Analysis of Integrated HIV Housing and Care Services

Final Report

February 2014

Mathematica Policy Research
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EXECUTIVE SUMMARY

In the United States, it is estimated that more than 1.1 million people are infected with HIV/AIDS (Centers for Disease Control and Prevention [CDC] 2013). Data indicate that individuals with HIV infection suffer far greater housing instability and homelessness than the general population: an estimated one-third to one-half are homeless or at risk of becoming homeless (Rourke et al. 2010). People living with HIV/AIDS (PLWHA) who lack stable housing are more likely to delay entering HIV care and less likely to have access to regular care, to receive anti-retroviral therapy (ART), or to adhere to their HIV medication regimen (White House Office of National AIDS Policy 2010).

The two main sources of federal housing assistance targeted specifically to PLWHA are the Housing Opportunities for Persons With AIDS program (HOPWA), provided through the U.S. Department of Housing and Urban Development (HUD); and the Ryan White HIV/AIDS Program (RWP), provided through the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS). HOPWA's primary focus is on providing housing assistance and related support services to PLWHA and their families. RWP's is to provide HIV treatment and care: grantees can spend only a portion of funds on support services (of which housing assistance is one type).

In 2010, the Obama administration created the country's first National HIV/AIDS Strategy (NHAS), designed to reduce the number of new HIV infections, increase access to HIV care, optimize health outcomes for PLWHA, and reduce related disparities (White House Office of National AIDS Policy 2010). Recognizing the role of housing in the HIV epidemic, the NHAS identified ways to increase federal HIV housing supports. To address the NHAS goal of greater access to HIV care, in 2011, the HUD Office of HIV/AIDS Housing awarded seven competitive Integrated HIV/AIDS Housing Plan (IHHP) grants that were designed to integrate housing assistance with HIV care and other supports at the individual service and community planning levels.

In 2012, the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) contracted with the Mathematica Policy Research/Cloudburst team to analyze current federal HIV housing assistance services and study best practices integrating HIV housing and health care services. This project includes a quantitative study of the costs, utilization, and outcomes of current federal HIV housing assistance services and a qualitative study of innovative IHHP programs integrating housing assistance with HIV care.

The quantitative analysis includes significant findings: (1) a direct comparison of 2010 HOPWA and RWP data; (2) a housing assistance analysis of 2010 RWP Services Report (RSR) data, (3) a feasibility assessment of a correlational study of HOPWA and RWP housing assistance and outcomes, and (4) national, state-level, and time trend analyses. The qualitative analysis documents key features of four IHHP sites, including their site characteristics, program models, and integration of HIV housing, health care, and other supports. These IHHP grants are unique in their efforts to integrate housing and HIV care at three levels: individual client services, organizational data systems, and community-level planning processes.

A. HIV Housing Analysis Findings

- The reported number of PLWHA in the United States in 2010 was 888,904.[1] Almost 1 in 10 (81,100) were receiving HOPWA and/or RWP housing assistance.
- Because HOPWA and RWP serve different purposes, the proportion of funding targeted toward housing assistance was very different. Whereas two-thirds (67%) of HOPWA's funding was used for housing assistance in 2010, a total of 3.2 percent of RWP funding was used for housing assistance.
- In general, the characteristics of participants served were similar across the two programs. HOPWA participants (which include family members) tended to be younger because HOPWA serves more families with children than RWP.
- In both programs, the majority of participants served were within the lowest poverty category (at or below 100% federal poverty level [FPL] for RWP and up to 30 percent of Area Median Income for HOPWA).
- Because HOPWA and RWP collect housing status data at different points of enrollment, it is not possible to compare housing status across the two programs prior to program entry. However, HOPWA reported that 13 percent of participants were homeless at entry.
- Although RWP housing status is measured "at the end of the reporting period" and not at program entry or exit, among RWP Clients receiving housing assistance, about one quarter (24%) were "temporarily or unstably housed," compared to 14 percent that were not receiving RWP-funded housing assistance.
- Of the RWP clients receiving housing assistance, 5 percent were still "unstably housed" at the end of the reporting period. This emphasizes the importance of connecting RWP clients to long-term or permanent housing assistance through HOPWA, homeless Continuum of Care (CoC), or other mainstream public housing programs.

B. HIV Housing Integration Study Findings

- The project studied four IHHP sites representing a range of service models and approaches: (1) the River Region Human Services (RRHS) FUSE project in Jacksonville, Florida; (2) the Frannie Peabody Center (FPC) statewide Maine IHHP project; (3) the Portland (Oregon) Housing Bureau (PHB) S4H project; and (4) the Albany Corporation for AIDS Research, Education, and Services (CARES) Foundations for Living (FFL) project in upstate New York.
- The four IHHP sites in this study have extensive experience providing HIV housing assistance and support services in collaboration with local partners. They have also been involved in community-level planning of homeless services through their

[1] The reported number of PLWHA differs from the 1.1 million estimate of the total number of people in the U.S. with HIV/AIDS due to the status of names-based HIV surveillance systems in 2010.

participation and leadership of CoC planning processes and in RWP planning councils, task forces, and provider networks.

- The IHHP program models show a gradient of service integration (from most to least): (1) all four sites provide direct housing assistance; (2) all four sites fund "housing coordinator" positions; two sites contract them out; (3) two sites fund "employment coordinator" positions; both sites contract them out; and (4) no sites fund medical case management directly; all four sites collaborate with medical case managers funded by RWP.
- Program components that facilitate service integration include (1) in-depth screening of clients' housing, health care, and other support service needs at intake; (2) development of individualized care plans for program clients tailored to their needs and circumstances; and (3) frequent in-person contact between housing coordinators, peer specialists, and clients and their medical providers and medical case managers.
- Two IHHP sites are also participating in a HRSA Special Project of National Significance addressing the coordination of housing and HIV care. In those medical home-focused programs, the sites are working with clients who are more medically needy and less likely than IHHP clients to become employed and mainstreamed into public housing.
- Recent funding restrictions at the federal, state, and local levels are limiting the grantees' ability to fully realize their IHHP goals. Additional concerns include (1) the lack of affordable housing available; (2) uncertainty about the potential impact of the Affordable Care Act on RWP-funded services, notably medical case management; and (3) the need for HIV service providers to shift from simply securing HIV-specific benefits for their clients to helping clients move into mainstream housing and employment.
- Neither HUD's Homeless Management Information System (HMIS) nor HRSA's CAREWare data system has the comprehensive set of housing and health care data needed to evaluate the effectiveness of the IHHP grantees' programs. All four sites are working on data system integration to address this problem.
- The IHHP grantees plan to bring together groups from public housing, homeless (CoC) grantees and service providers, city planning, RWP grantees, and AIDS service organizations to create community-wide IHHP plans, but note two challenges: (1) CoC and RWP grantees do not typically have a history of working together, and (2) some worried that HOPWA programs were historically marginalized in both CoC and RWP planning processes.

C. Opportunities for Improvement

This section offers ideas for how the service integration and data management of integrated housing and HIV care programs can be improved through further study and policy development.

- The IHHP sites should be revisited at the end of their grant cycle to see how they were able to develop an integrated planning process at the community level and what they have accomplished in terms of creating more integrated data systems.

- The potential impact of the Affordable Care Act on the linkage between HOPWA housing assistance and RWP case management programs could be significant. Monitoring and researching as Affordable Care Act coverage expansions are implemented in 2014 and beyond is warranted.
- The three-way model of housing assistance, employment services, and HIV care integration should be studied in more detail, and the model's effectiveness evaluated as an alternate model of service integration.
- New demonstration projects pooling HOPWA and RWP resources into one integrated HIV housing and care program should be considered and researched as an alternate model bundling housing with health care.
- Adding client-level variables that are common to both HOPWA and RWP data systems, including variables that capture the assistance received from both programs, would allow better linkage of the programs' databases and facilitate research examining the services received and resulting outcomes for participants served by both programs.
- Increased understanding of the differences between PLWHA who receive housing assistance and those who do not could help to inform and improve housing practices addressing the unique needs of these subgroups. It may also be valuable to explore state-level program differences in greater detail.
- The creation of new integrated CoC intake systems might involve developing new linkages among HMIS, CAREWare, and electronic health record data systems. This development should be monitored and studied to see what new data system forms result.

I. INTRODUCTION

In the United States, it is estimated that more than 1.1 million people are infected with HIV/AIDS (Centers for Disease Control and Prevention [CDC] 2013). Data indicate that individuals with HIV infection suffer far greater housing instability and homelessness than the general population: an estimated one-third to one-half are homeless or at risk of becoming homeless (Rourke et al. 2010). Homelessness and unstable housing are linked to higher risk of HIV infection, inadequate health care, poor health outcomes, and early death (National AIDS Housing Coalition 2007). People living with HIV/AIDS (PLWHA) who lack stable housing are more likely to delay entering HIV care and less likely to have access to regular care, to receive anti-retroviral therapy (ART), or to adhere to their HIV medication regimen (White House Office of National AIDS Policy 2010).

Unable to afford housing, some PLWHA turn to federal HIV programs for assistance. The two main sources of federal housing assistance targeted specifically for PLWHA are the Housing Opportunities for Persons With AIDS program (HOPWA), provided through the U.S. Department of Housing and Urban Development (HUD), and the Ryan White HIV/AIDS Program (RWP), provided through the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS).

In 2010, the Obama administration created a National HIV/AIDS Strategy (NHAS), designed to reduce the number of new HIV infections, increase access to HIV care, optimize health outcomes for PLWHA, and reduce related disparities (White House Office of National AIDS Policy 2010). Recognizing the role of housing in the HIV epidemic, NHAS identified ways to increase federal HIV housing supports. HHS, designated as the lead agency for implementing federal activities under the NHAS, is responsible for monitoring national progress toward meeting its goals. To address the NHAS goal of greater access to HIV care, in 2011, the HUD Office of HIV/AIDS Housing awarded seven competitive Integrated HIV/AIDS Housing Plan (IHHP) grants that were designed to integrate housing assistance with HIV care and other supports at the individual-service and community planning levels.

In 2012, the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) contracted with the Mathematica Policy Research/Cloudburst team to analyze current federal HIV housing assistance services and study best practices integrating HIV housing and health care services. This project includes a quantitative study of the costs, utilization, and outcomes of current federal HIV housing assistance, as well as a qualitative study of innovative HUD program models integrating housing assistance with HIV care. The overall goals of the project are (1) to review the current status of HIV housing programs; and (2) to document innovative, replicable program models integrating housing assistance with HIV health care.

A. Purpose of the Report

The purpose of this report is to present the findings from the project's quantitative analysis of federal HIV housing programs and qualitative study of a set of IHHP grantees. The report aims to answer the following questions for each component:

Quantitative HIV Housing Analysis Research Questions:

1. What is the prevalence and incidence of HIV/AIDS in the United States?
2. What proportion of the HIV/AIDS population receives federal HIV housing assistance?
3. What is the level of funding for federal HIV housing assistance?
4. What federal HIV housing assistance services are provided?
5. What are the characteristics of participants in federal HIV housing programs?
6. What are the outcomes of federal HIV housing assistance programs?
7. Can available federal data support an analysis of the association between housing assistance, enhanced housing status, increased access and retention in HIV care, and improved clinical outcomes?

Qualitative Study of Integrated HIV Housing Research Questions:

1. What are best practices among HOPWA's integrated HIV housing programs?
2. How do these program models integrate housing and HIV care at the individual service, organizational data management, and community planning levels?
3. How do these programs identify and enroll eligible people, assess their service needs, and integrate housing, HIV care, and other supports?
4. How do these programs link housing and health care data in their organizational data systems?
5. How is the planning and coordination of housing, HIV care, and other support services integrated at the community level?
6. What approaches promote or hinder the integration of housing, HIV care, and other support services?

B. Information Sources and Study Methods

The quantitative study analyzed HUD and HRSA administrative data from HOPWA and RWP. In addition, the team obtained publicly available HIV surveillance data from the CDC and homeless services needs assessment and service data from the HUD Office of Special Needs Assistance Programs. The study team finalized a statistical analysis plan based on the study objectives and on the aggregate nature of the data available, and conducted descriptive analyses of each of the variables of interest and compiled state and national summaries. The team also compared HOPWA and RWP services (such as relative percentages of participants served by type of housing assistance, income level, or demographics). For HOPWA data, the average cost per person served by specific type of housing was also calculated. The analysis drew on information from multiple sources (See Appendix A for details):

1. HOPWA Consolidated Annual Performance Evaluation Reports (CAPER) (2007-2010)
2. HOPWA Annual Performance Reports (APR) (2007-2010)

3. 2010 Annual Homeless Assessment Report (AHAR)
4. Homeless Management Information System (HMIS) (2010)
5. Ryan White Program Expenditure Reports (2007-2010)
6. Ryan White Program Data Reports (RDR) (2007-2010)
7. Ryan White Services Report (RSR) (2010)

The qualitative study selected program models drawn from HUD's seven IHHP grantees in 2011. In May 2013, Mathematica and Cloudburst conducted in-person site visits to four of the seven sites: (1) the River Region Human Services (RRHS) FUSE project in Jacksonville, Florida; (2) the Frannie Peabody Center (FPC) statewide IHHP project; (3) the Portland (Oregon) Housing Bureau (PHB) S4H project; and (4) the Albany Corporation for AIDS Research, Education, and Services (CARES) Foundations for Living (FFL) project in upstate New York. The one-day in-person visits at each site included discussions with IHHP grantees, community partners, and RWP grantees and service providers. Interviews were conducted with IHHP grant administrators, local housing program directors, IHHP housing coordinators, RWP-funded medical case managers, local IHHP grant evaluators and data systems managers, and other local housing agencies involved in planning community-level housing. Appendix L contains the study's site visit interview protocols.

The study collected information from the four IHHP grantees about three levels of activity: (1) the integration of program policies and practices at the client level; (2) efforts to integrate housing and health care data systems; and (3) community-level efforts to coordinate and align HIV housing, health care, and other support services. Site profiles were created using information gathered during the discussions and based on review of program documents, including grant applications, site reports, and APR data. The site profiles were systematically coded and analyzed to address the study's research questions. The project also used a mixed-methods approach to integrate the quantitative and qualitative studies and findings. Early findings from the quantitative analysis were used to inform the selection of the four sites for the IHHP case studies and to inform site visit topics and questions. For example, in the site visits, we asked questions about the compatibility of the HOPWA and RWP data sets, based on challenges encountered in the quantitative analysis.

C. Organization of this Report

The rest of this report comprises three chapters. Chapter II presents the findings from the quantitative analysis, providing an overview of the HIV/AIDS epidemic and key features of HOPWA and RWP, including their funding, service utilization, and participant characteristics and outcomes. Chapter III presents the findings from the qualitative study, comparing the integration of housing and HIV care in four IHHP site program models, and focusing on their client services, data systems, and community planning processes. Chapter IV offers ideas for improving the integration of federal housing, HIV care, and other support services for PLWHA.

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II. HIV HOUSING ANALYSIS

A quantitative analysis of federal housing assistance program data was conducted to understand and compare the scope of HIV housing assistance services funded by HOPWA and RWP, including the volume and types of services provided and the characteristics of the people receiving the assistance. The analysis also sought to compare the housing status and health outcomes of people who received housing assistance to those of people who did not. An additional goal was to explore the feasibility of conducting a correlational study of the relationship between individual housing assistance and health and housing outcomes.

The findings are significant in several ways. First, the analysis provides a direct comparison of 2010 program data available from HOPWA and RWP. Second, it provides the first public reporting of RSR housing assistance analyses. Third, it assesses the feasibility of conducting correlational studies of housing assistance and outcomes using HOPWA and RWP data. Last, where possible, findings are reported at both state and national levels to aid federal housing assistance planning and development.

A. Overview of HIV/AIDS Housing Assistance

Although HOPWA and RWP both provide housing assistance and support services to PLWHA, their missions differ. RWP's overall goal is to provide HIV care and related services to people who are without sufficient health care coverage or the financial resources to cope with the disease on their own (U.S. Department of Health and Human Services, HIV/AIDS Bureau [HAB] 2013). Although RWP provides housing assistance as part of its portfolio of support services, current law requires that most RWP funds are used for core medical services, including outpatient ambulatory medical care, prescription HIV medications, and oral health care. In contrast, HOPWA is the only federal program dedicated to addressing the housing needs of PLWHA and their families (HUD 2013). Most, but not all, HOPWA funds are spent on housing assistance. The differences in the programs' services are detailed below.

1. RWP Housing Assistance

RWP funds a range of medical and support services. The program's core medical services encompass outpatient ambulatory health care, oral health care, early intervention services, home health care, home and community-based health services, hospice care, mental health services, medical nutrition therapy, medical case management, outpatient substance abuse services, health insurance premium and cost-sharing assistance, prescription medications, and local pharmaceutical assistance. RWP-funded support services include nonmedical case management, food bank/home delivered meals, health education/risk reduction, transportation services, psychosocial support, child care, pediatric development assessment, emergency financial assistance, housing services, legal services, linguistic services, outreach services, permanency services, rehabilitation services, respite services, residential substance abuse services, and treatment adherence counseling (HAB 2013). Under the Ryan White HIV/AIDS Treatment Extension Act of 2009, RWP Part A, B, and C grantees are required to expend at least 75 percent of their grant on core medical services, including anti-retroviral drugs (Federal Register 2013). The other 25 percent can be used to pay for support services, including housing assistance.

RWP-funded housing assistance provides short-term aid to support emergency, temporary, or transitional housing so that an individual or a family can gain or maintain health care. However, RWP housing funds cannot include direct cash transfers to recipients of services and cannot be used for mortgage payments. In addition, the housing assistance cannot be permanent and must be accompanied by a strategy to transition the individual or family to long-term, stable housing.[2] The program can also fund housing referral services, including housing assessment, search, placement, advocacy services, and associated housing fees. RWP-funded housing may include housing with medical or support services (such as for residential treatment of substance abuse). RWP also funds Emergency Financial Assistance (EFA), which can provide one-time or short-term payments for emergency expenses related to utilities, housing, food, transportation, and medication. EFA was not included in these analyses, because it was not possible to separate out EFA expenditures and services from other types of financial assistance.

2. HOPWA Housing Services

HOPWA also funds both housing and support services. Housing services include the acquisition, rehabilitation, or new construction of housing units; costs for facility operations; rental assistance; and short-term payments to prevent homelessness. HOPWA may also fund health care and mental health services, chemical dependency treatment, nutritional services, case management, assistance with daily living, and other support services. The HOPWA housing service categories used in this analysis include tenant-based rental assistance (TBRA); permanent housing facilities; transitional/short-term housing facilities; and short-term rent, mortgage, and utility (STRMU) assistance. Within HOPWA, the following housing-related services are eligible[3]:

- TBRA: This rental subsidy program helps low-income households gain access to affordable housing. TBRA vouchers are not tied to specific units, so tenants can move to a different unit without losing their assistance.
- Permanent Housing Facilities
  - Operating subsidies pay for facility-based permanent housing expenses, including utilities, maintenance, equipment, insurance, security, furnishings, supplies, and salary for housing project (but not service delivery) staff.
  - The program pays for the cost of leasing permanent housing units (scattered sites or entire buildings) that a nonprofit or public agency leases from a landlord and then subleases to program participants.
  - HOPWA also pays for capital development projects, specifically for the acquisition, conversion, lease, repair, and rehabilitation of permanent housing facilities and the construction of Single Room Occupancy facilities and community residences dedicated to PLWHA.

[2] 2012 Annual Ryan White HIV/AIDS Program Services Report Instruction Manual. Available at [http://hab.hrsa.gov/Manageyourgrant/Files/Rsrmanual.pdf].

[3] HOPWA Program: Consolidated Annual Performance and Evaluation Report. Available at [https://www.onecpd.info/resource/1011/hopwa-caper-form-hud-40110-d].

- Transitional/Short-Term Facilities (Short-Term): This category includes short term supported housing facilities and transitional housing support that may also include provision of supportive services as part of an individualized plan to guide the client's linkage to permanent housing.

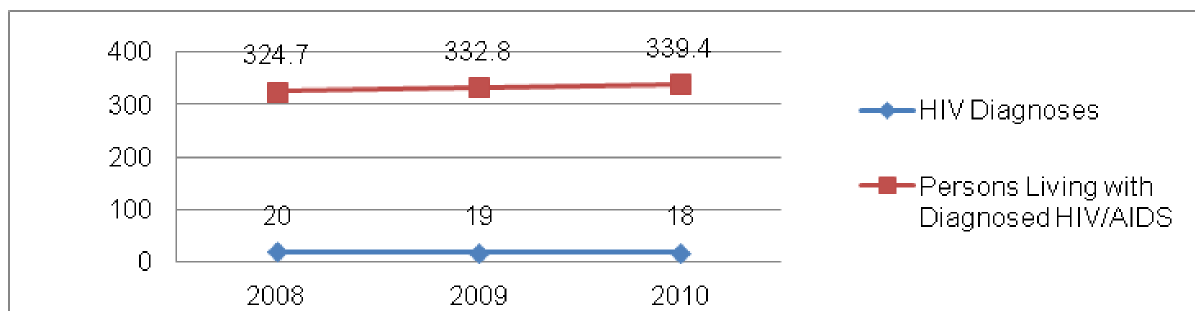
- STRMU Assistance: This time-limited housing subsidy provides short-term payment of rental costs, mortgage payments, or utilities; designed to prevent homelessness and increase housing stability. Assistance can be provided for up to 21 weeks in any 52-week period.

HOPWA also funds Permanent Housing Placement services which are used to establish a household in a housing unit. However, Housing Placement service data were not included in these analyses because it was not possible to de-duplicate the number of households that received housing assistance services from the number of households that received housing placement services.

B. Prevalence and Incidence of HIV/AIDS

As mentioned in Chapter I, the number of PLWHA in the United States has grown steadily, from 188,968 in 1993[4] to more than 1.1 million in 2013, as more people with the disease live longer, while the number of new infections remains steady, at about 50,000 per year (Centers for Disease Control and Prevention [CDC] 1993 & 2013). CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) collects and compiles surveillance data for 55 states and territories (NCHHSTP 2013).[5] This data-set provides a national picture of HIV/AIDS prevalence and incidence.[6] Since 2008, the national incidence of new HIV diagnoses has decreased slightly, but the national prevalence of PLWHA has increased (Figure II.1).

Figure II.1. United States HIV/AIDS Prevalence and Incidence (per 100,000 population)



Source: CDC NCHHSTP Atlas [http://www.cdc.gov/nchhstp/atlas].

The most recent (2010) data from CDC show that the states with the most PLWHA aged 13 and older were New York (132,523), California (111,666), and Florida (94,897) (Appendix B).

[4] HIV/AIDS Surveillance Report from [http://www.cdc.gov/hiv/pdf/statistics_hivsur54.pdf].

[5] NCHHSTP Atlas. Retrieved on March 7, 2013, from [http://www.cdc.gov/nchhstp/atlas/].

[6] Data not available for 2007.

Most PLWHA are concentrated in a few states; two-thirds reside in just 10 states. In 2010, Washington, D.C., had both the highest prevalence of HIV/AIDS and the highest incidence of HIV diagnoses. Other states and territories have a high prevalence of HIV/AIDS (Florida, Maryland, New York) and an incidence of HIV diagnoses substantially above the national average – although well below the incidence of Washington, D.C. (Florida, Louisiana, Maryland, Virgin Islands; Table II.1).

Table II.1. States and Territories with Highest Incidence and Prevalence of HIV/AIDS, 2010

States with Highest Incidence	Rate of HIV Diagnoses	States with Highest Prevalence	Rate of Persons Living with Diagnosed HIV/AIDS
District of Columbia	172.8	District of Columbia	2,704.3
Maryland	38.3	New York	810.0
U.S. Virgin Islands	35.8	U.S. Virgin Islands	667.1
Louisiana	31.3	Maryland	632.9
Florida	30.5	Florida	592.7

Source: CDC NCHHSTP Atlas [http://www.cdc.gov/nchhstp/atlas]. Rates are per 100,000 people.

C. Proportion of HIV/AIDS Population Receiving Housing Assistance

Surveillance reports indicate there were 888,904 PLWHA in the United States in 2010. Of that total, we calculated that almost 1 in 10 (81,100) were receiving HOPWA or RWP housing assistance.[7,8] However, this assumes that no individual received housing services from both HOPWA and RWP in the same year; as a result the total number served is not unduplicated and may be overstated. The proportion of PLWHA receiving HOPWA or RWP housing services varied significantly by state.[9] In Maine, for example, more than 40 percent of PLWHA received federal housing assistance in 2010, but in Arkansas, Kansas, New Jersey, and Virginia, 5 percent or less received housing assistance (see Appendix B).

People who are homeless in the United States have a higher rate of HIV/AIDS than the general population. According to HUD's Annual Homeless Assessment Report (AHAR), on a single night in January 2010, 3.9 percent of the adult sheltered homeless population self-reported living with HIV/AIDS, roughly 10 times the percentage of the adult general population living with HIV/AIDS (about 0.37 percent).[10] In addition to the 81,100 persons receiving housing services funded by HOPWA or RWP in 2010, an estimated 13,940 people with

[7] The number 888,904 does not include American Samoa (2 people) or the Northern Mariana Islands (14).

[8] Comprises 62,297 HIV-positive participants served by HOPWA and 18,803 served by RWP (3,049 of the 18,803 RWP participants had a "missing" or "unknown" HIV status).

[9] State numbers reported are from the RWP Data Report (versus the RWP Services Report), which are not unduplicated across providers.

[10] CDC. "Monitoring Selected National HIV Prevention and Care Objectives by Using HIV Surveillance Data—United States and 6 U.S.-Dependent Areas—2010." HIV Surveillance Supplemental Report 2012; June 2012. Available at [http://www.cdc.gov/hiv/pdf/statistics_2010_HIV_Surveillance_Report_vol_17_no_3.pdf]. Percentage calculated using 2010 Census Data for total U.S. population in 2010 (308,745,538). Annual data for the percentage of PLWHA who are homeless are not available.

