Newark EMA

HIV Health Services Planning Council

NEEDS ASSESSMENT UPDATE - 2020

July 2020

NEWARK EMA HIV HEALTH SERVICES PLANNING COUNCIL
NEEDS ASSESSMENT – Update 2020

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LIST OF ABBREVIATIONS

The following abbreviations and acronyms are used in this Needs Assessment.

ACA	Affordable Care Act of 2010 (Patient Protection and Affordable Care Act)
ADAP	AIDS Drug Assistance Program
ADDP	(New Jersey) AIDS Drug Distribution Program
ARV	Anti-Retroviral (therapies)
BH	Behavioral Health (includes both mental health and substance use disorder (SUD) issues)
BHIP	Behavioral Health Integration Project (of NJDOH)
CARE Act	Comprehensive AIDS Resources Emergency (CARE) Act
CBO	Community Based Organization
CDBG	Community Development Block Gran
CDC	U.S. Centers for Disease Control and Prevention
CHAMP	Comprehensive HIV/AIDS Management Program (the Newark EMA's Client Level Data Base)
CLD	Client Level Data (system)
CM	Case Management
CM-NM	Case Management – Non-Medical (nonmedical case management or managers)
CMS	Centers for Medicare and Medicaid Services (within USDHHS)
Cmte	Committee
CoC	Continuum of Care (HUD Housing program)
COC	Continuum Of Care Committee of NEMA Planning Council
COVID-19	Coronavirus 2019
CQM	Clinical Quality Management
CPC	Comprehensive Planning Committee of NEMA Planning Council
CTR	Counseling, Testing and Referral sites (for early identification of PLWHA)
DAYAM	Division of Adolescent and Young Adult Medicine (formerly at UMDNJ, now at Rutgers University)
DHCW	Newark Department of Health and Community Wellness (formerly Department of Child and Family Well Being)
DMAHS	Division of Medical Assistance and Health Services ("Medicaid Division" within the N.J. Department of Human Services)
DHSTS	Division of HIV/AIDS, STD, and TB Services, formerly the Division of HIV/AIDS Services
EFA	Emergency Financial Assistance (services)
EHE	Ending the HIV Epidemic Initiative (of USDHHS, HRSA, HAB)
EIIHA	Early Identification of Individuals Living with HIV/AIDS
EIRC	Early Intervention and Retention Collaborative (EIRCs as plural)
EIS	Early Intervention Services

EMA	Eligible Metropolitan Area
ESG	Emergency Solutions Grant (in 2012 name was changed by HUD from Emergency Shelter Grant)
FG	Focus Group
FQHC	Federally Qualified Health Center
HAART	Highly Active Anti-Retroviral Therapy
HAB	HIV/AIDS Bureau (of HRSA)
HCC	HIV Care Continuum
HIPAA	Health Insurance Portability and Accountability Act
HOPWA	Housing Opportunities for Persons With AIDS
HRSA	Health Resources and Services Administration (of the U.S. Department of Health and Human Services)
IDU	Injection Drug User
IHAP	Integrated HIV/AIDS Prevention and Care Plan 2017-2021
KI	Key Informant [interviews]
LGBTQ	Lesbian, Gay, Bisexual, Transgendered, Questioning
MAI	Minority AIDS Initiative (formerly Congressional Black Caucus – CBC)
MCM	Medical Case Management
MH	Mental Health
MMC	Medicaid Managed Care (NJFC for categorically eligible individuals also receiving Temporary Assistance to Needy Families (TANF) or Supplemental Security Income (SSI))
MNT	Medical Nutritional Therapy
MOA, MOU	Memorandum of Agreement, Memorandum of Understanding
MSM	Men who have Sex with Men
MSW	Morris, Sussex, Warren counties in the Newark EMA
NEMA	Newark Eligible Metropolitan Area
NHAS	National HIV/AIDS Strategy
NJCRI	North Jersey Clinical Research Initiative (New Jersey AIDS Partnership)
NJDHS	N.J. Department of Human Services (administers NJ Medicaid and DMAHS)
NJDOH	N.J. Department of Health
NJDS	New Jersey Dental School (at Rutgers University)
NJFC	New Jersey Family Care (Medicaid Expansion)
NJ-CLAS	New Jersey Culturally and Linguistically Appropriate Standards
PC	Planning Council (Newark EMA or NEMA)
PLWH	People Living With HIV (has replaced PLWHA as term describing those living with HIV disease)
PLWHA	People Living With HIV or AIDS
PPACA	Patient Protection and Affordable Care Act (also known as the “Affordable Care Act”
REC	Research and Evaluation Committee of NEMA Planning Council

RIC	Retention In Care
RW	Ryan White [Program]
RWHAP	Ryan White HIV/AIDS Program
RWTEA	Ryan White HIV/AIDS Treatment Extension Act of 2009
RWTMA	Ryan White HIV/AIDS Treatment Modernization Act of 2006
SA	Substance Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration (of the U.S. Department of Health and Human Services)
SUD	Substance Use Disorder
TGA	Transitional Grant Area
TRA	Temporary Rental Assistance
VLS	Viral Load Suppression
WICY	Women, Infants, Children and Youth
YMSM	Young Men who have Sex with Men

INTRODUCTION

The information below was extracted from the Ryan White Part A Manual published by HRSA/HAB in 2013 on its website. It reflects requirements of the Ryan White HIV/AIDS Treatment Extension Act (RWTEA) of 2009, Public Law 111-87, October 30, 2009. The citations are referenced to the Public Health Service Act (42 U.S.C. 300ff-11).

Legislative Background - Planning Council Duties

Completion of the needs assessment is a significant part of the **eight duties of the planning council**, as shown in federal law, most recently updated by the Ryan White Treatment Extension Act. Five sections - (4)(A), (B), (F), (G) and (H) - speak directly to the needs assessment. The purpose of the needs assessment is to assist the planning council in meeting Section (4)(C) – establish service priorities for the allocation of funds within the eligible area – and (4)(D) - develop a comprehensive plan for the organization and delivery of health and support services.

42 U.S. Code § 300ff–12 - Administration and planning council

(b) HIV health services planning council

(4) Duties: The planning council established or designated under paragraph (1) shall—

(A) determine the size and demographics of the population of individuals with HIV/AIDS, as well as the size and demographics of the estimated population of individuals with HIV/AIDS who are unaware of their HIV status;

(B) determine the needs of such population, with particular attention to—

(i) individuals with HIV/AIDS who know their HIV status and are not receiving HIV-related services;
(ii) disparities in access and services among affected subpopulations and historically underserved communities; and
(iii) individuals with HIV/AIDS who do not know their HIV status;

(C) establish priorities for the allocation of funds within the eligible area, including how best to meet each such priority and additional factors that a grantee should consider in allocating funds under a grant based on the—

(i) size and demographics of the population of individuals with HIV/AIDS (as determined under subparagraph (A)) and the needs of such population (as determined under subparagraph (B));
(ii) demonstrated (or probable) cost effectiveness and outcome effectiveness of proposed strategies and interventions, to the extent that data are reasonably available;
(iii) priorities of the communities with HIV/AIDS for whom the services are intended;
(iv) coordination in the provision of services to such individuals with programs for HIV prevention and for the prevention and treatment of substance abuse, including programs that provide comprehensive treatment for such abuse;
(v) availability of other governmental and non-governmental resources, including the State medicaid plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] and the State

Children's Health Insurance Program under title XXI of such Act [42 U.S.C. 1397aa et seq.] to cover health care costs of eligible individuals and families with HIV/AIDS; and
(vi) capacity development needs resulting from disparities in the availability of HIV-related services in historically underserved communities;

(D) develop a comprehensive plan for the organization and delivery of health and support services described in section 300ff–14 of this title that—
(i) includes a strategy for identifying individuals who know their HIV status and are not receiving such services and for informing the individuals of and enabling the individuals to utilize the services, giving particular attention to eliminating disparities in access and services among affected subpopulations and historically underserved communities, and including discrete goals, a timetable, and an appropriate allocation of funds;
(ii) includes a strategy to coordinate the provision of such services with programs for HIV prevention (including outreach and early intervention) and for the prevention and treatment of substance abuse (including programs that provide comprehensive treatment services for such abuse);
(iii) is compatible with any State or local plan for the provision of services to individuals with HIV/AIDS; and
(iv) includes a strategy, coordinated as appropriate with other community strategies and efforts, including discrete goals, a timetable, and appropriate funding, for identifying individuals with HIV/AIDS who do not know their HIV status, making such individuals aware of such status, and enabling such individuals to use the health and support services described in section 300ff–14 of this title, with particular attention to reducing barriers to routine testing and disparities in access and services among affected subpopulations and historically underserved communities;

(E) assess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the eligible area, and at the discretion of the planning council, assess the effectiveness, either directly or through contractual arrangements, of the services offered in meeting the identified needs;

(F) participate in the development of the **statewide coordinated statement of need** initiated by the State public health agency responsible for administering grants under part B of this subchapter;

(G) establish methods for obtaining input on community needs and priorities which may include public meetings (in accordance with paragraph (7)), conducting focus groups, and convening ad-hoc panels; and

(H) coordinate with Federal grantees that provide HIV-related services within the eligible area.

Needs assessment data are critical to conducting other planning tasks. Needs assessment results must be reflected in both the planning council's priority setting and resource allocations and in the EMA's/TGA's comprehensive plan. Planning councils are required to:

- Address coordination with programs for HIV prevention and the prevention and treatment of substance abuse
- Include links with outreach and early intervention services
- Address capacity development needs

- Be closely linked with comprehensive planning and annual implementation plan development, as interconnected parts of an ongoing planning process.

Section 2603(b)(1) specifies that in seeking supplemental funding, the EMA/TGA is expected to include in its application for funding an array of information, including needs assessment data that demonstrate need.

Section 2603(b)(2)(B) specifies that, in making awards for **demonstrated need**, the Secretary may consider any or all of the following factors:

i. "The unmet need for such services, as determined under section 2602(b)(4) or other community input process as defined under section 2609(d)(1)(A).

ii. An increasing need for HIV/AIDS-related services, including relative rates of increase in the number of cases of HIV/AIDS.

iii. The relative rates of increase in the number of cases of HIV/AIDS within new or emerging subpopulations.

iv. The current prevalence of HIV/AIDS.

v. Relevant factors related to the cost and complexity of delivering health care to individuals with HIV/AIDS in the eligible area.

vi. The impact of co-morbid factors, including co-occurring conditions, determined relevant by the Secretary.

vii. The prevalence of homelessness.

viii. The prevalence of individuals described under section 2602(b)(2)(M).

ix. The relevant factors that limit access to health care, including geographic variation, adequacy of health insurance coverage, and language barriers."

HAB Expectations

Needs assessment is expected to generate information about:

- The size and demographics of the HIV/AIDS population within the service area, including those who are unaware of their HIV status (not tested), and
- The needs of PLWHA, with emphasis on individuals with HIV/AIDS who know their HIV status and are not receiving primary health care, and on disparities in access and services among affected subpopulations and historically underserved communities.

HAB expects Part A needs assessments to meet all legislative requirements and to provide a sound information base for planning and decision making.

PURPOSE, RESEARCH QUESTIONS AND METHODOLOGY

Purpose

The purpose of the Needs Assessment – 2020 Update is to provide a special, more in-depth study of the impact of housing on health and outcomes of PLWH, their housing needs, and recommendations for use of additional funding for housing should the City of Newark receive such funding.

The outcome of this analysis is to better target RWHAP resources to address the housing needs and thus improve PLWH health outcomes.

Research Question and Methodology

Research Question #1

What are the housing needs of People Living with HIV (PLWH) that prevent or interfere with their achieving Viral Load Suppression and what are some strategies to improve their housing?

Methodological approach: The following methods were used.

- Analysis of CHAMP Data – Housing Status and RWHAP Health Outcomes of Viral Load Suppression (VLS) and Retention in Care (RIC).
- Key Informant Interviews. **Results of the Key Informant Interviews are not a separate section but are included in the other three sections.**
- Obtain consumer input from the Community Involvement Activities (CIA).
- Obtain input from agencies providing housing and related services by a Survey of Agencies providing Housing Related services regarding (1) consumer needs, and (2) recommendations for RWHAP for expansion of housing services through additional funding.

NEEDS ASSESSMENT – UPDATE 2020

1.1 Housing Status and RWHAP Health Outcomes

Housing (affordable, safe) is one of the greatest needs identified by PLWHA in Newark EMA Needs Assessments as essential to maintaining health and adherence to HIV medications and medical care. Awhile ago, the "Housing is Healthcare" document identified the importance of housing for PLWHA. In support of this, USDHHS has identified three general categories of housing – stable permanent, temporary, and unstable – as key measures of "universal outcomes" of PLWHA. The percent of PLWHA is unstable housing (shelter, homeless, jail/prison) is a "universal" outcome measure. HRSA HAB has assisted RWHAP recipients and subrecipients in categorizing housing by cross referencing the three HRSA HAB housing categories with those (16) of the US Department of Housing and Urban Development (HUD). This table was included in the 2019 Needs Assessment of the Newark EMA.

It is important to analyze the key health outcomes – Viral Load Suppression (VLS) and Retention In Care (RIC) – to assess differences in outcomes by housing status and help improve both outcomes and housing.

This document presents RWHAP clients in the Newark EMA by their housing status and VLS and RIC outcomes. Data are presented by geography – EMA, county and the EMA's 5 largest cities. **Data are as of the measurement year ending 12/31/19.**

Key Findings:

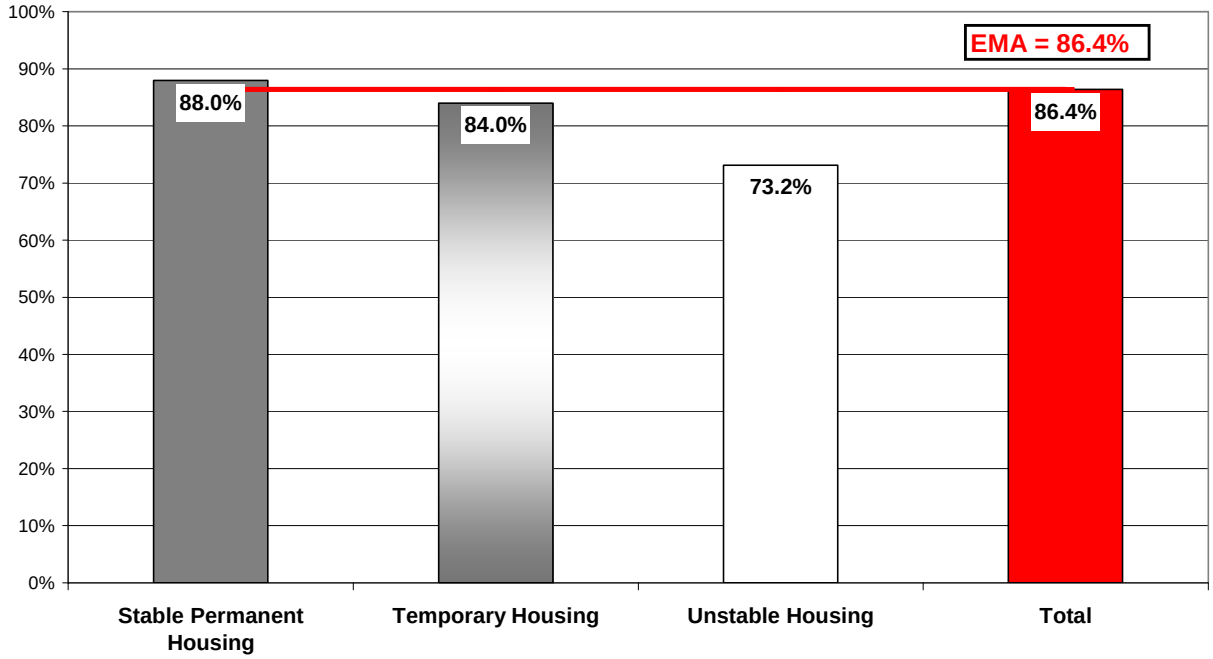
- Nearly **70% (4,417) of 6,340 PLWHA live in stable permanent housing, followed by 27% (1,689) in temporary housing and 4% (234) in unstable housing.** The following are the two most used housing arrangements:
- **55%** (3,477) live in stable permanent housing in a House/Apartment – Rent or Own Unsubsidized.
- **24%** (1,543) reside in a temporary housing - House/Apartment - Doubling up, staying with family/friends.
- There are **variances by county of residence**. A slightly lower percent of PLWHA in Essex live in stable permanent housing (unsubsidized house/apartment) and higher in temporary housing, especially doubling up. **Measures for PLWHA residing outside of the EMA are not shown.**
- **Viral Load Suppression (VLS). The VLS rate was 86.4% for the EMA.** VLS by housing status was:
  - **88.0% Stable Permanent Housing.**
  - **84.0% Temporary Housing.**
  - **73.2% Unstable Housing**
- **Viral Load Suppression by County.** In comparison to the EMA, VLS rates were lower for Essex County and higher for Union County and Morris/Sussex/Warren counties:
  - **84.4% Essex County**
  - **89.4% Union County**
  - **95.1% Morris/Sussex/Warren counties**

