
# Expanding Housing as Healthcare:

Interim results of a housing program for non-HASA-eligible people living with HIV from NYC

Schroeder, B., JD; Strauss, D., MPH

# 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

| | 2015 |
|---|---|
| Revenue | $42 million |
| Total Assets | $42 million |
| Service Area | The Bronx, Manhattan, and Brooklyn |
| Service Sites | 9 |
| Number of Clients Served (unduplicated index clients) | 16,242 |
| Number of Employees | 362 |

# Strategic Planning

Community Health Services

Integrated HIV 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

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

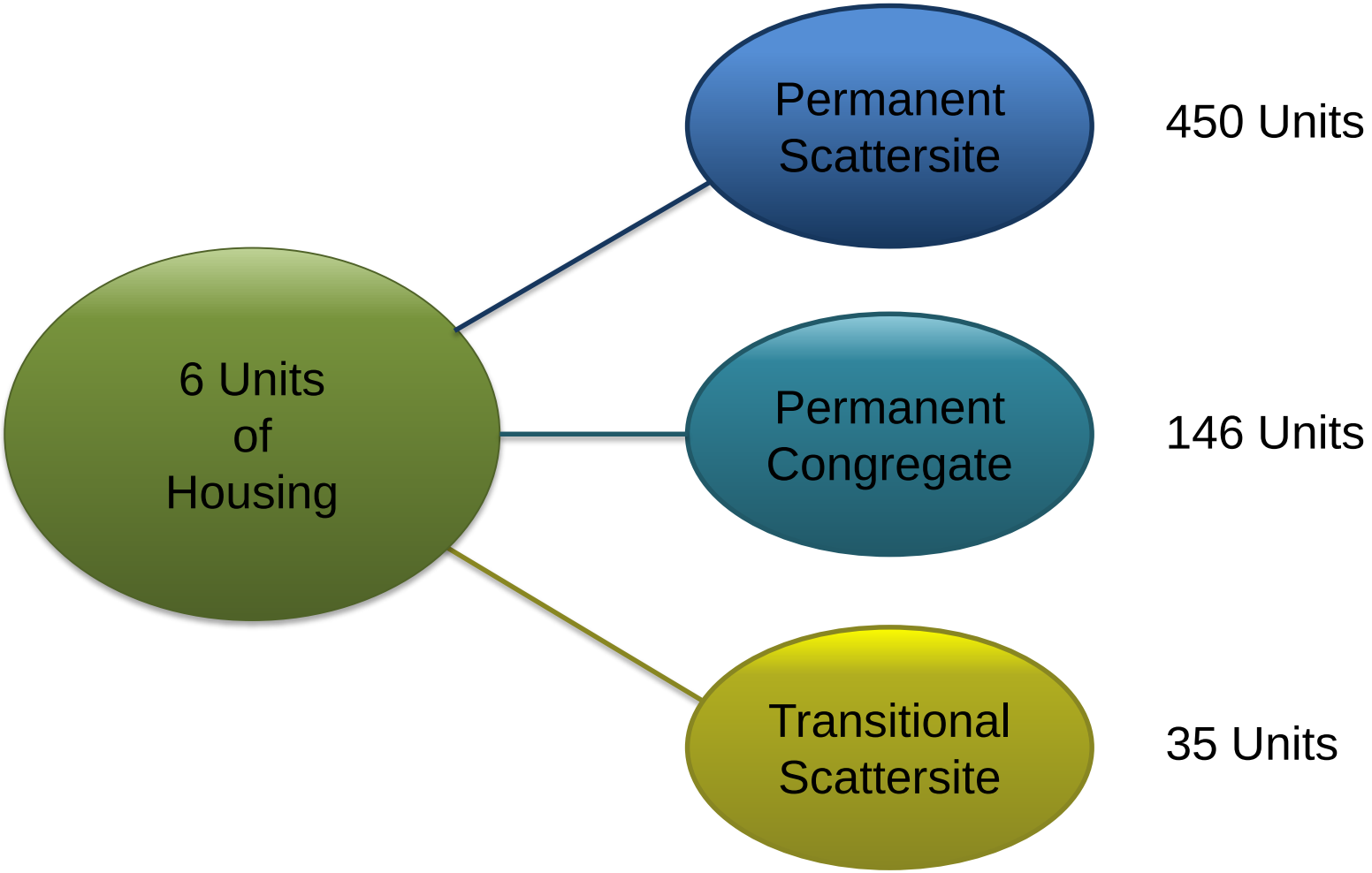
Food & Nutrition

Supportive Housing (Transitional & Permanent, Congregate & Scattersite)