HIV/AIDS and their families experiencing homelessness received Permanent Supportive Housing (PSH) services through HUD's Continuum of Care (CoC) grant program (U.S. Department of Housing and Urban Development, 2010 Annual Homeless Assessment Report to Congress.).[11] These Permanent Supportive Housing services are funded through the Shelter Plus Care (S+C) program and the Supportive Housing Program (SHP) under the CoC program. The CoC program is now a single grant program that includes the Supportive Housing program, the Shelter Plus Care program, and the Moderate Rehabilitation/Single Room Occupancy (SRO) program.[12]

Unfortunately, it is impossible to determine exactly how many PLWHA currently need housing assistance. HOPWA grantees provide an annual estimate of unmet housing needs, but they do not use a standard method for making their calculations.[13] In 2010, HOPWA grantees estimated that 191,809 HOPWA-eligible households had some form of unmet housing need at some point during the year.

D. HOPWA and RWP Housing Expenditures

Unlike HOPWA, which focuses primarily on housing, most RWP funds are allocated to core medical services as required by law. In 2010, only 3.2 percent of total RWP Part A and Part B funds were spent on housing assistance. In contrast, two-thirds (67 percent) of HOPWA's 2010 expenditures were allocated to housing (Figure II.2). In total housing program expenditures, in 2010, RWP's Part A grants (to metropolitan areas) and Part B grants (to states) spent a total of $27,541,664 on housing assistance, compared to the $211,114,260 spent on housing services through HOPWA's formula and competitive grants (Appendices C and D). While HOPWA's housing assistance expenditures rose substantially between 2007 and 2010, RWP expenditures for housing services remained relatively constant over the same period (Figure II.3).

RWP housing program allocations vary across states. Eighteen states and territories that received Part A or B grant funding in 2010 spent nothing on housing assistance, while another six spent less than 0.5 percent of their funding on housing services (Appendix C).[14] Only the Part A grantees in Massachusetts and Oregon spent 10 percent or more of their Part A grant on housing assistance. The states with the greatest share of Part B housing expenditures were Hawaii and Nebraska, which spent 19 and 13 percent of their Part B grants, respectively, on housing services. RWP housing policy limits the use of funding to short-term and emergency housing assistance. Due to the statutory limitation on RWP grantees' spending on non-medical support services such as housing assistance, it is difficult to draw conclusions from these spending data about the actual level of need that exists.

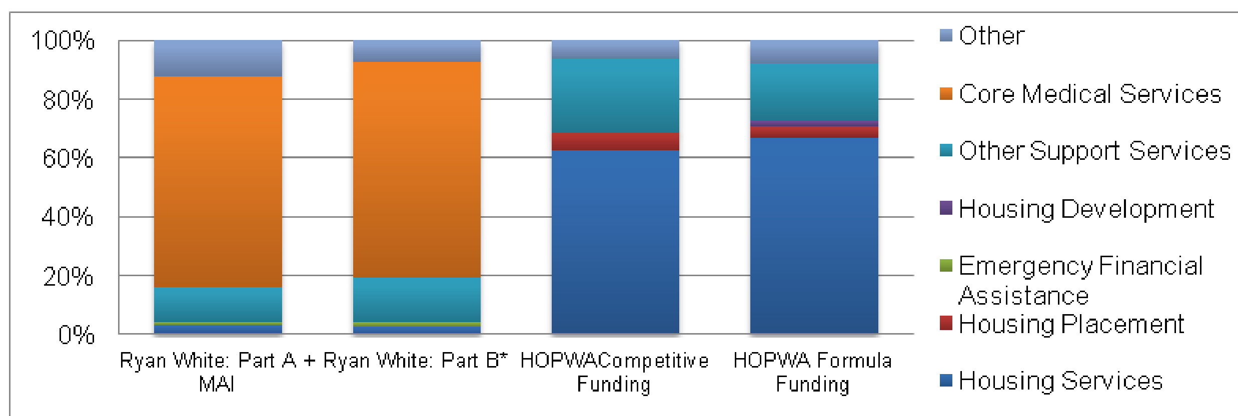
[11] Permanent Supportive Housing funding is provided through the CoC Grant program via Shelter Plus Care (S+C) or the Supportive Housing Program (SHP).

[12] These programs were consolidated under the HEARTH Act of 2009. The HEARTH Act was enacted after the 2010 AHAR was produced.

[13] For HUD Consolidated Annual Performance Evaluation Report reporting methods, see [https://www.onecpd.info/resource/1011/hopwa-caper-form-hud-40110-d].

[14] Percentage expenditures were rounded to the nearest whole number, so this total includes states that spent less than 0.5 percent of their funds on housing.

Figure II.2. Distribution of HOPWA and RWP Expenditures in 2010



Source: HRSA Ryan White Expenditure Reports, Part A and Part B, 2010; HUD HOPWA formula grant Consolidated Annual Performance Evaluation Report (CAPER) and HUD HOPWA competitive grant Annual Performance Report (APR), 2010.

MAI = Minority AIDS Initiative.

* Part B includes only Consortia, State Direct Services, and Emerging Communities Expenditures.

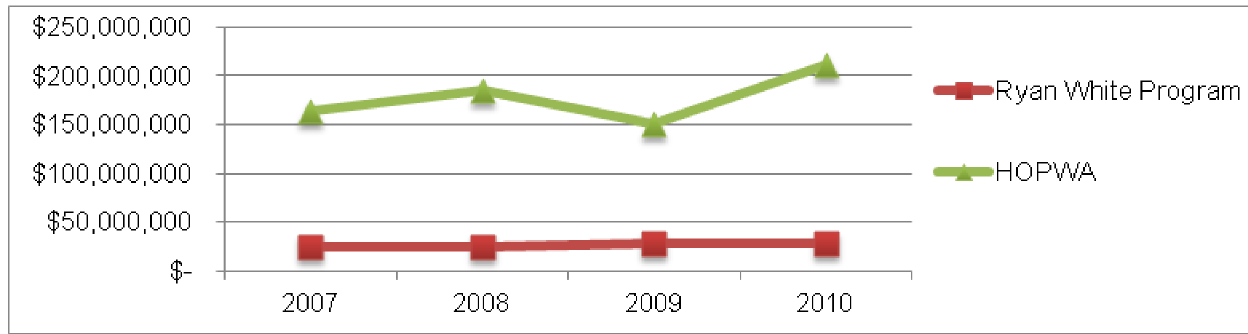
HOPWA formula funds are awarded to eligible cities on behalf of their metropolitan areas and to eligible States. Under current law, to be eligible for awards, states must have more than 1,500 cumulative AIDS cases outside of eligible metropolitan statistical areas.[15] The proportion of total HOPWA funds spent on housing services varied by state. Of the states with entitlement grant expenditures (reported through CAPER), 12 spent three-fourths (75 percent) or more of their reported total expenditures in 2010 on housing services, and 7 that received formula funding spent 44 percent or less of their grant on housing services. Of the states with competitive grant expenditures in 2010 (reported through APR), six spent three-fourths (75 percent) or more of their total expenditures on housing services, and four others spent 44 percent or less (Appendix C). States' combined formula and competitive spending on housing services ranged from 8.6 to 56.2 percent of their total funds.[16]

In 2010, of the two-thirds of HOPWA funds that were spent on housing assistance, more than half (51 percent) were spent on TBRA (Figure II.4). Of the total HOPWA housing funds, one quarter (26 percent) was spent on permanent housing facilities. HOPWA housing assistance resources (including capital, leasing, and operating resources, permanent and transitional project-based assistance, and TBRA assistance) often leverage RWP resources for case management at the project level, allowing HOPWA resources to be focused on providing housing assistance.

[15] Although HOPWA funds are awarded only to states, for the purposes of this report, the funds were aggregated at the state and national levels for comparison purposes.

[16] Guam has 0 percent but received only $78,927 total funds. South Dakota has 0 percent, and North Dakota has 1 percent; however, this is because their data are reported under Montana. Montana has a percentage of 60.68, but that includes North and South Dakota and thus is inflated.

Figure II.3. HOPWA and RWP Housing Assistance Expenditures



Source: HRSA Ryan White Expenditure Reports, 2007–2010; HUD HOPWA CAPER and APR data, 2007–2010.

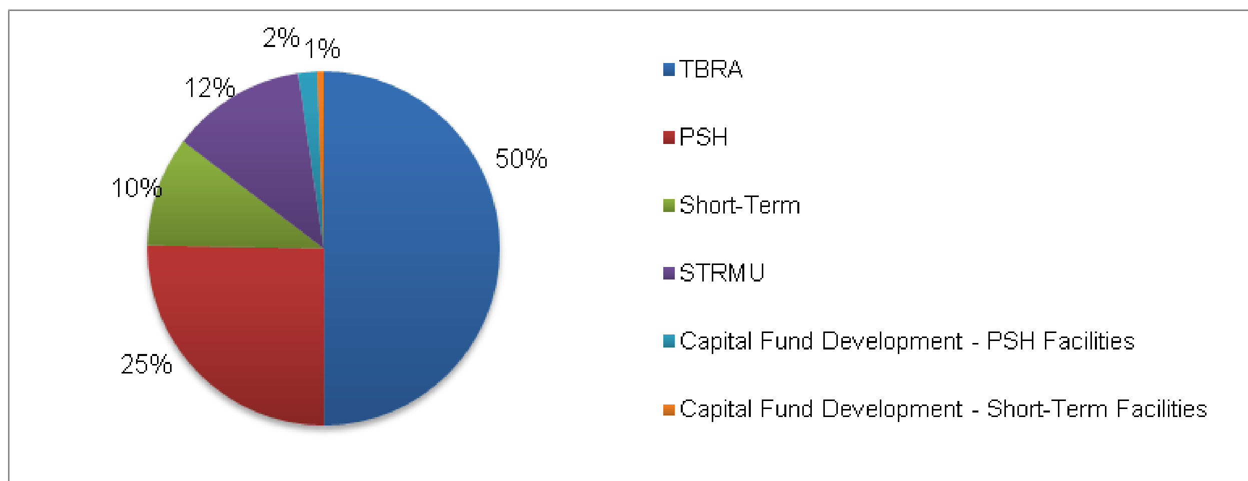
Housing assistance services vary by cost, duration, and intensity; some are more short-term or temporary than others. Among the primary types of HOPWA housing (TBRA, PSH, short-term, and STRMU), the average cost of housing a family in permanent facilities with operating subsidies or leased units is comparatively high. In 2010, in housing facilities with operating subsidies or leased units, average permanent assistance costs per household were more than twice the average cost per household in transitional/short-term housing facilities (in part because the two programs cover different activities). Permanent housing facilities assistance also cost 30 percent more, on average, per household than TBRA. In contrast, STRMU assistance costs were far less per household: three to seven times less than other types of HOPWA housing assistance (Table II.2 and Appendix E).

Table II.2. Average Annual Cost per Household, by Type of HOPWA Housing Service

HOPWA TBRA	HOPWA Permanent Housing Facilities	HOPWA Transitional/ Short-Term Facilities	HOPWA STRMU
$5,584	$7,303	$3,255	$930

Source: HUD HOPWA CAPER and APR data, 2010.

Figure II.4. Percentage of HOPWA Housing Expenditures, by Type



Source: HUD HOPWA CAPER and APR data, 2010.

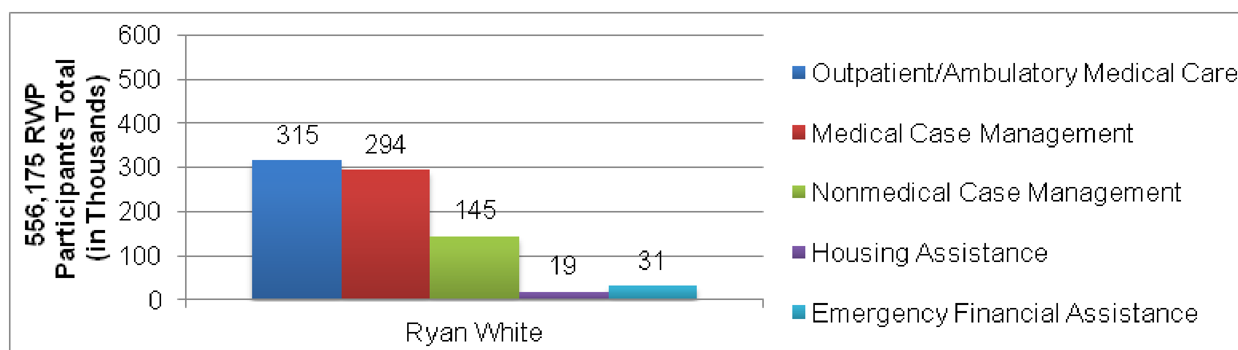
E. Housing Assistance Services

1. Services Provided

RWP is the largest federal program targeting core medical and support services specifically to PLWHA and their families. According to RDR, in 2010, RWP provided services to 556,175 people (including HIV-negative family members), of which 18,904 received housing assistance (Appendix A and Appendix F).[17]

Relatively few (3.4 percent) RWP clients received RWP-funded housing assistance in 2010.[18] This proportion remained fairly steady between 2007 and 2010, with no significant change in the percentage of HIV-positive/indeterminate clients receiving housing assistance.[19] In contrast, 57 percent of all RWP clients received outpatient ambulatory medical care, and 53 percent received medical case management services (Figure II.5). About 6 percent of RWP clients received some type of emergency financial assistance, which in some cases may have been used for short-term housing-related costs such as rent or utilities. Note that some unknown percentage of clients served by RWP also received housing assistance through HOPWA.

Figure II.5. Number of Ryan White Program Clients Served, by Type of Selected Service



Source: HRSA Ryan White Program Services Report, 2010.

In 2010, HOPWA provided housing assistance to 61,268 households.[20] There is no unduplicated count of the total number of HOPWA households who received assistance other than housing. Figure II.6 illustrates that of the 61,268 HOPWA households that received housing assistance in 2010, most (45 percent) received STRMU, the least expensive form of assistance (Table II.2), and 31 percent received TBRA, which makes up the largest percentage of HOPWA housing expenditures (Figure II.6).

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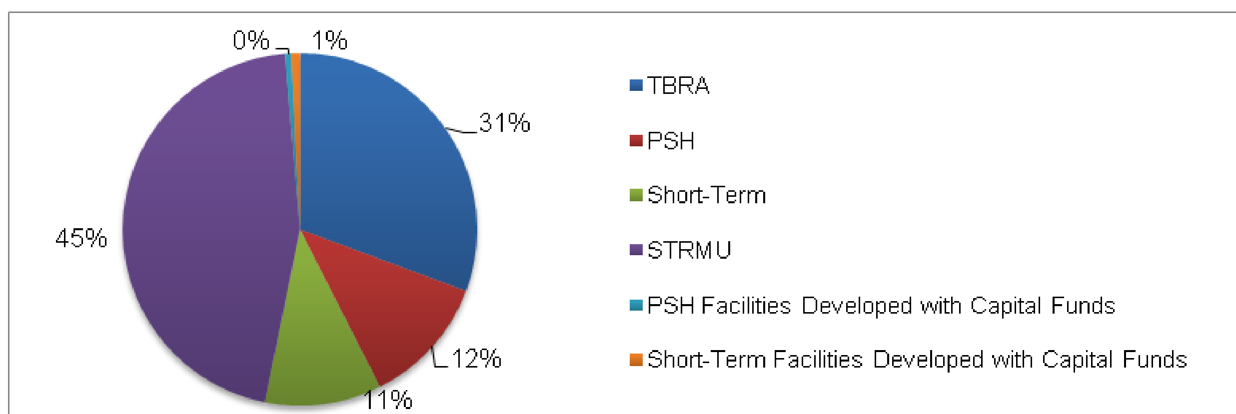
[17] This does not include households receiving Emergency Financial Assistance provided for housing-related costs. Housing services specifically include short-term emergency, temporary, and transitional housing assistance services to help participants access or remain in medical care, and housing referral services, including housing assessment, search, placement, and advocacy services, plus associated housing fees.

[18] No more than 25 percent of Ryan White Funds can be used for support services, which include housing. There is an option for grantees to apply for a waiver of this spending requirement.

[19] Comparison of 2007-2010 data was done using RDR data, which is not unduplicated across programs.

[20] This does not include households receiving housing placement services.

Figure II.6. Distribution of HOPWA Housing Assistance Households, by Type of Assistance



Source: HUD HOPWA CAPER and APR data, 2010.

2. Participant Demographics

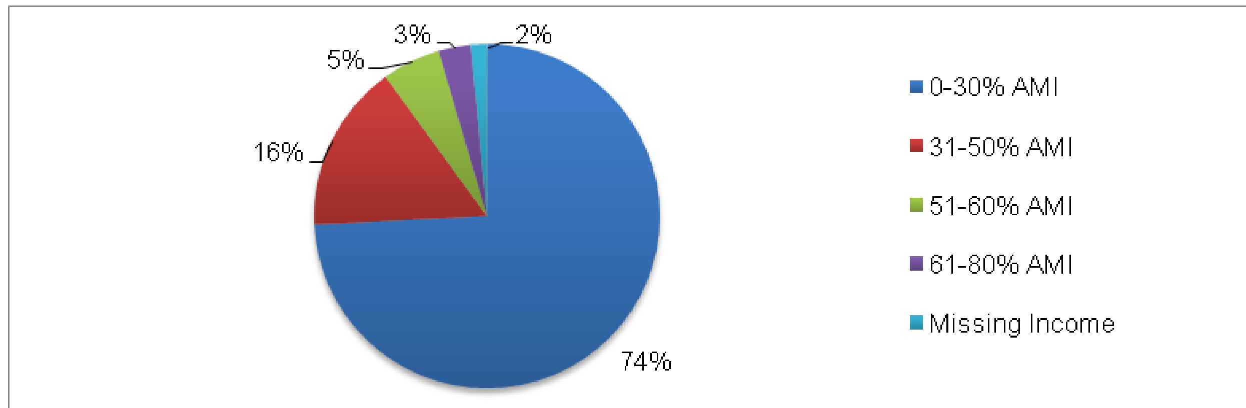
In 2010, HOPWA and RWP clients receiving housing services were similar in gender, race, and ethnicity. Both groups were predominantly male, and half (50 percent) were African American (Appendices G and H). HOPWA participants tended to be younger than RWP clients; 19 percent of HOPWA participants were under age 18, and only 2 percent of RWP clients receiving housing were under age 20 (Appendix G).[21] The demographics of RWP clients receiving housing assistance compared to those not receiving it were similar, with participants who did not receive it being slightly younger (35 percent under age 40 versus 28 percent).

Although income categories reported by the two programs are not the same, it is possible to compare the proportion of RWP clients and HOPWA households in the lowest income categories (Figures II.7 and II.8). Sixty-four percent of RWP clients receiving housing assistance were at or below 100 percent of FPL, compared to 74 percent of the HOPWA households who were below 30 percent of their area's median income (AMI).[22] This was slightly higher than the percentage of RWP clients not receiving housing (55 percent) who were at or below 100 percent of FPL.[23]

[22] The poverty guidelines are established annually by HHS and are used as an eligibility criterion for many federal programs. The poverty level issued by HHS is based on the poverty thresholds used by the Census Bureau and is adjusted annually on the basis of the Consumer Price Index for All Urban Consumers (CPI-U). AMI is calculated by dividing the income distribution in the area into two groups, half having income above that amount, and half having income below it.

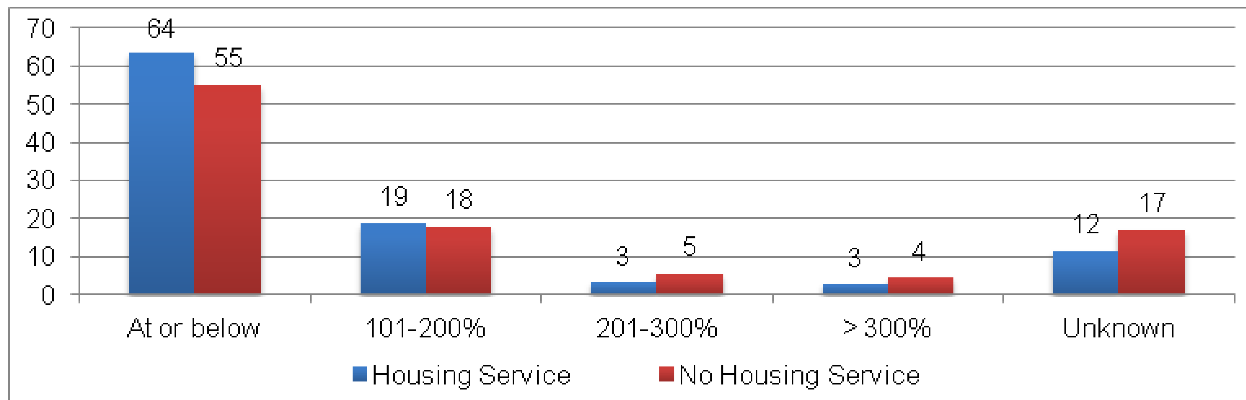
[23] 240,722 participants were at or below 100 percent of FPL, of 437,010 who did not receive a housing service and who reported income based on Ryan White Program Services Report Data, 2010.

Figure II.7. Area Median Income of HOPWA Households



Source: HUD HOPWA CAPER and APR data, 2010.

Figure II.8. Percentage of Federal Poverty Level: RWP Clients



Source: HRSA Ryan White Program Services Report, 2010.

The proportion of HOPWA households and RWP HIV-positive/indeterminate clients served at the lowest income category differed across the states and between the two programs. The percentage of HOPWA households with incomes up to 30 percent of AMI varied from 15 percent (North Carolina) to 99 percent (District of Columbia). Nine states served more than 90 percent of all HOPWA households with incomes up to 30 percent AMI (Appendix I). The percentage of RWP HIV-positive/indeterminate clients at or below 100 percent of FPL ranged from 26 percent (in the Virgin Islands) to 83 percent (in Puerto Rico) (Appendix I).[24]

3. Participant Housing Status

Unfortunately, the analysis was not able to compare the two programs on the housing status of participants, because each program captures this differently. HOPWA reports on the prior

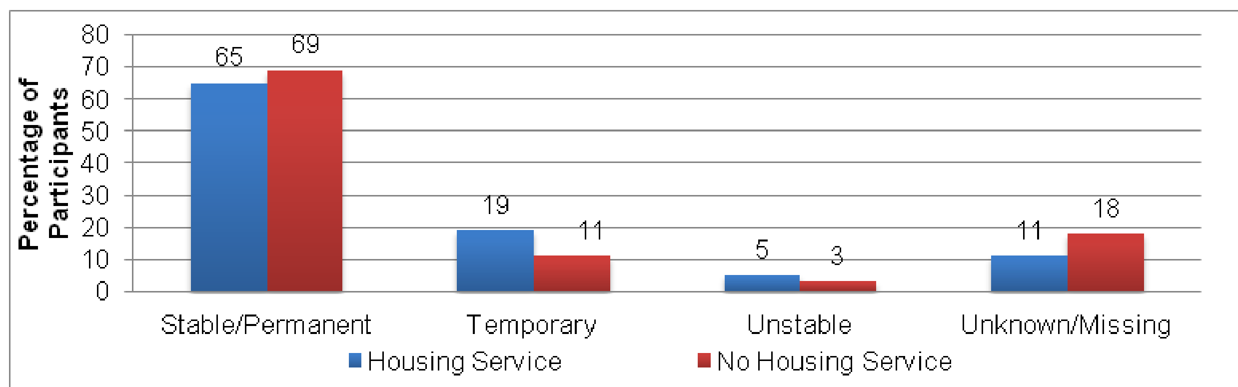
[24] State numbers reported are from the RWP Data Report (versus the RWP Services Report) and are not unduplicated across providers.

living arrangements of HOPWA-eligible housing participants entering the program during the reporting year, and RWP reports on the housing/living arrangements of clients receiving services as of the end of the reporting period. In addition, HOPWA collects information on a wide range of prior living arrangements, whereas RWP classifies living arrangements as "stable/permanent," "temporary, unstable," or "unknown," It is also challenging to make comparisons between the RWP categories of "temporary" and "unstable" and the HOPWA category of "homeless." Therefore, we report housing status separately for the two programs.

Housing Status of RWP Clients: Among RWP clients that did not receive housing assistance, relatively few (about 3 percent) reported their housing as "unstable" at the end of 2010 (Figure II.9).[25,26] This percentage was slightly higher when looking only at RWP clients who received a housing service (5 percent). In addition, 19 percent of clients receiving a housing service reported their housing status as temporary, compared to 11 percent of clients not receiving a housing service. There was a much higher percentage reporting an unknown or missing housing status among clients not receiving a housing service (18 percent).

Examination of RDR data on housing status shows there were no significant changes in this percentage over the four years examined (2007–2010).[27] However, the percentage varied across states and territories (Appendix J). Four states (New Mexico, North Dakota, South Dakota, and West Virginia) served less than 5 percent of RWP HIV-positive/indeterminate clients in nonpermanent housing situations, whereas Guam, New York, Pennsylvania, and Wyoming each served more than 15 percent of HIV positive/indeterminate clients who were in nonpermanent housing.

Figure II.9. Housing Status/Living Arrangements of RWP Clients



Source: HRSA Ryan White Program Services Report, 2010.

[25] "Unstable" includes participants who are homeless, as well as those living in transient or transitional housing. "Homeless" includes shelters, vehicles, the streets, or other places not intended as regular accommodations for living. "Transitional housing" includes any stable but temporary living arrangement, whether or not it is part of a formal program. "Homeless" is defined as having a prior living situation that includes a place not meant for human habitation, an emergency shelter, or transitional housing for people experiencing homelessness.

[26] Housing status was not collected for 7,250 RWP participants; therefore, the percentage is calculated using the 548,925 participants for whom housing status was collected.

