Alameda County

AIDS Housing Needs Assessment

CONDUCTED BY

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SUBMITTED TO

Housing and Community Development Department

Alameda County Community Development Agency

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Everyone has the right to a standard of living adequate for the health and well-being of [themselves] and of [their] family, including . . . housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability . . . .

United Nations General Assembly.
Universal Declaration of Human Rights, Article 25,
December 10, 1948

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Fox Courts, Oakland, CA
Affordable apartments for families, people with special needs, individuals, and seniors, completed in 2009 by Resources for Community Development.
Photograph by Richard Speiglman, 2014

Homeless Shelter

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Following graduate work in sociology and criminology and postdoctoral work in public health, **Richard Speiglman** helped design and implement Alameda County's Homeless Count and Survey. He has also evaluated the Shelter Plus Care and Project Independence programs in Alameda County and similar programs in other Bay Area jurisdictions and conducted longitudinal and point-in-time studies of participants in the Supplemental Security Income (SSI) and CalWORKs programs.

Tom Mosmiller served as the Alameda County Housing Opportunities for People With AIDS (HOPWA) Coordinator from 1998-2000 and then as a Contract Manager in the Alameda County Public Health Department's Office of AIDS Administration until September 2012.

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The last 12 months have involved a wonderful, challenging, and rewarding journey. More than four hundred fellow travelers accompanied us on our journey to assess the need for AIDS housing and associated services in Alameda County. People Living With HIV/AIDS (PLWHA), service providers, community activists, clinic administrators, housing developers, county agency administrators, property managers and others shared their stories, their pains and their hopes, and their insights about our community. What a door-opener and great entry card was the topic of "AIDS housing" – everyone wanted to help.

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[1] HOPWA and other acronyms and technical terms are explained in Appendix 1 of this report.

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The AHNA could not have taken place without the dedicated service of each project consultant listed on page iii of this report. Our debt to each is substantial. As we conclude this acknowledgment we want to express special thanks for the contribution that Jesse Brooks provided. He served as an informal guide, Work Group collaborator, focus group facilitator, clinic patient interviewer, and go-to person for history and contemporary perspective.

In the end we can say only how great it was to work in and with our community to produce this report. . . and, of course, that as the authors we are ultimately responsible for making sense of what we heard and drawing the conclusions that appear in this report.

Executive Summary

ES 1. Introduction

The Alameda County AIDS Housing Needs Assessment (AHNA)[1] was designed to provide information relevant to the County's Housing and Community Development (HCD) Department's planning processes about meeting the housing and housing-related service needs of People Living With HIV/AIDS (PLWHA) in Alameda County.

Needs Assessment approach and audiences. This report of findings from the AHNA makes use of multiple data sources, including consumer, service provider, and affordable housing developer and property manager focus groups; an on-line survey of HIV housing and other service provider staff and a survey of housing developers; a survey of low-income patients of HIV publicly funded clinics and one private practice; public health epidemiological and program service utilization data; a variety of literatures; and insights of key informants.

The AHNA was undertaken to inform HCD's future planning process in a period when stable housing is essential to successful HIV/AIDS medication protocol compliance and hence, more than ever, the well-being of PLWHA and the prevention of the spread of HIV. The AHNA report sets the stage in Chapters 1 and 2 by describing the national context in which this discussion of local policy takes place. It describes the complicated and challenging situation of the Alameda County context in terms of income, housing costs, and housing; HIV/AIDS in combination with mental illness, abuse of alcohol and other drugs; and homelessness and housing instability. Finally, there is a review of dedicated funding which may be used for housing for PLWHA in Alameda County – the Housing Opportunities for People With AIDS (HOPWA) program and the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act and its Minority AIDS Initiative. We end Chapter 2 taking note of the elimination of Redevelopment funding and of other changes affecting Alameda County's HIV/AIDS housing and service system today.

After a description in Chapter 3 of the methods that the AHNA employed, the report continues in Chapter 4 through Chapter 6 by presenting findings from focus groups, an on-line survey of housing and other service providers, and a survey of low-income HIV+ Alameda County

[1] For reference in reading this report, AHNA, other acronyms, and technical terms are defined in Appendix 1, The Glossary.

residents using publicly funded primary care clinics and one private physician's office. The report concludes with Chapter 7, a compilation of recommendations that emerge from the AHNA.

Breadth and depth of data. More than four hundred PLWHA, service providers and community colleagues have contributed to this project over the past year. Input from housing and other service providers represents an array of service areas and reflects almost 1,000 years of work experience in HIV services.