Health Home

Family Support

# Housing


6 Units of Housing
Permanent Scattersite
450 Units
Permanent Congregate
146 Units
Transitional Scattersite
35 Units

# 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

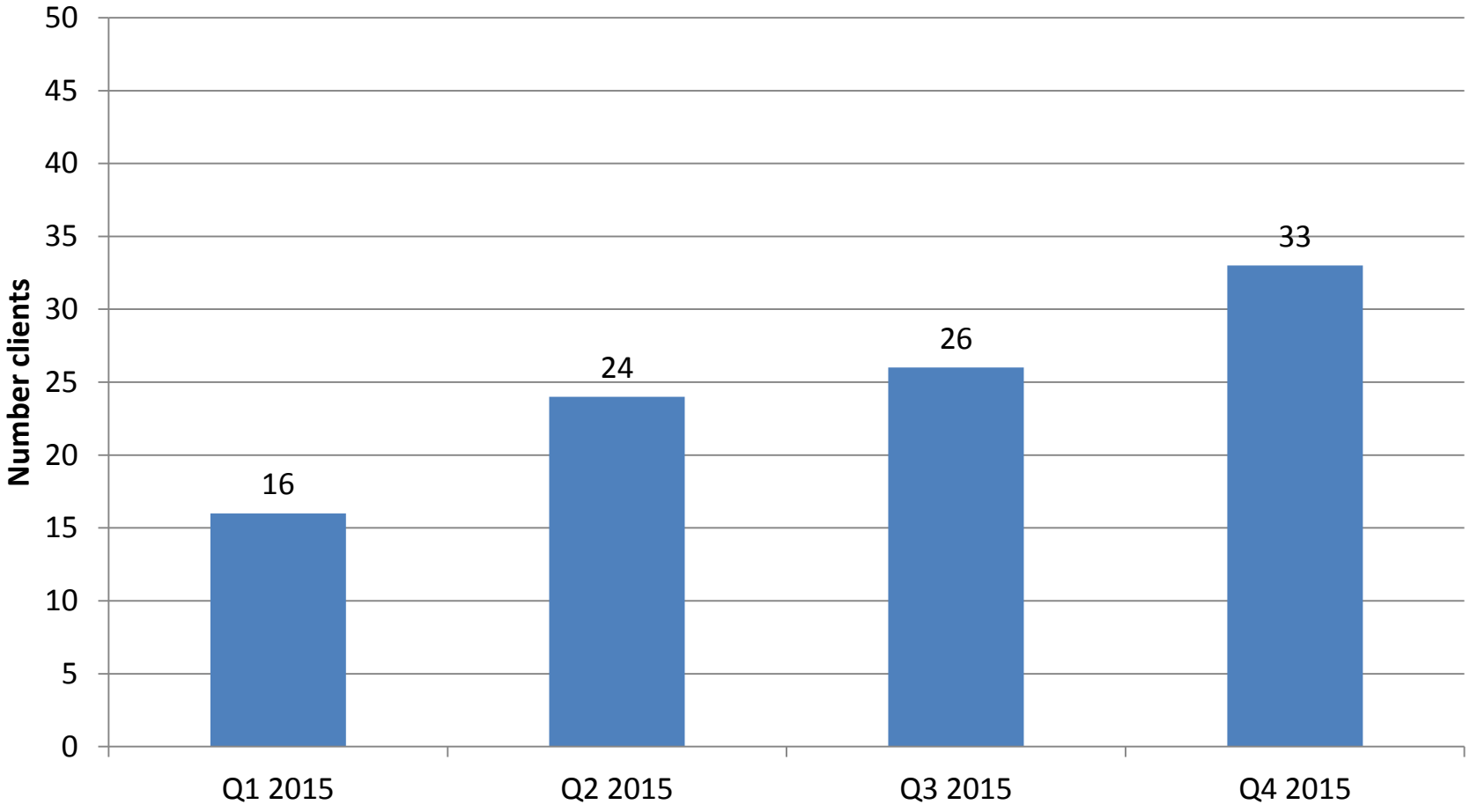
# Program Overview

- 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

# Program Overview

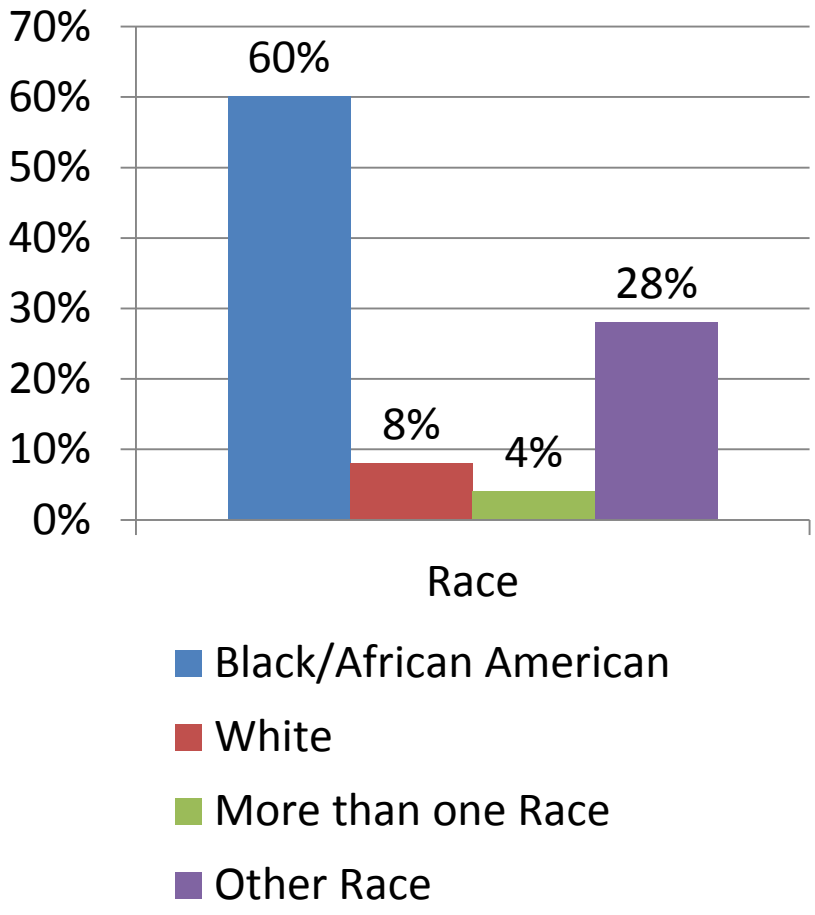
- Goals:
  - Provide housing and rental assistance
  - Provide ongoing supportive housing services & retention
  - Minimize Medicaid utilization
- Minimum services include monthly home visit and care coordination with client's HH provider

