Expanding Housing as Healthcare:
Interim results of a housing program for non-HASA-eligible people living with HIV from NYC

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Background Information
Agency Mission

• To provide 100% access to quality HIV/AIDS care for all our clients, regardless of race, socio-economic status, or sexual orientation;
• To ensure that each of our clients remains connected to treatment and obtains the best possible health outcomes;
• To provide quality HIV prevention, housing, and care services in a safe and nurturing environment;
• To unite Harlem’s diverse communities and address the needs of all people living with and threatened by HIV/AIDS;
• To empower our clients physically, emotionally, socially, and spiritually.
## Harlem United at a Glance

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue</td>
<td>$42 million</td>
</tr>
<tr>
<td>Total Assets</td>
<td>$42 million</td>
</tr>
<tr>
<td>Service Area</td>
<td>The Bronx, Manhattan, and Brooklyn</td>
</tr>
<tr>
<td>Service Sites</td>
<td>9</td>
</tr>
<tr>
<td>Number of Clients Served (unduplicated index clients)</td>
<td>16,242</td>
</tr>
<tr>
<td>Number of Employees</td>
<td>362</td>
</tr>
</tbody>
</table>
Strategic Planning

Community Health Services

Community Based HIV/STI/HCV Screening
Access to Care
Drug User Health Services (Syringe Access, Harm Reduction, Recovery Readiness)
HOME – integrated interventions for MSM of color

Integrated HIV Services

Holistic Provider-Led Patient-Centered Primary Care and Dental Services
Behavioral Health Services
Patient Navigation/Case Management Support
OB/GYN and Pediatric

Adult Day Health Centers
Food & Nutrition
Supportive Housing (Transitional & Permanent, Congregate & Scattersite)
Health Home
Family Support
Housing

- Permanent Scattersite: 450 Units
- Permanent Congregate: 146 Units
- Transitional Scattersite: 35 Units

6 Units of Housing
Housing as Healthcare

Homelessness and Unstable Housing
• HIV infection rates 16 times higher
• Within risk groups (MSM, persons of color, IV drug users, impoverished women), higher risk if not stably housed

For People Living with HIV/AIDS
• Housing is greatest unmet need
• If homeless or unstably housed:
  – Less likely to receive and adhere to antiretroviral therapy
  – Lower CD4 counts and higher viral load
  – Worse overall physical and mental health
  – More likely to die prematurely
Medicaid Redesign Team (MRT)

- Established January 2011 by Governor Cuomo

- Goals:
  - Improve health system quality and efficiency
  - Streamline and focus healthcare admin and financial
  - Reduce Medicaid costs
  - Emphasize well-managed, cost-effective health services
Program Information
Program Overview

• A pilot, demonstration project initiated in Dec. 2014
• Funded by MRT
• Target Population:
  – 50 unstably housed, non-HASA eligible, HIV positive people
  – Enrolled in Health Home
  – Active Medicaid
  – MH and/or SA diagnosis
  – To house and provide rental assistance to 50 unstably housed, non-HASA eligible, HIV positive individuals from NYC and provide them with ongoing supportive housing services to assist them with housing retention and minimize Medicaid utilization
• Eligibility includes enrollment in Health Home, active Medicaid, MH and/or SA diagnosis
Program Overview

• Goals:
  – Provide housing and rental assistance
  – Provide ongoing supportive housing services & retention
  – Minimize Medicaid utilization

• Minimum services include monthly home visit and care coordination with client’s HH provider
Total clients enrolled in 2015

- Q1 2015: 16
- Q2 2015: 24
- Q3 2015: 26
- Q4 2015: 33

* Includes three closed cases
Race & Ethnicity

**Race**
- Black/African American: 60%
- White: 8%
- More than one Race: 4%
- Other Race: 28%

**Ethnicity**
- Hispanic/Latino: 35%
- Non-Hispanic/Latino: 65%
Client Income

- Percent of Clients
  - Clients with income: Baseline 36%, Jan-16 27%
  - Clients without income: Baseline 24%, Jan-16 3%
  - Clients on PA: Baseline 39%, Jan-16 70%

N=33 for Baseline, N=30 for Jan-16
Rent Received - 2015

As a Percent of Rent Expected

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Client rent received</th>
<th>PA rent received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>86%</td>
<td>13%</td>
</tr>
<tr>
<td>Q2</td>
<td>91%</td>
<td>40%</td>
</tr>
<tr>
<td>Q3</td>
<td>82%</td>
<td>39%</td>
</tr>
<tr>
<td>Q4</td>
<td>81%</td>
<td>77%</td>
</tr>
</tbody>
</table>

Target: 80%
Primary Care 2015

PCP: Clients with PCP visits in last 6 months, as percentage of clients housed 6 months
VL <200: Clients with VL <200, as percentage of clients housed 6 months with updated labs
Hospital Utilization 2015