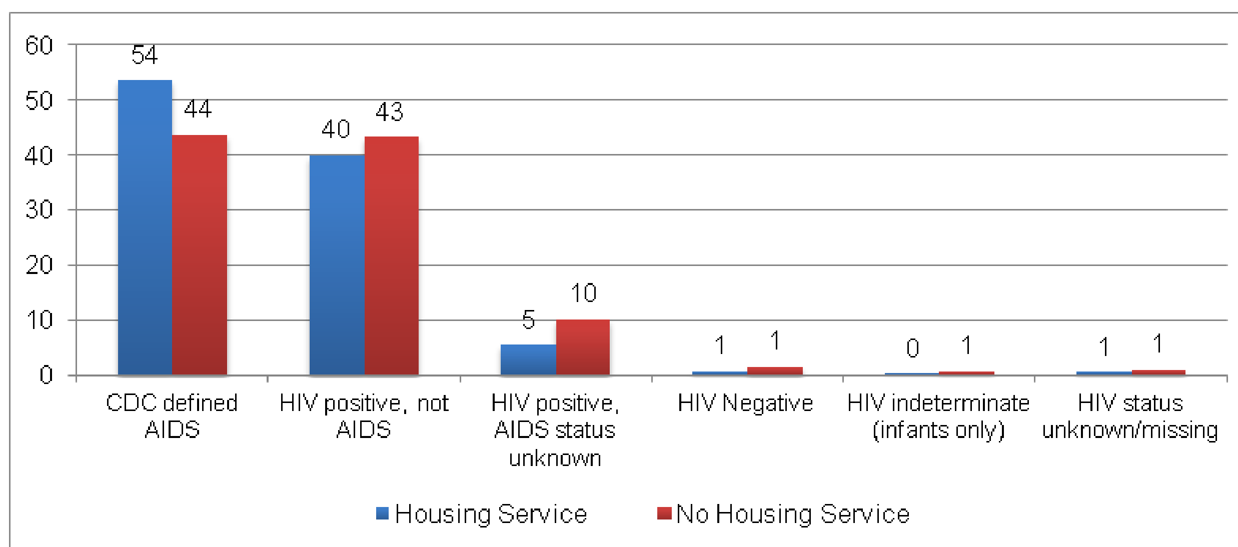
[27] RDR data do not provide an unduplicated across programs.

Housing Status of HOPWA Participants: Thirteen percent of HOPWA HIV-positive participants enrolling in housing services reported their prior living situation as homeless, defined as "a place not meant for human habitation, an emergency shelter, or transitional housing for homeless persons." The most common prior living situation reported was "rented room or apartment of house." Across states, the proportion of homeless status of the participants entering the HOPWA program varied. In five states (Idaho, Maine, New Hampshire, New Mexico, and Wyoming), no participants entered the program from a homeless living situation. In contrast, 44 percent of new participants in Puerto Rico were previously homeless; in two other states (Alabama and California), 20 percent of the new HOPWA participants were previously homeless (Appendix J).

4. Participant Health Characteristics

Unlike HOPWA, which does not report on participants' health characteristics, RWP does report health data. Among RWP clients who received a housing service, about 40 percent were HIV positive but did not have AIDS, and 54 percent had CDC-diagnosed AIDS (Figure II.10). Of the clients receiving housing services, just over 1 percent were HIV-affected participants (including those who were HIV negative or whose status was unknown). In comparison, there was a slightly lower percentage of participants with CDC-diagnosed AIDS among RWP clients not receiving housing services (44 percent) and a slightly higher percentage with HIV, AIDS status unknown (10 percent).

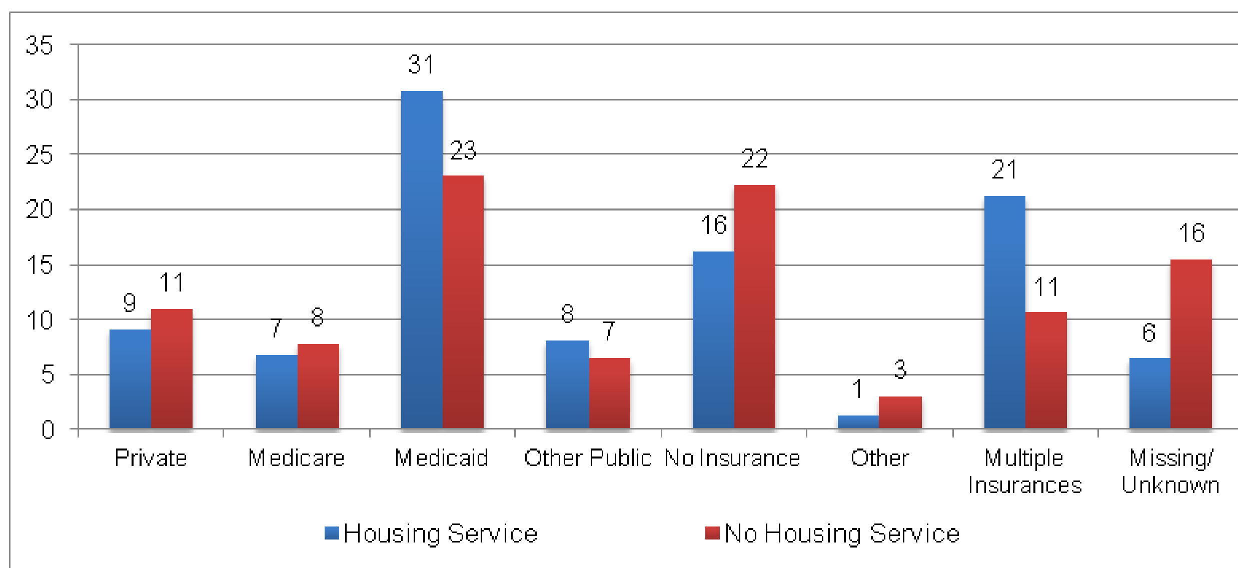
Figure II.10. HIV Status of RWP Clients



Source: HRSA Ryan White Program Services Report, 2010.

Sixteen percent of RWP clients receiving housing services reported having no insurance, and 46 percent reported having public insurance (Medicare, Medicaid, or other insurance) (Figure II.11). A higher percentage of RWP clients not receiving housing services did not have any insurance (22 percent), and a lower percentage reported having public insurance (38 percent).

Figure II.11. Insurance Status of RWP Clients



Source: HRSA Ryan White Program Services Report, 2010.

F. Housing Outcomes

Unlike RWP, which does not report the housing outcomes of program clients, HOPWA grantees do report on a number of outcomes. In 2010, reported outcomes included the household's housing status at program exit and their access to care (defined as their connection to medical care and other types of support). At program exit, more than four-fifths (80 percent) of HOPWA households were successfully connected to housing, case management, primary care, medical insurance, or income sources (Table II.3).

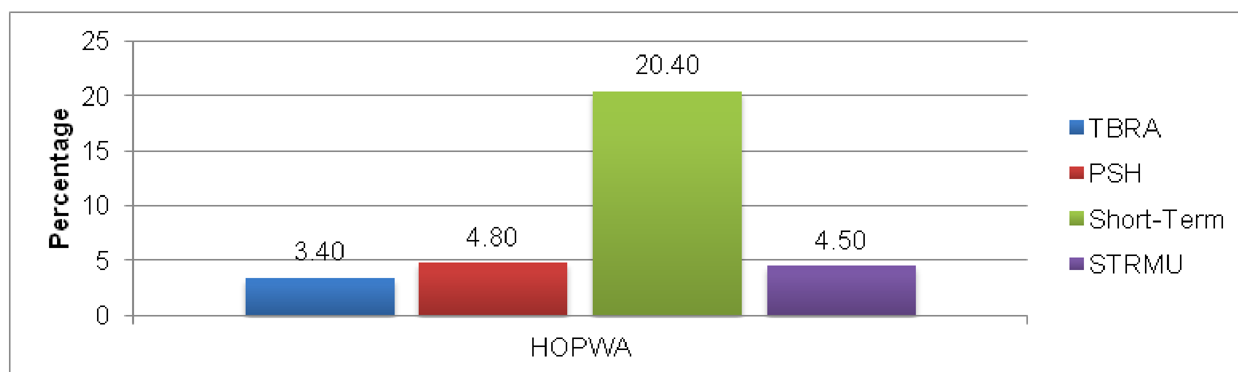
Table II.3. Percentage of HOPWA Households Receiving Housing Assistance Who Achieved Outcomes

Outcome	Percentage of Total Participants
Has a housing plan for maintaining or establishing ongoing housing	93
Has contact with a case manager as specified in individual service plan	91
Had contact with a primary health care provider	87
Has access and can maintain medical insurance/assistance	86
Successfully accessed or maintained income	83

Source: HUD HOPWA CAPER and APR, 2010.

In 2010, only 6 percent of all HOPWA households receiving housing assistance exited to an unstable situation, defined as an "emergency shelter, jail, prison, disconnected, or unknown." This proportion of unstable housing exits remained steady between 2007 and 2010). Three of the four types of housing assistance services have had relatively low rates of unstable housing exit (less than 5 percent); however, four times the percentage (20 percent) of the households residing in transitional/short-term facilities exited to unstable housing (1,415 households) (Figure II.12.)

Figure II.12. Exits to Unstable Housing, by Type of Housing Assistance



Source: HOPWA CAPER and APR, 2010.

The percentage of HOPWA households exiting to unstable housing varied widely across states, with one state (New Mexico) having no such exits in 2010 (Appendix K). Only four (California, Florida, Idaho, and South Carolina) had a percentage higher than 10 percent, with the highest (South Carolina) being 20 percent. Across states, HOPWA households also varied in their connection to primary care at exit, with a range of 13 to 100 percent (Appendix K). In eight states, 100 percent of HOPWA households reported having had contact with a primary care physician at program exit.[28]

1. Feasibility of Correlational Study

One of the original questions of the quantitative analysis was whether or not the available HOPWA and RWP data could support an analysis of the association between housing assistance, enhanced housing status, increased access and retention in HIV care, and improved clinical outcomes. Although RWP began collecting individual level data in 2010, before then, data were collected and reported at an aggregate level. All HOPWA data in this report are reported in aggregate. The lack of client-level data makes it difficult to examine any correlations between housing assistance and outcomes such as housing status, access to care or improved clinical outcomes. Although HOPWA does currently require grantees to report on participant outcomes, these outcomes are limited to housing status at exit from the program and are reported in aggregate across all participants. The lack of follow-up data for either program also makes it difficult to come to any conclusions about the intermediate and long-term impacts of HIV housing assistance.

G. Housing Data Analysis Summary

Based on the analysis of the national program data and CDC surveillance data, as many as 10 percent of the identified PLWHA in the United States and its territories are receiving some sort of housing assistance through RWP and/or HOPWA. Although there is no systematic way of

[28] Two states (New Jersey and Wyoming) had more than 100 percent because they reported more people receiving an outcome than total people.

assessing the extent of housing need among everyone with HIV/AIDS, it is clear from HUD's CoC data that housing is a definite need for a subset of the HIV/AIDS population. The 2012 national homeless point-in-time count found that 3.9 percent of the adults experiencing homelessness reported that they were living with HIV/AIDS. This is a much higher percentage than in the general population (less than 1 percent).

Because HOPWA and RWP serve different but complementary purposes, the proportions of funding they targeted toward housing assistance were very different. Whereas two-thirds (67 percent) of HOPWA's funding was used for housing assistance, and 61,268 participants received housing assistance in 2010, 3.2 percent of RWP funding was used for housing assistance, and 18,904 participants received RWP-funded housing assistance that year. RWP's primary focus is to provide HIV treatment and care, and grantees can spend only a portion of funds on support services (of which housing services is one type), whereas HOPWA's focus is on providing housing assistance and related support services. Another key difference is that RWP assistance is targeted toward emergency and short-term housing, whereas HOPWA provides help with a range of short-term, long-term, and permanent housing.

In general, the characteristics of participants served were similar across the two programs. HOPWA participants (which include family members) tended to be younger, because HOPWA serves more families with children than RWP. Within both programs, the majority of participants served were within the lowest poverty category (at or below FPL for RWP and up to 30 percent of AMI for HOPWA). Because the two programs collect housing status at different points of enrollment (HOPWA collects it prior to program entry; RWP collects it as of last day of reporting period), it is impossible to compare housing status prior to program entry across the two programs. HOPWA reported that 13 percent of participants were homeless at program entry.

Although housing status was based on the end of the reporting period and not program exit, among RWP clients receiving housing assistance, about one quarter (24 percent) were temporarily or unstably housed, compared to 14 percent of RWP clients not receiving RWP-funded housing assistance. Note that RWP housing assistance is intended to be a short-term aid, not a long-term solution. However, the fact that 5 percent of the RWP clients receiving housing assistance were still unstably housed at the end of the reporting period emphasizes the importance of connecting RWP clients to long-term or permanent housing assistance through HOPWA, CoC, or other mainstream public housing programs.

HOPWA also collects client information about housing status at exit and reports it separately for different types of assistance. The percentage of participants exiting to homelessness was below 5 percent for all types of assistance except for short-term transitional facilities, which saw 20 percent exit to homelessness. This indicates that participants served with STRMU were much less likely to exit to homelessness compared to the short-term facilities.

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III. ANALYSIS OF INTEGRATED HIV HOUSING AND CARE SERVICES

In response to the NHAS request for greater access to HIV care, in 2011 the HUD Office of HIV/AIDS Housing awarded seven competitive Integrated HIV/AIDS Housing Plan (IHHP) grants designed to combine housing assistance with a community planning component.[29] This chapter documents key features of the IHHP programs: their site characteristics, their program models, and details of their integration of HIV housing, health care, and other services.

While many HOWPA programs work closely with RWP providers to link housing with HIV care, these IHHP grants are unique in their integration of housing and HIV care at three levels: individual services, organizational data systems, and community-level planning processes. By documenting the program models, implementation processes, and integration challenges of these IHHP sites, we hope that lessons learned from this analysis can inform policy and program-planning discussions about how best to integrate these programs.

A. Overview of IHHP Grantees

The 2011 IHHP grants were intended to "combine housing support with a community planning component . . . to make community-wide system changes in service delivery for low-income HIV-positive individuals." A diverse group of organizations received the grants. Located across the country, they target different populations and use different program models (Table III.1).

Mathematica and Cloudburst worked with ASPE and HUD staff to select four of the seven grantees as study sites: (1) the RRHS FUSE project in Jacksonville, Florida; (2) the FPC statewide Maine IHHP project; (3) the PHB S4H project; and (4) the Albany CARES FFL project in upstate New York (see Table III.1). Although all seven IHHP sites were identified as implementing best practices, this study could examine only four of the sites, a result of study constraints. Consequently, we selected sites that represented diversity in grantees' (1) site characteristics and geographic scope, (2) project implementation status, (3) target populations, and (4) models of integration.[30] Of particular interest were the statewide scope of the Maine IHHP project, the FUSE project's targeting of African American families; and the program models of Portland's S4H and CARES FFL projects linking housing assistance, HIV care, and employment services.

The four selected sites have extensive experience providing HIV housing assistance and support services in collaboration with local partners. They have also been involved in community-level planning of homeless services through their participation and leadership of CoC planning processes and their participation in RWP planning councils, task forces, and provider networks. Through the IHHP grants, the sites are exploring new forms of system integration at multiple levels. We provide a brief overview of each grantee and IHHP project below:

[29] 2011 Integrated HIV/AIDS Housing Plan Special Projects of National Significance Program Grantees. Accessed August 11, 2013, at [https://www.onecpd.info/hopwa/2011-ihhp-spns-program-grantees].

[30] For example, the Los Angeles site was excluded because it implemented later than the other sites, and the Dallas site was excluded because its housing and health care data systems were not integrated.

Table III.1. IHHP Grantee Characteristics

Grantee Location	Program	Target Populations	IHHP Funding	Site Start Date	May 2013 Enrollment Status
City of Los Angeles, CA	CHISS	Homeless, at-risk of homelessness, and newly diagnosed or out of care	$1,375,000	July 1, 2012	Still enrolling 20/25 enrolled
River Region Human Services: Jacksonville, FL	FUSE	Homeless. Female heads of household with children less than 18 years old	$1,353,743	November 1, 2011	Full; 40 families and individuals enrolled
Frannie Peabody Health Center; Portland, ME	Maine IHHP	People with HIV/AIDS potentially eligible for public housing	$930,909	January 1, 2012	90 enrolled
Justice Resource Institute; Boston, MA	Youth Housing Initiative	Homeless youth, court-involved persons, other vulnerable groups	$1,223,388	January 1, 2012	Full; 20 enrolled
Portland Housing Bureau; Portland, OR	S4H	Homeless or at risk of homelessness	$1,365,900	January 1, 2012	Full; 60 enrolled
Albany CARES; Albany, NY	FFL	People with HIV/AIDS interested in employment	$1,344,375	January 1, 2012	20+ enrolled
City of Dallas, TX	Ex-offender and IHHP	Ex-offenders	$1,287,500	January 1, 2012	Full; 60 enrolled

Source: Discussions with program staff and program data, Mathematica Policy Research, 2013.

CHISS = Collaborative for Housing Integrated with Supportive Services; FFL = Foundations for Living; FUSE = Forging Useful Systems to Empower Project; S4H = Springboard to Stability, Self-Sufficiency and Health Program.

1. River Region Human Services: Forging Useful Systems to Empower Project

Established in 1979 as a nonprofit behavioral health organization with mental health counseling, RRHS's mission is to "improve the quality of life for individuals and families in northeast Florida affected by substance abuse, mental illness, homelessness, HIV/AIDS, and other communicable diseases through outreach, prevention, treatment, and housing services." The agency's HIV services include outreach and linkage, HIV testing and referral, case management, and housing assistance. Notably, RRHS was part of a core group that created a national model for peer-based HIV outreach services, and is the northeast Florida trainer of peer specialists. RRHS received $1,353,743 to implement the FUSE project, which is designed to provide tenant-based rental assistance and coordinated linkages to support services for households headed by PLWHA experiencing homelessness (primarily African American women and their children) in the Jacksonville, Florida, area. The project promotes stable housing, health outcomes, and client achievements toward self-sufficiency.

2. Frannie Peabody Center: Maine Integrated HIV/AIDS Housing Plan Project

FPC, a community-based organization headquartered in Portland, Maine, was formed in 2002 by the merger of two HIV/AIDS service providers. Currently the largest AIDS service organization in the state, FPC provides both prevention services for those at risk of HIV and direct services to HIV-positive individuals and their families. FPC's four HOPWA grants fund permanent supportive housing services for PLWHA statewide. Though service provision varies somewhat by program, these HIV housing services offer a combination of supports through local community resources, including access to case management, volunteer assistance, life skills education and training, and medical care. FPC was awarded $930,909 for their Maine Integrated HIV/AIDS Housing Plan. The project coordinates with four local housing authorities across the state to integrate HOPWA clients into mainstream HUD housing. The project hopes to promote stable housing and improved health outcomes by providing people with the support and services they need to facilitate their transition to HUD Housing Choice Vouchers. FPC is the only IHHP grantee with a statewide client base.

3. Portland Housing Bureau: Springboard to Stability, Self-Sufficiency and Health Program

A department in Portland, Oregon's municipal government, PHB manages a number of affordable housing development and assistance resources, including CoC funds, an Emergency Solutions grant, the city's HOPWA formula grant, a Community Development Block Grant, HOME, and other state and local housing-related resources. To better serve its low-income residents and those experiencing homelessness, PBH and the Housing Authority of Portland (known as Home Forward) combined several emergency and short-term housing assistance programs into one pooled fund to provide a continuum of eviction prevention, rapid re-housing, and housing retention services for PLWHA and others who are homeless or at risk of homelessness. PHB was awarded $1,365,900 for its S4H Project. The S4H project builds upon a successful collaboration with Worksystems, a Portland-based nonprofit organization that designs and coordinates workforce development programs. In addition to providing housing assistance and linkages to health care and other supports, the S4H project will expand and adapt the Worksystems model for PLWHA. The project also builds on other long-standing, collaborative relationships between public housing, HOPWA, Ryan White Program Part A and B grantees, workforce providers, and state and local planning groups.

4. Albany CARES: Foundations for Living Project

Founded in the early 1990s, CARES began as an AIDS service organization, providing HOPWA rental assistance and Shelter-Plus Care housing services in the Albany area. Since then, the agency's housing work has expanded to include community-level planning and administration of HUD's CoC (homeless) services. CARES currently serves as the collaborative applicant for six CoCs in the Capital Region, coordinating their joint funding applications; acts as the HMIS administrator for CoC programs in 21 counties; and provides technical assistance to the City of Rochester's HOPWA formula grant. CARES was awarded $1,344,375 to implement the FFL project, which provides permanent housing, linkages to medical care, employment services, and other supports, and supports comprehensive planning and coordination of HIV housing and CoC services in Albany and Rochester. CARES partners with project sponsors in both communities to provide local housing assistance and service coordination: the Albany Damien Center (ADC) and Catholic Charities Community Services (CCCS) in Rochester.

5. Factors Affecting Program Enrollment

Not all four sites chosen for in-depth study have currently met their enrollment targets (Table III.1). PHB's S4H project was fully enrolled early on, aided by the Cascade AIDS Project's (CAP) preexisting waiting list for other housing resources. In contrast, the other IHHP sites identified some challenges reaching and enrolling their clients. Although FUSE is fully enrolled, not all participants come from the program's target population of women and their families. To fill the gap, RRHS has enrolled some people from other target groups. CARES reported several issues that have slowed program implementation and recruitment, including setup and administrative burden. After sensing some reluctance among local service providers and case managers to refer clients to employment services, staff conducted two days of employment orientation to shift their thinking about the value of employment for PLWHA.

Despite having enrolled 90 clients, FPC encountered a number of enrollment barriers, including finding clients that qualify for mainstream housing assistance through FPC's four public housing authority partners; finding clients willing to leave their existing housing to move into public housing in another community; and ensuring that they are not initiating leases for IHHP clients that will not be able to sustain independent living when the IHHP grant ends. FPC staff felt that there have also been missed enrollment opportunities in other parts of the state, as not all AIDS service organizations are using the FPC screening/eligibility tool effectively, and statewide uptake of the tool has been slow. FPC also described difficulties serving the state's refugee population with HIV/AIDS, as Maine will not provide Medicaid to immigrants who have lived in the United States for less than five years. Finally, the limited availability of rental housing across the state has made it harder for FPC to move eligible clients into the IHHP program.

B. IHHP Housing Assistance and Care Coordination Models

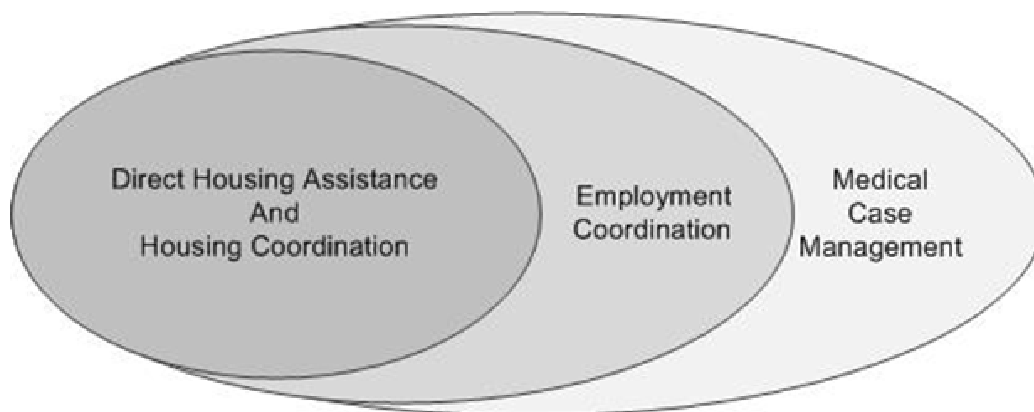
The 2011 Notice of Funding Availability for the HOPWA IHHP grants announced that funds were available for projects that addressed "(1) direct housing assistance and service delivery to low-income PLWHA and their families, including homeless individuals and families; and (2) comprehensive planning and coordination of local resources in meeting the housing and service needs of the population." It specified that the grants would support the NHAS goals of reducing HIV infection, increasing access to care, and improving the health outcomes of PLWHA through "improved cross-agency planning [and] resource utilization and service integration among mainstream housing and HIV-related agencies and providers." Finally, the notice stipulated that "grant applicants must commit to increasing coordination among local partners in providing housing as a base for access to services that target the needs of PLWHA and their families."[31]

The four IHHP sites we studied are fulfilling these requirements, working with a range of community partners to provide direct housing assistance funded by HOPWA, with service

[31] Department of Housing and Urban Development [Docket No. FR -5500-N-13 Notice of Funding Availability for HUD's Fiscal Year 2011 Housing Opportunities for Persons With AIDS. Accessed August 11, 2013, at [http://archives.hud.gov/funding/2011/hopwanofa.pdf].

coordination funded by their IHHP grants in collaboration with HIV medical case management funded by the RWP. In addition, they have developed and are starting to implement community-level integrated HIV housing planning efforts. Among the four IHHP sites, there is a gradient of service coordination in three areas: (1) direct housing assistance and housing service coordination, (2) coordination with employment services, and (3) linkage to HIV care through medical case management (See Figure III.1). In Figure III.1, the darkest oval represents the highest level of service coordination and collaboration. First, all four sites provide housing assistance (rental payments or housing units) directly to their clients. All four sites also fund "housing coordinator" positions, though two contract out that function. Second, of the four sites, only two fund "employment coordinator" positions, both contracted out. Third, the position of "medical case manager" is funded by none of the sites directly, but all four sites work closely and collaboratively with medical case managers funded by RWP to access medical case management for housing program participants.

Figure III.1. IHHP Service Components



FPC is the only grantee providing direct housing assistance. The other three grantees (RRHS, CARES, and PHB) are contracting with project sponsors to carry out housing assistance activities. All four include housing coordination services in the programs: identifying, recruiting, and enrolling program participants; assessing clients' service needs; and linking clients to support services. Of the four sites, two (RRHS and FPC) used their IHHP funding to hire internal staff to provide housing coordinator, case manager, and/or peer support functions. The other two (PHB and CARES) funded community partners to provide those services (See Table III.2).

The sites also differed in their approach to employment services. Two sites (PHB and CARES) are using their IHHP funds to build employment services into their program models. CARES used an evidenced-based "considering work" model; the CARES FFL project is working to create "a seamless collaborative team approach to service planning that includes service integration and coordination with health care and other support services (such as mental health and substance abuse treatment), with vocational rehabilitation, workforce development, and employment programs." PHB is expanding the Worksystems model of employment and vocational rehabilitation services for PLWHA. In contrast, the other two sites (RRHS and FPC) are using their housing coordinators to assess the education, employment, and training needs of clients and refer them to appropriate services, but are not funding employment services directly through IHHP funds.