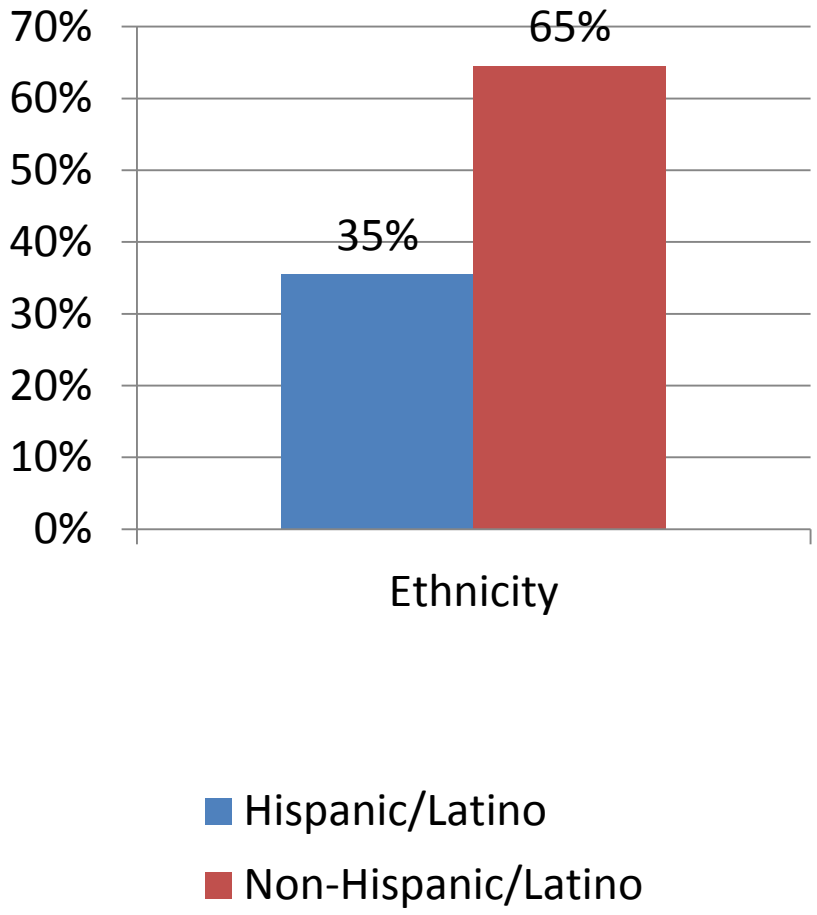
# Total clients enrolled in 2015



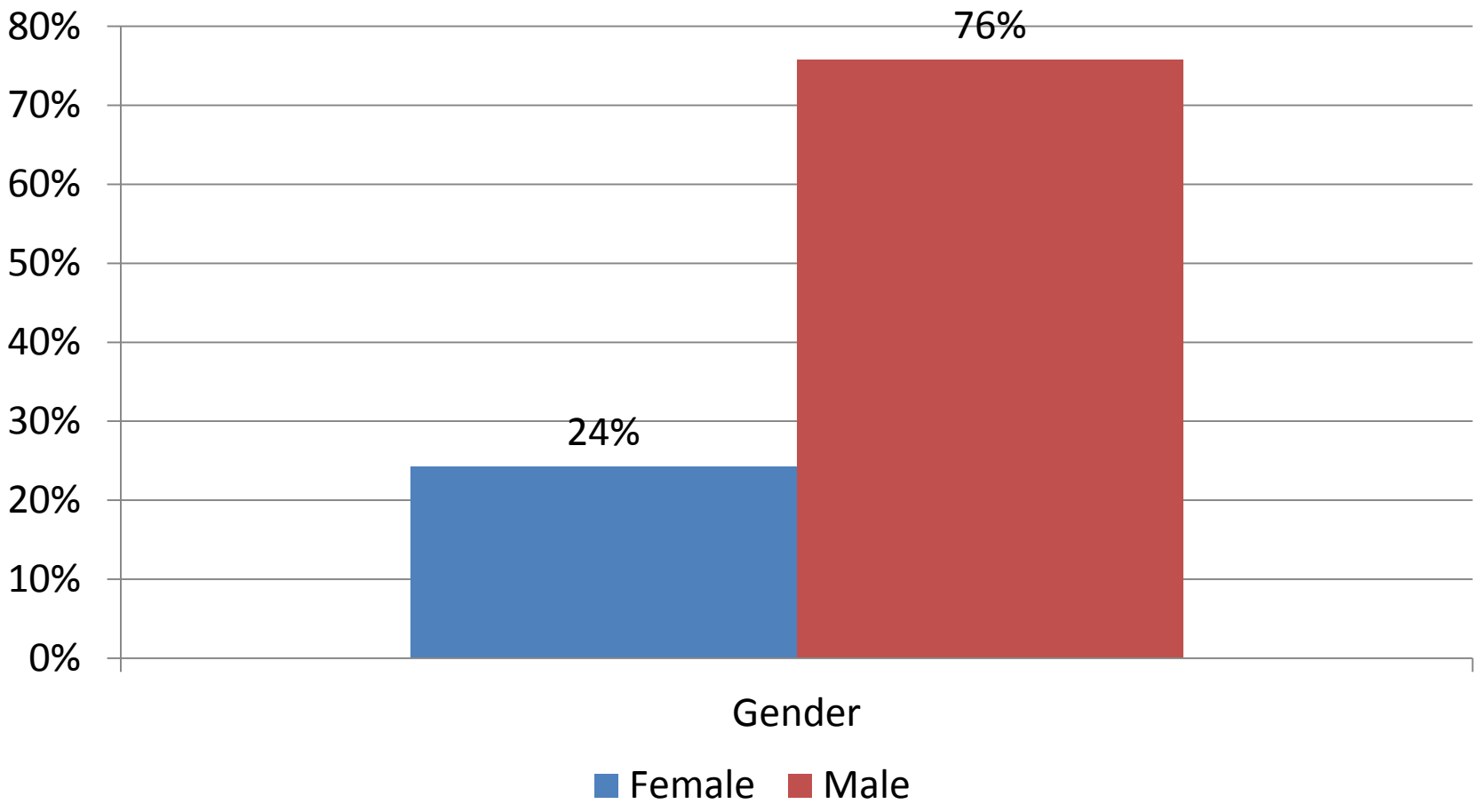

* Includes three closed cases

# Race & Ethnicity

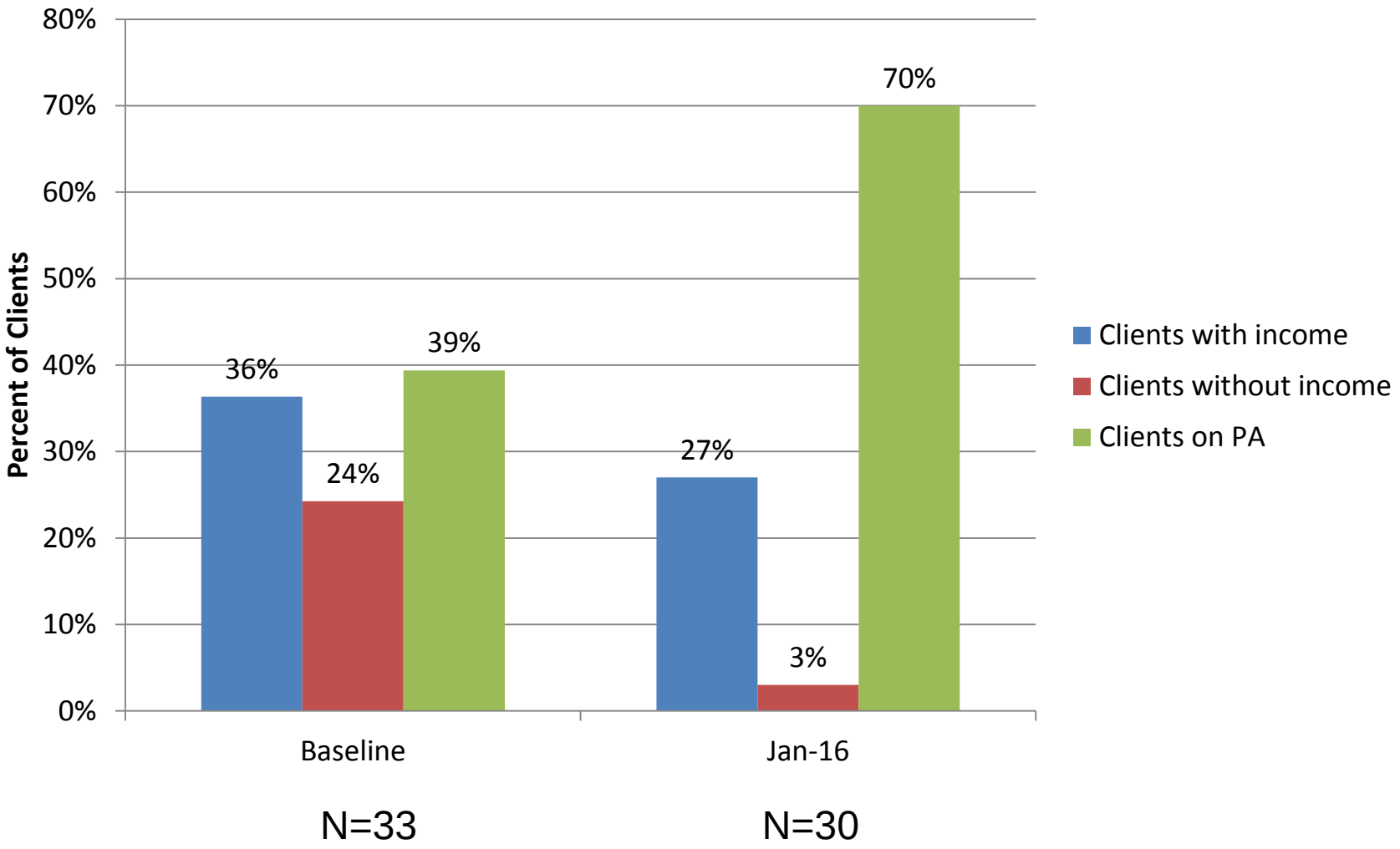


