Enhanced Housing Placement Assistance (EHPA): Baseline Characteristics of Homeless PLWHA in New York City

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Homelessness in New York City (NYC)

- **104,754**¹
  - unduplicated number of individuals accessing homeless shelter system in 2012

- **3,262**²
  - estimate of street homeless in 2012

- **886**³
  - PLWHA residing in emergency Single Room Occupancy (SRO) hotels in July 2013

- **3,108**⁴
  - PLWHA who utilized the homeless shelter system at least once between 2001 - 2003

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3. NYC Human Resources Administration. (2013). *HASA Facts (July 2013)*.
HIV in New York City, 2011

- 113,319 people living with HIV/AIDS (PLWHA) in NYC
  - 3,404 new HIV diagnoses
- NYC represents 10% of the national HIV prevalence
- Blacks and Hispanics are disproportionately affected
  - 77% of PLWHA in NYC are Black and/or Hispanic

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Housing Assistance for Low-Income PLWHAs

- The HIV/AIDS Services Administration (HASA), administered through the Human Resources Administration (HRA), provides public assistance to symptomatic, low-income PLWHAs
  - There are currently 32,510 PLWHAs enrolled in HASA\(^1\)
  - Nearly 85% of all HASA clients receive enhanced rental assistance\(^2\)
- Emergency housing placements for homeless PLWHAs enrolled in HASA are made to Single Room Occupancy (SRO) hotels
  - Placements are intended to be temporary, no more than 90 days
  - 800-900 PLWHAs daily; ~2,500 PLWHAs annually

What is EHPA?

- A pilot housing program, administered by the NYC Department of Health and Mental Hygiene (DOHMH)
- Enhanced version of traditional Housing Placement Assistance (HPA) programs (i.e., housing specialist assists client to prepare for and find independent housing)
- Target population is chronically homeless PLWHA living in emergency SROs in NYC

<table>
<thead>
<tr>
<th>Standard HPA</th>
<th>Enhanced HPA</th>
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<td>Short term</td>
<td>Long term</td>
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<tr>
<td>Referral and connection to services made as needed</td>
<td>Support services provided weekly and then monthly, for up to 1 year</td>
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<td>Clients closed post-placement (a few months)</td>
<td>Clients remain open for 1 year post-placement</td>
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Evaluation of EHPA

• Recruitment directly from emergency SROs in NYC
• Random assignment to either EHPA or Usual Care (referral to traditional HPA program)
• Baseline, six, and twelve month interviews
• Program evaluation data is linked to other available data sources at DOHMH: HIV/AIDS Surveillance Registry, housing data, service utilization data
  • Mitigates some issues with loss to follow-up
## Primary Longitudinal Outcomes

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<thead>
<tr>
<th>Housing stability</th>
<th>HIV health care</th>
<th>Risk behaviors</th>
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<tr>
<td>Placement</td>
<td>Engagement and retention in care</td>
<td>Decreased substance use or increased harm reduction techniques</td>
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<td>No. and % of months spent in stable housing</td>
<td>Sustained viral suppression</td>
<td>Decreased risky sex behaviors</td>
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<td>6- and 12-month housing retention</td>
<td>Stable/improved CD4 counts</td>
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<tr>
<td>No. of moves</td>
<td>Antiretroviral therapy (ART) adherence</td>
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<td>Gaps in stable housing</td>
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- Engagement and retention in care
- Sustained viral suppression
- Stable/improved CD4 counts
- Antiretroviral therapy (ART) adherence
- Decreased substance use or increased harm reduction techniques
- Decreased risky sex behaviors
Evaluation Timeline

- Apr 2012 – Apr 2013
  - Informed consent
  - Random assignment
  - Baseline interview

- Oct 2012 – Oct 2013
  - 6-month interview

- Apr 2013 – Apr 2014
  - 12-month interview
  - Qualitative portion

Recruitment 6 months 12 months
Recruitment for EHPA

- Randomized list of NYC emergency SROs and visited each in order
- Approached rooms in ascending order
- Continued to return to each SRO to try and get response from rooms that had not previously answered doors
- Obtained informed consent from eligible participants
- Provided emergency food vouchers as incentive
SRO Eligibility/Recruitment