Percent of Clients

Q1  Q2  Q3  Q4
0%  4%  13%  7%
13% 13% 21% 10%
0%  10% 20% 30%
40% 50% 60% 70%
80% 90% 100%

Clients w/hospital visits
Clients w/ER visits
Client Outcomes

- Since baseline:
  - 8 clients have begun public assistance
  - 4 clients gained employment
  - 5 clients entered vocational education and 2 clients have graduated
  - 2 clients entered college and have completed a combined 3 semesters
  - 2 clients have completed support programs (Seeking Safety and Life Skills)
Housing Retention Risk Assessment
Risk Assessment Background

• Danielle Strauss developed the Risk Assessment for HU’s MRT Housing Retention Program
• Used to identify and quantify housing stability risk

RISK FACTORS
• Housing Status
• Medical Status
• Substance use
• Mental Health Status
• Criminal Status
• Domestic Violence

PROTECTIVE FACTORS
• Engagement in Vocational/Educational activities and/or Social Support Services
• Personal support systems
Risk Assessment Methodology

• Response choices are given a value, where the higher the value, the greater the risk for housing instability
• Protective factors or positive behaviors are given negative values that reduce one’s risk
• Program staff administer the tool at baseline and every 6 months for as long as the client is in the program
• Recently adopted by AI for Housing Retention
Average Baseline Scores, all clients

N=33

<table>
<thead>
<tr>
<th>Series 1</th>
<th>- total</th>
<th>- housing</th>
<th>- ARV</th>
<th>- MH tx</th>
<th>- MH rx</th>
<th>- SU engagement</th>
<th>- SU frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7.5</td>
<td>6.4</td>
<td>-0.5</td>
<td>-0.3</td>
<td>-0.3</td>
<td>1.5</td>
<td>0.9</td>
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</table>
## Average Six-Month Scores, all clients

<table>
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<tr>
<th></th>
<th>- total</th>
<th>- housing</th>
<th>- ARV</th>
<th>- MH tx</th>
<th>- MH rx</th>
<th>- SU engagement</th>
<th>- SU frequency</th>
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</thead>
<tbody>
<tr>
<td>Series1</td>
<td>2.5</td>
<td>1.6</td>
<td>-0.3</td>
<td>0.0</td>
<td>-0.2</td>
<td>2.5</td>
<td>0.9</td>
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</table>

N=31
### Average Twelve-Month Scores, all clients

<table>
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<tr>
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<th>Series1</th>
</tr>
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<tbody>
<tr>
<td>- total</td>
<td>4.7</td>
</tr>
<tr>
<td>- housing</td>
<td>0.3</td>
</tr>
<tr>
<td>- ARV</td>
<td>-0.3</td>
</tr>
<tr>
<td>- MH tx</td>
<td>1</td>
</tr>
<tr>
<td>- MH rx</td>
<td>0</td>
</tr>
<tr>
<td>- SU engagement</td>
<td>2.4</td>
</tr>
<tr>
<td>- SU frequency</td>
<td>1.4</td>
</tr>
</tbody>
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N=10
Longitudinal Scores

Total Score

N=10
Longitudinal Scores

**Housing Score**

- Base: 6.3
- 6 mo: 1.9
- 12 mo: 0.3

**ARV Score**

- Base: -0.5
- 6 mo: -0.4
- 12 mo: -0.3

N=10
Longitudinal Scores

**Mental Health Scores**

- MH tx
- MH rx

**Substance Use Scores**

- SU eng
- SU freq

N=10
Comparative Measure
Housing Cascade

<table>
<thead>
<tr>
<th></th>
<th>Linked</th>
<th>Engaged</th>
<th>ARVs</th>
<th>Suppressed</th>
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<tbody>
<tr>
<td>US Average 2011</td>
<td>100%</td>
<td>56%</td>
<td>50%</td>
<td>38%</td>
</tr>
<tr>
<td>NYC HOPWA 2012</td>
<td>100%</td>
<td>96%</td>
<td>90%</td>
<td>69%</td>
</tr>
<tr>
<td>Positive Housing 2015</td>
<td>100%</td>
<td>100%</td>
<td>95%</td>
<td>81%</td>
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Summary
Lessons Learned

• Successes:
  – Stably housed 30 non-HASA-eligible clients
  – Low hospital and emergency room use
  – Increase in engagement in education and employment
  – High Primary Care engagement contributing to high viral suppression
  – Increase in mental health treatment
Lessons Learned

• Challenges:
  – Obtaining affordable units in NYC/lower Westchester
  – Care coordination with Health Home
  – Obtaining rent portion from Public Assistance
  – Lack of infrastructure for difficulties with client (e.g. HASA)