- **Retention In Care (RIC).** The RIC is measured by the "reverse" GAP measure = 1 medical visit in the first and second 6 months of the measurement year. **The RIC rate was 86.2% for the EMA. VLS by housing status was:**
  - **87.3% Stable Permanent Housing.**
  - **85.0% Temporary Housing.**
  - **68.9% Unstable Housing**
- **Retention In Care by County.** In comparison to the EMA, RIC rates were the same for Essex County, slightly lower for Union County and higher for Morris/Sussex/Warren counties:
  - **86.2% Essex County**
  - **85.4% Union County**
  - **91.7% Morris/Sussex/Warren counties**

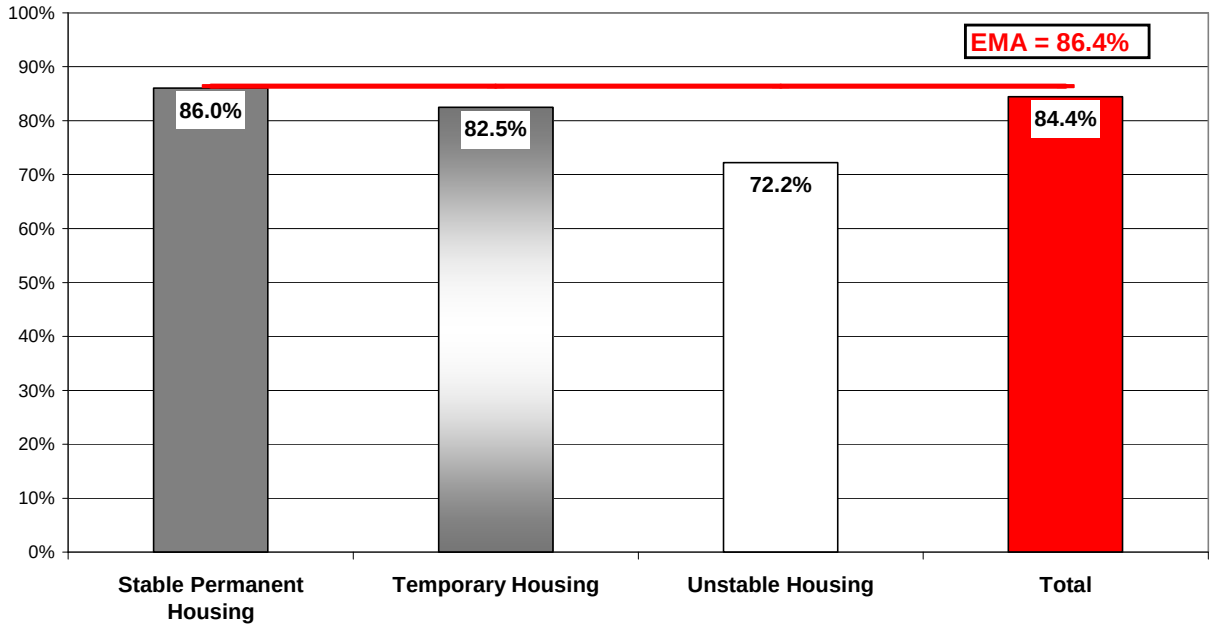
Table 1: Housing Status/Category and Outcomes by County/Region as of 12/31/19

Area/Housing Category	#	% Distn	#	% Distn	Outcomes	
					VLS	RIC
NEWARK EMA – TOTAL			**6,340**	**100%**	**86.4%**	**86.2%**
Stable Permanent Housing			***4,417***	***70%***	***88.0%***	***87.3%***
Rent/Own	3,477	55%			87.9%	86.7%
Long-Term HOPWA	205	3%			89.3%	92.6%
Long-Term Subsidized not HOPWA	585	9%			87.8%	90.3%
Temporary Housing			***1,689***	***27%***	***84.0%***	***85.0%***
Double Up –Family/Friends	1,543	24%			84.0%	85.5%
Unstable Housing			***234***	***4%***	***73.2%***	***68.9%***
Emergency Shelter	95	1%			76.1%	73.1%
Homeless	88	1%			64.4%	73.5%
ESSEX COUNTY – TOTAL			**4,217**	**100%**	**84.4%**	**86.2%**
Stable Permanent Housing			***2,848***	***68%***	***86.0%***	***87.4%***
Rent/Own	2,216	53%			86.1%	86.7%
Long-Term HOPWA	120	3%			82.4%	94.2%
Long-Term Subsidized not HOPWA	393	9%			86.0%	91.6%
Temporary Housing			***1,184***	***28%***	***82.5%***	***85.3%***
Double Up –Family/Friends	1,076	26%			82.5%	85.5%
Unstable Housing			***185***	***4%***	***72.2%***	***68.2%***
Emergency Shelter	89	2%			75.8%	71.4%
Homeless	70	2%			63.5%	71.0%
UNION COUNTY – TOTAL			**1,115**	**100%**	**89.4%**	**85.4%**
Stable Permanent Housing			***868***	***75.2%***	***91.4%***	***86.8%***
Rent/Own	708	61%			91.3%	86.8%
Long-Term HOPWA	44	4%			100.0%	86.2%
Long-Term Subsidized not HOPWA	106	9%			88.5%	86.8%
Temporary Housing			***264***	***23%***	***84.6%***	***82.4%***
Double Up –Family/Friends	247	21%			84.6%	82.6%
Unstable Housing			***23***	***2%***	***75.0%***	***57.1%***
Emergency Shelter	3	0%			50.0%	100.0%
Homeless	9	1%			75.0%	100.0%
MORRIS/SUSSEX/WARREN – TOTAL			**362**	**100%**	**95.1%**	**91.7%**
Stable Permanent Housing			***258***	***71%***	***97.9%***	***92.4%***
Rent/Own	159	44%			96.6%	92.5%
Long-Term HOPWA	38	10%			100.0%	95.2%
Long-Term Subsidized not HOPWA	53	15%			100.0%	89.5%
Temporary Housing			***91***	***25%***	***88.9%***	***90.9%***
Double Up –Family/Friends	82	23%			87.7%	94.0%
Unstable Housing			***13***	***4%***	***83.3%***	***80.0%***
Emergency Shelter	1	0%			100.0%	100.0%
Homeless	4	1%			75.0%	100.0%

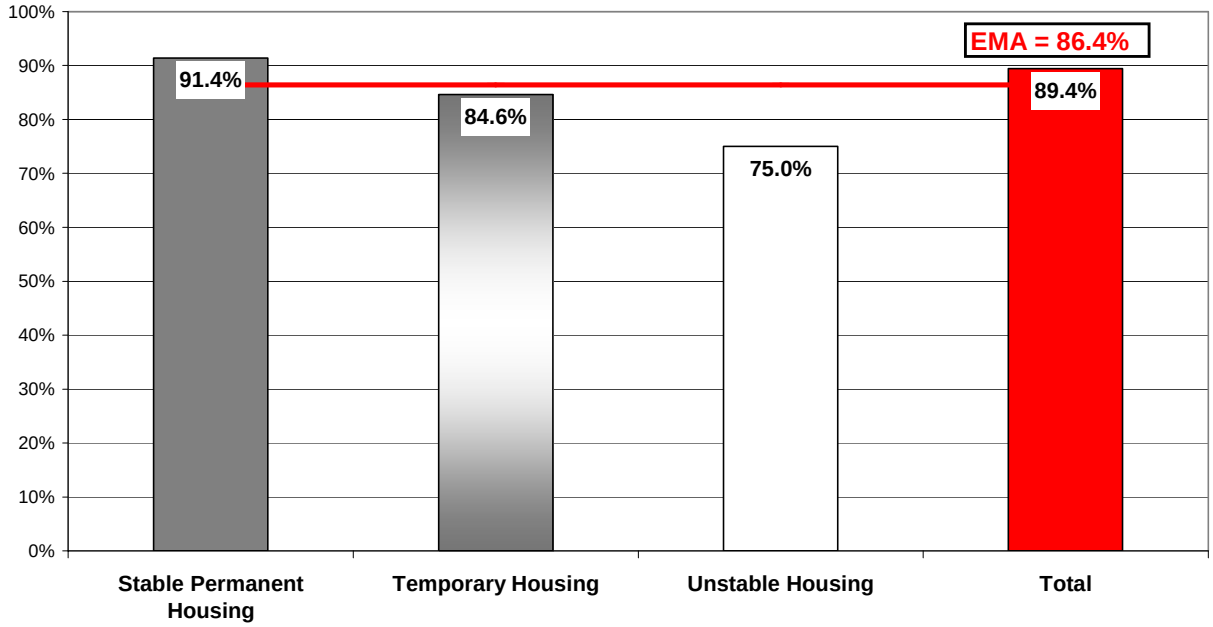
Viral Load Suppression by Housing Status - Newark EMA - Year Ending 12/31/19



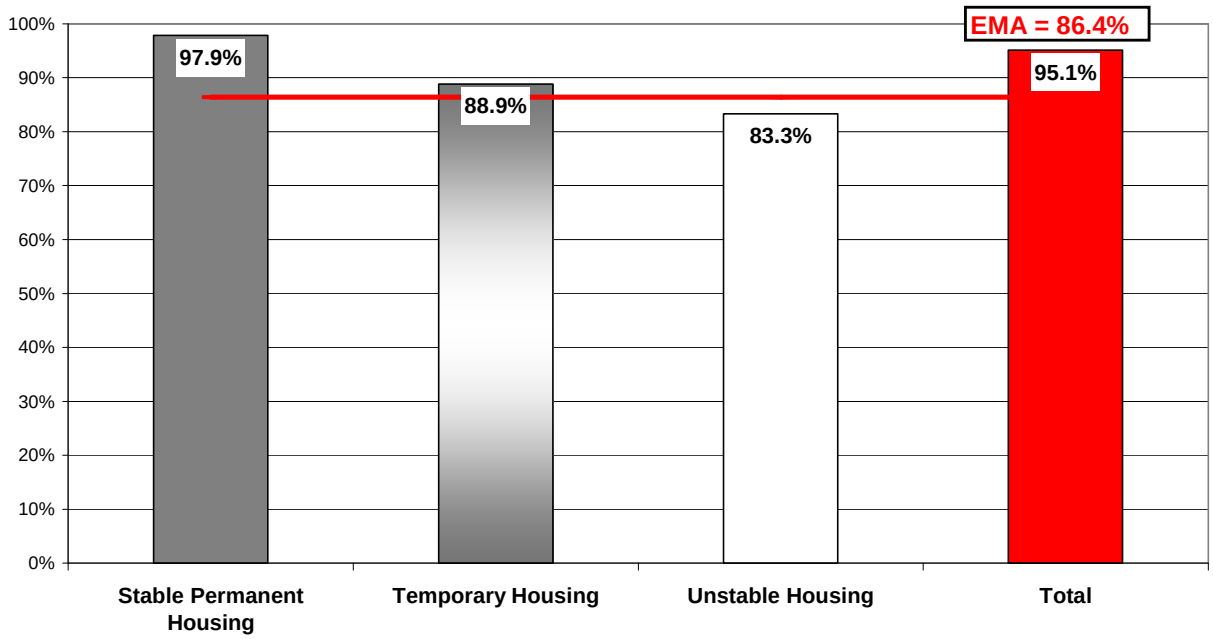
Viral Load Suppression by Housing Status - Essex County - Year Ending 12/31/19



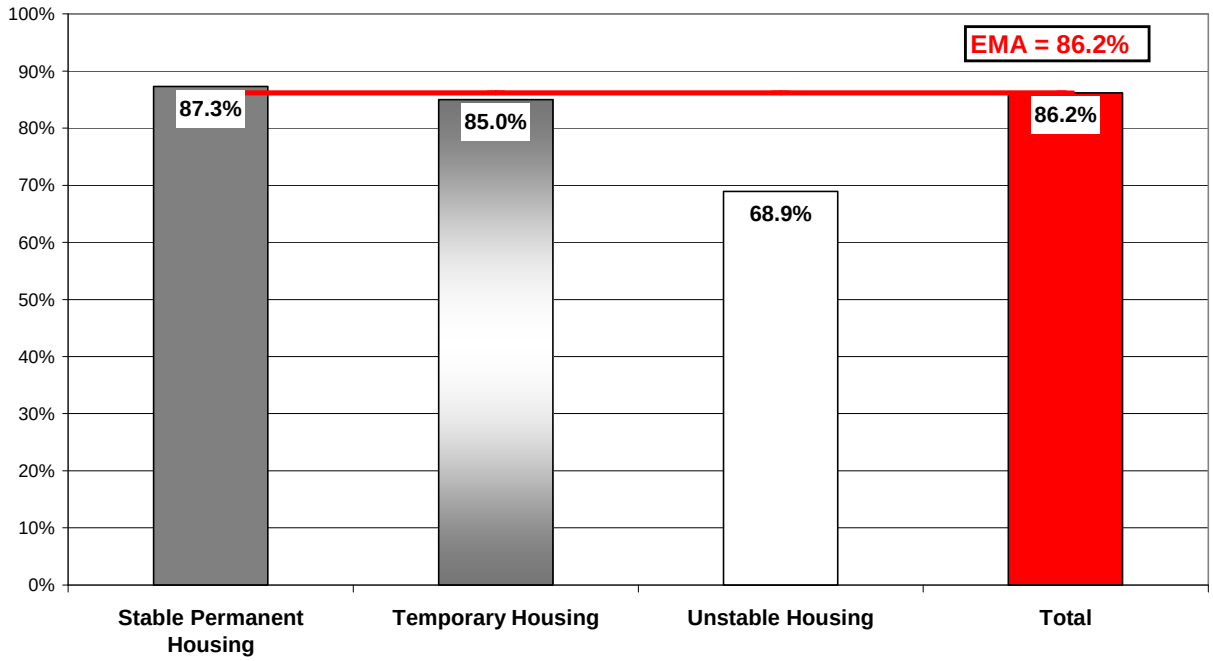
Viral Load Suppression by Housing Status - Union County - Year Ending 12/31/19



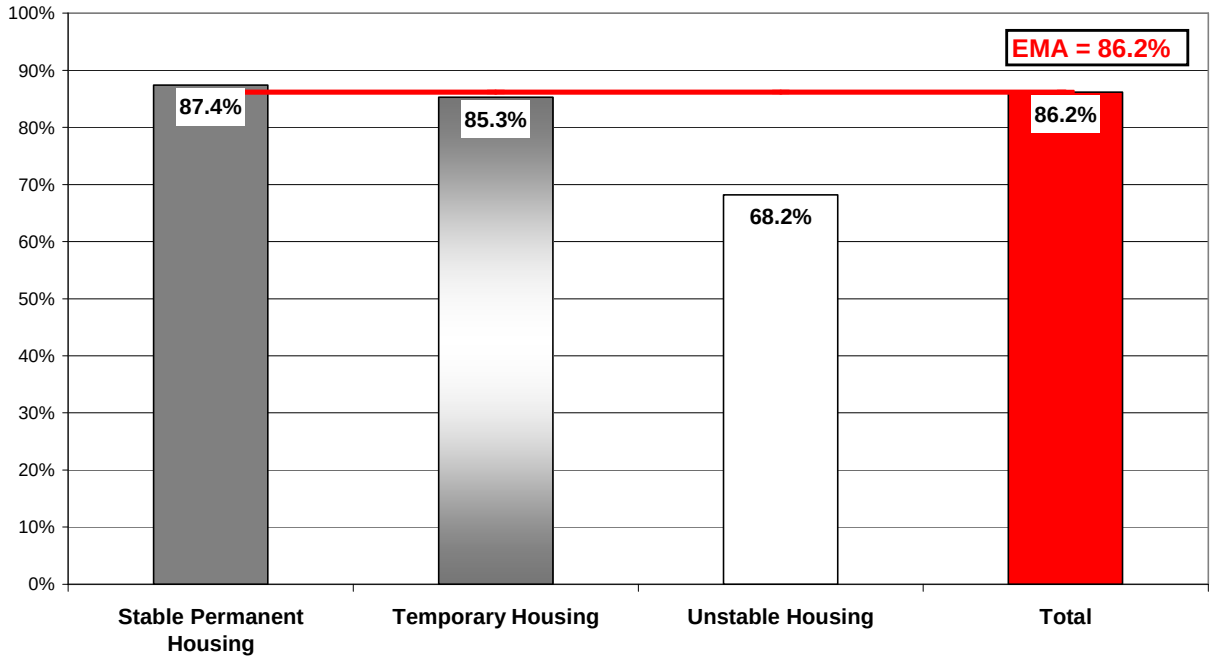
Viral Load Suppression by Housing Status - Morris, Sussex, Warren Counties - Year Ending 12/31/19