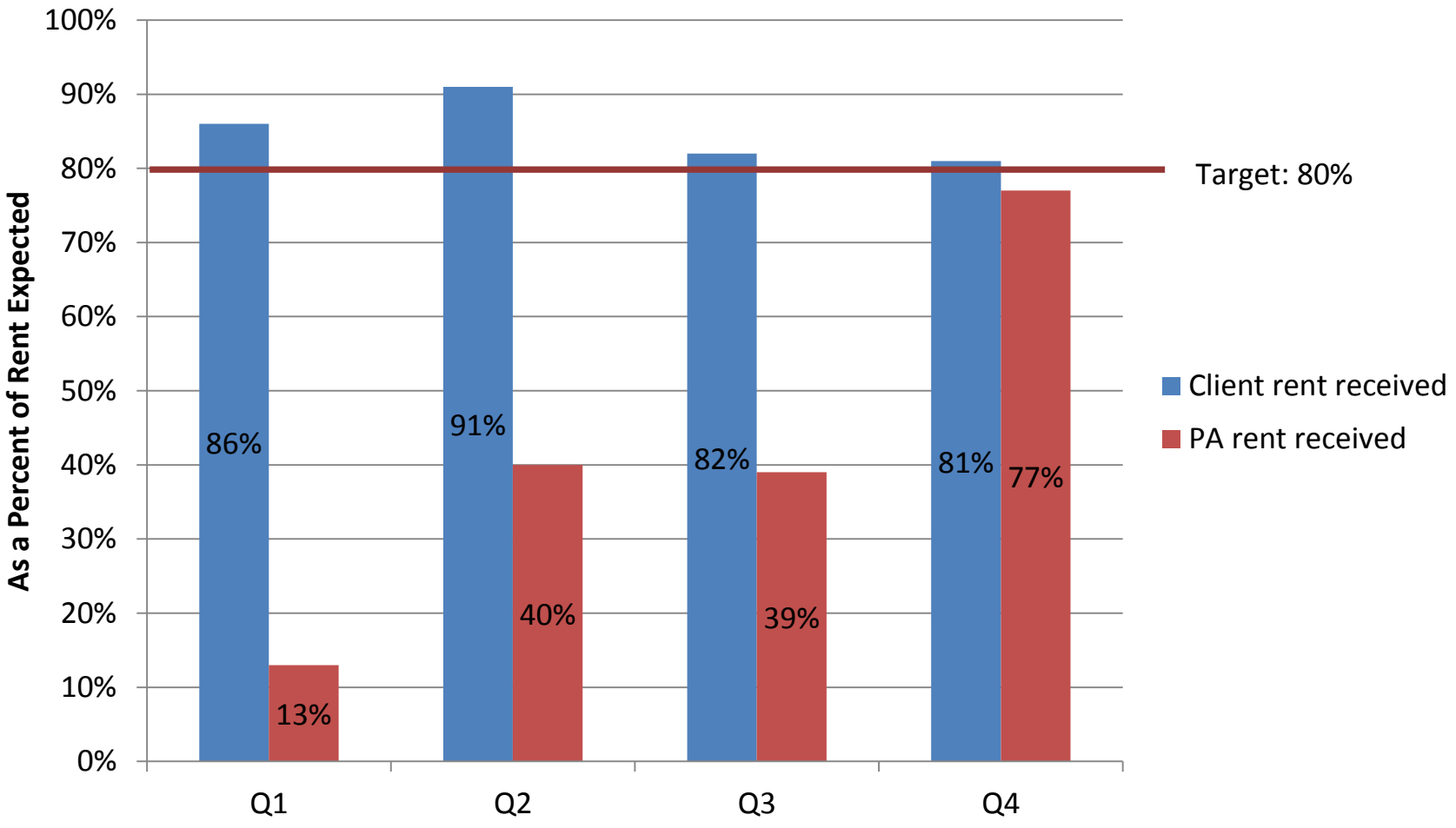
# Gender



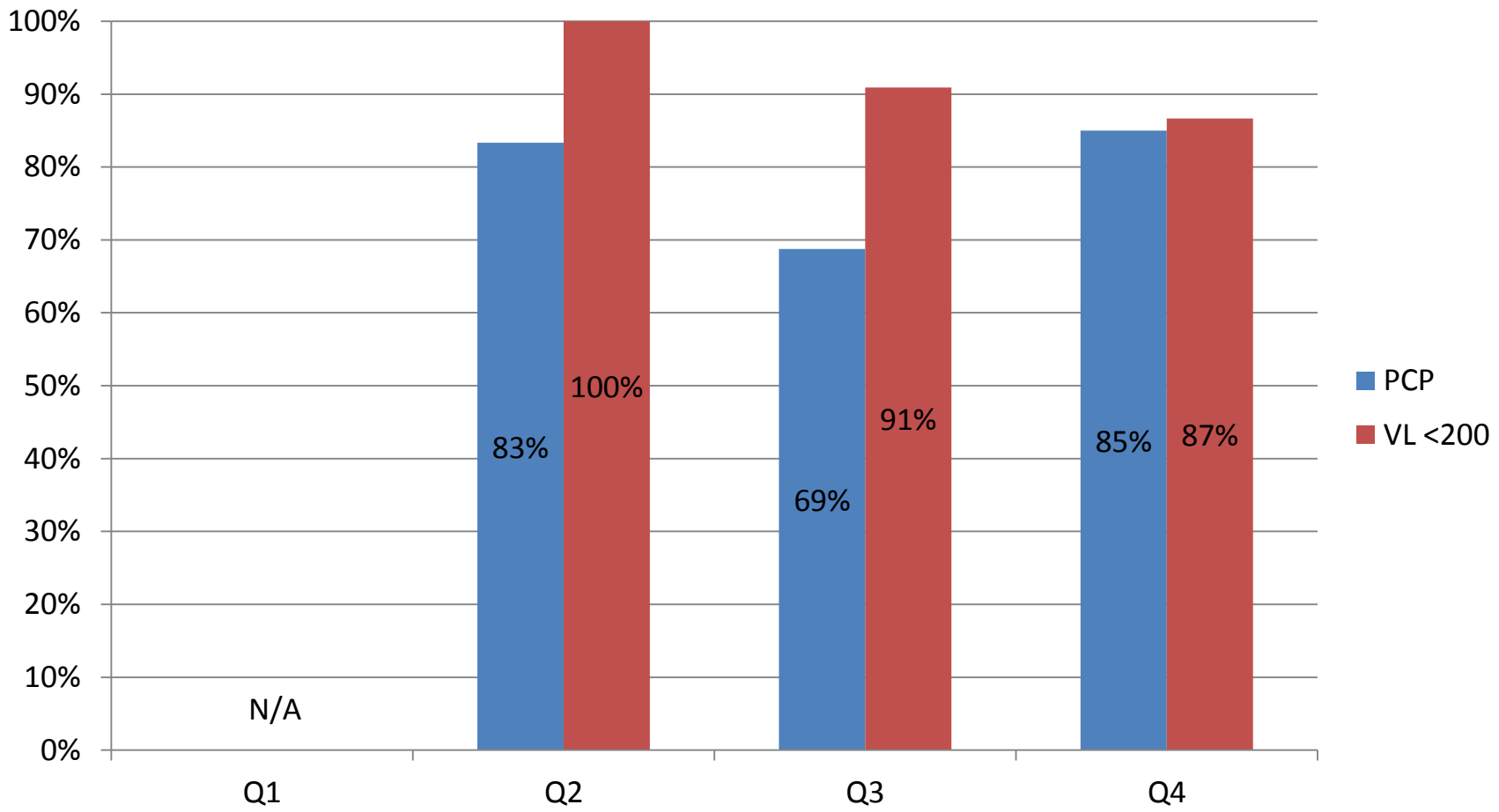
# Client Income



# Rent Received - 2015

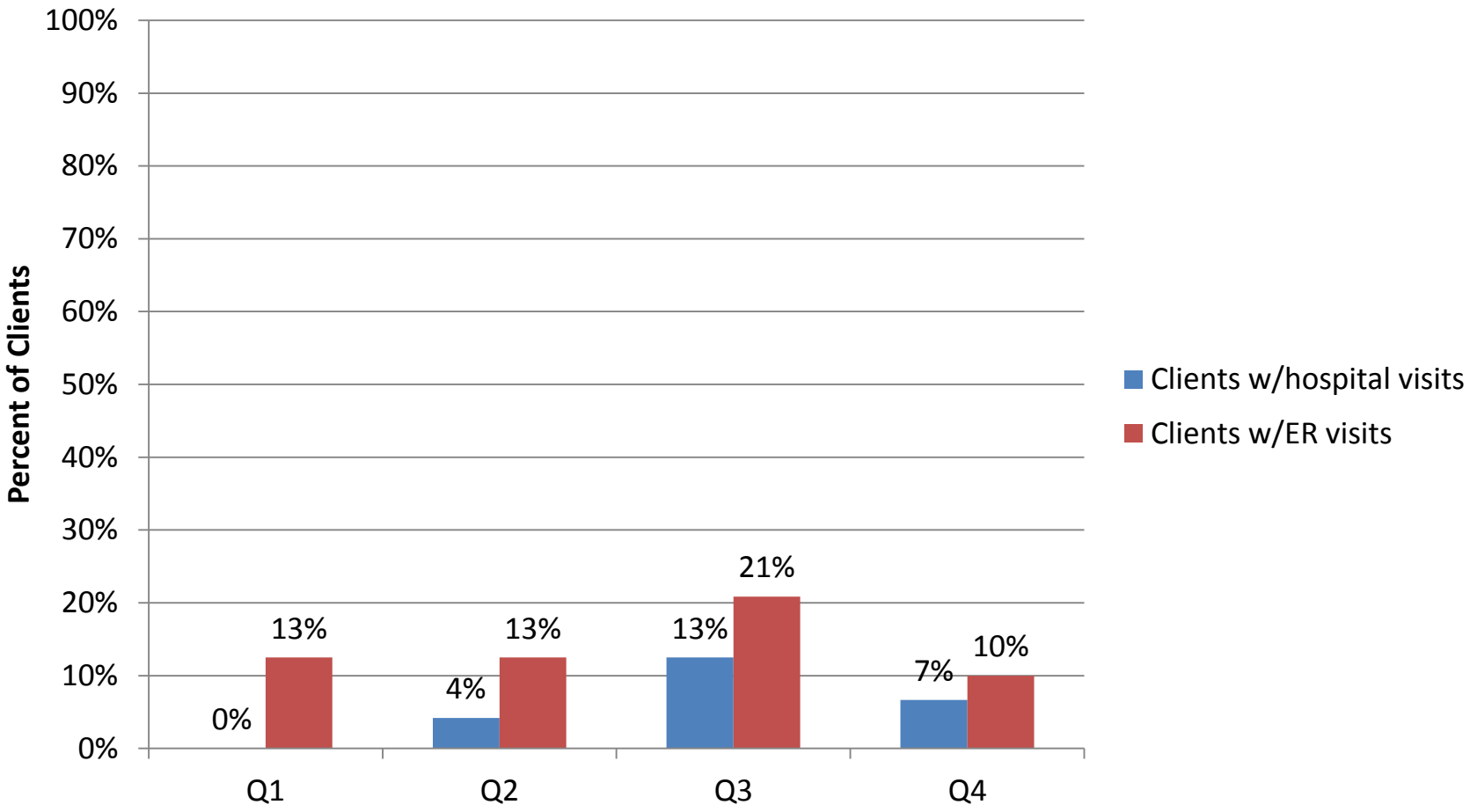


# Primary Care 2015