Table III.2. IHHP Program Models

.	RRHS FUSE	FPC Maine IHHP	PBH S4H	CARES FFL
Program Goal(s)	FUSE goals: to increase access to affordable housing for families headed by homeless PLWHA; to coordinate housing, HIV care, and other services; to integrate housing and HIV data; and to coordinate community planning to leverage public housing for PLWHA	FPC goal: to increase statewide access to public housing for PLWHA, with linkages to HIV care maintained by local HIV medical case management services	PHB goal: to improve health outcomes for PLWHA by leveraging collaboration among HIV housing and service providers in Portland and surrounding counties, and by adapting the Home Forward model to offer workforce development services to PLWHA	FFL goals: to offer housing assistance and services to low-income PLWHA interested in employment; to link housing, HIV, and employment systems; and to improve comprehensive planning and coordination of local services to meet the needs of PLWHA
Primary Partners	Ability Housing (AH); and Health Planning Council of NE Florida	Maine State Housing; Bangor, Portland and Sanford Housing Authorities; Maine's RWP Part B Grantee	Cascade AIDS Project (CAP); The Multnomah County Health Department (MCHD) Part A Grantee and Worksystems, Inc.	Albany Damien Center (ADC); Catholic Charities Community Services of Rochester (CCCS)
Staffing	The FUSE project funds three full-time staff: a program manager, a services coordinator, and a peer specialist, with part-time support from an evaluator and a database integration specialist	FPC funds an FT IHHP housing specialist and a portion of the program evaluator position, with in-kind assistance from FPC's occupancy specialist and housing coordinator	PHB funds an FT housing case manager and FT employment specialist at CAP; a PT position at Worksystems; a PT BHP consultant working with the S4H evaluation and data collection; and some BHP project management time	The FFL program funds a program coordinator, FT employment coordinators at ADC and CCCS, a PT CCCS program developer; and in-kind rent assistance, HMIS, and evaluation services (CARES)
Program Model	RRHS leases units in two AH apartment complexes. FUSE service coordinator and peer specialist work on site to enroll families in FFL, assess their needs, provide peer support and transportation to, and coordinate with RW-funded medical case managers on HIV care issues	FPC offers TBRA, STRMU, and related support services to HOPWA-eligible clients, while working with local housing authorities to move them into mainstream public housing. Local providers or AIDS service organizations provide medical case management, linking PLWHA to medical care	PHB coordinates the data collection, evaluation, and funds services provided by key partners: rental and homelessness prevention assistance (CAP); housing and employment case management (CAP); and linkage to employment (Worksystems), and coordinates with HIV-related care (MCHD)	Region-wide, CARES facilitates CoC planning; administers the HMIS, and provides HOPWA-funded rental assistance; ADC and CCCS staff provide direct housing services, outreach, intake, housing and employment counseling, and HIV care coordination

The fourth IHHP component is medical case management. All four sites also include linkages to HIV care in their program models, and their housing coordinators are working closely and collaboratively with medical case managers who are employed in local HIV clinics, supported by RWP funds. The details of these health care linkages are described in more detail in the next section.

1. HRSA Special Projects of National Significance

Two of the sites (RRHS and PHB) are also participating in a HRSA Special Project of National Significance (SPNS) that addresses the coordination of housing and HIV care. However, in those programs, the sites are working with client populations that are more medically needy than the IHHP clients and less likely to become employed and mainstreamed into public housing. In Florida, RRHS and its partner, Ability Housing, are working with the University of Florida CARES medical clinic, which is developing a medical home for people who are HIV positive or at high risk of HIV and who are homeless or in an unstable housing situation. UF CARES medical case managers refer their clients to RRHS for housing assistance, but do not fund housing services. An RRHS evaluator is assessing the interplay between the IHHP and HRSA SPNS projects in that site.

In Oregon, PHB's partner, the Multnomah County Health Department (MCHD) also manages a HRSA SPNS site. That program uses a medical home model to provide linkages to care for PLWHA who are experiencing homelessness and are multiply-diagnosed with substance use disorders and/or mental illness. MCHD contracts with CAP, which has three network navigators who are part of the medical team at clinic and spend time at CAP. The navigators accompany participants to medical appointments and address any barriers to housing. The project does not focus on employment; its goals include getting participants into permanent housing, into appropriate mental health and substance abuse treatment, and into routine (non-emergency, non-acute) medical care.

2. Factors Affecting Implementation of IHHP Models

Recent funding restrictions at the federal, state, and local levels are limiting the ability of grantees to realize their IHHP program goals. All four sites noted the challenges of these budget uncertainties. In May 2013, HUD announced that several of its programs, including its CoC programs, would be cut by 5 percent overall as a result of federal sequestration. The IHHP sites reports that these cuts are beginning to "trickle down" to state and local housing authorities and other programs. In Maine, for example, one of FPC's public housing partners, the Sanford Housing Authority, has already begun to reduce its housing vouchers through attrition, although this has not yet affected the Maine IHHP grant. In Oregon, PHB and its partners (CAP, Workforce Systems, and RWP Part B) are all planning budget reductions next year for between 5 and 8 percent of their total budgets.

Other concerns voiced by the IHHP sites include the lack of affordable mainstream housing available for their clients (FPC and CARES); uncertainty about the potential impact of the Affordable Care Act (health reform) on RWP-funded services, including medical case management (RRHS, PHB, and PHB); and the need for a paradigm shift among HIV providers away from simply securing benefits for their clients to helping them move into mainstream housing and employment (all four sites).

C. Integration of Individual Housing and Health Care Services

The IHHP notice stipulates that grantees should demonstrate "a concerted effort . . . to integrate and coordinate cross-cutting resources in providing a comprehensive approach to HIV/AIDS housing and support services." The IHHP sites we visited created program models involving significant service coordination among housing, health care, and other support service

coordinators. Key program components facilitated service integration: (1) in-depth screening of clients' housing, health care, and other support service needs at intake; (2) development of individualized care plans tailored to the needs and circumstances of participants; and (3) frequent in-person contact between housing coordinators and peer specialists, clients, and medical providers (Table III.3).

Table III.3. Service Provision and Linkage to Care

.	River Region Human Services	Frannie Peabody Health Center	Portland Housing Bureau	Albany CARES
Direct Housing Services	RRHS provides tenant-based rental assistance to FUSE clients and others	FPC provides tenant rental assistance and linkages to housing vouchers and public housing statewide	PHB provides short-term rental assistance: helping with eviction prevention, rapid re-housing, and housing retention	CARES provides tenant-based rental assistance and helps with clients' transition to housing self-sufficiency
Service Coordination	FUSE service coordinator and peer specialist offer coordinated linkages and transportation to medical care and support services	FPC works with AIDS service organization (ASO) partners across the state to coordinate local case management with IHHP housing assistance	System-wide, PHB and local partners use common assessment form and "acuity scale" to rate and assess client need for housing, employment, and HIV medical care	Local partner sites (Albany and Rochester) offer both housing and employment service coordination, and closely collaborate with local medical providers
Health Care Linkage	Site uses a single health impact assessment tool to link to care. The FUSE service coordinator is a former RWP-funded medical case manager who works closely with the local medical case manager network	Local ASO partners coordinate referrals and engage with local health care providers. Integration of HIV housing and medical care is coordinated statewide by FPC staff	PBH coordinates all services, but linkages to medical care are made directly by partner organizations. Program has strong system connections to HIV care	New York state is moving to a Medicaid health home model for PLWHA. CARES' local partner organizations are providing linkages to medical providers and medical homes

Source: Discussions with program staff and document review conducted by Mathematica Policy Research, 2013.

CoC = Continuum of Care; HOPWA = Housing Opportunities for Persons With AIDS; IHHP = Integrated HIV/AIDS Housing Plan; RWP = Ryan White HIV/AIDS Program.

Each program also uses an interdisciplinary team made up of internal staff and external partners with the technical knowledge, collaborative skills, and program experience to meet the multiple needs of the client population. All sites leverage existing staff resources, but they have used their IHHP grants to incorporate housing coordinator positions into their programs; such positions are deemed critical to the integration of care and housing services, which is achieved through the activities described below. Sites described using multidisciplinary teams and suggested frequent communication among core staff to help clients make and keep service

appointments, address problems with rental payments and compliance with rental requirements, motivate clients to make and work toward long-term self-sufficiency goals, and handle crises that could disrupt clients' housing stability and access to health care.

In addition, all four IHHP programs have developed policies and practices to facilitate care coordination. For example, RRHS employs an internal service coordinator/peer specialist team to maintain close personal contact with clients and with other agencies. FPC contracts with local partners to provide case management and care coordination. PHB uses a common client assessment form and "acuity scale" of clients' housing and HIV needs. CARES uses service coordinators that offer comprehensive housing and employment service planning and collaborate closely with medical providers. Other site-specific service integration-related practices are summarized below.

RRHS FUSE staff use a program-specific intake form that is a modified version of the RRHS general housing program intake form. The FUSE form includes RWP-specific data elements, including CD4/viral load counts, Medicaid status, enrollment in RWP, and medical and provider history. At intake, FUSE staff also inquire about the client's history of substance use and homelessness, criminal background, demographic information, income, and medications. Notably, the local CoC coalition task force is using the FUSE intake form as a model for the common intake and assessment form it is developing. If necessary, FUSE team members provide transportation and accompany clients to medical and other service appointments. The FUSE service coordinator also conducts home visits with each client at least monthly, and asks clients to provide their lab test results from each medical visit (every three to six months) to track their retention in care and clinical outcomes. The service coordinator also leverages his preexisting relationships with local medical providers and RWP medical case managers (he was previously a medical case manager himself), calling them once or twice a week to ask for verification of medical appointments and other information.

At intake, FPC staff also use a detailed screening form that is used in FPC housing programs and that FPC staff encourage AIDS service organization partners to use statewide. The screening tool is used to assess physical and mental health, oral health, financial assets, legal history, and transportation issues. The use of a universal screening form allows intake staff to ask clients about their long-term housing plans, beyond the three-year limit of the IHHP program. Physical and mental health status is assessed at intake and then annually, at a minimum. As part of the intake process, the case manager contacts the applicant's health care providers; for some clients, the case manager may call the provider as often as once a week. The case manager also creates an individualized housing plan, linking the client to a range of medical and social services, such as the AIDS Drug Assistance Program (ADAP), RWP, Medicaid, SSI, TANF, and SNAP. At FPC, health care coordination includes setting appointments; ensuring that clients get to appointments; working with pharmacies to help clients refill prescriptions, ensuring that clients understand any medical jargon, and accompanying clients to appointments, if needed. Overall, FPC described a high level of integration between HIV housing and medical care.

PHB's service partners, CAP and MCHD, use a "no wrong door" approach to intake. That is, they work closely together to integrate housing and care at the client level regardless of whether the initial point of contact by someone with HIV/AIDS is with the housing or the medical care system. CAP and MCHD conduct intake assessments independently. CAP collects clients' demographic information and creates a profile in HMIS. CAP staff assess clients across a wide range of indicators, including housing stability/status, behavioral health (mental health,

substance use, domestic violence), medical care, insurance, and risk indicators (unprotected sex and drug/alcohol use), then refer the client to the appropriate programs. MCHD also assesses clients' housing needs upon intake, relies on CAP for support on most housing-related issues, but also refers clients to other non-HIV-specific housing resources in the community, as appropriate. MCHD and CAP informants reflected on the relative merits of their case management approaches. MCHD medical case managers could confer directly and immediately with clients and health care providers, offering rapid referral and care coordination; however, they have high case loads, which reduces their frequency of client contact. CAP staff work with lower case loads and a higher degree of flexibility and thus are able to accompany clients to appointments (with lawyers, landlords, or even health care providers) and facilitate assistance with overcoming a variety of barriers to care.

CARES is working to create a seamless collaborative team approach to integrate housing programs with (1) health care, (2) support services (e.g., HIV prevention, mental health, and substance abuse treatment), and (3) vocational rehabilitation and employment programs. Like PHB, CARES' partner organizations, ADC and CCCS, use a similar in-depth intake and assessment process. Clients are referred to ADC or CCCS and assessed (using the same program assessment template) regarding their interest in employment, eligibility for HOPWA, and legal history. Clients are contacted at least once a month, but more frequently if required. Both ADC and CCCS conduct in-person visits at which they develop individualized service plans that address employment, improvement in health, and access to primary care. Clients are connected to housing, vocational training and employment services, and medical care depending on their needs and goals as detailed in their service plan. The case manager is in regular contact with medical providers to ensure that clients are complying with their recommended course of treatment and are attending primary care appointments. HIV-related documentation is also collected and includes viral loads and CD4 counts.

D. Integration of HMIS, HOPWA, and CAREWare Data Systems

The IHHP notice included several data collection and reporting requirements for the grantees. In addition to providing program-level HOPWA Annual Performance Reports each year, grantees are required to use HUD's CoC HMIS or an "equivalent client-level information system" to support the planning and reporting activities of their projects. The notice says that "participation in client-level information systems will support community collaboration in providing services across federal HIV/AIDS programs on outcomes related to housing stability for PLWHA and will foster further federal agency collaborations."

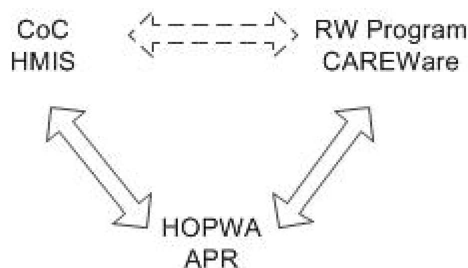
Housing and HIV care data integration can improve the performance of integrated HIV housing programs in multiple ways. At the service level, housing coordinators and HIV medical case managers can share client-specific information by "seeing" key data elements and case notes in the others' systems. Having access to integrated client-level housing status, housing service use, and housing and health outcome data can help managers evaluate the effectiveness of their programs. Linking client counts across programs also enables more accurate planning at the community level. For these reasons, all four IHHP sites were eager to improve the integration of their local housing (HMIS) and HIV care (CAREWare) systems.

No federal client-level data systems currently include a comprehensive set of housing and health care variables that can monitor the performance and evaluate the housing and health outcomes of integrated housing services. Neither HUD's HMIS nor HRSA's CAREWare

systems have the comprehensive set of housing and health care data needed to evaluate the effectiveness of the integrated HIV housing programs operated by the IHHP grantees. While the HMIS data system can track changes in housing status, it does not collect key client-level measures of health care access, use, and changes in clinical outcomes. Although CAREWare collects and reports client-level data on HIV status, health access, utilization and clinical outcomes, the data system does not collect baseline data on clients' housing status and stability at intake, and thus cannot measure client-level change in housing status. As discussed in the quantitative analysis in Chapter II, it was not possible to combine the data across these two data systems to conduct these analyses.[32]

Because HMIS and CAREWare were developed separately, they are incompatible. In order to build a comprehensive data system appropriate for their programs, the IHHP grantees must select one system or the other (HMIS or CAREWare) as their base, and then customize that system to add their APR data and other missing data elements (Figure III.2). Three IHHP sites (RRHS, PHB, and CARES) are using locally adapted HMIS data systems to collect and report their IHHP data. The fourth site (FPC) is using their state's CAREWare system for their IHHP program. Among the four sites, we found no direct linkages between local or state HMIS and CAREWare data systems (indicated by the dotted line in Figure III.2). The IHHP sites' aggregated APRs were also insufficient to track the client-level data needed to manage their integrated programs. The sites needed to incorporate their aggregate HOPWA data into either of the two larger client-level data systems to manage their programs better. All four IHHP sites in this study are using their grants to improve the integration of the housing, HIV care, employment, and other program-specific data elements in their data systems. However, they are facing different challenges in their efforts (Table III.4). For example, while the RRHS program currently tracks client-level FUSE program data in their CoC HMIS database, the local RWP Part A grantee utilizes CAREWare. The two systems are currently separate, but RRHS is spearheading an effort to link HMIS and CAREWare databases to coordinate their services and minimize duplicate data entry. The linking of these systems will open lines of communication between the RWP case managers and the FUSE service coordinators, allowing each to view the others' case notes and clients' lab test results (for example, CD4 counts). This will not involve making changes to CAREWare but rather will create external bridges from HMIS to access CAREWare data. Although the site is working to link the two data systems, the Part A grantee is concerned about making functional changes to CAREWare to foster data interoperability.

Figure III.2. HMIS, CAREWare, and HOPWA APR Data Relationships



[32] Though it is theoretically possible to conduct a correlation analysis for a subset of HOPWA and RWP clients enrolled in Medicaid. Such an analysis would exclude the impact of integrated housing services on uninsured clients—the bulk of HOPWA and RWP recipients.

FPC case managers collect client-level data from HOPWA TBRA, PHP, and STRMU housing applications and housing plans, and measure clients' housing stability at intake, at annual assessments, and during tenancy. They also collect qualitative information on clients' sobriety and other characteristics to track the impact of housing stability on sobriety and other outcomes. Although FPC staff use the state's CAREWare data system to input their HOPWA data, including their case notes, and report that CAREWare, at least in their state, limits their ability to share client-level data with other agencies. The state data system is set up so that FPC and partner agencies can see only program-level data, limiting the data's utility. Although some demographic fields are shared, many HOPWA-specific health and housing benchmarks are available only at the service provider level. Both FPC and the state's RWP Part B grant hope to modify their data systems in the near future, but the timing of these information technology (IT) projects may limit the opportunity for system integration. The state anticipates that its IT development process will take longer to complete than FPC's.

As the lead agency for Multnomah County CoC, PHB manages the CoC's HMIS data system and uses the system CoC, HOPWA, and RWP reporting. Using HMIS for collecting and reporting non-CoC programs (HOPWA and RWP) has been a challenge. The primary barrier for using HMIS systems for HOPWA data collection is the incompatibility between HOPWA data requirements and HUD's formal HMIS data standards. Even though HOPWA and CoC programs share common data elements, there are incompatibilities, including differing eligible activity types and performance outcomes. Further, HOPWA reporting does not track data at the client level, and HMIS does not have many data elements tracking changes in health status.

There is also minimal client-level data sharing between PHB and its partners. PHB requires HMIS for reporting HOPWA services; MCHD clinics collect data through electronic health records but use the TOURS system for reporting (soon to be replaced by CAREWare); and the state's RWP Part B grantee uses CAREWare. Although some RWP funds have been allocated to improve HMIS/CAREWare communicability, the federal sequestration and related state and local budget cuts have hampered this effort. Ultimately, the RWP grantee hopes to develop a data warehouse that would allow multiple users across systems to view common, real-time data.

Table III.4. Integration of Data Systems

.	RRHS FUSE	FPC Maine IHHP	PBH S4H	Albany CARES FFL
Data Systems Used	RRHS collects FUSE client-level data in the CoC HMIS database. RWP Part A utilizes CAREWare	CAREWare is used to input HOPWA program data, including case notes	PHB utilizes the CoC HMIS data system. MCHD clinics use electronic health records but report through TOURS system and will soon move to CAREWare. Oregon uses CAREWare	CARES utilizes HMIS, as implemented by Foothold Technology (FT), which includes a customization module called Form Builder. Both ADC and CCCS use the same FT HMIS system
Data Sharing and Integration	Currently, CAREWare and HMIS are separate data systems. There is no data bridge between them. The FUSE program coordinator uses an Excel spreadsheet to record clients' lab results, which are reported in the IHHP grant's APR	HOPWA data are uploaded to CAREWare, but data sharing is limited because it is set up only for provider-level viewing. FPC also shares HOPWA data with some medical providers	MCHD and CAP had used a common health care and housing assessment tool in the past but now have only a few data elements in common. Only medical engagement data are shared by MCHD and CAP	CARES does not share its data system with other organizations. Currently, an external evaluation tracks health outcomes
Outcomes Measured	HMIS tracks housing placement and stability; access to case management and medical care; access to and maintenance of income; housing planning; and CD4 counts and viral loads	FPC tracks housing type at program entry and exit; homelessness history; housing stability based on HOPWA codes; medical care source information; medical insurance coverage; client income; employment; and some health outcomes	PBH tracks housing placement and stability; access to case management and medical care; access to and maintenance of income; housing planning; employment; and engagement with medical case manager	CARES tracks housing placement and stability; access to case management and medical care; access to and maintenance of income; housing planning; and health, wellness, and employment data. The FFL evaluation also tracks health care status, mental health status, substance use, prevention/risk behaviors, and employment status
Challenges	The CoC's old HMIS system went off-line in December 2012, but the new HMIS system did not become operational at RRHS until May 2013. Over 200 paper notes created in the interim must be entered into HMIS	HOPWA-specific data elements in CAREWare are not maintained when the CAREWare system is upgraded on an annual basis. HOPWA-specific health and housing benchmarks are available only at the provider level	HOPWA data elements are incompatible with HMIS data standards, including differences in eligible activity types and performance outcomes. HOPWA reporting does not track client-level data; HMIS does not track key health status data	CARES opted not to provide evaluation data for FFL's 2012 APR because of data quality issues, including inconsistencies in defining and recording some data elements due to FFL staff turnover
Future Planning	RRHS is spearheading an effort to link the new HMIS and CAREWare databases. This will coordinate services and minimize duplicate data entry. The RWP Part A grantee is not seeking full integration of the two systems	FPC seeks a new data system combining housing, case management, and HIV care data. Maine's RWP Part B grantee also wants to replace CAREWare with a new system to meet state-specific needs. In the new system, there is potential for integrating housing and health care data	MCHD is transitioning to CAREWare from Tours. PHB and CAP are working together to export HMIS data into the Tours system and, eventually, into CAREWare	CARES is developing a common CoC intake and assessment model for housing, mental health, and other services. A new, integrated data system will be needed to manage this common assessment process

As the CoC HMIS administrator in 21 counties, CARES has the staff capacity to modify its HMIS data system. CARES staff use an HMIS module called Form Builder to collect additional information on health, wellness, and employment at six-month intervals. An outside evaluation of the FFL program is also using HMIS to measure client progress. At an operational level, employment counselors at ADC and CCCS (the FFL program's partner agencies) use the data system to track clients' employment, income documentation, and compliance with their medical appointments. The staff record diagnostic information, such as CD4 counts, in their HMIS progress notes. CoCs will now be required to create and monitor a common client intake and assessment system, which will eventually require a new data system.

E. Integration of Community Planning

The IHHP grants have many purposes. In addition to implementing innovative programs linking HIV housing assistance to medical care and other supports, grantees are expected to work at the community level to create integrated housing plans designed to improve the functioning and efficiency of the local HIV housing service delivery system. The community planning requirements were more prescriptive. Grantees had to develop and submit an integrated HIV housing plan that contained specific elements, including (1) a common vision or goal, (2) a list of planning team members, (3) a description of the community planning process, (4) an accounting of the systems changes planned to improve the delivery of housing and support services, (5) an assessment of the unmet housing and support service needs of the local HIV population, (6) an inventory of the local HIV service providers, and (7) a set of the outcomes expected from the community planning process. At the same time, the planning requirements were flexible, in terms of not prescribing how grantees were to go about the complex process of bringing together a wide range of stakeholders to jointly develop and implement a community-wide integrated housing and service plan. This flexibility recognized community-level differences in existing housing resources, planning structures, and relationships.

When we visited the IHHP grantees in May 2013, the four grantees had just finished writing and submitting their IHHP work plans. Some grantees were farther along than others in their planning, but all acknowledged that their top priority during the first year of the grant had been to get their programs up and running in order to maximize their programs' enrollment. Some teams were also getting technical assistance from HUD to help with their community planning efforts.

The grantees discussed two common challenges in bringing disparate groups "to the table" to work together on the IHHPs. First, all four grantees had extensive experience with community planning, serving on numerous councils, task forces, provider networks, coalitions, and work groups, often acting as a link between homeless and HIV service groups. However, some of the CoC and RWP groups they worked with did not have a history of working together. Second, some IHHP grantees felt that HOPWA programs were historically marginalized in both CoC and RWP planning processes. Although RWP planning councils often identified housing as a high priority, few allocated funds for housing assistance on the assumption that HIV housing needs were already being addressed by HOPWA. Likewise, some CoCs also felt that because PLWHA experiencing homelessness were already being served by HOPWA, there was no need to enroll them in CoC programs.

The IHHP grantees plan to use a variety of strategies to overcome these challenges and bring together groups from different sectors (public housing, homeless services, city planning, and HIV services) to create community-wide IHHP plans (see Table III.5).

- CARES plans to use its leverage as the lead "collaborative applicant" in six regional CoCs to roll up IHHP planning into a larger CoC planning process in which the six regional CoCs would develop integrated intake, assessment, and data systems.
- FPC plans to use its presence on state planning groups (on the state's Balance of State CoC, and on statewide ADAP and RWP Part B advisory committees) and in community planning processes (assessing unmet HIV housing needs for the City of Portland's Consolidated Plan and serving on Portland's CoC) to create statewide collaboration supporting the development of community-based IHHPs.
- RRHS hired the Health Planning Council of NE Florida to conduct a regional health impact assessment of potential changes in housing, consolidated planning, and other community policies. RRHS plans to use this impact assessment process to start the IHHP planning process and to build stronger relationships among these groups.
- PBH and its S4H partners have a history of successful collaboration, and plan to use this collaborative approach to work with the RWP Part A planning council and with the City of Portland's Consolidated and Action Planning process to create a local IHHP.

Table III.5. Integration of Community Planning

.	RRHS FUSE	FPC Maine IHHP	PBH S4H	Albany CARES FFL
Community Plan	The project director will work with the FUSE planning team and other local stakeholders to develop the IHHP. The task will begin with a community health impact assessment conducted by the Health Policy Council of NE Florida.	FPC is active in state and local RWP and CoC planning efforts, and with housing authorities. As part of a statewide collaboration, the project will assist in developing a community model for an IHHP.	Site has a strong, active planning group, with larger systems-change efforts and CoC coordination. The group will develop the IHHP plan.	CARES will form a planning team to create IHHP's implementation plan. CARES is not planning to create an IHHP-specific plan, but to roll IHHP planning up into a larger CoC planning process.

Source: Discussions with program staff and document review conducted by Mathematica Policy Research, 2013.

CoC = Continuum of Care; HOPWA = Housing Opportunities for Persons With AIDS; IHHP = Integrated HIV/AIDS Housing Plan; RWP = Ryan White HIV/AIDS Program.

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IV. CONCLUSIONS

The results of these analyses illustrate some key differences between the HOPWA and RWP programs that affect the integration of housing and HIV care. The findings also suggest the importance of exploring and capitalizing on the strengths of each program and identifying ways they can complement each other, rather than working to maximize the impact of each program in isolation. Exploring program models that focus on the integration of housing and medical care services—and on the integration of HOPWA and RWP data systems and community planning processes—may lead to more effective use of limited HIV program resources.