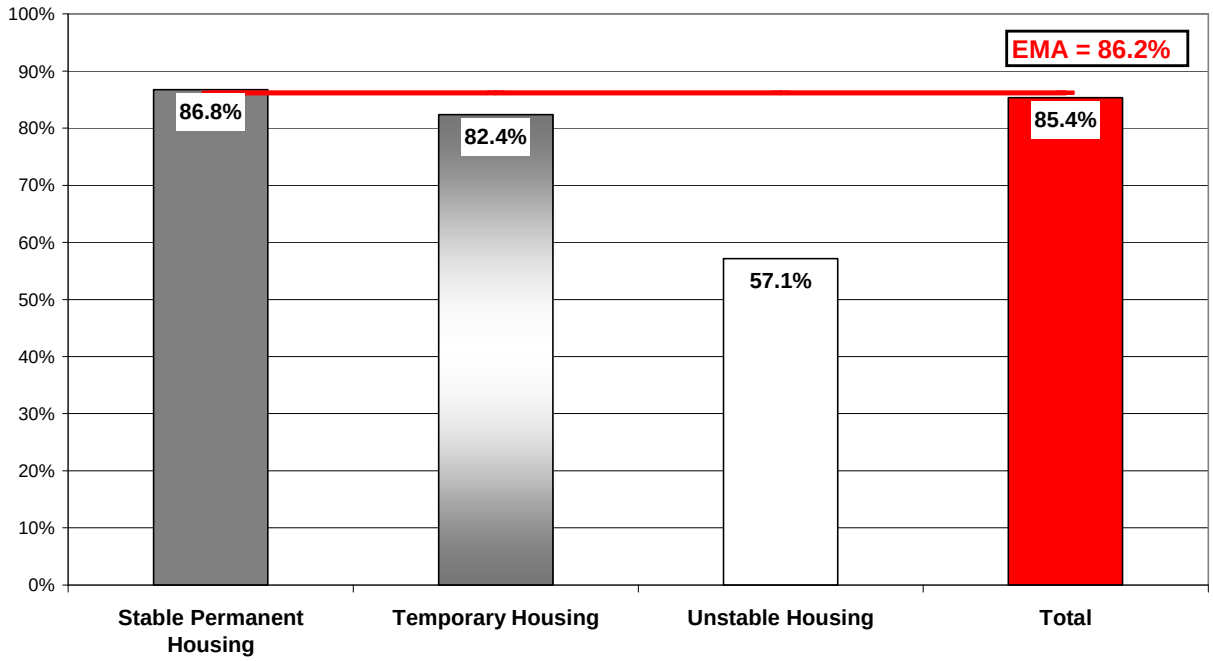
Retention In Care by Housing Status - Newark EMA - Year Ending 12/31/19



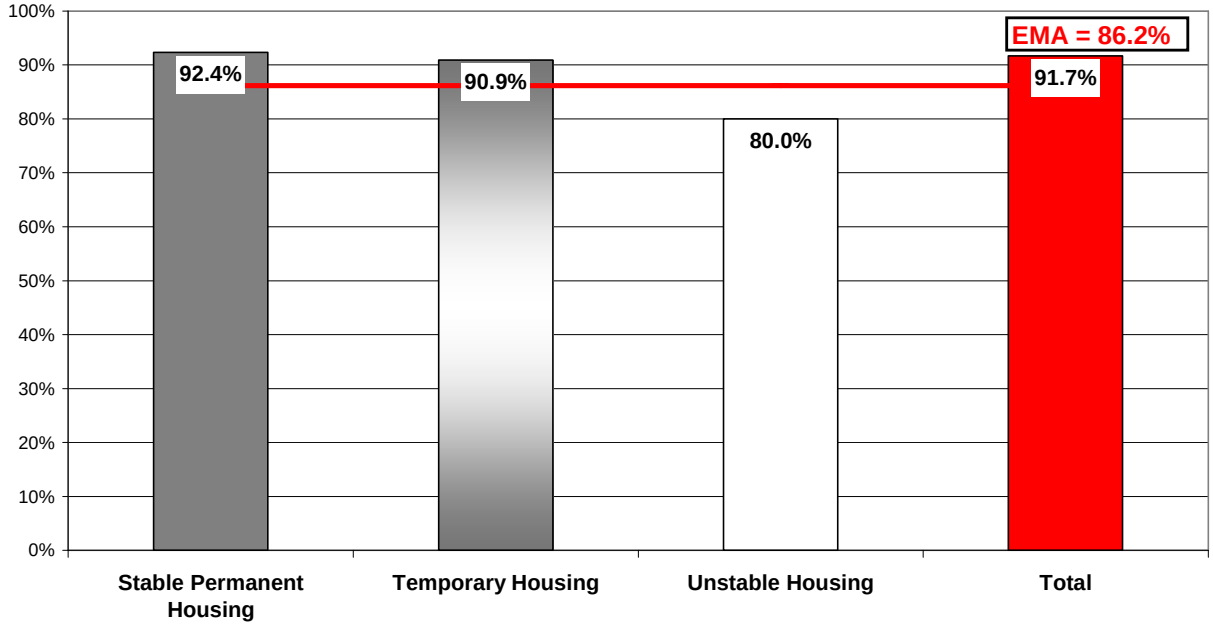
Retention In Care by Housing Status - Essex County - Year Ending 12/31/19



Retention In Care by Housing Status - Union County - Year Ending 12/31/19



Retention In Care by Housing Status - Morris, Sussex, Warren Counties - Year Ending 12/31/19



1.2 Consumer Survey of Housing Needs and Gaps

1.2.1 Purpose

The purpose of the **Consumer Housing Points Survey** was to obtain information about consumer needs for housing assistance and recommendations for development of possible housing solutions to improve viral suppression among PLWH. The survey was administered at the February 26, 2020 meeting of the Community Involvement Activities (CIA). Only items 1-13 were discussed. The remaining questions were postponed for another session. **See Appendix B for the survey instrument.**

1.2.2 Characteristics of Consumer Respondents

The survey was performed orally to 32 attendees and the following were the responses shared. **Not all individuals responded**, which is consistent with the confidentiality of the CIA meetings. The percentages shown are not representative of the 32 respondents, but of those who voluntarily responded to the specific question.

1.2.3 Consumer Responses

1. **What kind of housing do you/friends live in? House, apartment? Shelter? Other? Own, rent? (n=25)**
   - 14 attendees rent an apartment in a building **(56%)**
   - 10 attendees live in a house **(40%)**
   - One attendee owned a house **(4%)**
   - No one reported living in a shelter and there was no other type of housing mentioned

2. **Do you receive a subsidy? What kind? HOPWA, public housing, Section 8, etc.? (n=20)**
   - 13 attendees mentioned receive HOPWA **(65%)**
   - 4 receive Public Housing **(20%)**
   - 2 receive Section 8 and **(10%)**
   - 1 resides in a subsidized building **(5%)**

3. **Do you now or ever had to "double up"? (Stay with family, friends for a short term or longer-term basis?)**
   - 13 out of 32 **(41%)** attendees mentioned **doubled up with family, friends for a short term or longer-term basis at some point in their lives.**
   - One attendee mentioned that she was currently living with a friend. **(3%)**

4. **How would you describe your housing situation? Stable, temporary, transitional, unstable? Now and over time – say the past 1-2 years**?
   - 24 out of 32 **(66%)** attendees declared that their housing situation is **Stable**.
   - 3 attendees **(9%)** were living in **Temporary** housing

There was no mention of **transitional or unstable housing situations**, but someone stated that **some people might not feel comfortable disclosing that information openly.**

5. **Has your housing situation changed recently? Was that good or bad? Describe.**

5 attendees described their housing situations as bad for the following reasons:

- One attendee stated that an **eviction letter** was received and another said a recent roommate girlfriends' pregnancy (who now needed the apartment empty). Those attendees were referred to a housing agency to get services.
- One attendee mentioned that she's **living in an unsanitary house for over one year.**
- Another attendee mentioned there were **rodents** in his area.
- Another attendee reported that there is **bad housing maintenance** in his apartment.
- One attendee stated that he recently **transitioned from one Housing agency to another, which led to delays with rent payments.** Attendees added that some programs require a year to year lease or a month to month or by 6 months, which presents a barrier.
- The attendee also added that his new landlord wrote a long-term lease, but he doesn't want to sign since he wants to move in the near future. He added that if his **SSI benefits** increase, the rent goes up as well and that increase goes towards the rent. So he asked: "how much landlords can keep raising the rent?' Onque mentioned that a legal consultation can be providing to talk about housing issues. Client was referred to Legal Services of New Jersey.

On the other hand, 2 attendees mentioned the following:

- One got approved for HOPWA recently
- While, the other had a new residence.

6. **Are you able to take your medications on schedule in your current housing situation? Why or why not?**

27 out of 32 **(84%)** people responded that they **take their medications on schedule given their current housing situation** citing the following as reasons:

- "Being a responsible adult"
- "Stability"
- "I take the medication at the same time everyday"
- "I know that I have the virus [HIV]"
- I take the medications "because I want to live"
- "A habit"

Two answers on why someone might not take their medication on schedule in their current housing situation were shared:

- "If someone is in a shelter, the person might not be able to take it [their medications]" since some shelters have confidentiality rules/regulations. A non-Ryan White funded shelter was mentioned.

- Because the person has "not fully disclosed their status and was at someone else's house."

7. **Do you know anyone who has been denied housing? For what reasons?**
9 attendees (28%) mentioned they knew someone who had been denied housing. The reasons were the following:
    - "Age"
    - "Waiting List is too long"
    - Bad credit ("Poor Credit")
    - "Prior Eviction"
    - Not living in a city where assistance was requested
    - "No rental history"
    - "Single father" (Gender) – "Family shelters only allows women and kids and not dads".
    - "Incarceration"

8. **Do you know anyone who has lost their housing? For what reasons?**
15 out of 32 **(47%)** attendees stated they knew someone who has lost their housing. The following reasons were shared:
    - "Not paying rent"
    - "Drug use"
    - "Children that got taken away by DYFS" (Child Protective Services)
    - "No smoking inside" (Smoking where not permitted)
    - "Not following the rules" (Sub leasing)
    - "Bad attitude'
    - "Domestic Violence"
    - "Filing a complaint" (Whistle blowing)
    - "Vandalism"
    - "Hoarders" (Unsanitary conditions)
    - Not handicap accessible

9. **How can we use housing to improve health – viral load – so that you/friends are undetectable or virally suppressed?**
Attendees mentioned that **being stable means being less stressed. Stable housing was also said to help "be mentally healthy" and to improve health.**

    The following areas were mentioned as important:
    - Therapy, Psychology, and medications
    - Ownership of apartment
    - "Classes"
    - Inspecting apartment
    - "Giving incentives to make people want to be virally suppressed."
    - "Be able to structure your meals" (Housing Constructive Meals)
    - "Disabled housing" (Handicap accessible)

10. **If we were to add funding for housing – how could it work best to help people remain in care and improve health and viral suppression?** This question was addressed above

How could we best use the funds? (What kind of rules should we have?) This question was not asked.

11. **Who should get priority for additional housing funds? (VLS vs non-VLS)**
Attendees provided different perspectives on who should be a priority for additional housing funds. Some thought that **priority must be given to those Not Virally Suppressed for the following reasons:**

- "To get virally suppressed to stop transmission."
- "Mentally ill" people should get priority for additional housing funds "to become undetectable.
- People with in-home support
- "Non virally suppressed people that are on halfway houses" should be a priority. It was also mentioned to create a halfway house program for Non-Virally Suppressed that could last from 9 months to a year to graduate to help them reach Viral Load Suppression.

However, one consumer mentioned that **"all people are different" and might "not [be] able to reach viral load suppression."**

On the other hand, other consumers thought that virally suppressed clients should get priority for the following reasons:

- They "show stability"
- Must "further support to keep them stable"
- "Can help those who are not Virally suppressed"

12. **We would want to provide support for housing, such as medical/non-medical case management, substance abuse and/or mental health treatment. Would that be helpful?**

18 attendees said this would be helpful.

13. **We are allowed to provide up to 24 months (2 years) of housing support? Is that enough time to allow you/friends to get unsubsidized housing? How could we best use additional housing funds?**

Only one attendee stated that 24 months would be enough time to allow someone to get unsubsidized housing.

- "It depends on the mindset of the person."
- "Not good for everyone" – It varies on the circumstances of the individual.
- Depends on the support provided over the 24 months.

On the other hand, **8 attendees claimed that 24 years would not be enough time to allow someone to get unsubsidized housing** for the following reasons:

- "Don't know the future" Not enough time to get unsubsidized housing

- "Don't know the barriers that prevent people from having housing."
- "A person could be finishing school to get a job." Student Loan debt
- Not enough time to fix credit
- The rent is too high for income (most repeated answer)
- "Medical" reasons

It was mentioned that **2 years may be enough time to get subsidized housing but not enough time to afford unsubsidized.**

The consensus was that additional housing funds could be used for more subsidies because the market rent is too high, and many clients have fixed incomes that are not enough to afford rent.

1.3 Findings Regarding Agency Surveys of Housing Needs and Gaps

1.3.1 Purpose

The purpose of the **Housing Questionnaire for Agency Key informants** was to identify housing challenges faced by PLWH and to assist in development of possible housing solutions to improve viral suppression among PLWH. The survey was distributed to **32 agencies** who received RWHAP Part A funding for housing services, medical case management and non-medical case management. **A total of 22 agencies or 69% of total agencies with such funding provided responses.**

1.3.2 Characteristics of Agency Respondents

Geography. Of these agencies, **15 (68%) are located in Essex County, 4 (18%) in Union County, and 3 (14%) in the Morris, Sussex, Warren tri-county region.** However, most serve clients throughout the EMA.

Services. Most agencies provide more than one service related to housing assistance as follows.

Housing Services	**7**	**32%**
Emergency Financial Assistance	**9**	**41%**
Non-Medical Case Management	**12**	**55%**
Medical Case Management	**12**	**55%**
Legal Services	**1**	**5%**

1.3.3 PLWH and Housing Challenges and Needs

1. <u>Based on your experience, what are the housing characteristics and challenges faced by PLWH who are not virally suppressed? Are they in stable, temporary or unstable living arrangements? (See the attached chart for definitions). (The attached chart shows the comparison and cross walk of federal housing definitions by HRSA HAB and HUD.) See Appendix A.</u>

PLWH who are not virally suppressed often reside in unstable or temporary housing, or move back and forth ("yo-yo") between the two arrangements. These unreliable arrangements are compounded by substance use and more often mental health issues. However, even those in stable living arrangements are not virally suppressed due to behavioral issues – substance use and mental health – as well as stigma. Even young PLWH. The extent and variation among populations can be seen by agency responses below.

Stigma is not restricted to being HIV+ but also associated with receiving housing subsidies – Section 8 and HOPWA. Being HIV+ and poor or perceived to be on "welfare". Also stigma and the impact of homelessness and hopelessness

Housing arrangements of those not virally suppressed.

- Homeless men and women in temporary housing, fully homeless (e.g., living out of their car or sleeping in an abandoned house), homeless shelter (5)
- Unstable housing arrangements, sleeping on a couch at someone else's house. (4)
- Or in temporary housing. (3)
- Unstable living arrangements in general - shelter, food, safety - in order for a client to maintain VLS. (1)
- Not virally suppressed are not diligent in taking their medications as indicated; one main reason is that they are in unstable housing. (1)
- Subsidized housing and undocumented. (1)
- Unstable or temporary housing. And some **yoyo in between the two throughout the year**. (1)

Issues of those not virally suppressed who are in stable housing arrangements.

- Those who are stably housed and still not virally suppressed are usually still battling **addiction issues. (1)**
- Adolescents/young adults. **(2)**
- Stable homes/stable living arrangements. (smith center) (1)
- Most of our clients (adolescent/young adults) are still living at home but some are in temporary housing. Some clients, who are not virally suppressed and whose housing is stable, are still faced with the **perception of how the world views them** and this does not allow them to feel accepted. (1)

Housing issues of those virally suppressed.

- A small percentage of clients however who do not consistently stay in HIV treatment during the time we are assisting them. Sometimes the housing remains stable; for others, the housing is unstable as evidenced by people who are forced to live in temporary situations (i.e., moving amongst the apartments of family and friends) or are in danger of being evicted. The main challenge for these clients is that **a chaotic housing situation leads to chaos in other areas of their life, including maintaining medical treatment**. (1)

Challenges of PLWH not virally suppressed, especially as related to housing arrangements.