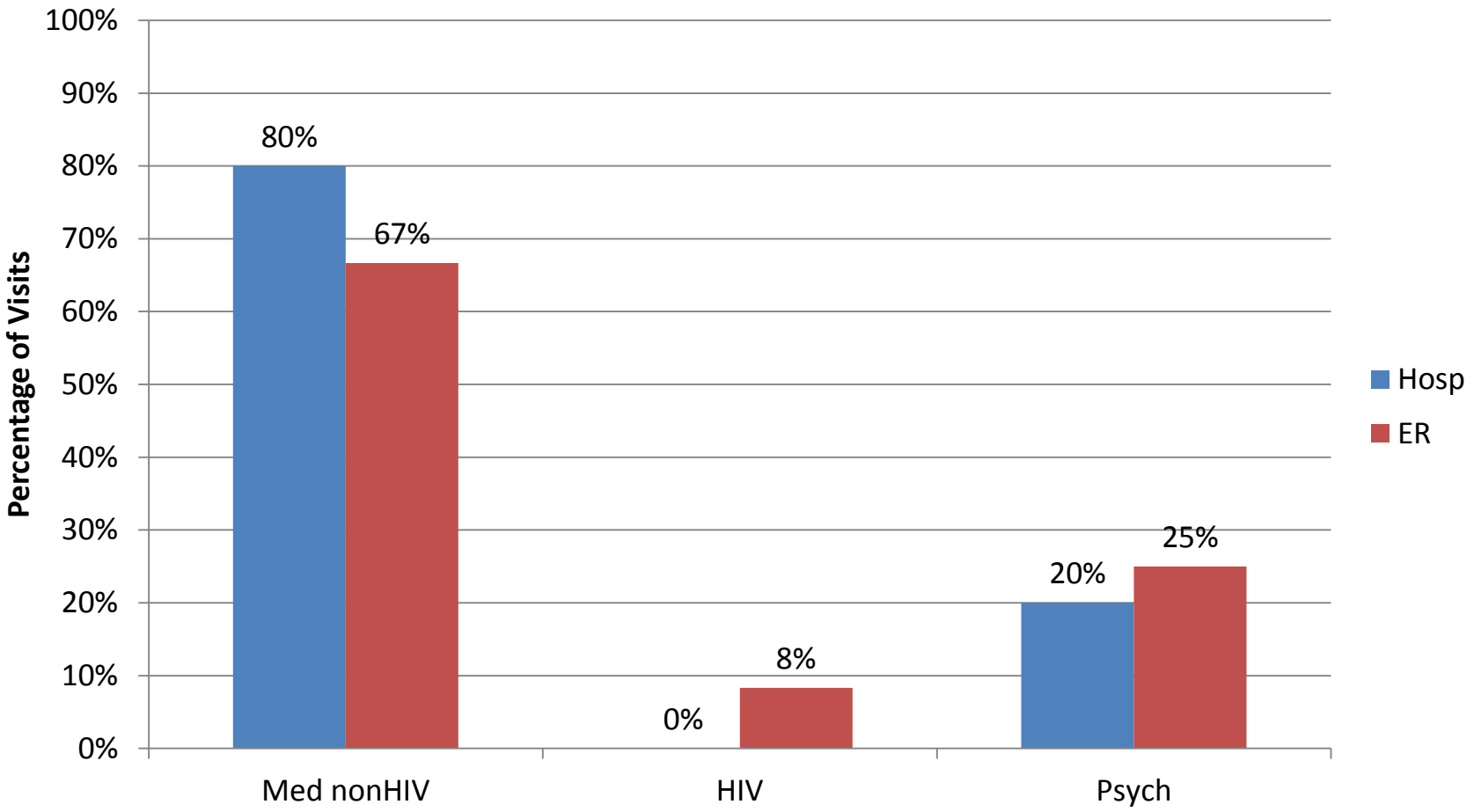



PCP : Clients with PCP visits in last 6 months, as percentage of clients housed 6 months
VL <200 : Clients with VL <200, as percentage of clients housed 6 months with updated labs

