the slide decks, the transcript of the recorded webinar will be available on the HUD Exchange within the next few weeks. And with that, I'll say, have a great afternoon. Thanks, everyone.