- **Income.** Inadequate/insufficient income, do not have steady income (2)
- Other medical competing needs. (1)
- **Lack of affordable housing** or limited amount of affordable housing units (2)
- **Behavioral health issues:** Active substance use (2) and/or mental health issues or untreated mental illness. (2)
- **Housing program limits/requirements.** Eligibility restrictions placed on programs by HUD. (1) Insufficient subsidy funding available to meet the rents in the area, long waiting list for low income housing assistance in Essex County. (2) Strict income criteria/expenditures in order for client to qualify for benefit (i.e. some view a car payment as a luxury when it really is a necessity) (1)
- **Stigma** attached to Section 8 and HOPWA housing benefits (1)
- Our agency assists those who are **being evicted or in danger of being evicted** - we don't check on their viral load other than when they first give us lab work so a case can be opened. Unless it

is a Social Security case, we don't customarily check in on whether they are maintaining medical treatment while we are representing them. (1)

- **Client housing history and income.** Unfortunately, due to the current implementation of gentrification within New Jersey, many PWLH are force to remain in temporary placements. Many of our patient's income falls 79% below the housing market; have rental evictions; poor credit and a criminal history, making this an ongoing challenge in the community. (1)
- Need for housing upon release from **incarceration**, and usually will go into temporary housing with associated instability. (1)
- Most PLWH experiencing homelessness could have prevented it with case management or financial support. For PLWH who are stably housed the focus should be case management support that can identify issues that threaten housing stability.
- For PLWH who are in temporary and unstable arrangements the work of developing a housing stability plan must begin as soon as the client is engaged in care. The pathway to housing stability is very different for everyone and a strong and well-developed plan is necessary to their success.

2. <u>What are other characteristics/challenges of these non-VLS PLWH?</u>

A total of 21 agencies provided responses, with an average of 3 responses per agency.

The primary characteristics are behavioral health issues, followed by unstable living arrangements, heath issues, stigma (due to HIV status), followed by health access issues, poverty, lack of living skills, social/personal and cultural issues.

Table 2: Characteristics/Challenges of Non-Virally Suppressed PLWH

Issues/Challenges Facing Non-VLS PLWH	By Response		By Category	
	#	%	#	%
Behavioral Health Issues			**19**	**90%**
Mental health issues	10	48%		
Substance abuse issues	9	43%		
Unstable Living			**11**	**52%**
Lack of affordable, stable housing	4	19%		
Unstable Living	2	10%		
Homelessness	2	10%		
Lack of housing subsidies	2	10%		
Nonpayment of rent	1	5%		
Health Issues			**11**	**52%**
Multiple co-morbid medical conditions	4	19%		
Lack of follow up with HIV Medical Care	2	10%		
Fear of HIV meds & side effects	2	10%		
Poor Dietary Habits	1	5%		
Denial (not sick enough)	1	5%		
Not educated on importance of VLS	1	5%		
Stigma (due to HIV status)	5	24%	**5**	**24%**
Lack of Access to Health Care			**5**	**24%**
Changes in insurance coverage, lack of insurance	4	19%		
Lack of transportation to medical care	1	5%		

Issues/Challenges Facing Non-VLS PLWH	By Response		By Category	
	#	%	#	%
Poverty, Income			**4**	**19%**
Lack of steady income	2	10%		
Poverty, financially unstable	2	10%		
Lack of Living Skills			**4**	**19%**
Finding &/or maintaining employment	2	10%		
Lack of daily living skills	2	10%		
Social/Personal Issues			**3**	**14%**
Lack of family support	2	10%		
Criminal background	1	5%		
Cultural Issues			**2**	**10%**
Undocumented	1	5%		
Culture	1	5%		
TOTAL	**64**			

3. What kind of housing assistance do you refer your HIV clients to? (Public housing, section 8, HOPWA, RW funded housing, CDBG, etc.)

Respondents provided the following which are tabulated. **Most agencies refer clients to all available sources of housing, with priority to HOPWA, followed by Section 8 and then Ryan White (RW) and non-RW sources.** Additional comments and responses are below.

Table 3: Sources of Housing Assistance Referrals for PLWH

All of the above	HOPWA	Section 8	Public Housing	RW-funded Housing agencies	Non RW-funded Housing (incl. CDBG, transitional, disabled housing)	Newark Housing Authority	CoC	Total
11	12	9	5	5	5	2	1	50
22%	24%	18%	10%	10%	10%	4%	2%	100%

- Our clients are referred to all Section 8 programs, HOPWA, and Continuum Of Care (CoC) funded programs which include **permanent supportive housing, rapid rehousing, Shelter+ Care.** Also, Public housing and senior/ disabled housing when permitted.
- All the above, I also suggest **shared housing (roommates) for clients.**
- There is very little in the way of permanent housing subsidies for HIV clients who are imminently losing their housing. For those seeking subsidies but it's not an emergency, NJ Dept of Community Affairs has a comprehensive list of all subsidized housing in State. We advise clients if they are either at least age 62 or receive SS benefits to apply to as many buildings and housing authorities as possible. Section 8 lists are rarely opened up and if it does, it's a lottery. For short term help, we advise clients to speak to their case manager if they have one, to find an agency to assist. We will also refer to **Welfare (if eligible)**.

- Those clients that have sustainable income are referred to HOPWA and Section 8 if there is available funding. Many public housing lists, however, are closed. Very few can get assistance from other sources.
- After completing a housing assessment (identifying barriers, i.e., income, criminal record, credit and rental history) an individual housing plan is developed based off available resources. All PWLH are referred to all types of affordable housing opportunities (e.g. transitional housing, Rental Subsidies, PBV and HOPWA, shared living programs, senior living, drug recovery programs etc.) All HOPWA, CDBG, COC, Emergency Housing Assistance, Ryan White Housing dollars, Newark Housing Authority public voucher, ESG and all of whatever is available for stable housing to further prevent homelessness in this population.
- Clients seeking housing assistance are often referred to other organizations who provide funding through CDBG, HOPWA, Ryan White and any others available to them.
- I refer clients to all type of housing programs available. However, HOPWA in the past years it has been a challenge as no agency is taking new clients. I had more success completing section 8 preliminary applications and clients being placed in the waiting list than find an agency that will place a client on their HOPWA waiting list. Also, if client is on SSI or receiving cash assistance thru the welfare office client maybe assisted for 12 months of TRA (temporary rental assistance).
- The type of housing depends on availability and need. Because affordable housing is so scarce we try to consider all options for the client.
- We refer our clients to HOPWA, after being on the HOPWA program the agency then transitions the client to either public housing or section 8. The client and other members in the household cannot have a **criminal record or conviction of any kind to qualify for public housing or Section 8.** Due to reduction in HOPWA funding we now also refer most patients to apply for public housing assistance and or section 8.
- Our agency will assist and refer clients/pts to subsidized housing, senior/ disabled Housing, HOPWA when available.

4. <u>Under what circumstances do you refer or provide PLWH with housing assistance? (Client circumstances, e.g., homelessness, etc. Other situations.)</u>

There were many circumstances for referral of clients for housing assistance. All cited **actual/imminent homelessness.** Other reasons include **domestic violence, expiration of transitional housing, recent release from incarceration, behavioral health issues including left rehab before completion of program.** Most agencies provide routine assessment and referral and others for emergency and unique situations. These are summarized below.

Table 4: Circumstances/Reasons for Referral for Housing Assistance

#	%	Reason
29	***62%***	***Actual/Imminent Homelessness***
14	30%	Homelessness
6	13%	Need for affordable housing
3	6%	Unstable living arrangements
3	6%	Being asked to leave home
3	6%	Imminent Eviction
3	***6%***	***Domestic Violence***
2	4%	In Shelters
2	4%	Housing no longer affordable
2	4%	Couch surfing
2	4%	Recently released from jail/prison
1	2%	Expiration of temporary/transitional housing
1	2%	Direct Shelter Assistance
1	2%	HOPWA
1	2%	Substance Use History
1	2%	Mental Heath History
1	2%	Routine screening by County Coordinated Entry System for permanent housing. & NJDCA programs
1	2%	Left rehab before completion
47	**100%**	**Total**

5. <u>For housing agencies: what kind of housing assistance do you provide to clients? (Financial, program, etc.)</u>

Eleven (11) or 50% of the 22 agencies responding provided housing assistance.

a. <u>Does this include only payment for housing or other support services?</u>

- **Supportive services** including advocacy, lease negotiation with landlords, and housing programs, housing search. We connect them for first and second month's rent, budget education. (1)
- Yes currently we provide support services through our SAMHSA homeless program for complete support services including mental health, medication management and linkage to housing care. Through Ryan White we provide additional support services to ensure community independence and PLWH achieving their housing goals and to prevent homelessness. (1)
- Both **rental assistance and support services** to ensure continued support to our clients. Full service supportive agency including payments for housing, case management, medication adherence and life skills where needed. Also Case Management, Substance Abuse, Support Group, Money Management, Budget Assistance, and Emergency Assistance. (5)
- **Housing related payments only.** Including payment of utility allowances, rental payments and arrears. It also includes PSE&G with a shut off notice. (3)

- Legal representation only. (1)

b. <u>For how long is this assistance? (Length of time, e.g., # months, years, etc.)</u>

Ten (10) agencies responded who provide direct housing assistance. (The remaining 12 did not as not applicable.) **Most provide short-term assistance consistent with RWHAP or HOPWA program parameters.**

- **Short term housing (5)**
  - One month
  - We assist clients once or twice for rental or utilities assistance for emergency assistance.
  - Assistance is provided during a grant year.
  - The back rental assistance is "emergency assistance" and is not intended to be a monthly subsidy. At present the grant allows to pay up to 3 months of back rent not exceeding $3,000 a year per client but our emergency assistance is so limited that we assess each case and like indicated before an income is necessary. If client has no income that client is refer to the welfare office to apply for cash assistance and TRA (temporary rental assistance – this is for 12 months)
  - Emergency can be up to 30 days, Transitional is up 2 years and Permanent Housing Programs do not have a limit.
- **HOPWA-related support (3)**
  - The HOPWA program is available to our clients until another housing voucher option becomes available, with each client being re-certified in the program every 6 months. The HUD CoC funding is considered permanent with re-certification occurring every 6 months.
  - Shelter stay is 24 months & HOPWA is the standard amount of time that the guidelines allotted.
  - HOPWA is long term. HPRPII is short-term assistance.
- **Housing plus supports (2)**
  - We assist the client through the housing search, and until 3 months after they are placed, providing post housing counseling. Referrals for EFA, legal, medical, mental health and substance Abuse treatment.
  - All support services and funding assistance available during active treatment in program indefinitely for long term continuum of care and after care.

6. <u>Are there any eligibility criteria you follow? (Financial, other, etc.)</u>

Of the 17 agencies responding, **all follow RWHAP criteria**. Many are assessed and referred through the **case management process – medical and non-medical**. Many have **internal agency criteria** as well, including risk of homelessness, recently-released [from incarceration] needing immediate housing, etc. (5= No answer/not applicable)

- **RWHAP eligibility criteria (3)**
  - We follow Ryan White eligibility criteria per PCN 16-02, upon the completion of assessment, including financial.
  - Eligibility Criteria are must be a Ryan White Recipients, must fall under federal poverty guidelines, must do an assessment and submit the required documents requested and continue with follow u appointments.

  - Our agency follows Ryan White Emergency Financial Assistance Service Standards. The client/pt must be w/in 500% of FPL level to qualify for EFA assistance, proof of HIV {+) status{copy of most recent lab work showing CD 4 and HIV viral load}, current lease or notarized letter from landlord{if no lease is available},copy of current income. Due to HRSA has given updated guidance in regards to RW EFA funding {effective 03/01/2020} our agency can no longer assist with paying security deposits as NJCRI had done in the past.

- **General RW eligibility (6)**
  - Clients eligible for this program are HIV positive clients who receive medical case management in the area. (2)
  - Active Ryan White status, in service referral, evictions (must provide eviction notice, utilities shut off notice or proof of hardships).All financial documents related to housing including lease agreements, electric and utilities, proof of income, and anything contributing or preventing and maintaining stable housing.
  - No, these programs are low-barrier. The person needs to HIV+ and in need of services.
  - Our MCM reviews all clients' financial status every 6 months to determine eligibility.
  - We use the following criteria:
    - HOPWA guidelines
    - Programmatic guidelines
    - HUD guidelines
    - Low income – usually below 50% AMI
    - FMR (Fair Market Rent) values
- **Agency specific criteria or guidelines (3)**
  - All clients of our agency are screened based on their risk of homelessness, if they are imminently homeless or are at that time a homeless individual. All forms of income are also evaluated to ensure that they do not exceed federal guidelines, and clients are HIV+.
  - No. The need for assistance has to be justified, reviewed by staff and approved by management.
  - Financial and the fact they have just been released.
- **Housing agency requirements (5)**
  - Medical documentation and proof of identity is the major criteria for the shelter stay.
  - Patients are referred to community agencies that provide housing assistance. Our agency assesses for RW eligibility and housing needs. Housing eligibility criteria is reviewed by the agency receiving the referral.
  - The criteria we follow is to assist the consumer with what their needs maybe and follow up with them.
  - This is often determined by agencies providing housing assistance.
  - Because most housing assistance programs follow financial guidelines for eligibility, we also follow those guidelines whenever we refer clients for housing assistance. Rental history is also important criteria. Having no rental history can be an issue for a patient as most landlords who accept section 8 requires a rental history.

7. What do you do if you do not have enough resources (financial, etc.) to serve all who need support? Eighteen (18) agencies provided responses. (No answer/not applicable =4)

All agencies provide transitional housing, referrals to other agencies, add to waiting lists, etc. Some provide advocacy [with landlords] to avoid eviction [pending another funding source]. See **Table 5** at the end of this section for detailed agency responses.

8. What happens to clients who do not receive housing assistance support? Where do they go? Where do they live? Twenty (20) agencies responded.

Basically the solutions are:

- Housing placement assistance.
- Support services.
- Application for transitional housing.
- Referral/placement in hotels/shelters as last resort, especially homeless
- Advocacy.
- Informal arrangements – staying with families/friends (couch surf)
- Eviction
- Truly homeless - Sleeping on park benches, abandoned houses, Penn Station.

Individual agency responses are listed at the end of this section. (Table 6**). They demonstrate agency caring, resource constraints, and lack of sufficient housing options.**

Table 5: Detailed Answers to Question 7 - What do you do if you do not have enough resources (financial, etc.) to serve all who need support

Advocacy
• When EFA funds are exhausted in the community, we try to advocate on clients behalf with landlords. If clients do not have an apartment yet and we offer to place them in transitional housing or shelter
Provision of housing assistance
• Our agency is well known for providing some charity beds if available.
• Try to accommodate clients' requests as much as possible. If unable, will refer clients out for additional services.
Referrals to Other Agencies
• Should a client come in and meets the screening criteria, however no funds are available to provide assistance directly through our agency or there are long wait list at housing authorities or Department of Community affairs, our agency will Outreach to 211-Coordinated Entry, Welfare for EA assistance, NJ Homeless Collaborative, local/other county shelters
• If we do not have enough resources to assist our consumers we reach out to various agencies that may be able to assist us like Hyacinth, Saint Clare's, the mental health association and Project live.
• Refer to other agencies.
• Our agency refers to the following if we do not have enough resources: ▪ refer to other housing agencies ▪ HPRPII ▪ Department of Community Affairs ▪ shelters ▪ NJ211 ▪ Office of Temporary Assistance ▪ NORWESCAP
• We assessed each client care based on the severity of needs. Clients referred to other agencies that have funds available, also placed on agency waiting list.
• My agency keeps good relationships with all RW funded programs, for this reason we able to call around and find some resources.
• Individuals in need are referred to agencies who have available resources and can provide financial assistance. It becomes a challenge certain times a year due to many places not having enough resources as they serve on a first come basis.
• Link all consumers to resources in the community for additional Ryan White funding or providers who may still have HOPWA unexpended dollars or ESG. Advocate to state and local representatives, state housing programs outside of EMA within the COC for additional resources and support.
• We always refer clients to agencies that can help or resources within our own agency.
• If there is not enough resources to serve all who need support, refer clients to other agencies and community partners who are able to.
• If we do not have enough resources in-house Ryan White or none Ryan White. Clients are referred to the welfare office. The case manager continues to work with the client and

makes sure client follow up with all welfare requirements.
• We leverage other community resources. Reaching outside of the HIV community is necessary to collaboratively address complex issues.
• When a client does not have the necessary resources, (financial or otherwise), our staff reach out to fellow colleagues from other agencies and refer patients to local social service agencies for assistance. This is always beneficial to the client and the staff.
• Our case managers research additional housing agencies for example: La Casa De Don Pedro, Positive Health, Proceed Inc, Integrity House, St. Clare's, Ryan White office, to see if there is any additional funding to assist if possible.