A. Service Integration Conclusions

This section summarizes the report's service integration findings and offers ideas for how service integration can be improved through further study and policy development.

The IHHP program models show a gradient of service coordination and collaboration in three areas: (1) housing assistance and housing service coordination, (2) employment service coordination, and (3) medical case management. All four sites provide housing assistance, and all four fund housing coordinator positions, though two contract out that function to community partners. Two sites fund employment coordinator positions, but both are contracted out to community partners. All four sites provided medical case management through coordination with RWP-funded medical case managers.

However, all four IHHP sites are concerned about the potential impact of the Affordable Care Act private health insurance coverage expansions and Medicaid expansion on their clients' future access to RWP-funded medical case managers. As a payer of last resort, RWP may not pay for duplicate services that are available through other sources. Sites expressed concern that RWP clients who enroll in Medicaid may lose their eligibility for RWP-funded case management. In Maine, for example, RWP's Part B program recently lost most of its case management clients when it was determined that those services duplicated case management services covered by Medicaid.

- The potential impact of the Affordable Care Act on this HOPWA housing-RWP case management linkage could be significant, and is worth monitoring and researching during the roll out of the implementation of Affordable Care Act coverage expansions in 2014 and beyond.

This study also offered a unique opportunity to observe two different housing-HIV care service integration models operating at the same time in the same program site in two different IHHP locations (PHB and RRHS). In both locations, the IHHP model features a "housing first" approach that funds clients' housing while reaching out to external medical case management and other support services. The HRSA medical home-based SPNS model in both sites addresses clients' physical health, mental health, and substance abuse issues first, while reaching out to local HOPWA programs for potential housing assistance. Both programs are made somewhat vulnerable by not funding both housing and HIV care elements. IHHP clients have housing, but rely on medical case management available through their health insurance (i.e., Medicaid) or RWP; conversely, HRSA SPNS clients are housed in an HIV medical home, but HOPWA-funded housing assistance may not be available and the client is waitlisted for housing services.

- There is potentially a third option of service integration that encompasses and funds both housing and HIV care, so that client access to both services is guaranteed. It would be useful to study examples of this third option to understand how it compares to the IHHP "housing first" and HRSA "health care first" models.

Two of the IHHP grants are also adding employment coordination to their integrated housing service models. This is a potentially important service integration model that offers clients an opportunity to move into mainstream housing through employment. In these models, IHHP clients become more financially self-sufficient as they gain housing stability and improve their health. The IHHP sites are challenged, however, by employment service providers who were not familiar with the service needs of PLWHA and were somewhat reluctant to take them on as new clients.

- This three-way model of integration (housing, employment, and health care services) should be studied in more detail, and the model's effectiveness evaluated.

The IHHP sites were studied early in their grant cycle, at the beginning of their second year of operation. As a result, the programs were not very far along in their community planning activities. The sites have developed First Year Implementation Strategies to bring together groups from public housing, homeless (CoC) services, city planning, and HIV (RWP) service organizations to create community-wide IHHP plans, but noted two challenges that they will have to overcome to succeed. First, local CoC and RWP groups have not typically had a history of working together. Second, some sites felt that the needs of their HOPWA clients had historically been marginalized in both local CoC and RWP planning processes.

- The IHHP sites should be revisited at the end of their grant cycle to see what they are able to accomplish in terms of developing integrated planning processes at the community level.

Finally, this study shows that PLWHA have complex housing needs that cannot always be solved through temporary, short-term assistance from RWP or HOPWA. Some PLWHA may need assistance from both programs to stabilize their housing on a long-term basis. Operationally, RWP planning councils should reconsider past decisions not to fund housing assistance.

- New demonstration projects that are designed to formally integrate HOPWA and RWP housing and HIV care components, or to pool HOPWA and RWP resources into one integrated program, should be considered and researched.

B. Data Systems Conclusions

This final section summarizes the report's data system integration findings and offers ideas for how housing data systems can be improved through further study and policy development.

There were numerous challenges in analyzing the HOPWA and RWP housing services. The data were compiled from several different sources that did not have identical collection methods. Some variables were collected across both programs, but the variables were collected in different formats and on different timelines. Other variables were collected in one program but not the

other, which made comparisons difficult. In addition, HOPWA data are collected at an aggregate level, whereas RWP data are collected at the client level as of 2010.

- Adding client-level variables that are common to both housing and HIV care programs, especially data variables that capture the assistance received from both programs, would allow linkage of the programs' databases and facilitate research examining services received and outcomes for participants served by both types of programs.

The implementation of the RSR in 2010 allowed for a comparison of the housing status of RWP clients who received housing services to the status of those who did not. This is particularly helpful for understanding the subset of RWP clients who are receiving housing assistance. There was also a great deal of variation across states in almost all the analyses. Unfortunately, it is impossible to determine whether or not these differences in housing status existed prior to program enrollment or as a result of services received, since most RSR variables are reported "as of end of the reporting period."

- Increased understanding of these subgroup differences could help to inform and improve RWP housing practices around the unique needs of clients with housing needs. It may also be valuable to explore state-level differences housing status in greater detail.

The qualitative analysis found that many factors affected the coordination and integration of the IHHP grantees' HMIS, HOPWA, and CAREWare data systems. The owners of these systems need to have the capacity, funding, interest, and timing to work together to integrate their systems.

- It will be important to revisit the IHHP sites at the end of their three-year grant period to see what they have accomplished in developing more integrated data systems.

At the data systems level of integration, the development of common intake and assessment systems for HUD's CoC programs creates an opportunity to enhance HMIS systems to accommodate a "no wrong door" approach to client intake, assessment, and service provision from any of three entry points through HOPWA, RWP, Medicaid, or other patient-centered medical home options.

- The creation of this new CoC intake system might involve developing new linkages among HMIS, CAREWare, and electronic health record data systems. This development should be monitored and studied.

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APPENDIX A
DESCRIPTION OF DATA SETS AND THEIR LIMITATIONS

A. Description of Data Sets

Ryan White HIV/AIDS Program, HRSA

The Ryan White HIV/AIDS Program is administered by the Health Resources and Services Administration (HRSA). The Ryan White Program provides a variety of services that cover the gaps in HIV care that are not provided by other resources.[33]

- **Ryan White Expenditure Reports 2007–2010.** Grantees submit expenditure reports to HRSA annually. Part A and Part B expenditure reports were used in this analysis.
- **Ryan White Program Data Reports 2007–2010.** The RDR is a program-level data report. All funded Ryan White grantees submitted an RDR data report annually until it was replaced by the RSR in 2011. Each grantee submits one RDR report, including data on services funded with any Ryan White funding. An important limitation of RDR data is that participant counts can be duplicated. Although each provider unduplicates participant counts, a participant can visit more than one provider.
- **Ryan White Program Services Report 2010.** The Ryan White HIV/AIDS Program Services Report (RSR) is a participant-level data-reporting system. All funded Ryan White grantees and providers must submit an RSR data report annually. The RSR data used for this analysis represent the first complete year of reporting. Therefore, there may be incomplete and inaccurate reporting from some providers.

1. Housing Opportunities for Persons with AIDS, HUD

The Housing Opportunities for Persons With AIDS program (HOPWA) is provided through the U.S. Department of Housing and Urban Development (HUD). HOPWA covers a variety of housing, social services, program planning and development costs.[34]

- **HOPWA Consolidated Annual Performance Evaluation Report 2007–2010.** The HOPWA Consolidated Annual Performance Evaluation Report (CAPER) is completed annually by formula grantees and provides information on expenditures, activities, and program accomplishments. Information collected and reported in CAPER represents activities carried out with HOPWA funds during the grantee's operating year, including any funds subcontracted to providers.

[33] About the Ryan White HIV/AIDS Program. Retrieved on March 7, 2013, from [http://hab.hrsa.gov/abouthab/aboutprogram.html].

[34] Housing Opportunities for Persons With AIDS propgram. Retrieved on March 7, 2013, from [http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/aidshousing/programs].

- **HOPWA Annual Performance Report 2007–2010.** All HOPWA Competitive Program grantees submit an Annual Progress Report (APR) to HUD annually. The APR provides information on expenditures, activities, and program accomplishments. Information collected and reported in the APR represents activities carried out with HOPWA funds during the grantee's operating year, including any funds subcontracted to providers. The information reported in the APR does not overlap with data reported by HOPWA Formula Program grantees (in CAPER).

2. Homeless Continuum of Care Program, HUD

HUD's CoC program is designed to promote community-wide planning to end homelessness, and it provides funding for efforts by nonprofit providers and state and local governments to quickly re-house homeless individuals and families. HUD sets specific community requirements regarding the collection of data on the met and unmet needs of homeless individuals and families in the geographic area covered by the CoC program.

- **The 2010 Annual Homeless Assessment Report (AHAR)**[35] is an annual report to Congress on the extent and nature of homelessness; it contains data from several sources, including:
  - **Homeless Point-in-Time Count.** Each Continuum is required to conduct a point-in-time count of the number of individuals and families experiencing homeless on a single night in the last week of January. The results of these counts are submitted to HUD at least every other year.
  - **Homeless Housing Inventory.** Each Continuum is required to conduct an annual inventory of the number and type of emergency, transitional, and permanent supportive housing units targeted to individuals and families. The results of the inventories are submitted to HUD annually.
  - **Homeless Management Information** System. HMIS data from participating communities report on the use of emergency shelter, transitional housing, and permanent supportive housing programs during the AHAR reporting period; these data are weighted to produce national estimates.

B. Limitations of Data and Analyses

Because data were compiled from several different sources that did not have identical collection methods, there are a number of considerations when examining the analyses:

- Ryan White Emergency Financial Assistance can be used for housing assistance; however, it was not included in these analyses because it was not possible to separate out the expenditures and clients for housing financial assistance versus other types of financial assistance.

[35] See [https://www.onecpd.info/resources/documents/2010HomelessAssessmentReport.pdf].

- HOPWA Permanent Housing Placement (PHP) can also be used for short-term financial assistance with housing including costs associated with helping participants to establish permanent residences; however, it was not included in these analyses as housing assistance because it was not possible to de-duplicate households served with housing assistance and housing placement.
- The Ryan White Program Data Report collects aggregate data on individuals and reports these separately for HIV positive and HIV affected. In contrast, the Ryan White Program Services Report collects and reports data on an individual level, which allows for de-duplication across service providers.
- The Ryan White Program Services Report collects data on individual clients served which is then unduplicated across grantees. However, not all variables are reported for all clients, therefore the total number of participants used to calculate percentages is the total number of participants required to answer that specific question.
- HOPWA reports did not provide an unduplicated count of households served across types of services; therefore, unduplicated households receiving support services was used as a proxy for the total of unduplicated households served.

Some HOPWA grants cover more than one state and report in aggregate; therefore, it is not possible to separate expenditures or participants by state for those grantees. This is particularly problematic for Montana (which includes North Dakota and South Dakota) and the District of Columbia (which includes parts of Virginia and West Virginia).

Due to a midyear change in grant year, the City of Miami submitted two CAPERs in 2010 and was not able to deduplicate information across the two reports. Both reports are included in the analysis, so the results for Florida are slightly higher than they should be.

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APPENDIX B
RECEIPT OF FEDERAL HOUSING ASSISTANCE COMPARED TO HIV/AIDS PREVALENCE, 2010

Table B. Receipt of Federal Housing Assistance, by State

State	Number of Persons Living with Diagnosed HIV/AIDS in 2010	Number of Individuals with HIV/AIDS Who Received HOPWA Housing Subsidy Assistance	Number of Ryan White Program HIV-Positive/ Indeterminate Clients Who Received Housing Services	Total Number of HIV-Positive Individuals Receiving Housing Assistance	Percentage of HIV-Positive Individuals Receiving Housing Assistance[a]
AK	628	74	83	157	25
AL	11,539	555	265	820	7
AR	4,684	224	0	224	5
AZ	12,532	793	128	921	7
CA	111,666	7,255	4,309	11,564	10
CO	11,006	376	857	1,233	11
CT	10,822	377	666	1,043	10
DC[b]	14,359	1,269	50	1,319	9
DE	2,968	250	117	367	12
FL	94,897	9,425	1,030	10,455	11
GA	33,920	2,220	69	2,289	7
GU	87	0	0	0	0
HI	2,310	184	67	251	11
IA	1,722	109	17	126	7
ID	792	117	5	122	15
IL	31,884	2,488	647	3,135	10
IN	8,511	744	0	744	9
KS	2,696	144	0	144	5
KY	5,225	1,060	295	1,355	26
LA	16,892	2,481	634	3,115	18
MA	17,502	669	931	1,600	9
MD	30,558	1,072	953	2,025	7
ME	1,162	227	274	501	43
MI	13,961	555	748	1,303	9
MN	6,564	352	29	381	6
MO	11,087	1,155	550	1,705	15
MS	8,213	1,107	38	1,145	14
MT[b]	376	218	2	220	59
NC	24,476	3,045	844	3,889	16

Table B *(continued)*

State	Number of Persons Living with Diagnosed HIV/AIDS in 2010	Number of Individuals with HIV/AIDS Who Received HOPWA Housing Subsidy Assistance	Number of Ryan White Program HIV-Positive/ Indeterminate Clients Who Received Housing Services	Total Number of HIV-Positive Individuals Receiving Housing Assistance	Percentage of HIV-Positive Individuals Receiving Housing Assistance[a]
ND[b]	185	0	7	7	4
NE	1,721	128	30	158	9
NH	1,152	201	0	201	17
NJ	35,860	1,373	423	1,796	5
NM	2,445	666	83	749	31
NV	6,894	412	124	536	8
NY	132,523	5,818	3,040	8,858	7
OH	17,146	1,453	834	2,287	13
OK	4,690	341	161	502	11
OR	5,130	374	659	1,033	20
PA	31,468	1,782	2,487	4,269	14
PR	18,129	1,614	424	2,038	11
RI	2,046	180	286	466	23
SC	14,044	951	2,296	3,247	23
SD[b]	443	0	1	1	0
TN	15,881	1,373	283	1,656	10
TX	64,498	4,392	2,227	6,619	10
USVI	589	42	0	42	7
UT	2,364	168	0	168	7
VA	20,721	721	109	830	4
VT	439	153	0	153	35
WA	10,732	653	662	1,315	12
WI	5,047	561	762	1,323	26
WV	1,476	369	0	369	25
WY	242	27	0	27	11
Total	888,904[c]	62,297	28,506	90,803[e]	10
RSR	NA	NA	18,803[d]	81,100[e]	9

Source: CDC NCHHSTP Atlas [http://www.cdc.gov/nchhstp/atlas]; HRSA Ryan White Program RDR Report, 2010; HUD HOPWA CAPER and APR Reports, 2010; Bottom column is based on Ryan White Program Services Report, 2010.

Table B *(continued)*

[a] Percentage of number of PLWHA.

[b] Some HOPWA grants cover more than one state and report in aggregate. Therefore, it is not possible to separate expenditures or participants by state for those grantees. The most notable are Montana (which includes North Dakota and South Dakota) and the District of Columbia (which includes parts of Virginia and West Virginia).

[c] Total Number of Persons living with diagnosed HIV/AIDS in 2010 does not include American Samoa (2 people) or the Northern Mariana Islands (14 people).

[d] Unduplicated number of RWP clients receiving a housing service (includes HIV positive, indeterminate, and 3,049 clients who's status was unknown/missing/not collected) based on 2010 RSR data. Number does not include 101 HIV negative clients who received a housing service.

[e] It is possible, but unlikely, that a person might receive housing services from both the HOPWA and Ryan White programs. More commonly, a person might receive housing assistance from HOPWA and other HIV-related services through the Ryan White Program.

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APPENDIX C

Table C. Ryan White Program Housing Expenditures and Percentage of Ryan White Program Expenditures Spent on Housing Assistance, by State

State	Part A + MAI FY 2010 Grant Service Dollars: Housing Services	Part A + MAI FY 2010 Total Expenditures	Percentage of Total	Part B FY 2010 Consortia, State Direct Services, and Emerging Communities Expenditures: Housing Services	Part B FY 2010 Consortia, State Direct Services, and Emerging Communities Expenditures: Total	Percentage of Total[a]
AK	$0	$0	NA	$0	$356,919	0
AL	$0	$0	NA	$2,750	$5,816,178	0
AR	$0	$0	NA	$0	$2,123,266	0
AZ	$0	$7,757,739	0	$5,260	$3,047,949	0
CA	$1,845,116	$102,770,803	2	$2,119,331	$22,490,825	9
CO	$0	$7,958,802	0	$93,086	$2,323,986	4
CT	$706,450	$11,390,496	6	$99,143	$2,500,110	4
DC	$895,854	$31,244,466	3	$0	$3,795,193	0
DE	$0	$0	NA	$175,535	$2,008,174	9
FL	$0	$73,509,017	0	$59,910	$19,087,169	0
GA	$0	$20,186,351	0	$39,539	$7,110,969	1
GU	$0	$0	NA	$0	$78,927	0
HI	$0	$0	NA	$134,630	$698,066	19
IA	$0	$0	NA	$0	$630,130	0
ID	$0	$0	NA	$0	$191,627	0
IL	$206,239	$26,136,053	1	$443,596	$6,727,548	7
IN	$101,089	$3,908,426	3	$0	$0	NA
KS	$0	$0	NA	$0	$710,784	0
KY	$0	$0	NA	$20,516	$2,601,128	1
LA	$70,443	$11,608,030	1	$0	$2,618,356	0
MA	$1,931,142	$13,894,998	14	$0	$4,560,865	0
MD	$1,135,663	$20,155,137	6	$0	$8,139,139	0
ME	$0	$0	NA	$0	$520,346	0

Table C *(continued)*

State	Part A + MAI FY 2010 Grant Service Dollars: Housing Services	Part A + MAI FY 2010 Total Expenditures	Percentage of Total	Part B FY 2010 Consortia, State Direct Services, and Emerging Communities Expenditures: Housing Services	Part B FY 2010 Consortia, State Direct Services, and Emerging Communities Expenditures: Total	Percentage of Total[a]
MI	$164,080	$8,396,135	2	$16,346	$3,747,312	0
MN	$34,954	$5,405,148	1	$0	$1,586,925	0
MO	$0	$0	NA	$0	$2,846,521	0
MS	$300,000	$10,655,100	3	$67,187	$5,026,013	1
MT	$0	$0	NA	$0	$123,554	0
NC	$89,905	$5,311,072	2	$20,616	$7,606,564	0
ND	$0	$0	NA	$1,070	$94,567	1
NE	$0	$0	NA	$110,847	$861,564	13
NH	$0	$0	NA	$0	$111,789	0
NJ	$985,634	$26,543,252	4	$14,805	$6,050,227	0
NM	$0	$0	NA	$899	$943,920	0
NV	$30,458	$5,484,289	1	$0	$725,527	0
NY	$10,292,753	$128,510,002	8	$1,786,460	$29,788,678	6
OH	$154,678	$4,117,162	4	$0	$5,880,695	0
OK	$0	$0	NA	$0	$1,959,565	0
OR	$458,171	$3,587,312	13	$64,619	$1,405,909	5
PA	$468,691	$24,299,388	2	$320,341	$9,220,597	3
PR	$1,068,703	$15,480,189	7	$116,750	$3,336,346	3
RI	$0	$0	NA	$0	$619,618	0
SC	$0	$0	NA	$919	$10,357,642	0
SD	$0	$0	NA	$0	$0	NA
TN	$22,284	$11,545,107	0	$930	$3,901,016	0
TX	$87,045	$47,205,372	0	$0	$12,994,124	0
USVI	$0	$0	NA	$0	$288,839	0
UT	$0	$0	NA	$0	$897,556	0
VA	$45,852	$6,234,944	1	$0	$5,295,740	0
VT	$0	$0	NA	$0	$413,344	0

Table C *(continued)*

State	Part A + MAI FY 2010 Grant Service Dollars: Housing Services	Part A + MAI FY 2010 Total Expenditures	Percentage of Total	Part B FY 2010 Consortia, State Direct Services, and Emerging Communities Expenditures: Housing Services	Part B FY 2010 Consortia, State Direct Services, and Emerging Communities Expenditures: Total	Percentage of Total[a]
WA	$696,360	$7,057,096	10	$35,017	$2,383,776	1
WI	$0	$0	NA	$0	$2,875,710	0
WV	$0	$0	NA	$0	$355,011	0
WY	$0	$0	NA	$0	$52,064	0
Total	$21,791,564	$640,351,887	3	$5,750,100	$219,888,368	3

Source: HRSA Ryan White Expenditure Reports, 2010.

[a] Percentages are rounded to the nearest whole number; therefore, states with a percentage less than 0.5 percent are reported as 0 percent.

FY = fiscal year; MAI = Minority AIDS Initiative; NA = No Funding Provided.

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APPENDIX D

Table D. HOPWA Housing Assistance Expenditures and Percentage of Expenditures Spent on Housing, by State

.	HOPWA Formula Grant Expenditures[b]				HOPWA Competitive Grant Expenditures[b]			
State	Number of Grantees	Total Housing Subsidy Assistance Funding	Total Expenditures	Percentage of Total	Number of Grantees	Total Housing Assistance Funds Expended	Total Expenditures	Percentage of Total
AK	0	$0	$0	NA	2	$256,474	$542,161	47
AL	2	$1,116,799	$1,922,346	58	4	$886,055	$1,613,151	55
AR	1	$458,777	$706,731	65	0	$0	$0	NA
AZ	3	$1,417,990	$1,935,741	73	2	$470,907	$633,218	74
CA	9	$17,663,859	$35,240,104	50	8	$1,792,262	$2,722,020	66
CO	2	$1,346,449	$2,135,826	63	2	$195,072	$362,573	54
CT	4	$1,553,411	$3,119,748	50	0	$0	$0	NA
DC[a]	1	$10,135,075	$13,253,700	76	0	$0	$0	NA
DE	2	$750,286	$885,823	85	2	$320,399	$520,943	62
FL	8	$32,377,134	$43,276,981	75	4	$1,284,811	$1,874,615	69
GA	3	$4,973,386	$10,030,493	50	2	$144,154	$417,033	35
GU	0	$0	$0	NA	0	$0	$0	NA
HI	2	$440,522	$617,539	71	2	$651,080	$865,965	75
IA	1	$232,194	$317,844	73	0	$0	$0	NA
ID	0	$0	$0	NA	1	$296,662	$409,166	73
IL	2	$5,214,949	$6,338,508	82	9	$2,089,233	$3,148,107	66
IN	2	$1,411,909	$1,874,632	75	0	$0	$0	NA
KS	1	$170,606	$453,200	38	0	$0	$0	NA
KY	2	$319,089	$1,036,444	31	2	$453,501	$748,773	61
LA	3	$4,802,962	$5,822,888	82	2	$336,138	$524,692	64
MA	6	$1,205,466	$3,498,207	34	4	$1,129,212	$1,708,323	66
MD	2	$8,134,056	$10,171,660	80	4	$1,143,782	$1,775,571	64
ME	0	$0	$0	NA	3	$1,008,931	$1,372,642	74
MI	3	$2,332,510	$3,285,795	71	1	$185,986	$246,143	76

Table D *(continued)*

State	HOPWA Formula Grant Expenditures[b]				HOPWA Competitive Grant Expenditures[b]			
.	Number of Grantees	Total Housing Subsidy Assistance Funding	Total Expenditures	Percentage of Total	Number of Grantees	Total Housing Assistance Funds Expended	Total Expenditures	Percentage of Total
MN	2	$805,266	$884,108	91	3	$104,269	$297,032	35
MO	3	$1,960,679	$2,704,757	72	2	$507,015	$602,418	84
MS	2	$2,195,996	$2,270,167	97	1	$295,463	$401,826	74
MT[a]		$0	$0	NA	2	$670,338	$981,080	68
NC	3	$2,685,364	$3,622,418	74	1	$158,273	$220,187	72
ND[a]	0	$0	$0	NA	0	$0	$0	NA
NE	1	$47,965	$149,977	32	0	$0	$0	NA
NH	0	$0	$0	NA	4	$625,721	$1,128,353	55
NJ	6	$8,552,325	$10,692,804	80	1	$434,630	$471,689	92
NM	1	$355,107	$488,158	73	1	$346,725	$399,485	87
NV	2	$605,110	$1,174,552	52	0	$0	$0	NA
NY	7	$44,576,347	$61,311,785	73	5	$870,934	$1,952,117	45
OH	4	$1,621,777	$3,196,764	51	0	$0	$0	NA
OK	3	$527,036	$945,215	56	0	$0	$0	NA
OR	2	$1,583,626	$2,104,348	75	3	$535,204	$788,054	68
PA	3	$6,570,898	$9,223,199	71	2	$246,156	$475,075	52
PR	2	$3,544,497	$6,831,828	52	0	$0	$0	NA
RI	1	$375,034	$969,488	39	2	$452,838	$681,479	66
SC	3	$1,748,994	$3,254,274	54	0	$0	$0	NA
SD[a]	0	$0	$0	NA	0	$0	$0	NA
TN	3	$2,233,283	$4,120,012	54	1	$244,659	$281,552	87
TX	7	$10,993,225	$18,578,935	59	3	$725,425	$1,065,934	68
USVI	0	$0	$0	NA	1	$226,474	$460,447	49
UT	2	$369,418	$460,062	80	0	$0	$0	NA
VA	3	$1,452,498	$2,529,047	57	0	$0	$0	NA
VT	0	$0	$0	NA	2	$392,963	$572,395	69

Table D *(continued)*

.	HOPWA Formula Grant Expenditures[b]				HOPWA Competitive Grant Expenditures[b]			
State	Number of Grantees	Total Housing Subsidy Assistance Funding	Total Expenditures	Percentage of Total	Number of Grantees	Total Housing Assistance Funds Expended	Total Expenditures	Percentage of Total
WA	2	$1,358,108	$2,280,885	60	4	$325,397	$889,422	37
WI	2	$408,594	$959,835	43	2	$322,319	$718,222	45
WV	1	$89,314	$200,952	44	1	$184,590	$357,957	52
WY	0	$0	$0	NA	1	$82,317	$189,511	43
Total	124	$190,717,893	$284,877,780	67	96	$20,396,367	$32,419,331	63

Source: HUD HOPWA CAPER and APR Reports, 2010.