ES 2. Findings

AHNA findings echo the new National HIV/AIDS Strategy's call to:

1) increase the percentage of low-income HIV+ primary care clients with permanent housing, and

2) consider additional efforts to support housing assistance and other services that enable PLWHA to obtain and adhere to HIV treatment, and

3) support case management and clinical services that work toward increasing access to non-medical supportive services (e.g., housing) for PLWHA.

AHNA findings address those and other issues, including:

Affordable housing. Each primary data source (consumers, service providers, and developers and property managers) – supported by secondary data sources – focuses on the situation resulting from a shortage of affordable housing. A complimentary perspective is that incomes – whether from SSI or other sources – are too low and rental subsidies too few. As a result almost one-half (45.2%) of the low-income HIV/AIDS population in Alameda County is now or has recently (i.e., within the past three years) been homeless or unstably housed. From the patient survey we estimate that, at a point in time, 187 PLWHA or seven percent of Alameda County's low-income, HIV+ population in primary care are homeless, and another 239 PLWHA, or nine percent, are unstably housed. In sum, we estimate 426 low-income HIV+ residents of Alameda County who are in primary care are homeless or unstably housed; that is, one in four low-income PLWHA in care who do not have a rental subsidy. Additionally, we estimate that among the population of 2,631 low-income HIV+ persons in primary care:

- 41% have been homeless or resided in unstable housing in the previous three years, and within that group one-third (32%) are currently homeless or unstably housed; of the 59%

who were stably housed in the past three years, only 5% are currently homelessness or unstably housed – a six-fold difference!

- 14% have had an eviction in the previous three years, which is associated with more than double the risk of current homelessness or unstable housing;
- 20% have moved three or more times in the previous three years, another factor associated with more than double the rate of current homelessness or unstable housing; and
- 31% have had trouble paying rent or mortgage in the last three months, another sign of risk of homelessness or residential instability.

Thus, beyond the statistics concerning number of low-income PLWHA who currently are homeless or residing in unstable living situations, additional PLWHA have also been without adequate housing – and likely are at risk for it in the future. Many service providers believe that a greater proportion of their clients are homeless or in an unstable housing situation. Additionally, many patients assessed as stably housed reside in housing with problems or that is sub-standard and/or in violent neighborhoods, conditions that put the residents at risk of future housing instability.

Income. Receipt of SSI and/or SSDI is not associated with a higher rate of stable housing. In fact, recipients of SSI/SSDI are one-third more likely to be homeless or unstably housed than those without such benefits. Controlling for income level does not erase this effect.

Personal, social, and system barriers. According to information from HIV/AIDS housing and other service providers, a variety of barriers hinder their clients' access to or retention of stable housing. Although these barriers exist in the context of the labor market and larger economy, personal barriers are thought to include financial problems associated with insufficient monthly income and lack of employment, poor credit history, and history of previous evictions. Personal barriers among PLWHA also include behavioral health challenges such as mental health problems and abuse of alcohol or other drugs. Barriers on the cusp between personal circumstances and social conditions include recent release from jail or prison, existence of a criminal record, and lack of social resources among immigrants and newcomers to the area. Program and system barriers include a lack of affordable housing in the county, long waits to receive a rental subsidy, rental subsidies that are not large enough, lack of housing in safe neighborhoods, lack of access to subsidized housing for people without required residency documents, lack of permanent supportive housing and transitional housing units, referral procedures and housing applications that are cumbersome and/or complicated, and service

providers' lack of information about the location of available units of housing, available subsidies, and procedures for clients to gain access to affordable housing.

Special issues.

- Improve access to housing and housing services for PLWHA households that include:
  - Gay men and heterosexual women (severe prevalence of problems paying rent/mortgage)
  - Bisexual men (severe prevalence of multiple moves and/or eviction histories)
  - PLWHA with criminal records (multiple moves, past homelessness or unstable housing, past evictions, and problems paying rent/mortgage)
  - PLWHA with mental health problems (multiple moves, past homelessness or unstable housing, past evictions, and problems paying rent/mortgage)
  - PLWHA with alcohol or drug problems (multiple moves, past homelessness or unstable housing, and pasts evictions)
  - PLWHA under age 30 (greater prevalence of evictions, recent moves, recent homelessness and unstable housing, days on the street in the last year, and trouble paying rent/mortgage, but half the rate of rental assistance, compared to those ages 30+)
  - Transgender PLWHA
  - Current and anticipated cohorts of immigrant and refugee PLWHA
  - Latinos/as (multiple moves and problems paying rent/mortgage; especially men who do not speak English well are more likely to have a current or recent history of homelessness or housing instability); and PLWHA without required residency documents
- Expand or revise the biennial Alameda County-wide count of all homeless people to incorporate questions about service connectivity and other characteristics in order to explain the extent of the overlap between the 2013 count estimate of 93 homeless PLWHA and the AHNA estimate of 187 homeless and 239 unstably housed individuals (plus an unknown number of homeless/unstably housed individuals outside the AHNA sample frame) and further investigate the service needs of homeless PLWHA.