Table 6: Detailed Responses to Question 8 - <u>What happens to clients who do not receive housing assistance support? Where do they go? Where do they live?</u>

<u>Housing placement assistance.</u>
• We offer housing placement assistance program to all HIV positive clients who elect to receive our services. Clients are not immediately placed in permanent housing. Homeless clients are immediately placed in hotel or shelters through our collaborations with the State's program as well as the Shelters of the area. We help them apply to transitional housing as well and advocate for them.
• Last year I was able to assist my clients thru the NJ Housing Collaborative.
<u>Support Services</u>
• For those that are unable to receive assistance, support services are put in place (case management, behavioral health, and nutrition etc.). Our agency will Outreach to 211-Coordinated Entry, Welfare for EA assistance, NJ Homeless Collaborative, local/other county shelters as well as family and friends for temporary shelter.
• We no longer have the HOPWA program housing support, how ever we do have support services for our clients in our emergency shelter.
<u>Referral to Other Agencies –Housing, etc.</u>
• This is the barrier that I run into all the time. Unfortunately, if all resources have been used sometimes client is referred to another shelter as the last resort.
• We have grants that can help assist the consumer with housing and we also refer them to other housing opportunities.
• The clients who not receive immediate housing assistance will go on a waiting list until a spot is open or are referred to other agencies/programs that could assist for the time being.
• Depending on their circumstances: ▪ Certain clients live with a relative, ▪ Rent a room if affordable, ▪ Refer to transitional housing, ▪ Refer to shelter, ▪ Refer to substance abuse residential program.
• No one is turned away from receiving placement through the agency's housing hotline. Often time, a referral is made for a shelter but some do not want a shelter placement and refuse. They then decide to stay with friends or family. Some do decide to stay in the streets or at Penn Station.
• For those who do not receive direct support and can't find stable housing on their own we refer them to ESG (Emergency Shelter Grant) and welfare for shelter and TRA (Temporary Rental Assistance) funding. We also leverage other homeless program dollars if available. Clients are also linked to 211 (State Homeless Hotline) after all resources have been exhausted in the community. These consumers often end up homeless, end up in institutions or experience other diseases leading to death. We often get our consumers in sheltered housing because we are a full behavioral health care agency with affiliations and partnerships with multiple community partners.
• Clients are referred to other community resources and asked to return if they are not helped.

Double Up or Shelters

- Clients who do not receive housing assistance support stay in shelters or "couch-surf".
- It depends. Best case scenario they are able to sleep at a friend's or family house.
- Typically, they couch serf or end up staying in an unsafe environment.
- If they can't receive assistance most go into temporary living situations such as living with family, friends, doubling up, couch surfing or continue to be homeless.
- For a client who's not VLS leads them to staying from couch to couch and then shelter to shelter. Living like this subject them to the use of drugs and pay for stay activities.
- Clients will most likely go to a shelter.
- **Shelter options -** If a client is undocumented and doesn't have the financial resources along with being female with no children or children in their custody, they will be referred to a shelter that receives Ryan White funding for women who are infected. At this shelter they'll be connected to other community-based organizations. The shelter also provides meals for the individual. If the client is male, our agency temporarily has some beds at the Newark YMCA for men only in which housing and two meals are provided. If patients do not receive housing assistance such as public housing or section 8 we look at alternatives such as shelters, or supportive housing programs. We have used The Salon for women living with HIV and who are victims of domestic violence / sexual abuse, and The Nest for gay youth who are homeless and living with HIV.
- **Stay with family/friends or shelters -** Many clients reside with other persons, stay where they are and medical case managers at our agency continue to assist clients until more stable housing is achieved. Those that are homeless reside in the shelter whenever there is a shelter that has the space. Some of the clients are currently residing in these shelters and are continued to be assisted as well. This continues until they obtain more stable housing. All clients are linked to housing agencies for additional assistance as needed.

Eviction

- For clients who cannot get housing assistance, they will be evicted.

Homeless on Streets

- It depends. Worst case scenario they are living on the streets and sleeping on park benches and abandoned houses.

Other

- This is our second year as a grantee and so far, we have not had a client who needed housing assistance and did not receive it.

1.4 Recommendations from Agency Surveys for RWHAP Housing Program and VLS

1.4.1 Purpose

The purpose of the second part of the Agency questionnaire was to assist in development of possible housing solutions to improve viral suppression among PLWH. The survey was distributed to **32 agencies** who received RWHAP Part A funding for housing services, medical case management and non-medical case management. **A total of 22 agencies or 69% of total agencies with such funding provided responses.**

1.4.2 RWHAP Housing Program Research Question

The research question to be asked for RWHAP housing program funding was as follows.

The Ryan White Program may be receiving additional funding for housing. However, we want to link this financial support to achievement of Viral Load Suppression (VLS) – either helping clients to achieve VLS or to assist in maintaining VLS. We need your input on how to structure this program.

1.4.3 RWHAP Housing Program Criteria, Considerations and Recommendations

9. What are some eligibility criteria you would recommend to receive financial housing assistance?

Respondents were empathetic and sympathetic to patient barriers and needs. However, **all recommended participation in and adherence to RWHAP eligibility criteria and services, medical care and structured programming, and maintaining VLS.** Twenty-one (21) agencies responded. The following were **mandatory.** See the details at the end of this section. (Table 9)

Table 7: Summary of Minimum Requirements for Additional RWHAP Housing Assistance

• Retention in **HIV medical care** (2 visits per year) and **medication adherence** (VLS or VL improvement)
• Participation in **behavioral care treatment** – substance use and mental health – as warranted by diagnosis. Agency knowledge of harm reduction methods.
• **Support services** – medical case management (MCM) and non-medical case management (NM-CM) as appropriate for the agency. **Regular monitoring by MCM/CM.**
• Participation in **training in client responsibility, financial [literacy] and life skills** to manage housing situation.
• Consider **client circumstances – homelessness, eviction, no family support or living arrangements.** Returning from **incarceration**.
• **Source of income** to sustain housing.
• **Require client commitment to improve health and comply with housing requirements.**

10. How long should this assistance last – what time period? 1 year? Longer?

Most recommended that housing assistance last at least one year or longer. At least 18 months an up to 36 months and beyond. Financial housing assistance should be coupled with supportive services, such as case management, harm reduction, "Housing First" models. During this period, client should be encouraged to arrange for more stable housing. Whether the agency or client should arrange for more long-term stable housing is an issue for this RWHAP and other housing assistance programs.

Table 8: Recommended Duration of RWHAP Housing Assistance - Summary

Time Period	#	%
1 year (or less)	6	27%
At least 1 year or longer (18 months)	8	37%
3-5 years (or more)	2	9%
No limit depending on client circumstances & when permanent housing is found	6	27%
Total	**22**	**100%**

11. We want to link assistance with VLS maintenance as well as overall health and mental health. Should we require clients to have a Housing Plan – including see a case manager regularly, participation in mental health and/or substance use services, etc.

All 22 respondents agreed on the need to have a client-specific Housing Plan as part of any additional RWHAP housing services. This Housing Plan would include maintaining medical appointments and health care leading to or maintaining Viral Load Suppression (VLS), participation in substance abuse or mental health treatment services as appropriate, and other needed services. It was also recommended that every client meet with a **Housing Placement Specialist or case manager** to create a service plan to follow. The plan would also include **"life skills" training** in the form of managing finances and payment of rent, to help the individual transition to unsubsidized housing status.

There are existing models of client/individual Housing Plans that can be followed. One agency cautioned against using the housing plan used by "welfare" which can be punitive. See Table 11 for detailed agency responses on the scope and contents recommended of Housing Plans.

12. What other services would you recommend?

Agencies (19) recommended an array of services both directly related to housing and for supportive services. These are summarized below and are listed in Table 12 at the end of this section.

- **Housing Assistance Positions** – case managers and others to specifically address housing issues and intervene to ensure client housing arrangements are in order and clients are not evicted unnecessarily.

- **Expanded and/or Targeted RWHAP services** – ensure services are available – behavioral care (mental health and substance abuse treatment), nutritional services, case management, support groups, family counseling. Intensive case management where needed.
- **Life Skills Training** – To enable clients to transition to economic self-support. Include budgeting, financial education and management, employment readiness, job placement, monthly savings plans, etc.
- **Improved Service Coordination – Within EMA** between housing and support services and HIV medical care team, as well as reaching out to counties **throughout the EMA and outside NEMA** to identify available housing placements/beds/resources to be used for PLWH as needed.

13. How would this type of program be administered? Through existing housing agencies?

A total of 20 agencies responded. **All agreed that existing housing agencies should be used to administer this type of program with the following conditions and considerations.**

- **Experience and expertise.** Currently throughout the EMA many agencies are already administering housing in some form. These agencies are already equipped to run housing programs and could be ready to execute services faster. Agencies with experience with housing PLWH and connections to the homeless community.
- **Capacity.** Yes, through existing agencies **if they have capacity**. If they had the staff to educate/assist clients with these services.
- **Qualifications.** Agencies which are qualified.
- A **one stop shop approach** to provision of HIV care and services is always preferable to ensure client's ability to access and utilize services and stay in care.
- Perhaps there could be a **Housing Case Manager** that is stationed at an existing Ryan White Agency but who covers multiple sites or counties. The position needs to report to someone but can serve multiple agencies.
  - One option is to have one specific case manager in each Ryan White organization that would be assigned to work with this targeted non-VLS population.
- **Existing Housing systems.** Utilizing the current housing collaborative along with the current ambassadors they have within each NEMA county to streamline the processes of building and maintaining the bridges within the subsidized housing properties within each NEMA county.
- **Collaboration.** Collaborate with different agencies/ programs to enhanced or better successful programs for the clients, and give incentives.
- **Centralized EMA Housing Program.** It would be most effective if there was a centralized housing program for the EMA that was effective and provided real-time assistance to clients and case managers.
- **State Funding support.** Support from the State and other funding organizations would best administer this recommendation. Perhaps assigning agencies to regions and having them meet would work best to maximize the conferencing among the care collaborative.

14. Would use of advance payments to housing agencies – up front initial payment versus reimbursement – assist in the success of this program?

Twenty agencies responded. **18 answered "Yes".** Two were not sure since one does not provide direct housing assistance and another thought it may be helpful in areas with limited inventory. **The 18 provided comments on the reason up front payments would work, including the following.**

- Advanced payment could **reduce agency overhead making it easier to administer the programs.** Additionally advanced payments alleviate the cash flow burden on the agency. Would streamline payments to agencies.
- Up front initial payments are essential in that most people DO NOT have the monies for security deposits. This will assist with rental security in cases where the client is not able to make rental deposits or first month's rent.
- Beneficial especially to the **smaller agencies** within the EMA. (2)
- **Easier to control and handle** instead of waiting for reimbursement.
- **Allows for immediate assistance and cash flow for the provider to serve the consumer** in real time and provides sustainability for the treatment and housing provider at the same time. Usually there is waiting list for some housing and by having the money up front in a housing fund the provider can secure an apartment immediately. Reimbursement creates a lag in funding sometimes for two more than two months which in turn prevent the agency for extending services to others who may have needs. The agency doesn't have to wait to assist the consumers because funds are on hand to do more.
- Reimbursement is cumbersome, time consuming and sometimes is not forthcoming in a timely manner and often delays placement and providing services. **Regarding reimbursement, I wish that the City of Newark would move to an electronic signature for invoices. We are expected to go to the RW unit to sign these forms as the City insists on original signatures.** This is difficult at the moment given the COVID-19 circumstances. I was told that mailing the invoices for signature is not a very good option, so it makes our job harder to get the reimbursement in a timely manner.

15. What other ideas do you have about housing assistance for PLWH? (List below)

Twelve (12) agencies provided additional ideas. Some are mentioned above but are worth repeating.

- **Increase availability of subsidized housing. And duration of assistance.**
  - More low income housing for HIV clients. More long term shelters and residents where clients can have the option to learn a trade, have job training and learn to live independently.
  - Other Ideas include creating more transitional Ryan White housing and Ryan White owned housing (such as the one Project Live has) for clients with mental and severe substance use issues that are willing to seek assistance with their illness while being able to live independently { having MH and SA counselors on site
- **Expand payment for housing costs not currently covered by RWHAP.** The absence of the following assistance is sometimes what causes our clients to give up on a lease. **Security**

deposits, Housing fees, Broker's fee, Other court fees. If we are able to assist the clients with such fees, it will help greatly.

- **Systems Coordination.** The proposed financial housing support being linked to achieving VLS would require **close collaboration between the housing agency and the medical provider/medical case manager.** It may be an option to determine how this program could be administered through an existing medical facility.
  - More funding for housing services. **Adding housing services to the funded agencies' scope of services. Particularly the agencies that provide a one-stop-shop model of care**, specifically primary care, medical case management and other core services.
  - **Increase access & knowledge of housing.** Would it be possible for agencies that assist with housing to reach out to RW agencies that don't to basically explain the services they provide. We use the agencies we are most familiar with, but maybe there are others out there that we could also support.
- **Improve PLWH ability to stay in housing – health, rent payment, employment.**
  - **Maintaining eligibility – VLS.** • Provide educational courses on financial literacy, medication adherence , treatment adherence, risk reduction that each client should attend to continue receiving assistance and understand the importance of being virally suppressed
  - **Training in life skills & money management.** Just being about to find suitable affordable housing for the consumers we assist and helping them with the life skills they need to get and maintain an apartment.
  - **Provide job training and assistance in obtaining employment to help make PLWH more economically self-sufficient.** Many HIV+ persons, after housing is addressed want to go back to work but have been out the work force for many years. Employment training would be beneficial.
- **Increase available rental housing stock.** Program should identify landlords who are willing to rent to PLWH through this program.
- **Develop assistance based on current Fair Market Rent (FMR).** • FMR values should be reconsidered and asses the cost of living that reflect accurate rental prices in today's market.
- **Help Clients Maintain housing subsidies.** Help clients that are already receiving any type of housing subsidy or are living on affordable housing not to lose this help. We can do this thru case management.
- Another housing suggestion to help **clients that are non VLS and to provide stable housing is to have a cap in the rent that RW will pay.** We did this many years ago with HOPWA. We had caps as follows:

  <u>We paid no more than:</u>
  $400 in a one bedroom apartment
  $500 in a two bedroom apartment
  $600 in a three bedroom apartment

  We did the 30% - 70% HUD Calculations, We used the Fair Market Rents in each area. the income could not be higher of the 80% of the FPL. Right now HOPWA uses 30%. We followed all the calculations given by HUD for HOPWA at the time but we did not exceed the amounts listed above. At least I can remember helping clients to better their health at the time.
- **Long term housing capacity solutions.** It would be very cost effective to the City of Newark and the county if the city renovated many of the abandoned buildings located throughout communities then award a grant for "properties" to provider agencies to manage and oversee for permanent and short term housing with complete support services on site. There must be

multiple providers in the community who specialize in Behavioral healthcare not just housing. A one stop shopping which is far more effective than having fragmented services throughout the community to better serve this vulnerable HIV population reducing the need to navigate through a myriad of services often losing out on valued treatment needed due to overload of appointments trying to get to several locations. This would provide a complete continuum of care including psychiatric and substance abuse treatment and counseling on site which would result in long term and permanent housing and retention in care.

Table 9: Recommendations for Eligibility Criteria for RWHAP Housing Program Assistance (Individual Agency Responses n = 22)

The following are individual agency responses. **Many cover more than 1 topic.**

Participation and Retention in HIV Medical Care (and Behavioral)

- The goal of housing program is to ensure that our clients are virally suppressed. Housing has been a barrier for people to remain in care so part of our housing criteria is that our clients engage in HIV medical care while in the program.
- Proof of enrollment in medical treatment (completed intake and seen by provider).
- Compliance with medical treatment – ART, labs, medical visits
  - If evidence of Substance Abuse issue, enrollment in SA treatment program
  - If evidence of mental health issue, enrollment in Behavioral Health Services
- Program could be for clients who are in care and remain in care. Medical appointments need to be kept along with medication adherence. **MCM & CM's would monitor the clients closely.** This could be one of the qualifying factors to participate in the housing program.
- Client needs to be engaged in care with at least 2 visits per year.
- Must have **some source of income** to sustain housing.
- Also it would be helpful if the client is engaged in regular health care so that we can monitor status particularly in terms of viral suppression.

Participation in Behavioral Care Treatment (and medical care)

- Substance abuse inpatient residential completion followed by outpatient treatment long term (mandated if needed as part of the agreement)
- Mental health long term (mandated if needed as part of the agreement)
- Mental Health and Substance Abuse treatment for clients with substance abuse issues, continuous Case Management sessions, routine medical doctor visits. Adhere to medication regimen.