[a] Some HOPWA grants cover more than one state and report in aggregate. Therefore, it is not possible to separate expenditures or participants by state for those grantees. The most notable are Montana (which includes North Dakota and South Dakota) and the District of Columbia (which includes parts of Virginia and West Virginia).

[b] Expenditures data were calculated using CAPER and APR reports and may not match the expenditures data in the HUD Integrated Disbursement Information System because of differences in reporting dates.

NA = No Funding Provided

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APPENDIX E

Table E. Average Annual HOPWA Cost per Household, by Type of Housing Assistance

State	Households Receiving Tenant-Based Rental Assistance (TBRA)	TBRA: Average Cost per Household	Households in Permanent Housing Facilities[b]	Permanent Housing Facilities: Average Cost per Household	House-holds in Transitional/ Short-Term Facilities[c]	Transitional/ Short-Term Housing Facilities: Average Cost per Household	Households Receiving Rent, Mortgage, and Utility Assistance (STRMU)	STRMU: Average Cost per Household
AK	35	$5,086	3	$3,547	0	NA	40	$1,696
AL	112	$5,134	122	$7,663	203	$1,909	129	$818
AR	140	$2,685	0	NA	0	NA	145	$572
AZ	203	$5,032	61	$4,631	136	$2,488	402	$613
CA	1,642	$5,917	401	$4,521	2,202	$2,074	2,972	$1,085
CO	258	$5,280	17	$6,230	0	NA	101	$726
CT	213	$4,655	29	$11,253	89	$2,248	47	$756
DC[a]	580	$13,180	13	$2,665	249	$6,922	378	$1,937
DE	178	$4,030	34	$9,424	0	NA	38	$868
FL	3,252	$6,745	186	$3,592	797	$7,096	4,820	$1,043
GA	443	$2,990	400	$6,166	474	$1,583	925	$623
GU	0	N/A	0	NA	0	NA	0	NA
HI	138	$7,280	0	NA	21	$1,887	25	$1,891
IA	48	$3,239	0	NA	0	NA	61	$1,258
ID	83	$3,289	0	NA	0	NA	34	$696
IL	756	$3,916	606	$5,313	38	$8,888	1,114	$706
IN	229	$3,959	20	$3,073	27	$557	481	$891
KS	42	$1,736	0	NA	0	NA	121	$807
KY	82	$1,845	11	$22,436	18	$2,019	972	$348
LA	178	$3,494	142	$3,128	378	$6,764	1,792	$846
MA	210	$8,686	21	$4,433	0	NA	443	$943
MD	951	$9,546	0	NA	27	$4,875	120	$568
ME	141	$6,222	0	NA	0	NA	87	$1,513
MI	348	$4,983	28	$6,642	15	$21,608	262	$1,048
MN	148	$4,682	49	$2,128	0	NA	155	$725
MO	467	$3,272	122	$3,216	67	$1,745	447	$851
MS	25	$4,998	6	$4,800	44	$2,778	1,034	$2,114
MT[a]	176	$3,383	0	NA	0	NA	56	$1,339

Table E *(continued)*

State	Households Receiving Tenant-Based Rental Assistance (TBRA)	TBRA: Average Cost per Household	Households in Permanent Housing Facilities[b]	Permanent Housing Facilities: Average Cost per Household	House-holds in Transitional/ Short-Term Facilities[c]	Transitional/ Short-Term Housing Facilities: Average Cost per Household	Households Receiving Rent, Mortgage, and Utility Assistance (STRMU)	STRMU: Average Cost per Household
NC	464	$3,885	105	$3,877	0	NA	1,643	$384
ND[a]	.	NA	.	NA	.	NA	.	NA
NE	52	$836	0	NA	0	NA	85	$53
NH	67	$6,602	0	NA	0	NA	144	$1,274
NJ	1,128	$6,534	43	$9,071	148	$5,169	389	$1,187
NM	325	$445	4	$86,681	0	NA	337	$624
NV	47	$3,884	22	$3,577	0	NA	349	$959
NY	1,160	$6,345	3,825	$9,603	270	$1,694	472	$809
OH	130	$4,296	82	$743	47	$3,243	1,198	$709
OK	146	$2,383	4	$3,371	38	$1,865	184	$515
OR	169	$6,184	88	$5,804	5	$2,301	91	$1,231
PA	1,055	$5,132	104	$6,777	15	$9,163	618	$907
PR	578	$4,851	70	$4,169	751	$529	219	$237
RI	7	$6,512	61	$8,502	28	$6,796	78	$941
SC	245	$4,619	13	$15,160	16	$1,677	685	$574
SD[a]	.	NA	.	NA	.	NA	.	NA
TN	156	$5,227	20	$16,625	55	$4,548	1,142	$946
TX	1,567	$4,160	500	$2,070	271	$3,690	2,016	$1,331
USVI	0	N/A	27	$7,634	0	NA	20	$1,018
UT	59	$4,426	18	$1,788	5	$3,549	87	$671
VA	192	$4,433	12	$8,452	49	$2,196	476	$824
VT	35	$6,287	11	$5,919	0	NA	107	$1,008
WA	187	$3,629	94	$3,016	109	$5,114	241	$680
WI	143	$2,226	30	$1,024	36	$3,589	374	$676
WV	144	$750	10	$6,782	0	NA	217	$452
WY	23	$3,001	0	NA	0	NA	6	$2,215
Total	19,157	$5,584	7,414	$7,303	6,628	$3,255	28,379	$930

Source: HUD HOPWA CAPER and APR Reports, 2010.

[a] Some HOPWA grants cover more than one state and report in aggregate. Therefore, it is not possible to separate expenditures or participants by state for those grantees. The most notable are Montana (which includes North Dakota and South Dakota) and the District of Columbia (which includes parts of Virginia and West Virginia).

Table E *(continued)*

[b] Permanent housing includes households reported as being in permanent housing facilities that receive operating subsidies/leased units.

[c] The Transitional/Short-Term facilities category includes households reported as being in transitional/short-term facilities that received operating subsidies or leased units.

NA = not available.

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APPENDIX F

Table F. Ryan White Program Clients and HOPWA Households Receiving Housing Assistance

State	Number of Ryan White Program HIV-Positive/ Indeterminate Clients Who Received Housing Services[a]	Number of Ryan White Program HIV-Positive Clients	Percentage of Total Ryan White Program HIV-Positive Clients[b]	Number of HOPWA Households Receiving Housing Assistance[c, d]
AK	83	799	10	74
AL	265	9,394	3	555
AR	0	3,787	0	224
AZ	128	13,736	1	793
CA	4,309	89,906	5	7,341
CO	857	9,661	9	376
CT	666	11,467	6	377
DC[a]	50	13,224	0	1,220
DE	117	4,207	3	250
FL	1030	91,251	1	9,051
GA	69	25,892	0	2,220
GU	0	18	0	0
HI	67	1,734	4	184
IA	17	2,102	1	109
ID	5	798	1	117
IL	647	28,304	2	2,501
IN	0	6,551	0	744
KS	0	2,334	0	144
KY	295	4,778	6	1,060
LA	634	17,903	4	2,481
MA	931	20,314	5	674
MD	953	21,530	4	1,097
ME	274	1,290	21	227
MI	748	10,850	7	635
MN	29	7,497	0	352
MO	550	15,855	3	1,155
MS	38	4,562	1	1,107

Table F *(continued)*

State	Number of Ryan White Program HIV-Positive/ Indeterminate Clients Who Received Housing Services[a]	Number of Ryan White Program HIV-Positive Clients	Percentage of Total Ryan White Program HIV-Positive Clients[b]	Number of HOPWA Households Receiving Housing Assistance[c, d]
MT[a]	2	522	0	218
NC	844	19,840	4	2,168
ND[a]	7	101	7	0
NE	30	1,966	2	128
NH	0	1,323	0	201
NJ	423	28,450	1	1,631
NM	83	2,771	3	666
NV	124	6,207	2	412
NY	3,040	122,092	2	5,712
OH	834	14,756	6	1,453
OK	161	3,369	5	320
OR	659	5,855	11	374
PA	2,487	40,488	6	1,782
PR	424	18,421	2	1,614
RI	286	8,097	4	180
SC	2,296	12,725	18	951
SD[a]	1	376	0	0
TN	283	18,400	2	1,373
TX	2,227	56,496	4	4,357
USVI	0	317	0	42
UT	0	1,983	0	168
VA	109	12,384	1	721
VT	0	648	0	153
WA	662	8,681	8	630
WI	762	5,950	13	561
WV	0	1,548	0	358
WY	0	158	0	27
Total	28,506	813,668	3.5	61,268
RSR	18,904[e]	556,175[f]	3.4	.

Table F *(continued)*

Sources: HUD HOPWA CAPER and APR Reports, 2010; HRSA Ryan White Program RDR, 2010; Bottom column is based on Ryan White Program Services Report, 2010.

[a] The Ryan White Program Housing Services category does not include housing assistance paid for through Emergency Financial Assistance.

[b] The total number of clients receiving housing includes clients that were HIV “Indeterminate” (clients under the age of two whose HIV status is unknown.) However, these clients were not included in the total column because they are all under age 2. This may result in some percentages being slightly higher. The number of children who are HIV Indeterminate accounts for 0.6 percent of total Ryan White Program clients.

[c] Some HOPWA grants cover more than one state and are reported in aggregate. Therefore, it is not possible to separate expenditures or participants by state for those grantees. The most notable are Montana (which includes North Dakota and South Dakota) and the District of Columbia (which includes parts of Virginia and West Virginia).

[d] The HOPWA Housing Assistance category does not include housing assistance paid for through housing placement services.

[e] Unduplicated number of RWP clients receiving a housing service (includes HIV positive, negative, and indeterminate) based on 2010 RSR data.

[f] Unduplicated count of clients receiving any type of service regardless of their HIV status (HIV positive, negative, and indeterminate) based on 2010 RSR data.

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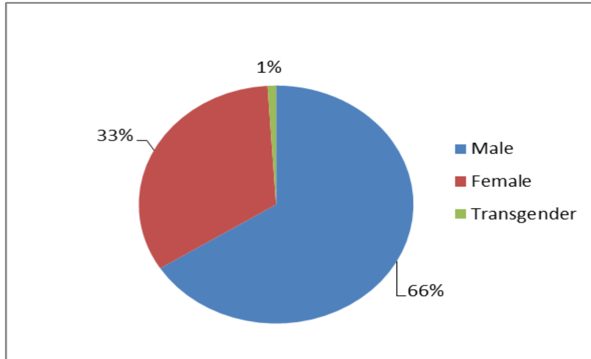
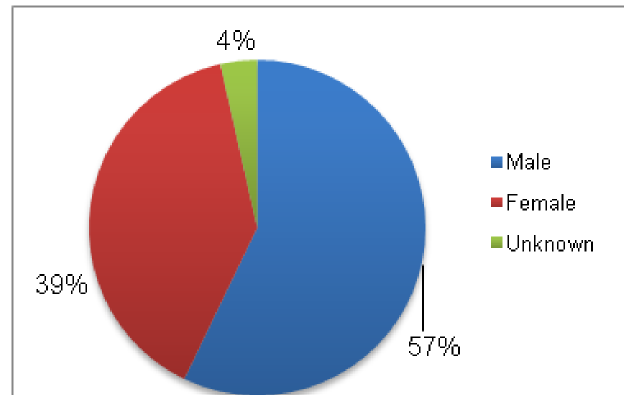
APPENDIX G
HOPWA AND RYAN WHITE PROGRAM PARTICIPANT DEMOGRAPHICS

Figure G.1a. Gender: Ryan White Program Clients Receiving Housing



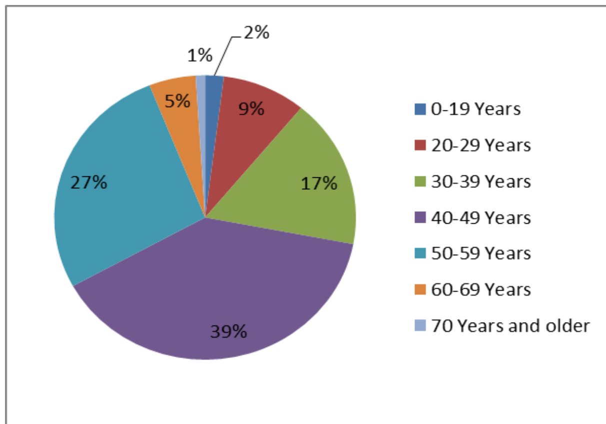
Source: HRSA Ryan White Program Services Report, 2010

Figure G.1b. Gender: HOPWA Housing Participants



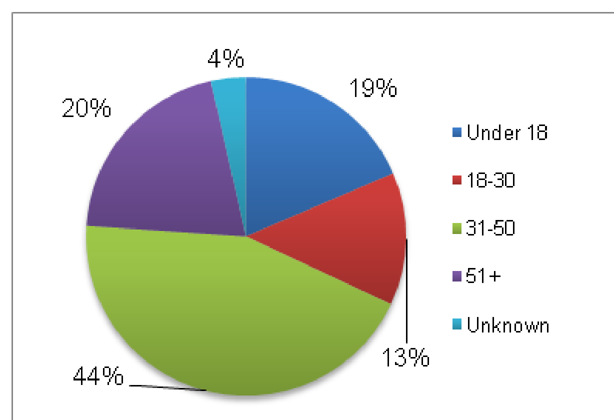
Source: HRSA Ryan White Program Services Report, 2010

Figure G.2a. Age: Ryan White Program Clients Receiving Housing



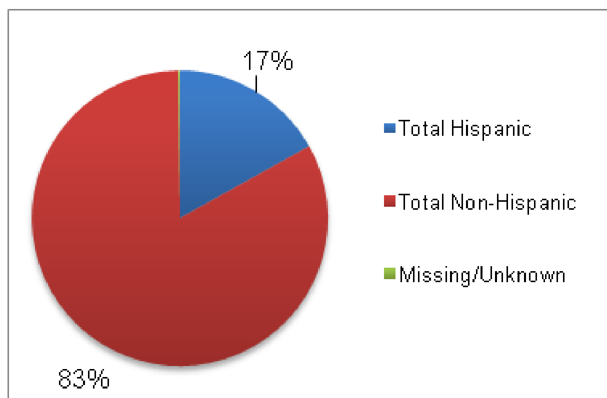
Source: HRSA Ryan White Program Services Report, 2010

Figure G.2b. Age: HOPWA Housing Participants



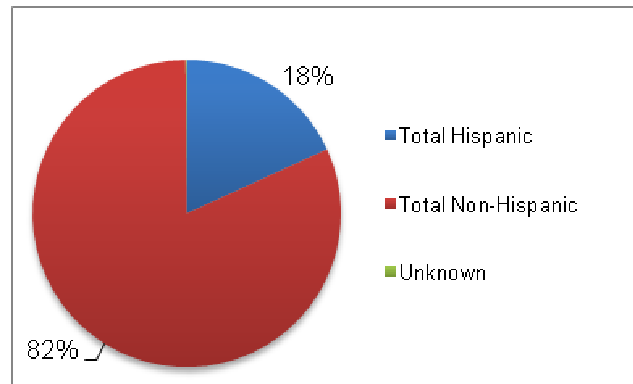
Source: HUD HOPWA CAPER and APR Reports, 2010.

Figure G.3a. Ethnicity: Ryan White Program Clients Receiving Housing



Source: HUD HOPWA CAPER and APR Reports, 2010.

Figure G.3b. Ethnicity: HOPWA Housing Participants



Source: HUD HOPWA CAPER and APR Reports, 2010.

Table G.1. Racial Distribution of All Ryan White Program Clients

Race Category	Number of Clients	Percentage of Total
American Indian	89	0
Asian	102	1
African American	9,846	63
NHPI	33	0
White	4,959	32
Multiracial	330	2
Race Not Reported or Missing or Unknown	350	2
Total	15,709	100.00

Source: HRSA Ryan White Program Services Report, 2010.

Note: All RWP Clients includes all clients and associated family members receiving any type of Ryan White service. Hispanic is included as a separate race within the Ryan White Services Report and therefore clients that are Hispanic are not included in the above table.

Table G.2. Racial Distribution of HOPWA Housing Participants

Race Category	Number of Participants	Percentage of Total
American Indian/Alaskan Native	667	0.7
Asian	375	0.4
Black/African American	49,318	51.7
Native Hawaiian/Other/Pacific Islander	212	0.3
White	32,055	37.6
Multiracial	8,355	9.2
Race Not Reported	117	0.1
Total	95,332	100.0

Source: HUD HOPWA CAPER and APR Reports, 2010.

Note: HOPWA Housing Participants includes only those HIV-positive participants and associated family members receiving housing assistance.

APPENDIX H

Table H. Ryan White Program and HOPWA Participants Served, by Gender

.	Ryan White Program Clients[b]					HOPWA Housing Participants[b]			
State	Male (%)	Female (%)	Transgender (%)	Unknown (%)	Total	Male (%)	Female (%)	Unknown (%)	Total
AK	73	26	1	0	802	58	42	0	118
AL	64	36	0	0	10,015	61	39	0	802
AR	75	25	0	0	3,867	60	40	0	317
AZ	81	18	1	0	14,048	66	34	0	1,300
CA	80	18	2	0	97,626	71	29	0	10,032
CO	79	20	0	0	9,996	63	37	0	587
CT	60	40	1	0	12,660	54	46	0	549
DC[a]	60	38	2	1	14,224	53	43	4	1,816
DE	63	36	0	0	4,242	54	46	0	347
FL	62	38	0	0	102,974	53	47	0	14,853
GA	67	33	1	0	27,817	59	41	0	3,215
GU	80	14	6	0	35	NA	NA	NA	0
HI	86	13	1	0	1,742	72	28	0	253
IA	76	24	1	0	2,117	58	42	0	185
ID	79	21	0	0	799	53	47	0	245
IL	72	27	1	0	29,310	67	33	0	3,293
IN	64	31	1	5	11,591	69	31	0	1,098
KS	77	22	0	1	2,365	68	32	0	252
KY	75	24	1	0	4,799	68	32	0	1,474
LA	62	37	1	0	19,933	58	42	0	3,584
MA	67	33	1	0	20,513	54	46	0	1,090
MD	60	39	1	0	22,788	51	49	0	1,969
ME	80	20	1	0	1,294	73	27	0	310
MI	73	26	1	0	11,467	49	50	1	1,010
MN	71	28	1	0	7,684	56	44	0	603
MO	72	27	0	0	18,075	67	33	0	2,114
MS	61	39	0	0	4,717	58	42	0	1,929
MT[a]	83	17	0	0	527	57	43	0	405

Table H *(continued)*

.	Ryan White Program Clients[b]					HOPWA Housing Participants[b]			
State	Male (%)	Female (%)	Transgender (%)	Unknown (%)	Total	Male (%)	Female (%)	Unknown (%)	Total
NC	65	35	1	0	21,338	9	8	82	3,964
ND[a]	74	26	0	0	101	NA	NA	NA	0
NE	70	29	0	0	2,062	62	38	0	203
NH	66	33	1	0	1,357	59	41	0	387
NJ	61	38	0	0	32,899	46	54	1	2,160
NM	88	12	0	0	2,779	76	24	0	943
NV	76	23	1	0	6,358	64	36	0	862
NY	64	35	1	0	130,627	58	42	0	8,474
OH	72	25	1	3	16,822	60	40	0	2,309
OK	80	20	0	0	3,372	70	30	0	566
OR	83	17	1	0	5,944	67	33	0	617
PA	65	34	1	0	47,433	54	46	0	3,049
PR	63	37	0	0	19,224	59	41	0	2,152
RI	63	36	1	0	8,746	53	47	0	286
SC	63	36	0	0	13,087	53	47	0	1,752
SD[a]	68	32	0	0	376	NA	NA	NA	0
TN	69	31	0	0	19,275	57	43	0	2,416
TX	73	26	1	0	58,092	57	43	0	7,201
USVI	58	42	0	0	325	50	50	0	78
UT	84	16	0	0	1,989	63	37	0	262
VA	66	33	1	0	12,474	54	46	0	1,237
VT	80	20	0	0	648	65	35	0	249
WA	80	19	0	0	8,937	71	29	0	935
WI	69	30	1	0	6,696	60	40	0	922
WV	78	22	0	0	1,548	55	45	0	517
WY	75	25	0	0	158	73	27	0	41
Total	68	31	1	0	880,694	57	39	4	95,332
RSR Total	66	33	1	0	18,904[c]	.	.	.	.

Table H *(continued)*

Source: HRSA Ryan White Program Data Report, 2010; HUD HOPWA CAPER and APR Reports, 2010; Bottom column is based on Ryan White Program Services Report, 2010.

[a] Some HOPWA grants cover more than one state and report in aggregate. Therefore, it is not possible to separate expenditures or participants by state for those grantees. The most notable are Montana (which includes North Dakota and South Dakota) and the District of Columbia (which includes parts of Virginia and West Virginia).

[b] Clients includes HIV-positive clients and all associated family members receiving services.

[c] Unduplicated number of RWP clients receiving a housing service (includes HIV positive, negative, and indeterminate) based on 2010 RSR data.

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APPENDIX I

Table I. Number and Percentage of Ryan White Program Clients and HOPWA Households, by Income Level

States	Number of Ryan White Program Clients, HIV-Positive/ Indeterminate Whose Income Is Equal to or Below the FPL[b,c]	Unduplicated Number of Ryan White Program Clients Who Are HIV Positive or Indeterminate	Percentage of Unduplicated Number of Ryan White Program Clients Who Are HIV Positive or Indeterminate	HOPWA Households Served with Housing Assistance at 0 to 30 Percent of AMI[b,d]	Number of HOPWA Households Receiving Housing Assistance	Percentage of Total HOPWA Households Receiving Housing Assistance
AK	402	802	50	42	74	57
AL	5,944	9,506	63	481	555	87
AR	2,377	3,788	63	175	224	78
AZ	7,688	13,829	56	550	793	69
CA	49,597	90,103	55	5,677	7,341	77
CO	6,334	9,694	65	342	376	91
CT	4,493	11,492	39	279	377	74
DC[a]	6,018	13,366	45	1,210	1,220	99
DE	2,621	4,239	62	205	250	82
FL	54,242	92,167	59	7,648	9,051	84
GA	17,573	26,103	67	1,718	2,220	77
GU	14	18	78	NA	NA	NA
HI	635	1,734	37	161	184	88
IA	1,043	2,102	50	42	109	39
ID	391	798	49	85	117	73
IL	17,569	28,442	62	2,253	2,501	90
IN	3,584	6,551	55	381	744	51
KS	1,287	2,334	55	95	144	66
KY	2,818	4,788	59	630	1,060	59
LA	9,959	18,088	55	1,185	2,481	48
MA	12,918	20,403	63	521	674	77

Table I *(continued)*

States	Number of Ryan White Program Clients, HIV-Positive/ Indeterminate Whose Income Is Equal to or Below the FPL[b,c]	Unduplicated Number of Ryan White Program Clients Who Are HIV Positive or Indeterminate	Percentage of Unduplicated Number of Ryan White Program Clients Who Are HIV Positive or Indeterminate	HOPWA Households Served with Housing Assistance at 0 to 30 Percent of AMI[b,d]	Number of HOPWA Households Receiving Housing Assistance	Percentage of Total HOPWA Households Receiving Housing Assistance
MD	11,141	21,642	51	948	1,097	86
ME	708	1,290	55	158	227	70
MI	5,865	10,910	54	329	635	52
MN	4,335	7,523	58	297	352	84
MO	8,974	15,951	56	999	1,155	86
MS	3,477	4,652	75	653	1,107	59
MT[a]	270	522	52	177	218	81
NC	12,447	19,908	63	318	2,168	15
ND[a]	55	101	54	NA	NA	NA
NE	1,149	1,991	58	119	128	93
NH	564	1,329	42	73	201	36
NJ	17,493	28,652	61	908	1,631	56
NM	1,348	2,777	49	517	666	78
NV	3,065	6,252	49	315	412	76
NY	60,631	122,528	49	5,453	5,712	95
OH	7,044	14,845	47	610	1,453	42
OK	2,094	3,369	62	246	320	77
OR	3,874	5,855	66	320	374	86
PA	29,040	40,590	72	1,404	1,782	79
PR	15,253	18,466	83	1,469	1,614	91
RI	5,936	8,218	72	165	180	92
SC	8,822	12,960	68	632	951	66
SD[a]	163	376	43	NA	NA	NA
TN	12,379	18,492	67	639	1,373	47

Table I *(continued)*

States	Number of Ryan White Program Clients, HIV-Positive/ Indeterminate Whose Income Is Equal to or Below the FPL[b,c]	Unduplicated Number of Ryan White Program Clients Who Are HIV Positive or Indeterminate	Percentage of Unduplicated Number of Ryan White Program Clients Who Are HIV Positive or Indeterminate	HOPWA Households Served with Housing Assistance at 0 to 30 Percent of AMI[b,d]	Number of HOPWA Households Receiving Housing Assistance	Percentage of Total HOPWA Households Receiving Housing Assistance
TX	38,218	56,804	67	3,051	4,357	70
USVI	84	317	26	32	42	76
UT	1,161	1,983	59	138	168	82
VA	7,101	12,444	57	400	721	55
VT	315	648	49	91	153	59
WA	4,261	8,710	49	567	630	90
WI	3,638	6,012	61	528	561	94
WV	812	1,548	52	231	358	65
WY	57	158	36	16	27	59
Total	479,281	818,170	59	45,483	61,268	74
RSR – Housing Service	10,159[e]	15,940[f]	64	.	.	.
RSR – No Housing Service	240,722[g]	437,010[h]	55	.	.	.

Source: HRSA Ryan White Program Data Report, 2010; HUD HOPWA CAPER and APR Reports, 2010.

[a] Some HOPWA grants cover more than one state and report in aggregate. Therefore, it is not possible to separate expenditures or participants by state for those grantees. The most notable are Montana (which includes North Dakota and South Dakota) and the District of Columbia (which includes parts of Virginia and West Virginia).

[b] Includes HIV-positive and -indeterminate clients receiving any type of Ryan White Program services but ONLY HOPWA Households receiving Housing Assistance.

[c] FPL = federal poverty level: The poverty guidelines are established annually by HHS and are used as an eligibility criterion for many federal programs. The poverty level issued by HHS is based on the poverty thresholds used by the Census Bureau and is adjusted annually on the basis of the Consumer Price Index for All Urban Consumers (CPI-U).