- Individuals were eligible if they reported:
  - Symptomatic HIV/CDC-defined AIDS diagnosis
  - Current residence in emergency SRO
  - Ability to live independently without home health aide
- Recruited clients from 18 SROs in NYC
- 236 clients eligible and enrolled (from April 2012 to April 2013)
  - 119 in EHPA
  - 117 in HPC
Baseline Survey

• Survey took 60-90 minutes
• Conducted in participants’ room or other private, comfortable space in emergency SRO
• Collected data on:
  • Basic demographics
  • Housing/homelessness history
  • History of incarceration
  • Sexual behaviors
  • Drug and alcohol use
  • Antiretroviral therapy (ART) use and adherence
  • Social service history
  • Social network history
PROGRAM PARTICIPANT DEMOGRAPHICS
Demographics of program participants vs. all SRO residents¹

Study sample was reflective of the general homeless population: primarily male, over the age of 40 and Black or Hispanic.

¹ All HASA clients spending any time in SRO in 2011
Snapshot of Program Participants

• 94% of clients make less than $15,000 per year

• 94% are disabled for work or unemployed

• 53% are never married
  • 22% are married or living together as married

• 99% have health insurance (Medicaid/Medicare/ADAP)

• 52% receive Social Security benefits (SSI/SSDI)
EXPERIENCE IN SROS
The majority of participants cycled between stable housing and homelessness, indicating inability to maintain independent living.

Inability to maintain permanent housing

- 73% were stably housed (either supportive housing or independent rental apartment) before regressing to emergency housing.
Top 8 Most Important Reasons for Moving into Current SRO

1. Recently discharged from facility/institution (17%)
2. Safety became an issue in prior housing (11%)
3. Could not afford to pay rent at last place (10%)
4. Temporarily staying with friends or relatives (8%)
5. Substance abuse issues (8%)
6. Prior housing not meant to be permanent (8%)
7. Falling out with people living there (7%)
8. Evicted/going to be evicted (7%)

1. Jail/prison/substance abuse treatment, psychiatric facility, nursing home
The vast majority of participants have a history of incarceration, one-third of whom had been incarcerated in the past two years.
SUBSTANCE USE
Substance Use, Past 12 Months

Participants reported high levels of substance use with almost two-thirds reporting non-injection drug use in the past 12 months.
Of those who had used non-injection drugs in the past year, over half used crack. This is the most commonly reported drug, other than marijuana.
Injection Drug Use

Of those injecting drugs in the past year, most participants are using clean needles and not sharing works.
Injection Drug Use

Of those injecting drugs in the past year, most are injecting heroin or heroin and cocaine together.
SEX RISK BEHAVIORS
29% of all participants reported two or more sexual partners.
Sex Behaviors, Past 12 Months

Sex Without Condom (N= 161)

- Yes: 53%
- No: 47%

Sex with Negative/Unknown HIV Status Partner (N= 161)

- Yes: 67%
- No: 33%

Of those who had sex in the past year, more than half had sex without a condom.
The majority of participants have been diagnosed with a mental health disorder, with almost half diagnosed with a mood disorder.
CLINICAL INDICATORS
The vast majority of participants are engaged in care, but only 41% are virally suppressed.
Conclusions

• EHPA participants have experienced high levels of instability including homelessness and histories of incarceration
• Most participants have histories of chronic homelessness punctuated by short episodes of stable housing, indicating that individuals can secure permanent housing but are unable to maintain it
• Despite consistent engagement in HIV primary care, homeless PLWHA have poor health outcomes – the majority are not virally suppressed and have a mental health disorder
• There are high self-reported rates of drug usage among homeless PLWHA
• Homeless PLWHA are using harm reduction practices (i.e., using clean needles and not sharing works) and most report zero or only one sexual partner
Discussion

• This data reflects the complex needs of this chronically homeless population and the need to further assess existing service delivery models to better serve this population.

• While access to and retention in HIV primary care is high, homeless clients struggle with viral suppression and chronic mental illness, indicating the need for interventions beyond primary medical care.

• The pattern of cycling between independent housing and homelessness indicates that independent living may not be a sustainable housing option for all chronically homeless PLWHA.

• Need to preserve and increase supportive housing.

• Need to develop strategies to better engage chronically homeless PLWHA and directly connect them to permanent supportive housing.
Acknowledgements

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