Support Services and Regular MCM/CM Monitoring

- As many of the clients come to our agency with ongoing issues that have contributed to their unstable housing, support services would be crucial in maintaining permanent housing. It would be recommended that case management, substance abuse treatment (when warranted) behavioral health treatment, (when warranted) financial counseling and money management training become part of any program. It would also be very important that any case manager working with any housing client have a working understanding of harm reduction and housing first models.

Specific Eligibility Criteria Recommendations

- Follow Ryan White eligibility criteria per PCN 16-02.
- The following are some eligibility criteria that we would recommend:
  - low income / financially unstable
  - HIV verification
  - Should be transitioning out of a temporary housing situation (example: towards the end of a drug treatment or from an institution) OR in unstable housing.
  - should receive medical or non-medical case management
  - keeping up with medical appointments, (bloodwork, medication etc.) and provide recent lab work
  - maintain viral suppression to continue assistance
  - Has to have primary medical care and be in treatment – if not case manager will assist client to obtain services

- **For PLWH at/near homelessness**
  - Stable attendance in a mental health program.
  - Completion Job readiness or continuing education program.
  - financial need / and or financial stability classes
  - Lab work every 6 months with proof of VLS.

- **Income and VL Status:** Possible eligibility criteria could include
  - Income, has a source of income or ability to gain employment but not enough to afford housing and basic needs
  - History of difficulty maintaining VLS
  - Definition of **chronic homelessness criteria** should be revised.

- **Income and VL Status:** Recommended are clients/pts meet the 500% FPL income criteria, **proof of client/pt viral load decreasing to achieve viral load suppression and eventual undetectable status**; for clients/pts that are virally suppressed or undetectable lab work for the last 6 months showing continued viral load suppressed or undetectable.

- Eligibility criteria that I would recommend for financial housing assistance:
  - PLWH must be **active in treatment with 90 day retention (Primary care, mental health, substance abuse, etc.)**
  - Complete a **housing plan,**
  - Require client to **attend a series of classes**, group or webinars to education clients on retention of housing. We incorporate a reward and milestone program for retention and with intervals of 90 days of compliance at 3, 6, 9 and 12 months.
  - At each **achievement level consumer receives additional rewards** for staying drug free and keeping all psychiatric appointments with doctor with medication adherence; health outcomes are generally improving along with each 90 day achievement in care.
  - Patients must be sober and drug free for minimum of six months to a year to be eligible for permanent housing or housing dollars consumer. Must be compliant in program.
  - Must adhere to personal housing plan.
  - All consumers must have their CD4 levels kept up to date at each 90 day interval.

Client Circumstances

- Clients that are **homeless, no family to assist them, unable to work or have children to support**

- Returning from **incarceration**

- It should be **low-barrier access.** We need to make it very easy for folks to apply. Minimize paperwork and documentation needed.

Most of the clients we see are virally suppressed – therefore the idea of linking financial support to VLS does not really apply to them.

- Anyone who is in **danger of being evicted. RW program should adopt a "Housing First" policy.** That means the first priority is **protect the housing they have**. Linking housing assistance to achievement of VLS is punitive and likely to be counter productive. For particularly difficult clients, there should be intensive case management both medical and non medical.

Client Behavior and Commitment

- Resources may be provided with **additional commitment from client.** Making commitments such as clients keeping regular appointments with providers (medical, dental, MCM, GYN etc.), regularly take medications, attend support groups, receiving mental health services and completion of yearly financial attestation/annual certifications are all recommended. Also having an assigned case manager work with them on an ongoing basis upon receiving housing assistance regularly should be a requirement.

- Like many years ago, they should be **required to be medically compliant** and go to the doctor at least once or twice a year. Find an apartment within the HUD Fair Market Rent. They need to **pay their rent copayment on time**, provide proof of rent payment to the housing agency. Keep the apartment/room in good condition. Provide proof of income if any. Provide information of all the household members. **Basically follow HOPWA guidelines.**

Table 10: Recommended Duration of RWHAP Housing Assistance – Agency Responses (22)

1 year (or less)
One year – during this period client should be encouraged to arrange for more stable housing
At least six-12 months.
Assistance should last for one year and be assessed every 6 months.
The assistance should last for one year which would provide the provider enough time to secure permanent housing or HOPWA monies for patient. The 12 month period would indicate retention in care and afford consumer the ability for workforce training or job placement for sustainability and economic stability. PLWH must remain in treatment to continue qualifying for any housing resources. Initial assessments, groups, individual counseling over a 12 weeks period with retention in S/A care.
This is very difficult to determine but if they find an apartment that they can afford with their own income assistance should be for 12 months.
6 months to 1 year to start with and having an option to extend it if the circumstances warrant it e.g. if the client is still not virally suppressed but is showing progress and a commitment.
At least 1 year or longer (18 months)
As many of the clients have never had such supports or training before, it would be recommended that all support services be offered for at least 1 year. Again as stated above it would also be very important that any case manager working with any housing client have a working understanding of harm reduction and housing first models. This would ensure that any housing plan written can utilize the client's strengths and pinpoint weak areas that may need work.
I would suggest 18 months because the client should already be VLS due to medical compliance being the main qualifying component to enter the program.
Housing assistance for one year or longer would be most beneficial.
Should last longer than a year during the time the housing specialist./ case manager will assist PLWH in applying for stable housing(Sect. 8 etc..)
At least a year, this would give a client time to get to a place where they would not need the assistance anymore.
At least one year.
Assistance should last a minimum of two years. By that time, due to working with a housing and medical case manager; the client should be virally suppressed and financially stable.
Housing assistance should last between 12-36 months. Evaluations should be on a semiannual basis until a stable housing environment has been achieved.
3-5 years (or longer)
We think 3-5 years – with option to extend depending on client's situation (for example: financial upset, medical issues etc) Having a limit allows agencies to reach more PLWH throughout the area as well as avoiding long waiting lists.
Program should last 5 years or longer.

No limit depending on client circumstances & when permanent housing is found
Clients can remain in the program until permanent housing is found. And, when we house a client, we follow up on them for a period of three months or more, depending on needs.
Assistance that is time limited does not help most clients who are on fixed incomes. Once the assistance ends, they can no longer afford the rent. Realistically there are no other subsidy programs that they can turn to.
Time period that housing assistance should last should be dependent on the client's ability to secure an income that will allow the client to be self-sufficient and live independently.
I think this assistance should last as long as the consumers can meet the requirement of the program, for instance keeping a steady income maintaining their viral load and T-cell so they can stay health. I think this will give them a reason to stay on top of things. If they cannot do this they will be terminated from the program.
I believe the duration of assistance should be dependent on the client's situation, as no two are alike.
The assistance should be determined by their housing plan and its goals.

Table 11: Support and Agency Comments for Housing Plan

Housing Plan – General
• A housing plan has been common practice is most housing programs. It has proven to be and effective tool in reaching housing goals. All items listed above can be included in this plan.
• Absolutely. This is a crucial part of the intervention.
• Yes definitely a housing Plan helps the consumer stay on track and allow the case managers to get them to the next step of their life by becoming self sufficient and knocking down most of their barriers.
• Housing status is addressed upon initial intake and as part of the 6 month re-assessment. If an issue is identified then yes, a Housing Plan should be initiated.
• Yes. Just like HOPWA used to do it many years ago.
• Yes, Housing Plans are necessary. Services should not be required but a check-in with a case manager should be done frequently to monitor progress.
• Yes (4 responses).
Housing Plan and VLS
• I believe that in order to remain VLS clients need to have a housing plan if they're not in permanent housing. Clients need stability in order to do medical compliance.
• Yes, housing plans keep clients engaged and active in their medical and housing care. It allows for accountability. This also helps identify areas of need to keep the client virally suppressed.
• Absolutely. It should also require ongoing consultation between members of the care collaborative so that the client is receiving complete wrap around services that could result in VLS maintenance and solving of problems and issues as they arise and not when it's too late.
• Yes, absolutely for effective monitoring of treatment progression, navigating the community identifying resources, support challenging barriers or any other unforeseen circumstances. All services should be monitored to assure housing requirements and regulations are met to maintain permanent housing. There must be compliance with S/A treatment, mental health appointments and medication management and adherence.
• The program should be holistic and provide all of the above services with provider and should be

dictated in a Personal Housing Plan. The retention in care must be physical, spiritual and mental to provide a safety net for patient and strong foundation to remain in care.
Housing Plan – Behavioral Health
• Answer to question 9 addresses need for treatment for Mental Health & Substance Abuse issues.
• Since these two issues can lead to a client not qualify for housing, or to lose their housing, they must be addressed.
• Yes, Non-VLS PLWH may have more than one factor contributing to their inability to maintain VL suppression. It would be most beneficial for the program and clients to have a comprehensive care plan that addresses mental health and substance use.
• Yes, clients should have a housing plan inclusive of case management and participation in mental health and/or substance use services.
• Yes all clients should have a housing plan in which they are required to see their Case Manager, Substance Abuse Counselor and Mental Health therapist often. Also apply for different housing program such as disabled and senior housing.
• Yes, definitely for patients that need services such as substance /mental health services
• A housing plan should definitely be a part of this care plan process and developed together by the client and their case manager. It should reflect that, if needed, a client should be engaged in MH / SA services.
• All clients/pts with not stable, suitable housing should require a housing plan and should be seen by their case manager {medical case managers} and other services needed { SA, MH, IOP, MATS} minimum every 30 days until housing becomes stable and once stable for the 1st year every 30-45 days, after 2 years every 60 days.
Housing Placement Specialist/Case Manager
• Yes. It would be very helpful for PLWH to meet with Housing Placement Specialist or Case Manager to create a service plan to follow. In addition, the staff can address and support issues early.
Housing Plan – Caution
• That sounds like what Welfare does. The housing plan is usually not realistic and is later used as a reason to terminate services to very vulnerable clients. There might be a way to design a program that helps clients but it probably involves intensive case management that can be pro-active in dealing with clients with serious underlying issues (i.e., substance use, mental health issues).

Table 12: Agency Recommendations for Additional Services for a RWHAP Housing Program

Housing Assistance Positions
• Experience has shown that relationships with landlords are vital to making any housing program work. Funding for "**housing case management**" would be beneficial. This position could focus on resource location (help in finding affordable housing) housing financial assistance (security deposit, first month's rent, moving assistance furniture acquisition etc.)
• Would suggest the development of a new position of **"Housing Case Manager"**. This position would focus specifically on the development of a Housing Plan for a client with an identified housing need. They would see the client upon referral from the Medical Case Manager and other members of the care team to ensure client's needs are being met from all sides. Also would provide someone who can focus specifically on addressing the housing needs, follow up with the client and quickly identify a potential problem and address it BEFORE the client loses their housing. As it stands now the MCM hears of the housing problem once the client has

already lost their housing and are in a homeless situation.
• Also, an individual who focuses specifically on housing issues can develop relationships with landlords, legal services, housing authority reps., etc that can potentially expedite the housing process. Case managers, whether medical or non-medical, are responsible for addressing multiple issues and things can easily fall through the cracks.
Expand RWHAP Services
• It would be great if a **housing placement assistance** position also had a budget for EFA as well as furniture vouchers.
• Maybe nutritional services and Nutritional counseling. Food pantry. (5)
• Intensive case management for the most difficult clients. (3)
• Emergency financial assistance when needed.
• Transportation (2)
• Behavioral health services. Mental health and substance abuse services. (2)
• Coordination with medical providers that service PLWH.
• Support/coping groups or retreats to keep viral suppression.
• Family counseling in case there is a chance client can be placed with family.
• All other services are covered in the CHAMP system.
Life Skills
• Workshops, seminars, attend support groups, and meetings.
• Budgeting.
• Assistance with employment if the patient is able to work.
• Financial Education and Counseling – Complete a financial management class, develop some relationship with a bank for patient to have checking/savings account if not already in place.
• Employment Counseling and Training
• I would recommend teaching the life skills and helping them become employable.
• Wellness activity support such as exercise plans and/or gym memberships.
• To help with retention of housing we should offer ongoing programs for money management, personal life skills, social skills, employment skills and job training and linkage to employment initiative to create individual economic stability. We offer job training through the HRSA SPNS program. We have over 20 years of working with Work First NJ programs to engage at risk populations back into the workforce.
• A monthly savings plan
Improved Service Coordination
• Continuous scheduled care collaborative forums, perhaps monthly or quarterly, in which all providers have the opportunity to formally meet and case conference. This meeting could be via Zoom Conference or WebEx.
• Recommended: Forming a MOA with local subsidized housing authorities to house a certain number or clients of Ryan White status equally within each NEMA county. Looking into outside counties to see if beds are available and be able to move clients within the state. Looking into reaching out to hometown celebrities from NJ for assistance with donating funds.

1.5 Conclusions and Recommendations

1.5.1 Conclusions

- **Housing and Outcomes.** PLWH living in temporary or unstable housing have lower rates of Viral Load Suppression (VLS) and Retention In Care (RIC) than those in stable housing – especially in Essex County.
- **Need.** Stable, affordable housing continues to be an overwhelming need for PLWH in the EMA.
- **Stable Housing but Not VLS.** PLWH who are in stable housing arrangements and not virally suppressed often have comorbidities of active substance use and/or mental health issues.
- **Additional PLWH Issues.** PLWH who are not VLS and living in temporary or unstable housing arrangements often have additional problems: behavioral health – active substance use and/or mental health issues, other comorbid health problems, stigma, poverty, lack of employment, lack of life skills, denial of HIV status and social/personal issues including no family support and criminal background.
- **Circumstances.** Agencies give high priority for housing to PLWH experiencing actual or imminent homelessness. Additional circumstances include: domestic violence, expiration of transitional housing, recent release from incarceration, etc. An assessment is completed before housing assistance or a housing referral is made.
- **Types of Housing Assistance.** Of the 11 agencies providing RWHAP-funded housing assistance – five (5) provide comprehensive services of housing/rental payments, case management, EFA and other supports. Three provide housing and utility payments only. Two provide supportive services – case management and adherence or advocacy, and one provided legal representation only. **However, housing assistance is of short-term duration at 1-3 months. Eligibility follows appropriate RWHAP or HOPWA limits.**
- **Alternatives if Inadequate Housing Resources.** Agencies will make referrals for transitional housing, to other non-RWHAP agencies, add clients to waiting lists, and advocate with landlords to postpone eviction.
- **Unserved PLWH** go to agencies for housing placement assistance, support services and apply for transitional housing. Options are referrals/placement in hotels, motels, shelters. Advocacy still continues. Some are encouraged to seek informal arrangements (doubling up with family or friends, "couch surfing" for short periods of time). If all else fails, there is eviction, and homelessness – sleeping on park benches, abandoned houses, Penn Station.

1.5.2 Recommendations

If the Ryan White Program receives additional funding for housing with the goal of improving Viral Load Suppression (VLS), what are some recommendations on how to structure this program.

<u>Recommendation #1: There should be Minimum Eligibility Criteria for a Client.</u> For example:

- **Retention in HIV Medical care (at least 2 visits per year) and medication adherence – demonstrated by VLS or viral load improvement.**

- **Participation in Behavioral Care Treatment – Substance Use Disorder and/or Mental Health as diagnosed.** Agency knowledge of harm reduction methods.
- **Provision of Support Services** to client, client and agency-specific. **Regular monitoring of client [participation] by medical or non-medical case manager, as appropriate to the agency.**
- **Participation by client in training for client responsibility, financial literacy, and life skills** to ensure that client can manage his/her housing situation.
- **Consideration of client circumstances that warrant [immediate] housing** – e.g., homeless, eviction, no family support or living arrangements, returning from incarceration.
- **Sources of income** to sustain housing payments after subsidy.
- **Require client to improve their health and comply with housing requirements.**

Recommendation #2: There should be Sufficient Duration of Housing Assistance/Support to enable client to get life together and find affordable unsubsidized housing.

- Most recommendations were for **at least 18 months or longer.**

Recommendation #3: Require a client-specific Housing Plan which details client's responsibilities in maintaining the housing situation.

- Every client would be required to meet with a **Housing Specialist or case manager** to establish plans for the client to maintain their housing arrangements.
- **Housing Plan** specifications would include payment of rent (or co-pay) on time, compliance with facility and lease requirements (no smoking, sublease, etc.), participation in life skills and similar training to help the client manage finances, pay rent, and help the client transition to unsubsidized living arrangements.
- The **Housing Plan would be coordinated with the client's Medical Case Management (MCM) Care Plan** which includes the plans to achieve and/or maintain VLS.
- The EMA can use existing models of a Housing Plan available through USDHHS and HUD and other sources.