# Hospital Utilization 2015



# Reasons for Hospitalization 2015



# 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

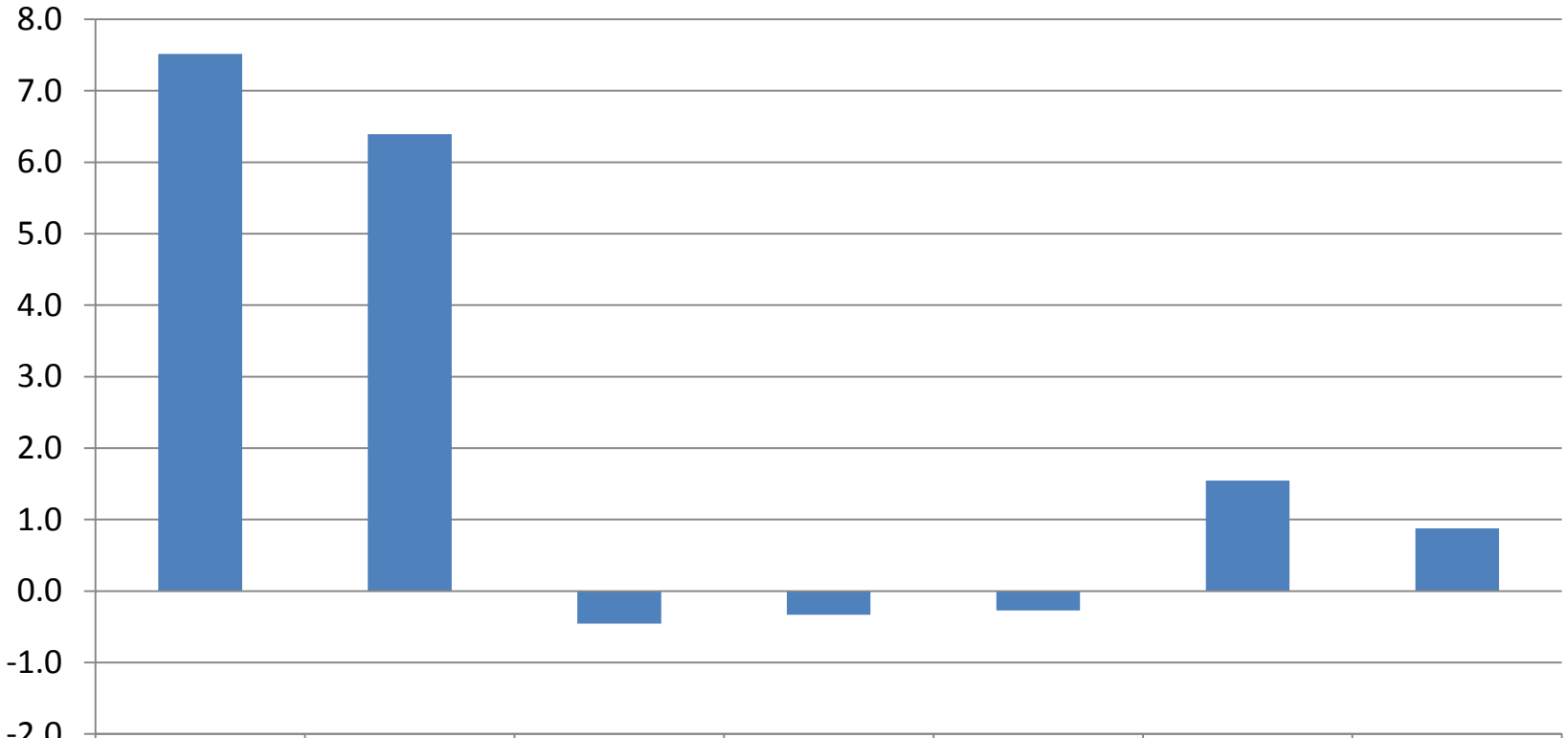
**PROTECTIVE FACTORS**

- 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

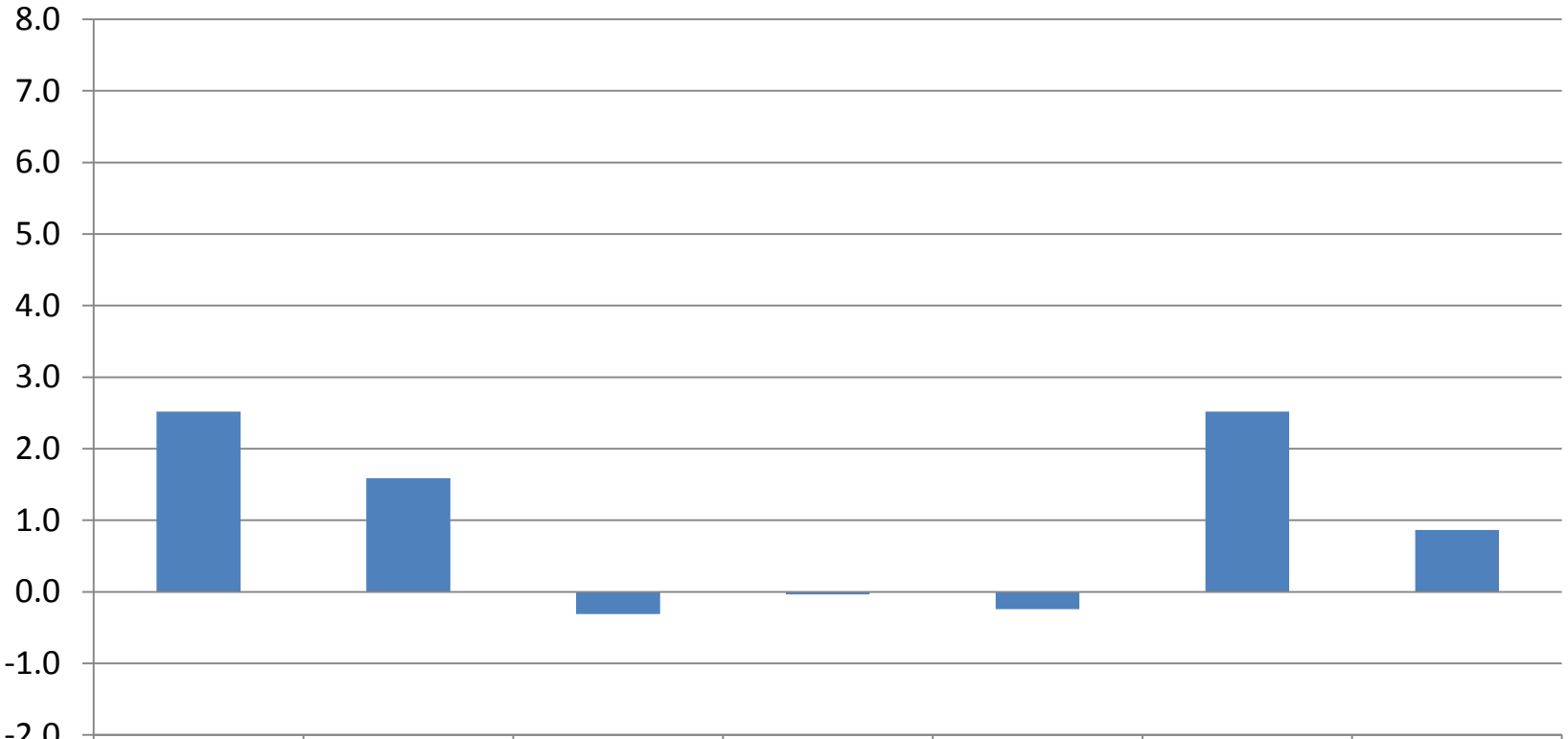
# Average Baseline Scores, all clients




| | - total | - housing | - ARV | - MH tx | - MH rx | - SU engagement | - SU frequency |
|---|---|---|---|---|---|---|---|
| Series1 | 7.5 | 6.4 | -0.5 | -0.3 | -0.3 | 1.5 | 0.9 |

N=33

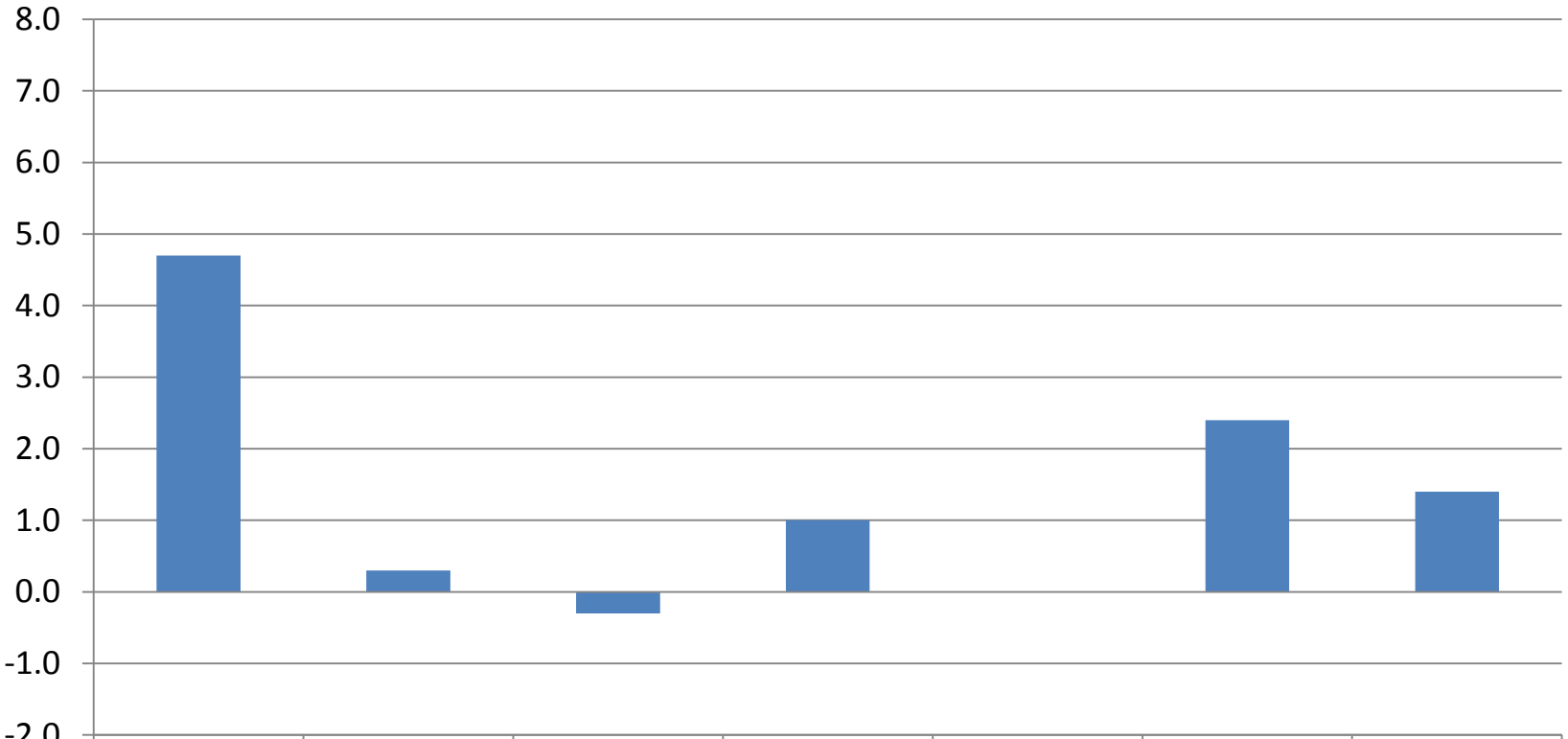
# Average Six-Month Scores, all clients




| | - total | - housing | - ARV | - MH tx | - MH rx | - SU engagement | - SU frequency |
|---|---|---|---|---|---|---|---|
| Series1 | 2.5 | 1.6 | -0.3 | 0.0 | -0.2 | 2.5 | 0.9 |