Table I *(continued)*

[d] AMI = area median income. The AMI is calculated by dividing the income distribution in the area into two groups, half having income above that amount, and half having income below.

[e] Unduplicated number of RWP clients receiving a housing service (includes HIV positive, negative, and indeterminate) that were at or below 100 percent FPL based on 2010 RSR data.

[f] Unduplicated count of clients receiving a housing service regardless of their HIV status (HIV positive, negative, and indeterminate) that reported income in 2010 RSR data.

[g] Unduplicated number of RWP clients who did not receive a housing service (includes HIV positive, negative, and indeterminate) that were at or below 100 percent FPL based on 2010 RSR data.

[h] Unduplicated count of clients who did not receive a housing service regardless of their HIV status (HIV positive, negative, and indeterminate) that reported income in 2010 RSR data.

NA = not applicable; FPL= federal poverty level.

APPENDIX J

Table J. Number and Percentage of Ryan White Program and HOPWA HIV-Positive Participants with Unstable Housing

State	Number of Ryan White Program Clients, HIV-Positive/Indeterminate Whose Housing/Living Arrangements Were "Nonpermanently Housed" at the End of the Reporting Period	Number of Ryan White Program Clients Who Are HIV Positive or Indeterminate	Percentage of Ryan White Program Clients Who Are HIV Positive or Indeterminate who were "Nonpermanently Housed" at the End of the Reporting Period	Number of New Eligible Individuals Served with HOPWA Housing Assistance whose Prior Living Arrangements Were Homeless	Number of New Eligible Individuals Served with HOPWA Housing Assistance	Percentage of New HOPWA-Eligible Participants Served
AK	99	802	12	1	27	4
AL	742	9,506	8	76	378	20
AR	366	3,788	10	7	164	4
AZ	1,247	13,829	9	25	455	5
CA	6,957	90,103	8	943	4,758	20
CO	1,069	9,694	11	12	111	11
CT	1,757	11,492	15	22	132	17
DC [a]	1,697	13,366	13	79	517	15
DE	289	4,239	7	24	161	15
FL	9,824	92,167	11	565	5,028	11
GA	2,267	26,103	9	313	1,949	16
GU	3	18	17	0	0	NA
HI	125	1,734	7	7	55	13
IA	146	2,102	7	1	59	2
ID	75	798	9	0	16	0
IL	3,984	28,442	14	225	1,467	15
IN	341	6,551	5	89	546	16
KS	115	2,334	5	1	111	1
KY	342	4,788	7	11	779	1
LA	1,264	18,088	7	165	1,710	10
MA	3,078	20,403	15	74	574	13
MD	2,861	21,642	13	20	170	12
ME	85	1,290	7	0	59	0
MI	762	10,910	7	32	277	12

Table J *(continued)*

State	Number of Ryan White Program Clients, HIV-Positive/Indeterminate Whose Housing/Living Arrangements Were “Nonpermanently Housed” at the End of the Reporting Period	Number of Ryan White Program Clients Who Are HIV Positive or Indeterminate	Percentage of Ryan White Program Clients Who Are HIV Positive or Indeterminate who were “Nonpermanently Housed” at the End of the Reporting Period	Number of New Eligible Individuals Served with HOPWA Housing Assistance whose Prior Living Arrangements Were Homeless	Number of New Eligible Individuals Served with HOPWA Housing Assistance	Percentage of New HOPWA-Eligible Participants Served
MN	932	7,523	12	9	110	8
MO	1,625	15,951	10	97	833	12
MS	392	4,652	8	10	1,040	1
MT [a]	42	522	8	8	56	14
NC	1,549	19,908	8	22	193	11
ND [a]	1	101	1	0	0	NA
NE	205	1,991	10	1	22	5
NH	104	1,329	8	0	46	0
NJ	2,143	28,652	7	83	477	17
NM	90	2,777	3	0	542	0
NV	314	6,252	5	22	306	7
NY	23,635	122,528	19	208	1,508	14
OH	1,670	14,845	11	69	834	8
OK	261	3,369	8	15	190	8
OR	762	5,855	13	25	180	14
PA	8,571	40,590	21	51	850	6
PR	2,677	18,466	14	751	1,717	44
RI	1,220	8,218	15	6	122	5
SC	1,827	12,960	14	29	438	7
SD [a]	11	376	3	0	0	N/A
TN	1,415	18,492	8	26	802	3
TX	2,929	56,804	5	287	2,980	10
USVI	31	317	10	1	15	7
UT	231	1,983	12	11	129	9
VA	1,158	12,444	9	12	258	5
VT	78	648	12	1	33	3
WA	1,229	8,710	14	61	334	18

Table J *(continued)*

State	Number of Ryan White Program Clients, HIV-Positive/Indeterminate Whose Housing/Living Arrangements Were "Nonpermanently Housed" at the End of the Reporting Period	Number of Ryan White Program Clients Who Are HIV Positive or Indeterminate	Percentage of Ryan White Program Clients Who Are HIV Positive or Indeterminate who were "Nonpermanently Housed" at the End of the Reporting Period	Number of New Eligible Individuals Served with HOPWA Housing Assistance whose Prior Living Arrangements Were Homeless	Number of New Eligible Individuals Served with HOPWA Housing Assistance	Percentage of New HOPWA-Eligible Participants Served
WI	342	6,012	6	15	371	4
WV	40	1,548	3	7	136	5
WY	29	158	18	0	5	0
Total	95,008	818,170	12	4,519	34,030	13
RSR – Housing Services	843[b]	18,904[c]	5	.	.	.
RSR – No Housing Service	14,269[d]	530,021[e]	3	.	.	.

Sources: HRSA Ryan White Program Data Report, 2010; HUD HOPWA CAPER and APR Reports, 2010.

[a] Some HOPWA grants cover more than one state and report in aggregate. Therefore, it is not possible to separate expenditures or participants by state for those grantees. The most notable are Montana (which includes North Dakota and South Dakota) and the District of Columbia (which includes parts of Virginia and West Virginia).

[b] Unduplicated number of RWP clients receiving a housing service who reported they were in unstable housing at the end of the reporting period (includes HIV positive, negative, and indeterminate) based on 2010 RSR data. The categories for housing status are different in the Ryan White Services Program Report versus the Ryan White Program Services Report. "Nonpermanently housed" (RDR) and "unstable housing" (RSR) may not be comparable.

[c] Unduplicated count of clients receiving a housing service regardless of their HIV status (HIV positive, negative, and indeterminate) who reported housing status at the end of the reporting period in 2010 RSR data.

[d] Unduplicated number of RWP clients not receiving a housing service who reported they were in unstable housing at the end of the reporting period (includes HIV positive, negative, and indeterminate) based on 2010 RSR data. The categories for housing status are different in the Ryan White Services Program Report versus the Ryan White Program Services Report. "Nonpermanently housed" (RDR) and "unstable housing" (RSR) may not be comparable.

[e] Unduplicated count of clients not receiving a housing service regardless of their HIV status (HIV positive, negative, and indeterminate) who reported housing status at the end of the reporting period in 2010 RSR data.

NA = not available.

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APPENDIX K

Table K. HOPWA Housing Participant Outcomes

State	Total Exits to Unstable Housing	Total Number of Households Receiving TBRA, Permanent Housing Facilities Transitional/Short-Term Housing Facilities, or STRMU Assistance	Percentage of Total Households Who Exited to Unstable Housing	Had Contact with Primary Health Care Provider Consistent with the Schedule Specified in Participant's Individual Service Plan	Total Households on Which Outcomes Were Reported	Percentage of Total Households on Which Outcomes Were Reported
AK	78	4	5	73	74	99
AL	566	24	4	653	737	89
AR	285	25	9	211	294	72
AZ	802	36	4	743	793	94
CA	7,710	961	12	10,261	12,324	83
CO	376	2	1	660	736	90
CT	378	14	4	443	455	97
DC*	1,232	60	5	284	2,265	13
DE	250	2	1	250	250	100
FL	7,581	870	11	8,035	8,616	93
GA	2,242	158	7	3,589	3,665	98
GU	0	0	NA	0	0	NA
HI	184	7	4	351	351	100
IA	109	4	4	99	109	91
ID	117	12	10	68	117	58
IL	2,501	79	3	2,261	2,505	90
IN	757	30	4	744	744	100
KS	163	10	6	144	144	100
KY	1,083	12	1	1,699	1,728	98
LA	2,490	97	4	2,440	2,578	95
MA	694	7	1	1,338	1,411	95
MD	1,098	14	1	1,272	1,379	92
ME	228	3	1	368	368	100

Table K *(continued)*

State	Total Exits to Unstable Housing	Total Number of Households Receiving TBRA, Permanent Housing Facilities Transitional/Short-Term Housing Facilities, or STRMU Assistance	Percentage of Total Households Who Exited to Unstable Housing	Had Contact with Primary Health Care Provider Consistent with the Schedule Specified in Participant's Individual Service Plan	Total Households on Which Outcomes Were Reported	Percentage of Total Households on Which Outcomes Were Reported
MI	573	11	2	461	567	81
MN	352	9	3	277	352	79
MO	1,175	51	4	1,136	1,155	98
MS	1,109	41	4	288	1,107	26
MT*	232	19	8	213	218	98
NC	2,212	56	3	2,226	2,233	100
ND*	0	0	NA	0	0	NA
NE	137	4	3	109	128	85
NH	211	10	5	170	201	85
NJ	1,643	43	3	1,834	1,073	171
NM	666	0	0	1,604	1,604	100
NV	418	16	4	320	1,050	30
NY	5,765	256	4	39,268	43,350	91
OH	1,457	50	3	1,734	1,762	98
OK	372	2	1	415	443	94
OR	376	6	2	462	487	95
PA	1,792	66	4	1,652	1,782	93
PR	1,618	124	8	2,412	2,990	81
RI	180	5	3	272	287	95
SC	959	192	20	1,092	1,300	84
SD*	0	0	NA	0	0	NA
TN	1,373	27	2	1,813	4,161	44
TX	4,425	157	4	4,465	5,309	84
USVI	47	1	2	42	42	100
UT	165	5	3	215	224	96
VA	729	9	1	688	721	95
VT	153	1	1	148	153	97

Table K *(continued)*

State	Total Exits to Unstable Housing	Total Number of Households Receiving TBRA, Permanent Housing Facilities Transitional/Short-Term Housing Facilities, or STRMU Assistance	Percentage of Total Households Who Exited to Unstable Housing	Had Contact with Primary Health Care Provider Consistent with the Schedule Specified in Participant's Individual Service Plan	Total Households on Which Outcomes Were Reported	Percentage of Total Households on Which Outcomes Were Reported
WA	672	38	6	733	743	99
WI	583	15	3	550	599	92
WV	371	1	0	189	358	53
WY	29	1	3	42	27	156
Total	60,718	3,647	6	100,816	116,069	87

Source: HUD HOPWA CAPER and APR Reports, 2010.

Note: In some cases, the number of households reported with outcome was higher than the number of households reported as receiving housing assistance. In addition, percentages over 100 percent were reporting errors.

[a] Some HOPWA grants cover more than one state and report in aggregate. Therefore, it is not possible to separate expenditures or participants by state or those grantees. The most notable are Montana (which includes North Dakota and South Dakota) and the District of Columbia (which includes parts of Virginia and West Virginia).

NA = not available.

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APPENDIX L
DISCUSSION GUIDES

ANALYSIS OF INTEGRATED HIV HOUSING AND CARE SERVICES FLORIDA IHHP PROJECT SITE VISIT: RIVER REGION HUMAN SERVICES IHHP GRANTEE DISCUSSION GUIDE

Introduction

Thank you for agreeing to participate in this discussion. My name is Meg Hargreaves and I work for Mathematica Policy Research, an independent research firm. As you know, Mathematica Policy Research and Cloudburst are conducting a study for the U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE) about housing and care services for people living with HIV. The study has two components: (1) a quantitative analysis of national HIV housing assistance data and (2) a qualitative study of Integrated HIV/AIDS Housing Plan (IHHP) projects funded by the U.S. Department of Housing and Urban Development (HUD). Findings from this study will inform Federal policymakers about innovative program integration models that address both housing and health.

The information we are gathering from the IHHP projects will be summarized in a final report for ASPE describing the IHHP programs and their local contexts. While our report will describe the experiences and viewpoints expressed by local program staff and partners, we will not quote any individuals by name. Your participation is entirely voluntary; if you decide not to participate in this interview, your grant will not be affected. With your permission, I would like to tape record this discussion to as a back-up for my notes. Recordings will be retained throughout the remainder of the project and then destroyed after the final report is complete. Do you have any objections?

We have scheduled up to 90 minutes for our discussion today, though we may not use the entire time. Do you have any questions before we start?

A. Respondent Information

1. To start the discussion, please state your job title and briefly describe your role at River Region Human Services and on the Forging Useful Systems to Empower Project (FUSE) project (i.e., IHHP project).
2. How much of your time is currently spent working on the IHHP project?
3. How long have you worked for River Region Human Services?

B. Program Context and Characteristics

I have a few background questions for you about the River Region Human Services and the SPNS grant.

1. Please describe the overall size, scope, and mission of River Region Human Services?

2. How long has River Region Human Services provided HIV housing services? What types of services are currently provided, to whom, and in what locations?

3. What motivated your agency's decision to apply for the IHHP SPNS grant?

4. What does the agency hope to accomplish through this grant?

5. When did the agency receive the grant award and for how much funding?

6. How is the funding being used – to start a new program, modify an existing program, or expand existing services to a new area or population? Please explain.

7. What is the IHHP program's current budget?

8. In addition to the IHHP grant, what funding, if any, comes from other sources (HOPWA, other HUD sources, Ryan White HIV/AIDS Program Part A or B, and other sources)?

9. When did River Region Human Services start serving IHHP clients?

10. How many are currently being served?

11. In what locations are clients being served?

    FOLLOW UP:

    - Describe the project's demographic characteristics of the program's clients, for example age, gender, language(s) spoken, race/ethnicity, income, housing status, and HIV status.

C. Program Staffing

We are interested in understanding how the IHHP program is staffed.

1. How many staff work in the program, and in what positions/roles?

[Note: program staff may include: a housing program manager, director, or coordinator; a housing planner or specialist; a direct service supervisor; service coordinator, or social worker; an outreach or intake worker; a program data manager; a mental health or substance abuse treatment counselor; a clinical care physician, nurse, or physician assistant; and/or others.]

2. What percent of their time is spent on the IHHP program?

    PROBES:

    - Does the program use a team-based approach, where clients are assigned to specific teams, or are clients assigned to certain staff?

    - If team-based, what are the team's responsibilities? Are teams multidisciplinary or interdisciplinary? Who is included on the team?

    - Are teams composed of members from other organizations? If so, what organizations?

3. What is the average number of clients served by each staff?

4. What program-specific trainings have staff members received?

   FOLLOW UP:

   - What topics are covered?
   - What is the duration and frequency of training?
   - Describe any HIV/AIDS competency training provided.
   - Describe any cultural competency training provided.

D. Client Outreach

Now, I would like to ask about the program's outreach process.

1. Who handles the program's client outreach activities?
2. How are potential clients made aware of the IHHP program and its services?
3. Is outreach tailored for different locations or client groups? If so, please explain.

E. Client Intake, enrollment, and Care Planning

Let's discuss the program's intake, enrollment, and care planning processes.

1. Please describe the intake and enrollment process. Who handles the process?
2. How do staff members determine whether an individual is eligible to enroll in the program?
3. Please describe the client assessment and care planning process. Who handles the process?
4. What issues or topics are included in the client assessment and care plan development?

   - Housing stability barriers
   - Other basic needs, including food insecurity
   - Employment, income, or self-sufficiency barriers
   - Health insurance issues
   - Behavioral health issues
   - Mental health status
   - HIV transmission risks
   - Barriers to accessing and staying in HIV clinical care
   - Anti-retroviral therapy medication adherence issues

- Other? Please specify.

5. What formal assessment and care planning tools (if any) are used? Please describe.

   [INTERVIEWER SHOULD ASK FOR A COPY OF THE TOOL(S), IF APPLICABLE]

6. What program requirements or rules are clients expected to follow? Please explain.

7. From your observation, what are the clients' greatest service needs?

   - Do the needs of people living with HIV/AIDS differ from other clients you serve? Please explain.

8. How does the program address those needs?

F. Client Housing and Support Services

Let's discuss the program's services and the integration of housing and HIV care.

1. Who provides direct services to the program's clients?

2. What direct services are provided to program clients?

   - Housing Assistance. Are you moving clients from tenant-based rental assistance to public housing choice vouchers? Why?
   - Employment or Other Income Assistance. What assistance do clients receive accessing economic or employment assistance (SNAP, Medicaid, SSI/SSDI, TANF, RWHAP, other public assistance, or other resources)?
   - Medical Assistance. Does the program provide direct medical care and/or link clients to medical, mental health, and/or substance abuse treatment services provided elsewhere?
   - Medical Case Management: Is this service provided on-site or through an outside provider?
   - Other Direct Services: Please describe.

3. Are program clients referred to other organizations to obtain services? If so, what are those services?

4. How are the program's services modified or customized, if at all, to meet the needs of people living with HIV/AIDS?

G. Linkage to HIV Care

1. How is housing assistance coordinated with medical care through the program?

2. Does the program have any formal or informal arrangements with health care providers to coordinate housing assistance and medical care?

   FOLLOW UP:

   - Does your program work with specific clinics and health centers, or providers to link and retain clients in HIV care?

   - Are particular referral processes used to help clients access services from other providers? Please provide an example of how clients are linked to appropriate health care services.

   - How do providers share client information or coordinate services to make referrals, or to ensure proper HIV care for program clients?

   - How frequently does the program attempt to communicate with health centers and/or providers regarding program clients?

   - In the program's efforts to link clients to healthcare services, have staff members developed shared goals and/or protocols with outside clinics and health centers?

   - To facilitate partnerships with outside agencies has the program changed the way that clients are linked to healthcare services?

H. Program Data Collection and Use

We are interested in understanding better your process for data collection.

1. Who handles the program's data management duties?

2. Please describe how the program collects and tracks client-level demographic, service use, and program outcome data, including HIV/AIDS status.

   FOLLOW UP:

   - What data elements are collected, how frequently, using what data forms?

   - Do the data elements include health outcomes? If so, what health outcomes are reported?

   - In what data systems are the data stored and accessed?

   - In your application, you mentioned that you use the HMIS and CAREWare to maximize service coordination and minimize duplication of services and data entries. Do you currently utilize HMIS and CAREWare? Has it been modified or customized your program?

   - What other data information systems do you use, if any, and how are they coordinated with HMIS and CAREWare?

- How would you describe the quality of the data, particularly, the data on clients' service use or outcomes?

- Is the HIV/AIDS status data based on self-report, staff report, or a combination?

Now, I would like to talk about the ways that the program makes use of client-level data.

3. How does the program use client-level demographic, service use, and/or outcome data in service planning, program monitoring, evaluation, or quality improvement? Please explain and provide examples.

   INDICATOR PROBES:

   - Client Characteristics. Age, gender, race/ethnicity, other demographics, chronic homelessness, prior living situations.

   - Client Service Needs. Basic income needs, housing, employment, food, mental health, substance use, access to insurance and to a primary care provider.

   - Housing Service Utilization and Outcomes. Avoidance of homelessness, use of transitional housing, housing stability and permanency.

   - HIV Medical Care Utilization and Outcomes. Health insurance status, designated primary care provider, ongoing engagement in care, ART medication adherence, suppression of viral load.

4. Can your program's information system(s) be used to generate planning reports? If so, please describe the reports.

5. Has the program's data system been used to tabulate outcomes by demographic characteristics and/or HIV/AIDS status? If so, how often have reports been generated and used?

6. In general, are there efforts to share aggregate and client-level data with partner agencies? If so, who are these partner agencies, what information is shared, how often, and for what reasons?

   FOLLOW UP:

   - Are housing indicators and/or outcomes data shared with these partners? Please describe.

   - Are HIV clinical care indictors and/or outcomes data shared with these partners? Please describe.

   - [If reports are generated] Are reports shared with external partners/agencies/providers? If so, which reports are shared and how frequently?

- How regularly do program staff members have contact with these other agencies about data issues and/or findings?

- Do these efforts require ongoing cooperation with partner agencies? For what purpose [PROBES: to prevent duplication efforts and ensure data quality among agencies]?

- In your efforts to share data, have you developed shared goals and/or protocols with outside partners?

- To facilitate data partnerships with outside agencies, have you made changes in the way the program collects, uses, and shares data?

I. Community HIV and Housing Planning

We are interested in learning more about how your agency is involved in community planning activities and processes.

1. In what way(s) is the agency involved, if at all, in the following in community/state planning activities?

   - HUD Consolidated Plan and Annual Action Plans
   - HUD Continuum of Care Homeless Assistance Planning
   - Public Housing Agency Plans – 5-Year Plans and Annual Plans
   - RWHAP HIV Planning Council - Comprehensive Plans and Needs Assessments
   - CDC Prevention Community Planning Group – Comprehensive HIV Prevention Plan
   - State Mental Health Planning Council – Comprehensive Mental Health Services Plan
   - Online planning forums for program clients and other people living with HIV
   - Other HIV housing related community planning activities

   FOLLOW UP:

   - How frequently do you communicate with other agencies, including both federal agencies and non-profit organizations, regarding community planning activities? With which agencies, in particular?
   - Do these efforts require cooperation or coordination with each other? Please explain.
   - Have you and other agencies developed shared goals and/or protocols as part of these planning efforts.
   - To facilitate this collaboration, have you made system-wide changes in the ways in which you are involved in community planning activities?

- Do you share resources with other organizations in order to facilitate community planning activities? Please describe.

2. Have you participated in or conducted a community-level needs assessment or census related to stable housing and health outcomes for people living with HIV/AIDS?

   IF YES:

   - When, and how often, have such community-level needs assessment efforts occurred?
   - Please describe the methods used to assess community-level HIV housing and health care needs.
   - What issues did the most recent community-level needs assessment explore?

   FOLLOW UP:

   - What barriers to stable housing and health outcomes for people living with HIV/AIDS have been identified at the community-level?
   - What strategies, if any, have been implemented to address these housing and health barriers at the community-level?

3. One of the IHHP grant requirements is to develop an integrated housing plan at the community-level. How do you plan to fulfill that requirement?

   FOLLOW UP:

   - What do you want to achieve through this grant to support the comprehensive planning and coordination of local resources for the housing and HIV care of people with HIV?
   - What has been done to develop and implement this community plan? What has been accomplished thus far?
   - When completed, would this new integrated housing plan change what is currently happening at the community-level? If so, how?
   - How do you plan to sustain these changes in community planning and local service integration?

4. Describe any additional policy work your program does to support HIV housing system development and integration.

J. Program Implementation and Progress

I'd like to wrap up this discussion by learning more about your program's successes and challenges.

1. In general, how is IHHP grant program going? What aspects of the program have been the most successful?

2. What challenges, if any, have you encountered in implementing your program?

   FOLLOW UP:

   - Have you implemented any strategies to address these challenges? If so, please describe.

3. What elements of your program do you think are the most important in meeting the needs of people living with HIV/AIDS?

4. Are there innovative features that you feel distinguish the IHHP project from other housing programs targeting people living with HIV/AIDS?

   PROBES:

   - Integrated practices in client outreach, enrollment, services, and linkages to care.
   - Enhanced staff qualifications and training; comprehensive, coordinated care teams.
   - Integration of housing and health care data collection, reporting, and evaluation systems.
   - Local coordination of service providers, streamlined access to housing and health care.
   - Collaborative community needs assessment and planning, local awareness and support.
   - Local and state policy advocacy supporting the integration of HIV housing and health care services.

5. What are some lessons that your program has learned about integrating housing and health care services for people with HIV/AIDS?

6. What programmatic changes would you make, if any, to help the program better serve your clients and to sustain the integration the grant has achieved?

K. Closing

1. Before we end the discussion, is there anything I haven’t asked that you think would be important for me to know in understanding the effectiveness of the IHHP program?

   Thank you again for your participation!

ANALYSIS OF INTEGRATED HIV HOUSING AND CARE SERVICES
FLORIDA IHHP PROJECT SITE VISIT: RIVER REGION HUMAN SERVICES
RWHAP GRANTEE DISCUSSION GUIDE
CITY OF JACKSONVILLE

Introduction

Thank you for agreeing to participate in this discussion. My name is Meg Hargreaves and I work for Mathematica Policy Research, an independent research firm. As you know, Mathematica Policy Research and Cloudburst are conducting a study for the U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE) about housing and care services for people living with HIV. The study has two components: (1) a quantitative analysis of national HIV housing assistance data and (2) a qualitative study of Integrated HIV/AIDS Housing Plan (IHHP) projects funded by the U.S. Department of Housing and Urban Development (HUD). Findings from this study will inform Federal policymakers about innovative program integration models that address both housing and health.

The information we are gathering from the IHHP projects will be summarized in a final report for ASPE describing the IHHP programs and their local contexts. While our report will describe the experiences and viewpoints expressed by local program staff and partners, we will not quote any individuals by name. Your participation is entirely voluntary; if you decide not to participate in this interview, your grant will not be affected. With your permission, I would like to tape record this discussion to as a back-up for my notes. Recordings will be retained throughout the remainder of the project and then destroyed after the final report is complete. Do you have any objections?

We have scheduled up to 90 minutes for our discussion today, though we may not use the entire time. Do you have any questions before we start?

A. Respondent Information

1. To start the discussion, please state your job title and briefly describe your role as the Ryan White HIV/AIDS Program (RWHAP) Part A Program Coordinator as part of the City of Jacksonville.
2. How long have you worked for the City of Jacksonville in this role?

B. Characteristics of Partnership with HOPWA IHHP Grantee

I have a few background questions for you regarding your work with River Region Human Services and the IHHP project?

1. What role does the RWHAP Part A program currently play in supporting HIV housing services in the state? Has the Part A program ever funded HIV housing services?

2. Could you briefly describe your program's relationship to River Region Human Services?

3. When did the connection begin? How formal is the relationship? Is there a memorandum of understanding or a contract between the two agencies?

4. How would you describe the primary goals of this partnership?

5. How long have you been working with River Region Human Services? What role, if any, do you play in the River Region Human Services' current IHHP project?

6. What is your familiarity with the River Region Human Services' IHHP project? Are there innovative features that you feel distinguish the River Region Human Services' IHHP project from other housing programs targeting people living with HIV/AIDS?