Recommendation #4: Fund the position(s) of Housing Specialist or Housing Assistance to assist in housing placement, homelessness prevention, and housing service coordination. Functions include:

- **Establishing housing stock.** Identify landlords interested in renting to PLWH and low income clients receiving housing subsidies through, e.g., HOPWA, Section 8, RWHAP housing. Maintain relationships with landlords so that they are comfortable accepting subsidies and working with clients receiving these vouchers.
- **Working with clients on housing readiness and maintenance.** Assessing clients on ability and understanding of responsibilities of housing, including payment and compliance, and ability to meet such requirements. Recommending appropriate training such as life skills and financial management, coordinating for training and referrals for clients. Working with case management staff accordingly.
- **Preparing a Housing Plan** with client on responsibilities of housing, as discussed above.
- **Homelessness prevention.** For "noncompliant" clients in housing, working with landlords to assist in identifying solutions to forestall eviction for the short term.

Recommendation #5: Improve coordination of housing services within and outside of the Newark EMA to expand access to affordable housing.

- **Expand and/or Target RWHAP services.** Investigate expanding housing services, both within the Housing category and Emergency Financial Assistance (EFA), and coordination with [provision of] outpatient substance use treatment and mental health services.
- **Increase RWHAP housing payment amounts and duration.** The maximum duration for RWHAP housing allowable by HRSA HAB is 24 months. Investigate options for payment of non-RWHAP housing costs, e.g., security deposits.
- **Build on existing housing payment models like HOPWA.** Agencies recommended following the HOPWA payment algorithm of 70% subsidy and 30% client payment which has been successful for our low income clients.
- **Leverage Existing RWHAP-funded Housing Agencies to administer.** Agencies have a range of experience and expertise in housing services which can be use for expanded housing services.
- **Seek advance RWHAP payments from City of Newark for housing services (rental assistance).** This will enable housing agencies to pay for services up front instead of reimbursement, which ties up agency funds for a 2-3 month period while awaiting Newark reimbursement payment. Appropriate fiscal controls and fiscal monitoring would accompany this policy.
- **Promote Life Skills training among clients.** Many courses are available through county governments, schools, etc. These teach financial literacy, job skills, preparation for employment, etc. This could be done by case management for clients and part of the MCM or CM Care Plan.
- **Newark EMA Resource Inventory.** PC support staff should identify housing programs in the North Jersey region and statewide which would give access to NEMA PLWH to more housing options.
- **Establish a Housing work group or subcommittee [of Continuum of Care Committee – COC?]** to start planning and coordinating resources on behalf of NEMA PLWH. Make recommendations for coordinating housing subsidies of RWHAP, HOPWA, and other NJ and HUD programs. Make recommendations based on housing needs and program requirements and opportunities.
- **Utilize existing models across the US for HRSA, CMS and HUD, including those presented at the 2020 National Ryan White Conference August 11 – 14, 2020 and available on the Target HIV website.**

APPENDIX A:

HOUSING CATEGORIES: RYAN WHITE HIV/AIDS PROGRAM AND HUD

The definitions of **Housing Status** from US DHHS and HUD and CHAMP housing status ("live in" variable) are shown below.

USDHHS	CHAMP/US HUD
Stable Permanent Housing	HOPWA - Long Term
	House/Apartment - Rent or Own Unsubsidized
	House/Apartment - Subsidized Non HOPWA
	Nursing Home/Hospice
	SRO or Group Housing
Temporary Housing	Hotel or motel no subsidy-voucher
	House/Apartment - Doubling up, staying with family/friends
	Institution (Hospital, Psych.)
	Residential Treatment Program
	Ryan White Housing
	Transitional Housing - Not Ryan White
	Transitional Housing - Ryan White
Unstable Housing	Emergency Shelter
	Homeless
	Hotel or motel with subsidy-voucher
	Jail/Prison

APPENDIX B:

DETAILED CHAMP HOUSING DATA AND OUTCOMES BY COUNTY/REGION AS OF 12/31/19

ANALYSIS OF CHAMP HOUSING AND VIRAL LOAD SUPPRESSION (VLS) BY CLIENTS - NEWARK EMA 2019

This document presents housing status of RWHAP clients for the EMA for the measurement year ending: December 31, 2019. Data are from CHAMP Cycle 68 (ending 12/31/19 and run 4/24/20). This is the final file.

There are two categories of measures: DHHS Housing (3 categories) and HUD Housing Types (16 types). These are cross-referenced in the HRSA HAB annual RSR Manual.

NEWARK EMA **Total Clients = 6,340** **Total Clients Meeting VLS measure = 4,827**

DHHS Housing Categories	#	% Distn	VL Suppressed	Not VL Suppressed	Total	VL Suppressed	Not VL Suppressed	Total
Stable Permanent Housing	4417	69.7%	2909	398	3307	88.0%	12.0%	100.0%
Temporary Housing	1689	26.6%	1152	219	1371	84.0%	16.0%	100.0%
Unstable Housing	234	3.7%	109	40	149	73.2%	26.8%	100.0%
Total	**6340**	**100.0%**	**4170**	**657**	**4827**	**86.4%**	**13.6%**	**100.0%**

HUD Housing Categories	#	% Distn						
SPH House/Apartment - Rent or Own Unsubsidized	3477	54.8%	2353	324	2677	87.9%	12.1%	100.0%
SPH HOPWA - Long Term	205	3.2%	117	14	131	89.3%	10.7%	100.0%
SPH House/Apartment - Subsidized Non HOPWA	585	9.2%	374	52	426	87.8%	12.2%	100.0%
SPH SRO or Group Housing	26	0.4%	18	3	21	85.7%	14.3%	100.0%
SPH Nursing Home/Hospice	124	2.0%	47	5	52	90.4%	9.6%	100.0%
TH Hotel or motel no subsidy-voucher	2	0.0%	2	0	2	100.0%	0.0%	100.0%
TH House/Apartment - Doubling up, staying with family/friends	1543	24.3%	1063	203	1266	84.0%	16.0%	100.0%
TH Ryan White Housing	7	0.1%	2	1	3	66.7%	33.3%	100.0%
TH Transitional Housing - Ryan White	64	1.0%	39	8	47	83.0%	17.0%	100.0%
TH Transitional Housing - Not Ryan White	21	0.3%	13	3	16	81.3%	18.8%	100.0%
TH Residential Treatment Program	38	0.6%	23	4	27	85.2%	14.8%	100.0%
TH Institution (Hospital, Psych.)	14	0.2%	10	0	10	100.0%	0.0%	100.0%
UH Hotel or motel with subsidy-voucher	7	0.1%	5	0	5	100.0%	0.0%	100.0%
UH Emergency Shelter	95	1.5%	51	16	67	76.1%	23.9%	100.0%
UH Homeless	88	1.4%	38	21	59	64.4%	35.6%	100.0%
UH Jail/Prison	44	0.7%	15	3	18	83.3%	16.7%	100.0%
Total	**6340**	**100.0%**	**4170**	**657**	**4827**	**86.4%**	**13.6%**	**100.0%**

ANALYSIS OF CHAMP HOUSING AND VIRAL LOAD SUPPRESSION (VLS) BY CLIENTS - NEWARK EMA 2019

ESSEX COUNTY **Total Clients = 4,217** **Total Clients Meeting VLS measure = 3,239**

DHHS Housing Categories	#	% Distn	VL Suppressed	Not VL Suppressed	Total	VL Suppressed	Not VL Suppressed	Total
Stable Permanent Housing	2848	67.5%	1852	301	2153	86.0%	14.0%	100.0%
Temporary Housing	1184	28.1%	792	168	960	82.5%	17.5%	100.0%
Unstable Housing	185	4.4%	91	35	126	72.2%	27.8%	100.0%
Total	4217	**100.0%**	**2735**	**504**	**3239**	**84.4%**	**15.6%**	**100.0%**

HUD Housing Categories	#	% Distn						
SPH House/Apartment - Rent or Own Unsubsidized	2216	52.5%	1502	242	1744	86.1%	13.9%	100.0%
SPH HOPWA - Long Term	120	2.8%	61	13	74	82.4%	17.6%	100.0%
SPH House/Apartment - Subsidized Non HOPWA	393	9.3%	245	40	285	86.0%	14.0%	100.0%
SPH SRO or Group Housing	16	0.4%	11	2	13	84.6%	15.4%	100.0%
SPH Nursing Home/Hospice	103	2.4%	33	4	37	89.2%	10.8%	100.0%
TH Hotel or motel no subsidy-voucher	1	0.0%	1	0	1	100.0%	0.0%	100.0%
TH House/Apartment - Doubling up, staying with family/friends	1076	25.5%	728	154	882	82.5%	17.5%	100.0%
TH Ryan White Housing	6	0.1%	1	1	2	50.0%	50.0%	100.0%
TH Transitional Housing - Ryan White	52	1.2%	31	6	37	83.8%	16.2%	100.0%
TH Transitional Housing - Not Ryan White	18	0.4%	12	3	15	80.0%	20.0%	100.0%
TH Residential Treatment Program	29	0.7%	18	4	22	81.8%	18.2%	100.0%
TH Institution (Hospital, Psych.)	2	0.0%	1	0	1	100.0%	0.0%	100.0%
UH Hotel or motel with subsidy-voucher	4	0.1%	4	0	4	100.0%	0.0%	100.0%
UH Emergency Shelter	89	2.1%	47	15	62	75.8%	24.2%	100.0%
UH Homeless	70	1.7%	33	19	52	63.5%	36.5%	100.0%
UH Jail/Prison	22	0.5%	7	1	8	87.5%	12.5%	100.0%
Total	**4217**	**100.0%**	**2735**	**504**	**3239**	**84.4%**	**15.6%**	**100.0%**

ANALYSIS OF CHAMP HOUSING AND VIRAL LOAD SUPPRESSION (VLS) BY CLIENTS - NEWARK EMA 2019

UNION COUNTY **Total Clients = 1,155** **Total Clients Meeting VLS measure = 852**

DHHS Housing Categories	#	% Distn	VL Suppressed	Not VL Suppressed	Total	VL Suppressed	Not VL Suppressed	Total
Stable Permanent Housing	868	75.2%	566	53	619	91.4%	8.6%	100.0%
Temporary Housing	264	22.9%	187	34	221	84.6%	15.4%	100.0%
Unstable Housing	23	2.0%	9	3	12	75.0%	25.0%	100.0%
Total	**1155**	**100.0%**	**762**	**90**	**852**	**89.4%**	**10.6%**	**100.0%**

HUD Housing Categories	#	% Distn						
SPH House/Apartment - Rent or Own Unsubsidized	708	61.3%	459	44	503	91.3%	8.7%	100.0%
SPH HOPWA - Long Term	44	3.8%	31	0	31	100.0%	0.0%	100.0%
SPH House/Apartment - Subsidized Non HOPWA	106	9.2%	69	9	78	88.5%	11.5%	100.0%
SPH SRO or Group Housing	6	0.5%	4	0	4	100.0%	0.0%	100.0%
SPH Nursing Home/Hospice	4	0.3%	3	0	3	100.0%	0.0%	100.0%
TH Hotel or motel no subsidy-voucher	1	0.1%	1	0	1	100.0%	0.0%	100.0%
TH House/Apartment - Doubling up, staying with family/friends	247	21.4%	176	32	208	84.6%	15.4%	100.0%
TH Ryan White Housing	0	0.0%	0	0	0	0.0%	0.0%	0.0%
TH Transitional Housing - Ryan White	7	0.6%	5	2	7	71.4%	28.6%	100.0%
TH Transitional Housing - Not Ryan White	1	0.1%	0	0	0	0.0%	0.0%	0.0%
TH Residential Treatment Program	2	0.2%	0	0	0	0.0%	0.0%	0.0%
TH Institution (Hospital, Psych.)	6	0.5%	5	0	5	100.0%	0.0%	100.0%
UH Hotel or motel with subsidy-voucher	2	0.2%	1	0	1	100.0%	0.0%	100.0%
UH Emergency Shelter	3	0.3%	1	1	2	50.0%	50.0%	100.0%
UH Homeless	9	0.8%	3	1	4	75.0%	25.0%	100.0%
UH Jail/Prison	9	0.8%	4	1	5	80.0%	20.0%	100.0%
Total	**1155**	**100.0%**	**762**	**90**	**852**	**89.4%**	**10.6%**	**100.0%**

ANALYSIS OF CHAMP HOUSING AND VIRAL LOAD SUPPRESSION (VLS) BY CLIENTS - NEWARK EMA 2019

MORRIS, SUSSEX, WARREN COUNTIES **Total Clients = 362** **Total Clients Meeting VLS measure = 266**

DHHS Housing Categories	#	% Distn	VL Suppressed	Not VL Suppressed	Total	VL Suppressed	Not VL Suppressed	Total
Stable Permanent Housing	258	71.3%	184	4	188	97.9%	2.1%	100.0%
Temporary Housing	91	25.1%	64	8	72	88.9%	11.1%	100.0%
Unstable Housing	13	3.6%	5	1	6	83.3%	16.7%	100.0%
Total	**362**	**100.0%**	**253**	**13**	**266**	**95.1%**	**4.9%**	**100.0%**

HUD Housing Categories	#	% Distn						
SPH House/Apartment - Rent or Own Unsubsidized	159	43.9%	115	4	119	96.6%	3.4%	100.0%
SPH HOPWA - Long Term	38	10.5%	23	0	23	100.0%	0.0%	100.0%
SPH House/Apartment - Subsidized Non HOPWA	53	14.6%	40	0	40	100.0%	0.0%	100.0%
SPH SRO or Group Housing	1	0.3%	1	0	1	100.0%	0.0%	100.0%
SPH Nursing Home/Hospice	7	1.9%	5	0	5	100.0%	0.0%	100.0%
TH Hotel or motel no subsidy-voucher	0	0.0%	0	0	0	0.0%	0.0%	0.0%
TH House/Apartment - Doubling up, staying with family/friends	82	22.7%	57	8	65	87.7%	12.3%	100.0%
TH Ryan White Housing	1	0.3%	1	0	1	100.0%	0.0%	100.0%
TH Transitional Housing - Ryan White	2	0.6%	2	0	2	100.0%	0.0%	100.0%
TH Transitional Housing - Not Ryan White	0	0.0%	0	0	0	0.0%	0.0%	0.0%
TH Residential Treatment Program	2	0.6%	1	0	1	100.0%	0.0%	100.0%
TH Institution (Hospital, Psych.)	4	1.1%	3	0	3	100.0%	0.0%	100.0%
UH Hotel or motel with subsidy-voucher	1	0.3%	0	0	0	0.0%	0.0%	0.0%
UH Emergency Shelter	1	0.3%	1	0	1	100.0%	0.0%	100.0%
UH Homeless	4	1.1%	1	0	1	100.0%	0.0%	100.0%
UH Jail/Prison	7	1.9%	3	1	4	75.0%	25.0%	100.0%
Total	**362**	**100.0%**	**253**	**13**	**266**	**95.1%**	**4.9%**	**100.0%**

ANALYSIS OF CHAMP HOUSING AND RETENTION IN CARE (RIC) BY CLIENTS - NEWARK EMA 2019

This document presents housing status of RWHAP clients for the EMA for the measurement year ending: December 31, 2019. Data are from CHAMP Cycle 68 (ending 12/31/19 and run 4/24/20). This is the final file.

There are two categories of measures: DHHS Housing (3 categories) and HUD Housing Types (16 types). These are cross-referenced in the HRSA HAB annual RSR Manual.