N=31

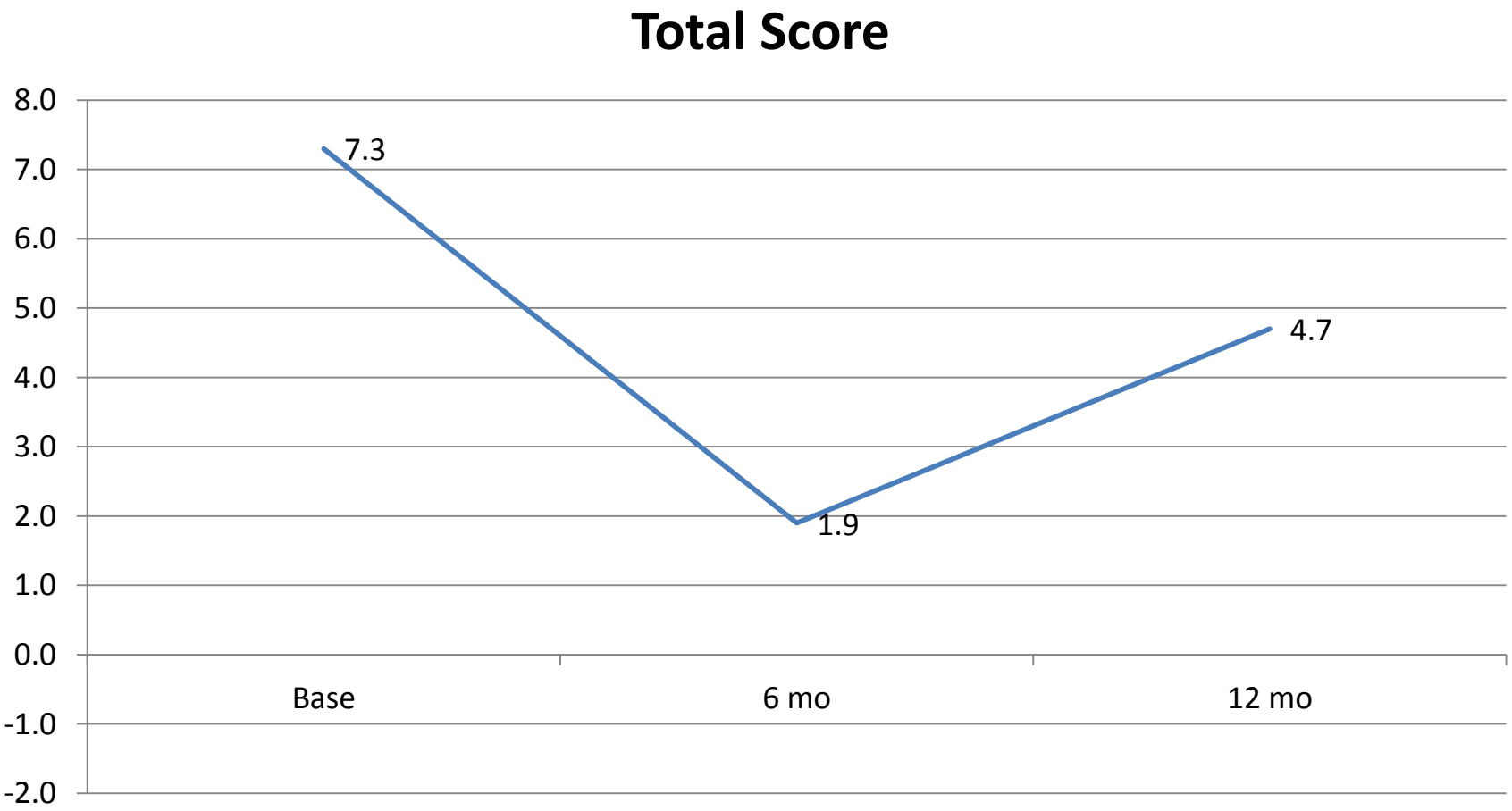
# Average Twelve-Month Scores, all clients




| | - total | - housing | - ARV | - MH tx | - MH rx | - SU engagement | - SU frequency |
|---|---|---|---|---|---|---|---|
| Series1 | 4.7 | 0.3 | -0.3 | 1 | 0 | 2.4 | 1.4 |