7. Has your agency provided any consultation or assistance to River Region Human Services regarding service provision for people with HIV/AIDS?

   IF YES:

   - What type of consultation or assistance did you provide?

C. Program Data Collection and Use

We are interested in better understanding the process for data sharing and use.

1. As part of your partnership River Region Human Services are there systematic efforts to share data and/or track common indicators and outcomes?

   FOLLOW UP:

   - What kinds of data are shared and how frequently?
   - How regularly do program staff members communicate about data issues and/or findings?
   - Do these efforts require ongoing cooperation? For what purpose [PROBES: to prevent duplication efforts and ensure data quality among agencies]?
   - In your efforts to share data with River Region Human Services, have you developed shared goals and/or protocols?
   - To facilitate data partnerships, have you made changes in the way the program collects, uses, and shares data?

Now, I would like to talk about the ways that the Part A program/City of Jacksonville makes use of client-level program data.

2. How does the Part A program/the City of Jacksonville use client-level demographic, service use, and/or outcome data in service planning, program monitoring, evaluation, or quality improvement? Please explain and provide examples.

   INDICATOR PROBES:

- Client Characteristics. Age, gender, race/ethnicity, other demographics, chronic homelessness, prior living situations.
- Client Service Needs. Basic income needs, housing, employment, food, mental health, substance use, access to insurance and to a primary care provider.
- Housing Service Utilization and Outcomes. Avoidance of homelessness, use of transitional housing, housing stability and permanency.
- HIV Medical Care Utilization and Outcomes. Health insurance status, designated primary care provider, ongoing engagement in care, ART medication adherence, suppression of viral load.

D. Community HIV and Housing planning

We are interested in learning more about how the Part A program/the City of Jacksonville is involved in community planning activities and processes.

1. In what way(s) is the Part A program/the City of Jacksonville involved in the following in community/state planning activities?

   - RWHAP HIV Planning Council - Comprehensive Plans and Needs Assessments
   - CDC HIV Prevention Community Planning Group – Comprehensive HIV Prevention Plans
   - HUD Consolidated Plan and Annual Action Plans
   - HUD Continuum of Care Homeless Assistance Planning
   - Public Housing Agency Plans – 5-Year Plans and Annual Plans
   - State Mental Health Planning Council – Comprehensive Mental Health Services Plan
   - Online planning forums for program clients and other people living with HIV
   - Other HIV housing related community planning activities

   FOLLOW UP:

   - How frequently do you communicate with other agencies, including both federal agencies and non-profit organizations, regarding community planning activities? With which agencies, in particular?
   - Do you work with the River Region Human Services, in particular, on community planning? If so, please describe.
   - Have you and other agencies, such as the River Region Human Services, developed shared goals and/or protocols as part of these planning efforts. Please describe.

- To facilitate this collaboration, have you made system-wide changes in the ways in which you are involved in community planning activities?
- Do you share resources with others, such as the River Region Human Services, to facilitate community planning activities? Please explain.

2. Have you participated in or conducted a community-level needs assessment or census related to stable housing and health outcomes for people living with HIV/AIDS?

   IF YES:

   - When, and how often, have such community-level needs assessment efforts occurred?
   - Who conducted the needs assessment? What other agencies were involved?
   - What methods were used to assess community-level HIV housing and health care needs?
   - What issues did the most recent community-level needs assessment explore?

   FOLLOW UP:

   - What barriers to stable housing and health outcomes for people living with HIV/AIDS have been identified at the community-level?
   - What strategies, if any, have been implemented to address these housing and health barriers at the community-level?

3. One of the IHHP grant requirements is to develop an integrated housing plan at the community-level. Do you know whether the Part A program/the City of Jacksonville will be involved in that activity?

   FOLLOW UP:

   - What has been done to develop and implement this community plan? What has been accomplished so far?
   - How does this new integrated housing plan differ, if at all, from other community planning efforts?

4. Please describe any additional policy work that DHHS does to support HIV housing system development and integration.

E. Program Implementation and Progress

I'd like to wrap up this discussion by learning more about the lessons you have learned so far from your partnership with River Region Human Services.

1. In general, what aspects of the partnership have been the most successful?

2. What challenges, if any, have you encountered as part of your relationship with River Region Human Services?

   FOLLOW UP:

   - Have you implemented any strategies to address these challenges? If so, please describe.

3. What are some lessons that your agency has learned about integrating housing and health care services for people with HIV/AIDS?

4. What lessons has your agency learned about sharing or using HIV housing and health care service use and measuring client outcomes?

F. Closing

1. Before we end the discussion, is there anything I haven't asked that you think would be important for me to know in understanding your partnership with River Region Human Services?

   Thank you again for your participation!

ANALYSIS OF INTEGRATED HIV HOUSING AND CARE SERVICES
FLORIDA IHHP PROJECT SITE VISIT: RIVER REGION HUMAN SERVICES
DIRECT SERVICE PROVIDER DISCUSSION GUIDE
ABILITY HOUSING OF NE FLORIDA

Introduction

Thank you for agreeing to participate in this discussion. My name is Meg Hargreaves and I work for Mathematica Policy Research, an independent research firm. As you know, Mathematica Policy Research and Cloudburst are conducting a study for the U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE) about housing and care services for people living with HIV/AIDS. The study has two components: (1) a quantitative analysis of national HIV housing assistance data and (2) a qualitative study of Integrated HIV/AIDS Housing Plan (IHHP) projects funded by the U.S. Department of Housing and Urban Development (HUD). The goal of the study is to identify potential best practices. Findings from the study will inform Federal policymakers about innovative program integration models that address both housing and health.

The information we gather will be used to write a report for ASPE describing integrated HIV housing and care programs and the local contexts in which they operate. While our report will describe the experiences and viewpoints expressed by IHHP programs staff from each site, we will not attribute specific comments to individuals. Please note that we will not quote any individuals by name in any report. Your participation is voluntary; if you decide not to participate in this interview, your decision will not affect your grant. With your permission, I would like to tape record this discussion to help me remember your comments when I write up my notes. Recordings will be retained throughout the remainder of the project and then destroyed after the final report is complete. Do you have any objections?

We have scheduled up to 90 minutes for our discussion today, though we may not use the entire time. Do you have any questions before we start?

A. Respondent Information

1. To start the discussion, please state your job title and briefly describe your role at Ability Housing of NE Florida and on the IHHP project.

2. How much of your time is currently spent working on the IHHP project?

3. How long have you worked for Ability Housing?

B. Program Staffing

We are interested in understanding how the IHHP program is staffed.

1. What is the average number of clients you serve?

   FOLLOW UP:

   - What is your optimal client caseload?

2. What program-specific trainings have you received?

   FOLLOW UP:

   - What topics are covered?
   - What is the duration and frequency of training?
   - Describe any HIV/AIDS competency training provided.

C. Client Outreach and Recruitment

Now, I would like to ask you about your outreach and recruitment process.

1. How do you make your target population aware of your program and the services you provide?
2. Do you tailor your outreach approach to different subgroups? If so, please explain.

D. Client Intake and Care Planning

Let's discuss the program's intake, enrollment, and care planning processes.

1. Please describe the intake and enrollment process.
2. How do staff members determine whether an individual is eligible to enroll in the program?
3. Please describe the client assessment and care planning process. Which staff lead the care planning process? For example, a social worker or nurse.
4. What issues or topics are included in the client assessment and care plan development?

   - Housing stability barriers
   - Other basic needs, including food insecurity
   - Employment, income, or self-sufficiency barriers
   - Health insurance issues
   - Behavioral health issues
   - Mental health status
   - HIV transmission risks
   - Barriers to accessing and staying in HIV clinical care
   - Anti-retroviral therapy medication adherence issues

- Other? Please specify.

5. What formal assessment and care planning tools (if any) are used? Please describe.

   [INTERVIEWER SHOULD ASK FOR A COPY OF THE TOOL(S), IF APPLICABLE]

6. What program requirements or rules are clients expected to follow? Please explain.

7. From your observation, what are the clients' greatest service needs?

   - Do the needs of people living with HIV/AIDS differ from other clients you serve? Please explain.

8. How does the program address those needs?

E. Client Housing and Support Services

Let's discuss the program's services and the integration of housing and HIV care.

1. Who provides direct services to the program's clients?

2. What direct services are provided to program clients?

   - Housing Assistance. Are you moving clients from tenant-based rental assistance to public housing choice vouchers? Why?

   - Employment or Other Income Assistance. What assistance do clients receive accessing economic or employment assistance (SNAP, Medicaid, SSI/SSDI, TANF, RWHAP, other public assistance, or other resources)?

   - Medical Assistance. Does the program provide direct medical care and/or link clients to medical, mental health, and/or substance abuse treatment services provided elsewhere?

   - Medical Case Management: Is this service provided on-site or through an outside provider?

   - Other Direct Services: Please describe.

3. Are program clients referred to other organizations to obtain services? If so, what are those services?

4. How are the program's services modified or customized, if at all, to meet the needs of people living with HIV/AIDS?

F. Linkage to HIV Care

1. How is housing assistance coordinated with medical care through the program?

2. Does the program have any formal or informal arrangements with health care providers to coordinate housing assistance and medical care?

   FOLLOW UP:

   - Does your program work with specific clinics and health centers, or providers to link and retain clients in HIV care?
   - Are particular referral processes used to help clients access services from other providers? Please provide an example of how clients are linked to appropriate health care services.
   - How do providers share client information or coordinate services to make referrals, or to ensure proper HIV care for program clients?
   - How frequently does the program attempt to communicate with health centers and/or providers regarding program clients?
   - In the program's efforts to link clients to healthcare services, have staff members developed shared goals and/or protocols with outside clinics and health centers?
   - To facilitate partnerships with outside agencies has the program changed the way that clients are linked to healthcare services?

G. Data Collection and Use

We are interested in better understanding your involvement in the program's data collection and use.

1. Who handles the program's data management duties?
2. Please describe how the program collects and tracks client-level demographic, service use, and program outcome data, including HIV/AIDS status. Do the data include health outcomes? If so, which health outcomes?
3. How does the program use client-level demographic, service use, and/or outcome data in service planning, program monitoring, evaluation, or quality improvement? Please explain and provide examples.
4. Can your program's information system(s) be used to generate planning reports? If so, please describe the reports.
5. Has the program's data system been used to tabulate outcomes by demographic characteristics and/or HIV/AIDS status? If so, how often have reports been generated and used?
6. In general, are there efforts to share aggregate and client-level data with partner agencies? If so, who are these partner agencies, what information is shared, how often, and for what reasons?

FOLLOW UP:

- Are housing indicators and/or outcomes data shared with these partners? Please describe.
- Are HIV clinical care indictors and/or outcomes data shared with these partners? Please describe.
- [If reports are generated] Are reports shared with external partners/agencies/providers? If so, which reports are shared and how frequently?
- How regularly do program staff members have contact with these other agencies about data issues and/or findings?
- Do these efforts require ongoing cooperation with partner agencies? For what purpose [PROBES: to prevent duplication efforts and ensure data quality among agencies]?
- In your efforts to share data, have you developed shared goals and/or protocols with outside partners?
- To facilitate data partnerships with outside agencies, have you made changes in the way the program collects, uses, and shares data?

H. Community Planning

We are interested in learning more about how you are involved in community planning activities.

1. In what way(s) are you involved, if at all, in the following in community/state planning activities? If so, please describe your involvement and responsibilities:
    - HUD Consolidated Plan and Annual Action Plans
    - HUD Continuum of Care Homeless Assistance Planning
    - Public Housing Agency Plans – 5-Year Plans and Annual Plans
    - RWHAP HIV Planning Council - Comprehensive Plans and Needs Assessments
    - CDC Prevention Community Planning Group – Comprehensive HIV Prevention Plan
    - State Mental Health Planning Council – Comprehensive Mental Health Services Plan
    - Online planning forums for program clients and other people living with HIV
    - Other HIV housing related community planning activities
2. Have you participated in or conducted a community-level needs assessment or census related to stable housing and health outcomes for people living with HIV/AIDS?

    IF YES:

- When, and how often, have such community-level needs assessment efforts occurred?
- Please describe the methods used to assess community-level HIV housing and health care needs.
- What issues did the most recent community-level needs assessment explore?

FOLLOW UP:

- What barriers to stable housing and health outcomes for people living with HIV/AIDS have been identified at the community-level?
- What strategies, if any, have been implemented to address these barriers at the community-level?

3. One of the IHHP grant requirements is to develop an integrated housing plan at the community-level.

FOLLOW UP:

- How does the program plan to fulfill that requirement?
- What has been done to develop and implement this community plan? What has been accomplished thus far?

I. Program Implementation and Progress

I'd like to wrap up this discussion by learning more about your program's successes and challenges.

1. In general, how is IHHP grant program going? What aspects of the program have been the most successful?
2. What challenges, if any, have you encountered in implementing your program?

FOLLOW UP:

- Have you implemented any strategies to address these challenges? If so, please describe.

3. What elements of your program do you think are the most important in meeting the needs of people living with HIV/AIDS?
4. Are there innovative features that you feel distinguish the IHHP project from other housing programs targeting people living with HIV/AIDS?

PROBE:

- Integrated practices in client outreach, enrollment, services, and linkages to care.

- Enhanced staff qualifications and training; comprehensive, coordinated care teams.
- Integration of housing and health care data collection, reporting, and evaluation systems.
- Local coordination of service providers, streamlined access to housing and health care.
- Collaborative community needs assessment and planning, local awareness and support.
- Local and state policy advocacy supporting the integration of HIV housing and health. care services.

5. What are some lessons that you have learned about integrating housing and health care services for people with HIV/AIDS?
6. What programmatic changes would you make, if any, to help improve the program?

J. Closing

1. Before we end the discussion, is there anything I haven't asked that you think would be important for me to know in understanding the effectiveness of the Integrated Housing & Planning Project?

Thank you again for your participation!

ANALYSIS OF INTEGRATED HIV HOUSING AND CARE SERVICES
FLORIDA IHHP PROJECT SITE VISIT: RIVER REGION HUMAN SERVICES
COMMUNITY SERVICE PARTNER DISCUSSION GUIDE
HEALTH PLANNING COUNCIL OF NE FLORIDA

Introduction

Thank you for agreeing to participate in this discussion. My name is Meg Hargreaves and I work for Mathematica Policy Research, an independent research firm. As you know, Mathematica Policy Research and Cloudburst are conducting a study for the U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE) about housing and care services for people living with HIV. The study has two components: (1) a quantitative analysis of national HIV housing assistance data and (2) a qualitative study of Integrated HIV/AIDS Housing Plan (IHHP) projects funded by the U.S. Department of Housing and Urban Development (HUD). Findings from this study will inform Federal policymakers about innovative program integration models that address both housing and health.

The information we are gathering from the IHHP projects will be summarized in a final report for ASPE describing the IHHP programs and their local contexts. While our report will describe the experiences and viewpoints expressed by local program staff and partners, we will not quote any individuals by name. Your participation is entirely voluntary; if you decide not to participate in this interview, your grant will not be affected. With your permission, I would like to tape record this discussion to as a back-up for my notes. Recordings will be retained throughout the remainder of the project and then destroyed after the final report is complete. Do you have any objections?

We have scheduled up to 90 minutes for our discussion today, though we may not use the entire time. Do you have any questions before we start?

A. Respondent Information

1. To start the discussion, please state your job title and briefly describe your role as the Director of Health Assessment and Urban Planning at the Health Planning Council of NE Florida.

2. How long have you worked for the Health Planning Council in this role?

B. Program context and Characteristics

I have a few background questions for you about the Health Planning Council.

1. Please describe the overall history, scope, and mission of the Health Planning Council?

2. How long has the Health Planning Council provided HIV housing services? What types of services are currently provided, to whom, and in what locations?

3. How long have you been working with the River Region Human Services? What role do you play in the River Region Human Services' current IHHP project?

4. How much of your time is spent working on that project?

5. How did your agency become a partner on the IHHP grant?

6. How is the partnership structured? Is there are formal memorandum of understanding or service contract for the partnership?

7. What percent of the Health Planning Council's total funding does the IHHP grant represent? How much funding did you receive for the IHHP grant?

8. How is the grant funding being used [PROBES: to start a new program; modify an existing program; or expand existing services to a new area or population]? Please explain.

9. When did the Health Planning Council start serving IHHP clients?

10. How many are currently being served?

11. In what locations are clients being served?

FOLLOW UP:
Describe the project's demographic characteristics of the program's clients, for example age, gender, race/ethnicity, income, housing status, and HIV status.

C. Program Staffing

We are interested in understanding how the Health Planning Council's IHHP grant-related activities are being staffed.

1. How many staff work in the program, and in what positions/roles?

2. What percent of their time is spent on the program?

PROBES:

- Does the program use a team-based approach, where clients are assigned to specific teams, or are clients assigned to certain individual staff?

- If team-based, what are the team's responsibilities? Are teams multidisciplinary or interdisciplinary? Who is included on the team?

- Are teams composed of members from other organizations? If so, what organizations?

3. What is the average number of clients served by each staff?

4. What program-specific trainings have staff members received?

FOLLOW UP:

- What topics are covered?

- What is the duration and frequency of training?
- Describe any HIV/AIDS competency training provided.
- Describe any cultural competency training provided.

D. Client Outreach

Now, I would like to ask about the program's outreach process.

1. Who handles the program's client outreach activities?
2. How are potential clients made aware of the IHHP program and its services?
3. Is outreach tailored for different locations or client groups? If so, please explain.

E. Client Intake, Enrollment, and Care Planning

Let's discuss the program's intake, enrollment, and care planning processes.

1. Please describe the intake and enrollment process.
2. How do staff members determine whether an individual is eligible to enroll in the program?
3. Please describe the client assessment and care planning process. Which staff lead the care planning process? For example, can a social worker or nurse or case manager work with the client to create a care plan?
4. What issues or topics are included in the client assessment and care plan development?
    - Housing stability barriers
    - Other basic needs, including food insecurity
    - Employment, income, or self-sufficiency barriers
    - Health insurance issues
    - Behavioral health issues
    - Mental health status
    - HIV transmission risks
    - Barriers to accessing and staying in HIV clinical care
    - Anti-retroviral therapy medication adherence issues
    - Other? Please specify.
5. What formal assessment and care planning tools (if any) are used? Please describe.

[INTERVIEWER SHOULD ASK FOR A COPY OF THE TOOL(S), IF APPLICABLE]

6. What program requirements or rules are clients expected to follow? Please explain.

7. From your observation, what are the clients' greatest service needs?

   - Do the needs of people living with HIV/AIDS differ from other clients you serve? Please explain.

8. How does the program address those needs?

F. Client Housing and Support Services

Let's discuss the program's services and the integration of housing and HIV care.

1. Who provides direct services to the program's clients?

2. What direct services are provided?

   - Housing Assistance. Are you moving clients from tenant-based rental assistance to public housing choice vouchers? Why?

   - Employment or Other Income Assistance. What assistance do clients receive accessing economic or employment assistance (SNAP, Medicaid, SSI/SSDI, TANF, RWHAP, other public assistance, or other resources)?

   - Medical Assistance. Does the program provide direct medical care and/or link clients to medical, mental health, and/or substance abuse treatment services provided elsewhere?

   - Medical Case Management: Is this service provided on-site or through an outside provider?

   - Other Direct Services: Please describe.

3. Are program clients referred to other organizations to obtain services? If so, what are those services?

4. How are the program's services modified or customized to meet the needs of people living with HIV/AIDS?

G. Linkage to HIV Care

1. How is housing assistance coordinated with medical care through the Health Planning Council's IHHP program?

2. Does the program have any formal or informal arrangements with health care providers to coordinate housing assistance and medical care?

   FOLLOW UP:

- Does your program work with specific clinics and health centers, or providers to link and retain clients in HIV care?
- Are particular referral processes used to help clients access services from other providers? Please provide an example of how clients are linked to appropriate health care services.
- How do providers share client information or coordinate services to make referrals, or to ensure proper HIV care for program clients?
- How frequently does the program attempt to communicate with health centers and/or providers regarding program clients?
- In the program's efforts to link clients to healthcare services, have staff members developed shared goals and/or protocols with outside clinics and health centers?
- To facilitate better linkages, has the program changed the way that clients are linked to healthcare services?

H. Program Data Collection and Use

We are interested in understanding better your process for data collection.

1. Who handles the program's data management duties?

2. Please describe how the program collects and tracks client-level demographic, service use, and program outcome data, including HIV/AIDS status?

   FOLLOW UP:

   - What data elements are collected, how frequently, using what data forms?
   - Do the data include health outcomes? If so, what health outcomes are reported?
   - In what data systems are the data stored and accessed?
   - How would you describe the quality of the data, particularly, the data on clients' service use and outcomes?
   - Is the HIV/AIDS status data based on self-report, staff report, or a combination?

Now, I would like to talk about the ways that the Health Planning Council makes use of client-level SPNS program data.

3. How does the program use client-level demographic, service use, and/or outcome data in service planning, program monitoring, evaluation, or quality improvement? Please explain and provide examples.

   INDICATOR PROBES:

- Client Characteristics. Age, gender, race/ethnicity, other demographics, chronic homelessness, prior living situations.

- Client Service Needs. Basic income needs, housing, employment, food, mental health, substance use, access to insurance and to a primary care provider.

- Housing Service Utilization and Outcomes. Avoidance of homelessness, use of transitional housing, housing stability and permanency.

- HIV Medical Care Utilization and Outcomes. Health insurance status, designated primary care provider, ongoing engagement in care, ART medication adherence, suppression of viral load.

4. Can your program's information system(s) be used to generate planning reports? If so, please describe the reports.

5. Has the program's data system been used to tabulate outcomes by demographic characteristics and/or HIV/AIDS status? If so, how often have reports been generated and used?

6. In general, are there efforts to share aggregate and client-level data with partner agencies? If so, who are these partner agencies, what information is shared, how often, and for what reasons?

   FOLLOW UP:

   - Are housing indicators and/or outcomes data shared with these partners? Please describe.

   - Are HIV clinical care indictors and/or outcomes data shared with these partners? Please describe.

   - [If reports are generated] Are reports shared with external partners/agencies/providers? If so, which reports are shared and how frequently?

   - How regularly do program staff members connect with these other agencies about data issues and/or findings?

   - Do these efforts require formal coordination of shared activities with partner agencies? For what purpose [PROBES: to prevent duplication efforts and ensure data quality among agencies]?

   - In your efforts to share data, have you developed shared goals and/or protocols with outside partners?

   - To facilitate data partnerships with outside agencies, have you made changes in the way the program collects, uses, and shares data?

I. Community HIV and Housing planning

We are interested in learning more about how your agency is involved in community planning activities and processes.

1. In what way(s) is the Health Planning Council involved, if at all, in the following in community/state planning activities?

   - HUD Consolidated Plan and Annual Action Plans
   - HUD Continuum of Care Homeless Assistance Planning
   - Public Housing Agency Plans – 5-Year Plans and Annual Plans
   - RWHAP HIV Planning Council - Comprehensive Plans and Needs Assessments
   - CDC HIV Prevention Community Planning Group – Comprehensive HIV Prevention Plans
   - State Mental Health Planning Council – Comprehensive Mental Health Services Plans
   - Online planning forums for program clients and other people living with HIV
   - Other HIV housing related community planning activities

   FOLLOW UP:

   - How frequently do you communicate with other agencies, including both federal agencies and non-profit organizations, regarding community planning activities? With which agencies, in particular?
   - Do you work with the River Region Human Services, in particular, on community planning?
   - Do these efforts require cooperation or coordination with each other? Please explain.
   - Have you and other agencies, such as the River Region Human Services, developed shared goals and/or protocols as part of these planning efforts. Please explain.
   - To facilitate this collaboration, have you made system-wide changes in the ways in which you are involved in community planning activities?
   - Do you share resources with other organizations, such as the River Region Human Services, to facilitate community planning activities? Please describe.

2. Have you participated in or conducted a community-level needs assessment or census related to stable housing and health outcomes for people living with HIV/AIDS?

   IF YES:

- When, and how often, have such community-level needs assessment efforts occurred?
- Who conducted the needs assessment? What other agencies were involved?
- What methods were used to assess community-level HIV housing and health care needs?
- What issues did the most recent community-level needs assessment explore?

FOLLOW UP:

- What barriers to stable housing and health outcomes for people living with HIV/AIDS have been identified at the community-level?
- What strategies, if any, have been implemented to address these barriers at the community-level?

3. One of the IHHP grant requirements is to develop an integrated housing plan at the community-level.

FOLLOW UP:

- Have you heard of this grant requirement? Do you know whether the Sanford Housing Authority will be involved in that activity?
- What has been done to develop and implement this community plan? What has been accomplished so far?
- How does this new integrated housing plan differ, if at all, from other community planning efforts?

4. Please describe any additional policy work the Health Planning Council does to support HIV housing system development and integration.

J. Program Implementation and Progress

I'd like to wrap up this discussion by learning more about your program's successes and challenges.

1. In general, how is the partnership with the River Region Human Services going? What aspects of the partnership have been the most successful?

2. What challenges, if any, have you encountered as part of your collaboration on this IHHP program?

FOLLOW UP:

- Have you implemented any strategies to address these challenges? If so, please describe.

3. What elements of the River Region Human Services' IHHP project do you think are the most important in meeting the needs of people living with HIV/AIDS?

4. Are there innovative features that you feel distinguish the IHHP project from other housing programs targeting people living with HIV/AIDS?

   PROBES:

   - Integrated practices in client outreach, enrollment, services, and linkages to care.
   - Enhanced staff qualifications and training; comprehensive, coordinated care teams.
   - Integration of housing and health care data collection, reporting, and evaluation systems.
   - Local coordination of service providers; streamlined access to housing and health care.
   - Collaborative community needs assessment and planning; local awareness and support.
   - Local and state policy advocacy supporting the integration of HIV housing and health care services.

5. What are some lessons that the Health Planning Council has learned about integrating housing and health care services for people with HIV/AIDS?

K. Closing

1. Before we end the discussion, is there anything I haven't asked that you think would be important for me to know in understanding the effectiveness of the IHHP program and its integration of its housing and health care services?

   Thank you again for your participation!

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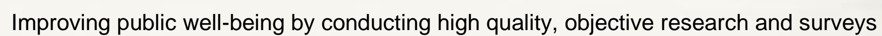

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