NEWARK EMA **Total Clients = 6,340** **Total Clients Meeting RIC (Reverse GAP) measure = 4,065**

DHHS Housing Categories	#	% Distn	RIC (Rev Gap)	Not RIC	Total	RIC (Rev Gap)	Not RIC	Total
Stable Permanent Housing	4417	69.7%	2473	361	2834	87.3%	12.7%	100.0%
Temporary Housing	1689	26.6%	959	169	1128	85.0%	15.0%	100.0%
Unstable Housing	234	3.7%	71	32	103	68.9%	31.1%	100.0%
Total	**6340**	**100.0%**	**3503**	**562**	**4065**	**86.2%**	**13.8%**	**100.0%**

HUD Housing Categories	#	% Distn						
SPH House/Apartment - Rent or Own Unsubsidized	3477	54.8%	1971	302	2273	86.7%	13.3%	100.0%
SPH HOPWA - Long Term	205	3.2%	112	9	121	92.6%	7.4%	100.0%
SPH House/Apartment - Subsidized Non HOPWA	585	9.2%	346	37	383	90.3%	9.7%	100.0%
SPH SRO or Group Housing	26	0.4%	17	1	18	94.4%	5.6%	100.0%
SPH Nursing Home/Hospice	124	2.0%	27	12	39	69.2%	30.8%	100.0%
TH Hotel or motel no subsidy-voucher	2	0.0%	2	0	2	100.0%	0.0%	100.0%
TH House/Apartment - Doubling up, staying with family/friends	1543	24.3%	895	152	1047	85.5%	14.5%	100.0%
TH Ryan White Housing	7	0.1%	2	0	2	100.0%	0.0%	100.0%
TH Transitional Housing - Ryan White	64	1.0%	27	8	35	77.1%	22.9%	100.0%
TH Transitional Housing - Not Ryan White	21	0.3%	11	3	14	78.6%	21.4%	100.0%
TH Residential Treatment Program	38	0.6%	14	5	19	73.7%	26.3%	100.0%
TH Institution (Hospital, Psych.)	14	0.2%	8	1	9	88.9%	11.1%	100.0%
UH Hotel or motel with subsidy-voucher	7	0.1%	3	0	3	100.0%	0.0%	100.0%
UH Emergency Shelter	95	1.5%	38	14	52	73.1%	26.9%	100.0%
UH Homeless	88	1.4%	25	9	34	73.5%	26.5%	100.0%
UH Jail/Prison	44	0.7%	5	9	14	35.7%	64.3%	100.0%
Total	**6340**	**100.0%**	**3503**	**562**	**4065**	**86.2%**	**13.8%**	**100.0%**

ANALYSIS OF CHAMP HOUSING AND RETENTION IN CARE (RIC) BY CLIENTS - NEWARK EMA 2019

ESSEX COUNTY **Total Clients = 4,217** **Total Clients Meeting RIC (Reverse GAP) measure = 2,743**

DHHS Housing Categories	#	% Distn	RIC (Rev Gap)	Not RIC	Total	RIC (Rev Gap)	Not RIC	Total
Stable Permanent Housing	2848	67.5%	1621	233	1854	87.4%	12.6%	100.0%
Temporary Housing	1184	28.1%	683	118	801	85.3%	14.7%	100.0%
Unstable Housing	185	4.4%	60	28	88	68.2%	31.8%	100.0%
Total	4217	**100.0%**	**2364**	**379**	**2743**	**86.2%**	**13.8%**	**100.0%**

HUD Housing Categories	#	% Distn						
SPH House/Apartment - Rent or Own Unsubsidized	2216	52.5%	1287	197	1484	86.7%	13.3%	100.0%
SPH HOPWA - Long Term	120	2.8%	65	4	69	94.2%	5.8%	100.0%
SPH House/Apartment - Subsidized Non HOPWA	393	9.3%	239	22	261	91.6%	8.4%	100.0%
SPH SRO or Group Housing	16	0.4%	12	0	12	100.0%	0.0%	100.0%
SPH Nursing Home/Hospice	103	2.4%	18	10	28	64.3%	35.7%	100.0%
TH Hotel or motel no subsidy-voucher	1	0.0%	1	0	1	100.0%	0.0%	100.0%
TH House/Apartment - Doubling up, staying with family/friends	1076	25.5%	632	107	739	85.5%	14.5%	100.0%
TH Ryan White Housing	6	0.1%	2	0	2	100.0%	0.0%	100.0%
TH Transitional Housing - Ryan White	52	1.2%	25	5	30	83.3%	16.7%	100.0%
TH Transitional Housing - Not Ryan White	18	0.4%	10	3	13	76.9%	23.1%	100.0%
TH Residential Treatment Program	29	0.7%	12	3	15	80.0%	20.0%	100.0%
TH Institution (Hospital, Psych.)	2	0.0%	1	0	1	100.0%	0.0%	100.0%
UH Hotel or motel with subsidy-voucher	4	0.1%	2	0	2	100.0%	0.0%	100.0%
UH Emergency Shelter	89	2.1%	35	14	49	71.4%	28.6%	100.0%
UH Homeless	70	1.7%	22	9	31	71.0%	29.0%	100.0%
UH Jail/Prison	22	0.5%	1	5	6	16.7%	83.3%	100.0%
Total	**4217**	**100.0%**	**2364**	**379**	**2743**	**86.2%**	**13.8%**	**100.0%**

ANALYSIS OF CHAMP HOUSING AND RETENTION IN CARE (RIC) BY CLIENTS - NEWARK EMA 2019

UNION COUNTY **Total Clients = 1,155** **Total Clients Meeting RIC (Reverse GAP) measure = 704**

DHHS Housing Categories	**#**	**% Distn**	RIC (Rev Gap)	Not RIC	**Total**	RIC (Rev Gap)	Not RIC	**Total**
Stable Permanent Housing	868	75.2%	452	69	521	86.8%	13.2%	100.0%
Temporary Housing	264	22.9%	145	31	176	82.4%	17.6%	100.0%
Unstable Housing	23	2.0%	4	3	7	57.1%	42.9%	100.0%
Total	**1155**	**100.0%**	**601**	**103**	**704**	**85.4%**	**14.6%**	**100.0%**

HUD Housing Categories	**#**	**% Distn**						
SPH House/Apartment - Rent or Own Unsubsidized	708	61.3%	363	55	418	86.8%	13.2%	100.0%
SPH HOPWA - Long Term	44	3.8%	25	4	29	86.2%	13.8%	100.0%
SPH House/Apartment - Subsidized Non HOPWA	106	9.2%	59	9	68	86.8%	13.2%	100.0%
SPH SRO or Group Housing	6	0.5%	3	0	3	100.0%	0.0%	100.0%
SPH Nursing Home/Hospice	4	0.3%	2	1	3	66.7%	33.3%	100.0%
TH Hotel or motel no subsidy-voucher	1	0.1%	1	0	1	100.0%	0.0%	100.0%
TH House/Apartment - Doubling up, staying with family/friends	247	21.4%	138	29	167	82.6%	17.4%	100.0%
TH Ryan White Housing	0	0.0%	0	0	0	0.0%	0.0%	0.0%
TH Transitional Housing - Ryan White	7	0.6%	2	2	4	50.0%	50.0%	100.0%
TH Transitional Housing - Not Ryan White	1	0.1%	0	0	0	0.0%	0.0%	0.0%
TH Residential Treatment Program	2	0.2%	0	0	0	0.0%	0.0%	0.0%
TH Institution (Hospital, Psych.)	6	0.5%	4	0	4	100.0%	0.0%	100.0%
UH Hotel or motel with subsidy-voucher	2	0.2%	1	0	1	100.0%	0.0%	100.0%
UH Emergency Shelter	3	0.3%	1	0	1	100.0%	0.0%	100.0%
UH Homeless	9	0.8%	1	0	1	100.0%	0.0%	100.0%
UH Jail/Prison	9	0.8%	1	3	4	25.0%	75.0%	100.0%
Total	**1155**	**100.0%**	**601**	**103**	**704**	**85.4%**	**14.6%**	**100.0%**

ANALYSIS OF CHAMP HOUSING AND RETENTION IN CARE (RIC) BY CLIENTS - NEWARK EMA 2019

MORRIS, SUSSEX, WARREN COUNTIES **Total Clients = 362** **Total Clients Meeting RIC (Reverse GAP) measure = 230**

DHHS Housing Categories	**#**	**% Distn**	RIC (Rev Gap)	Not RIC	**Total**	RIC (Rev Gap)	Not RIC	**Total**
Stable Permanent Housing	258	71.3%	157	13	170	92.4%	7.6%	100.0%
Temporary Housing	91	25.1%	50	5	55	90.9%	9.1%	100.0%
Unstable Housing	13	3.6%	4	1	5	80.0%	20.0%	100.0%
Total	**362**	**100.0%**	**211**	**19**	**230**	**91.7%**	**8.3%**	**100.0%**

HUD Housing Categories	**#**	**% Distn**						
SPH House/Apartment - Rent or Own Unsubsidized	159	43.9%	98	8	106	92.5%	7.5%	100.0%
SPH HOPWA - Long Term	38	10.5%	20	1	21	95.2%	4.8%	100.0%
SPH House/Apartment - Subsidized Non HOPWA	53	14.6%	34	4	38	89.5%	10.5%	100.0%
SPH SRO or Group Housing	1	0.3%	1	0	1	100.0%	0.0%	100.0%
SPH Nursing Home/Hospice	7	1.9%	4	0	4	100.0%	0.0%	100.0%
TH Hotel or motel no subsidy-voucher	0	0.0%	0	0	0	0.0%	0.0%	0.0%
TH House/Apartment - Doubling up, staying with family/friends	82	22.7%	47	3	50	94.0%	6.0%	100.0%
TH Ryan White Housing	1	0.3%	0	0	0	0.0%	0.0%	0.0%
TH Transitional Housing - Ryan White	2	0.6%	0	1	1	0.0%	100.0%	100.0%
TH Transitional Housing - Not Ryan White	0	0.0%	0	0	0	0.0%	0.0%	0.0%
TH Residential Treatment Program	2	0.6%	1	0	1	100.0%	0.0%	100.0%
TH Institution (Hospital, Psych.)	4	1.1%	2	1	3	66.7%	33.3%	100.0%
UH Hotel or motel with subsidy-voucher	1	0.3%	0	0	0	0.0%	0.0%	0.0%
UH Emergency Shelter	1	0.3%	1	0	1	100.0%	0.0%	100.0%
UH Homeless	4	1.1%	1	0	1	100.0%	0.0%	100.0%
UH Jail/Prison	7	1.9%	2	1	3	66.7%	33.3%	100.0%
Total	**362**	**100.0%**	**211**	**19**	**230**	**91.7%**	**8.3%**	**100.0%**

APPENDIX C:

HOUSING TALKING POINTS – CIA 2/26/20

HOUSING TALKING POINTS – CIA February 26, 2020

Intro to consumers: The Newark EMA is embarking on a new initiative to end HIV - by (1) diagnosing more people earlier, (2) getting them into care ASAP, (3) helping them stay in care, and (4) locating those out of care and bringing them back with ongoing support. This is part of a new national "Ending the HIV Epidemic" initiative – to reduce new HIV infections by 90% by 2030. 48 geographical areas are targeted for high HIV – in NJ, this is **Essex** and Hudson counties. Since many HIV+ residents of Essex receive care and services in Union and Morris/Sussex/Warren – all counties will be participating.

We need your advice and tips on how to help us make this happen. Real solutions, especially on an individual person to person basis. Because there are no more broad solutions. **How do we reach each person?** The **outcome** is to get recommendations workable, doable, feasible solutions. **This will be an ongoing process.**

One of our priorities is to use **Community Health Workers (CHWs)** to do field outreach and help return people to care. Another is to address the needs you have repeatedly told us about – **need for housing – and to provide more housing assistance (funding) – possibly following a HOPWA-type model.** We have data on housing for RW clients – but today want to hear some of the **realities and challenges for housing to help us develop possible solutions. We are asking information about both you and people you know. All information is anonymous.**

1. What kind of housing do you/friends live in? House, apartment? Shelter? Other? Own, rent?
2. Do you receive a subsidy? What kind? HOPWA, public housing, Section 8, etc?
3. Do now or ever had to "double up"? Stay with family, friends for a short term or longer term basis?
4. How would you describe your housing situation? Stable, temporary, transitional, unstable? Now and over time – say the past 1-2 years?
5. Has your housing situation changed recently? Was that good or bad? Describe.
6. Are you able to take your medications on schedule in your current housing situation? Why or why not?
7. Do you know anyone who has been denied housing? For what reasons?
8. Do you know anyone who has lost their housing? For what reasons?
9. How can we use housing to improve health – viral load – so that you/friends are undetectable or virally suppressed?

HOUSING TALKING POINTS – CIA February 26, 2020

10. If we were to add funding for housing – how could it work best to help people remain in care and improve health and viral suppression? How could we best use the funds? (What kind of rules should we have?)

11. Who should get priority for additional housing funds? (VLS vs non-VLS)

12. We would want to provide support for housing, such as medical/non-medical case management, substance abuse and/or mental health treatment. Would that be helpful?

13. We are allowed to provide up to 24 months (2 years) of housing support? Is that enough time to allow you/friends to get unsubsidized housing? How could we best use additional housing funds?

ADDITIONAL TOPICS

14. What are [continued] barriers to treatment, VLS?

15. If behavioral services are a barrier - how can we help remove? Substance use. Mental health? How would you recommend?

16. What about Community Health Workers (CHWs) - outreach workers or peers - what do we need from these persons/positions?

17. What about peer support - to help people manage their HIV and stay on track and take meds?

18. Support groups - we have some - do we need more?

19. What about CABs - should we have more [in Essex]? Do regular meetings help?

20. How could we provide better feedback to consumers to help support you? And keep everyone engaged and involved?

APPENDIX D:

AGENCY SURVEY – 2020

NEWARK EMA NEEDS ASSESSMENT – UPDATE 2020
HOUSING QUESTIONNAIRE FOR AGENCY KEY INFORMANTS

Hello Agencies!

The Newark EMA HIV Planning Council, in coordination with the Newark EMA Ryan White HIV/AIDS Program (RWHAP), is seeking your input on one of the most important non-medical issues facing Persons Living with HIV (PLWH) in the Newark EMA – **housing**. We are using a comprehensive approach to focus on needs, barriers and opportunities for housing and specifically how can housing be used to maintain or improve health outcomes, specifically Viral Load Suppression (VLS) and Retention In Care (RIC). Results of this 2020 Needs Assessment will be used to identify PLWH needs and to assist in restructuring RWHAP housing services.

The overall **Research Question** to be answered is: **What are the housing needs of PLWH that prevent or interfere with their achieving Viral Load Suppression and what are some strategies to improve their housing?**

We are seeking input from you as "Key Informants". Your agencies include those that are providing medical case management, or non-medical case management or housing services or emergency financial assistance. That is, **providing direct housing services or referrals to housing services.**

Please take time to complete this survey. It should take a maximum 30 minutes to review & identify responses and an additional 15-30 minutes to enter responses, review and finalize. Only one survey is needed per agency.
The survey is in Microsoft word. Please enter your responses directly into this form, which will make it easier for us to tabulate. Take as much space as needed to fully answer the questions and reflect your agency experience and input. We read and incorporate all responses!
THANK YOU!

NOTE: You may refer to the time-period of the past fiscal year (March 1, 2019 to February 29, 2020).

Contact information (Confidential, in case follow-up is needed)

Agency Name: _____

Person Answering Survey: _____

Phone Number: _____

Email: _____

The purpose of this questionnaire is to identify housing challenges faced by PLWH and to assist in development of possible housing solutions to improve viral suppression among PLWH.

1. Based on your experience, what are the housing characteristics and challenges faced by PLWH who are not virally suppressed? Are they in stable, temporary or unstable living arrangements? (See the attached chart for definitions)

2. What are other characteristics/challenges of these non-VLS PLWH?

3. What kind of housing assistance do you refer your HIV clients to? (Public housing, section 8, HOPWA, RW funded housing, CDBG, etc.)

4. Under what circumstances do you refer or provide PLWH with housing assistance? (Client circumstances, e.g., homelessness, etc. Other situations.)

5. For housing agencies: what kind of housing assistance do you provide to clients? (Financial, program, etc.)

   a. Does this include only payment for housing or other support services?

   b. For how long is this assistance? (Length of time, e.g., # months, years, etc.)

6.	Are there any eligibility criteria you follow? (Financial, other, etc.)

7.	What do you do if you do not have enough resources (financial, etc.) to serve all who need support?

8.	What happens to clients who do not receive housing assistance support? Where do they go? Where do they live?

The Ryan White Program may be receiving additional funding for housing. However, we want to link this financial support to achievement of Viral Load Suppression (VLS) – either helping clients to achieve VLS or to assist in maintaining VLS. We need your input on how to structure this program.

9.	What are some eligibility criteria you would recommend to receive financial housing assistance?

10.	How long should this assistance last – what time period? 1 year? Longer?

11.	We want to link assistance with VLS maintenance as well as overall health and mental health. Should we require clients to have a Housing Plan – including see a case manager regularly, participation in mental health and/or substance use services, etc.

12.	What other services would you recommend?

13.	How would this type of program be administered? Through existing housing agencies?

14.	Would use of advance payments to housing agencies – up front initial payment versus reimbursement – assist in the success of this program?

15.	What other ideas do you have about housing assistance for PLWH? (List below)

THANK YOU FOR YOUR TIME AND VALUABLE INPUT!

HOUSING CATEGORIES: RYAN WHITE HIV/AIDS PROGRAM AND HUD

The definitions of **Housing Status** from US DHHS and HUD and CHAMP housing status ("live in" variable) a
below.

USDHHS	CHAMP/US HUD
Stable Permanent Housing	HOPWA - Long Term House/Apartment - Rent or Own Unsubsidized House/Apartment - Subsidized Non HOPWA Nursing Home/Hospice SRO or Group Housing
Temporary Housing	Hotel or motel no subsidy-voucher House/Apartment - Doubling up, staying with family/friends Institution (Hospital, Psych.) Residential Treatment Program Ryan White Housing Transitional Housing - Not Ryan White Transitional Housing - Ryan White
Unstable Housing	Emergency Shelter Homeless Hotel or motel with subsidy-voucher Jail/Prison