N=10

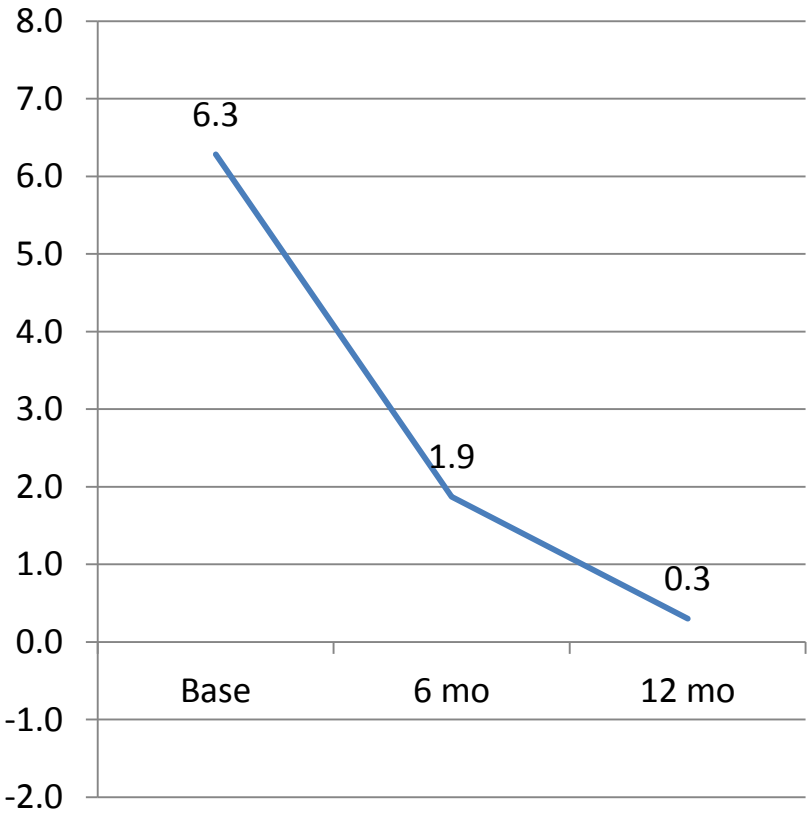
# Longitudinal Scores




N=10

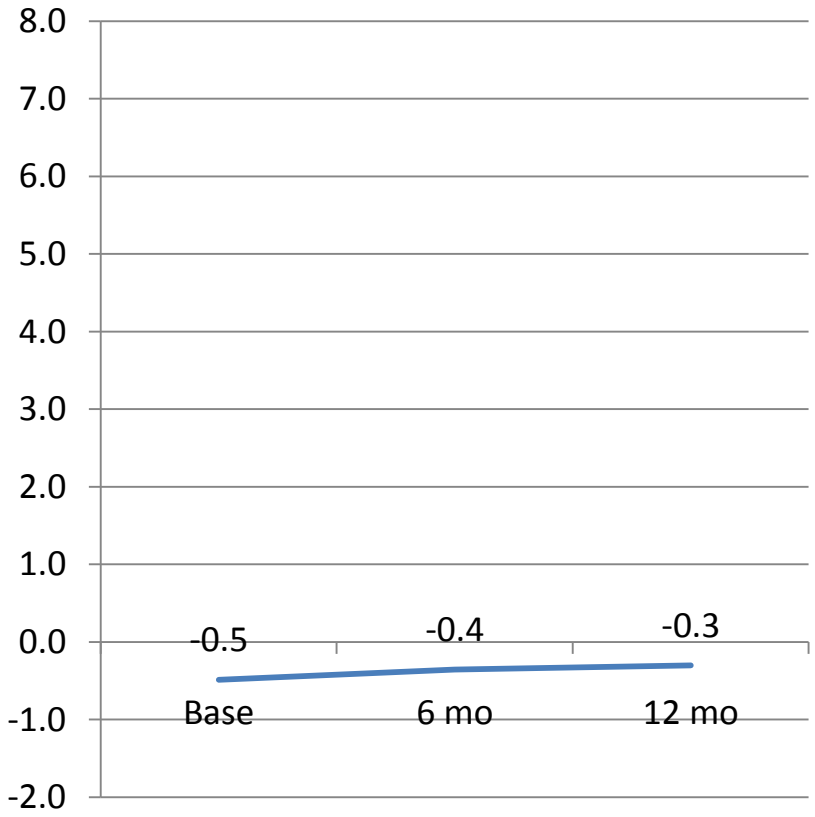
# Longitudinal Scores

## Housing Score



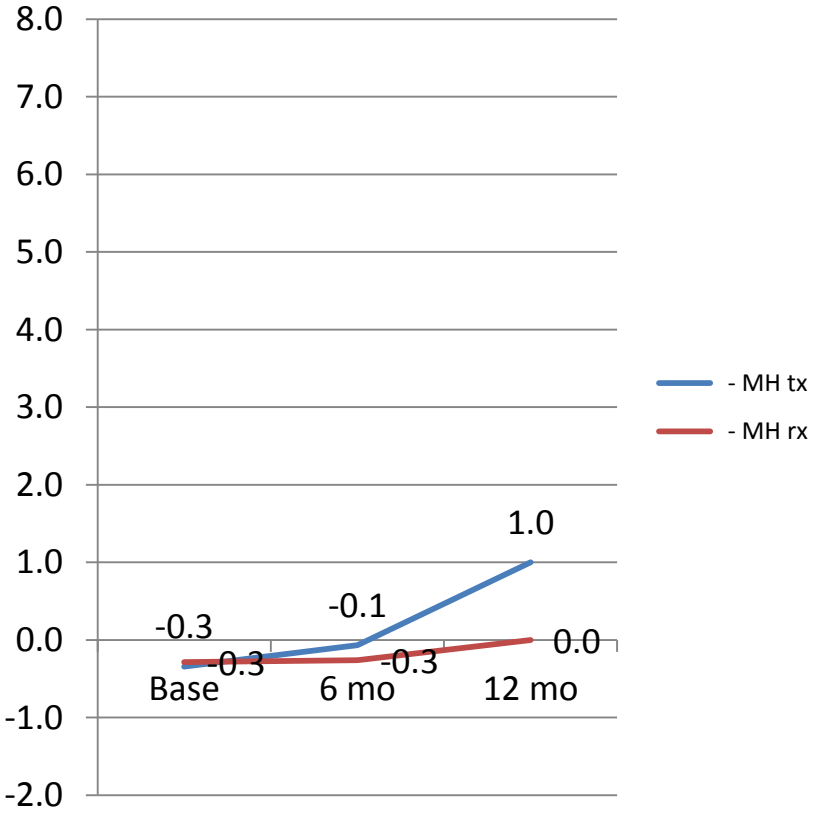

N=10

## ARV Score



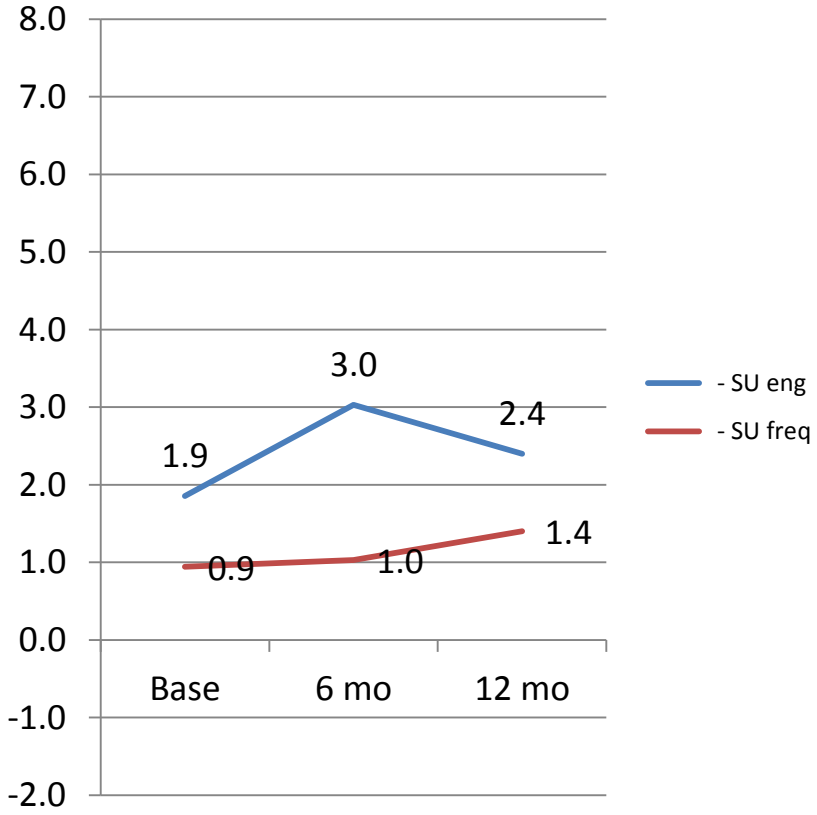
# Longitudinal Scores

## Mental Health Scores



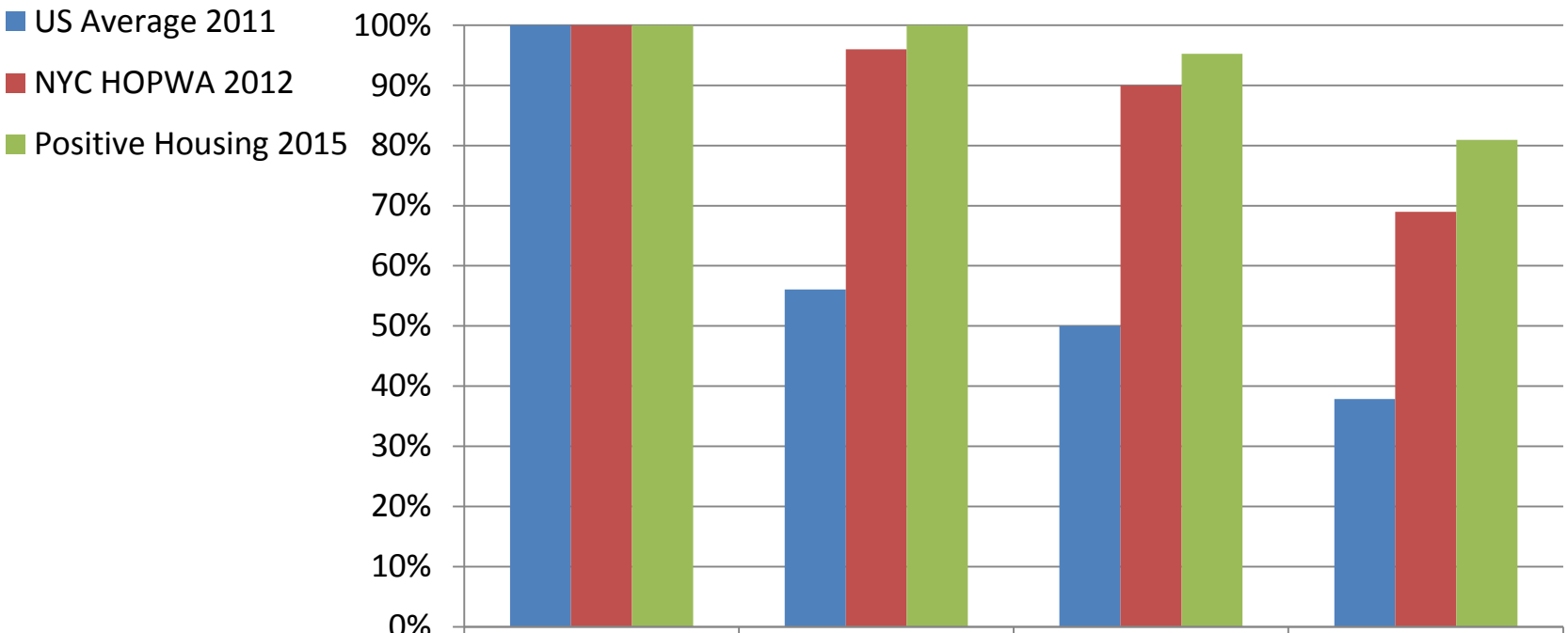

N=10

## Substance Use Scores



# Comparative Measure

# Housing Cascade




| | Linked | Engaged | ARVs | Suppressed |
|---|---|---|---|---|
| US Average 2011 | 100% | 56% | 50% | 38% |
| NYC HOPWA 2012 | 100% | 96% | 90% | 69% |
| Positive Housing 2015 | 100% | 100% | 95% | 81% |

Source: NYC Dept. of Health & Mental Hygiene. HIV Care Cascade in the New York City HOPWA Program. September 2013. Accessed 4 March 2016 at https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/key_resources/housing_and_supportive_services/hiv_care_cascade_nychopwa.pdf

# 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)