Waiting lists and the status of those waiting for Shelter Plus Care (S+C) and other program assistance. Because of a combination of at least three factors – 1) lack of adequate income among members of the HIV+ population and an overall shortage of 2) affordable housing and of 3) rental assistance – PLWHA enroll on waiting lists for affordable housing and/or rental assistance. Following application to the S+C program, if one is placed on the waiting list, per Federal requirements, continued eligibility requires that the individual be homeless. Several

informants commented on the perceived unfairness of a housing program for the homeless that seems to require those in line for its services to remain homeless. (The Federal expectation is that S+C is the housing option for those who cannot locate other housing options, and the applicant will continue to look for permanent housing and not wait for S+C.) It was also noted that appropriate transitional housing that clients need while on the wait list(s) for other programs is in short supply.

Housing services. Clients, developers, property managers and service providers share the perspective that additional case management, service coordination, housing search services, and other services (including assistance with re-establishing credit or addressing and resolving poor credit histories, clearing previous eviction records, expunging criminal records and budgeting and timely bill payment) are needed to promote access to housing and maintain stability once housed. Needed services specified by PLWHA during the patient survey include:

- Assistance with moving expenses
- Assistance finding decent housing in safe neighborhoods
- Assistance completing and submitting housing applications
- Assistance working or negotiating with landlords and property managers

Housing application procedures. Agreement is widespread that it would greatly assist PLWHA to obtain subsidized housing if housing applications were more straight-forward and more centralized, so individuals do not have to submit multiple applications and continually track their status on several wait lists.

Location of housing. Developers and property managers suggest that new developments ought to be sited near HIV service providers. However, many PLWHA prefer to reside in quality neighborhoods and safe communities that currently have few HIV services and little in the way of AIDS housing. This may be related to the relative availability of public transportation in Alameda County.[2]

Community awareness of rental subsidy programs. Knowledge about rental subsidy programs, even major ones that have been operating for more than a decade, is limited among consumers and service staff. Despite the collective years of work in this area, many service providers do not know about the Project Independence and/or S+C programs. We estimate that over half of the

[2] Facente Consulting (2013) notes that travel time is not the only consideration for PLWHA.

low-income HIV+ patients in primary care know about only one out of four housing subsidy or emergency rental assistance programs about which we asked. And 59% of persons unstably housed are not on any waiting list for a subsidized rental unit.

Additional consumer concerns. Consumers in focus groups express additional concern with housing and neighborhood quality, discrimination against Latino/as, and limitations on moving once project-based rental subsidies are received.

ES 3. Priority Recommendations

In Chapter 7, the AHNA recommendations address housing and housing development, housing services, collaboration, special issues, and additional data collection and research. We highlight the importance of one theme appearing in several recommendations: all affordable housing (both existing units and new developments), rental assistance, and housing service programs should be marketed in both Spanish and English and accessible to persons speaking either language. We conclude that priority attention should be given to four broad categories: 1) affordable, quality housing, 2) rental subsidies, 3) housing services, and 4) communication and collaboration. Full implementation of all priority and other recommendations would require additional financial and other resources. The 11 priority recommendations are listed below as P1-11.

- P1 and P2 would expand opportunities, relatively quickly, for stable housing and for additional quality housing.
- P3 - P5 would bring currently homeless or unstably housed individuals into stable situations.
- P6 would be directed at promoting continued stable housing.
- P9 involves an on-going effort not to be ignored.
- P7, P8, P10, and P11 are recommendations to implement at low- to moderate-cost that would have the most immediate effect on promoting continued stable housing for those currently in housing.

Affordable, quality housing. Alameda County and its constituent cities need an adequate supply of good quality, affordable housing in safe neighborhoods, for both low-income PLWHA and others. Housing development and improved code enforcement would each promote this objective. We suggest the following be prioritized:

P1. Take the lead in developing and promoting city agency programs to improve housing standard inspections for PLWHA residing in non-subsidized housing

Rental subsidies. Rental subsidies such as those provided by both Project Independence and S+C assist more households to remain stably housed and, by virtue of housing inspections, upgrade the quality of the housing stock. We suggest the following be prioritized:

P2. Expand shallow and deep rental subsidy assistance; consider funding an additional Project Independence hub agency

Housing services. Even were there sufficient affordable, quality housing stock in safe neighborhoods with public transportation making health care and other services accessible, some PLWHA would still need assistance to secure and maintain stable housing. A variety of services are required – some for all PLWHA and some for different sub-groups. We suggest the following are priorities:

P3. Establish a pro-active outreach campaign to identify, find, and offer housing assistance to homeless PLWHA

P4. Establish a centralized wait list for PLWHA applying for affordable housing units developed with HOPWA funds

P5. Provide low-threshold housing for PLWHA with a mental health disability and/or who abuse alcohol and other drugs

P6. Establish and evaluate a pilot program for a voluntary county-wide payee service for PLWHA

P7. Ensure adequate funding for emergency housing assistance to prevent eviction through HOPWA or in collaboration with the Office of AIDS Administration (OAA) of the Alameda County Public Health Department or other agencies

P8. Fund and support new, more intensive, and comprehensive housing referral services, in addition to the information dissemination provided by the AIDS Housing and Information Project (AHIP) of Eden I & R (Information & Referral). This service would help PLWHA find appropriate available housing units in safe neighborhoods and negotiate with landlords to move in and help PLWHA identify and gain access to fiscal resources for move-in costs, including access to EHA funds. Conduct trainings for service providers about these new services.

P9. Provide bilingual Spanish/English individual counseling to help consumers clean-up their credit records. Consider providing this and other financial assistance services on-site at housing developments.

Communication and collaboration. We emphasize two additional priority recommendations to improve the delivery of services. These focus on different strategies to improve staff communications across agencies:

> P10. Require the establishment of a communication link, as an eviction prevention strategy, between affordable housing property managers and the clinic-based medical case managers of their HIV+ residents in primary care.
>
> P11. Establish regular meetings of all HOPWA and Ryan White Program housing and housing service providers, and property managers and housing service providers, in conjunction with the OAA, to provide input on planning issues, promote program and services coordination, and assist with the implementation of these recommendations.

ES 4. Conclusion

The AHNA has identified 34 recommendations, some with multiple sub-parts. Above we highlight 11 of those recommendations. Several might be easily implemented at little or no cost. However all of the recommendations that appear in Chapter 7, whether or not in the list of eleven above, and the findings, throughout this report, on the housing needs of PLWHA merit serious consideration.

Reference

Facente Consulting. (2013). *Oakland Transitional Grant Area (TGA) 2013 HIV/AIDS Needs Assessment.* Richmond, CA.

Introduction

Background. In 2012 the Alameda County Housing and Community Development (HCD) Department[1] issued a Request for Proposals (RFP) for an AIDS housing needs assessment in Alameda County that would:

- Identify needs for HIV/AIDS housing and housing-related services, and
- Guide the decision-making process about the allocation of Housing Opportunities for People With AIDS (HOPWA) funding for housing and housing-related service needs of People Living With HIV/AIDS (PLWHA), including housing development, operations and support services.[2]

The Alameda County AIDS Housing Needs Assessment (AHNA) was written to inform HCD's decision-making process. We anticipate that other audiences – in particular, PLWHA as well as public health, housing, and clinical services practitioners and planners – will also find the results of use.

Eighteen years of assessment. The current AHNA falls within a long tradition of the HCD's "taking the pulse" of the housing needs of PLWHA. In 1996, HCD combined the use of both local formula funds through the U.S. Department of Housing and Urban Development's (HUD) HOPWA program and national HOPWA technical assistance resources to create a Multi-year AIDS Housing Plan (AIDS Housing of Washington, 1996). An update was issued in 1998 (AIDS Housing of Washington, 2006).

From 2004-2006, HCD, the Alameda County Public Health Department Office of AIDS Administration (OAA) and the Alameda County Social Services Agency, together with the cities of Oakland and Berkeley, collaborated to study the extent of homelessness and the dimensions of HIV disease and produce the *Alameda Countywide Homeless and Special Needs Housing Plan* (AIDS Housing of Washington, 2006). The collaboration creatively leveraged knowledge, funding, passion, and expertise to address countywide multi-dimensional issues. The *Alameda*

[1] For reference in reading this report, HCD, other acronyms, and technical terms are defined in Appendix 1, The Glossary.

[2] Alameda County CDA-HCD-RFP# HCDHOPWA002

Countywide Homeless and Special Needs Housing Plan took the unprecedented approach of combining housing planning efforts for three distinct and overlapping populations: individuals and families who are homeless, living with HIV/AIDS, and/or mentally ill. Problems with the use of alcohol and other drugs were found to affect a substantial portion of each of these three populations and play a significant role in the provision of housing and services. The goal was to enhance Alameda County's strong HIV/AIDS housing and services programs, funded primarily by the HOPWA program and Title I, now Part A, of the Ryan White CARE Act, through greater collaboration with homeless services and behavioral health care programs. (The Ryan White CARE Act is described below in Chapter 2.) These expanded partnerships have assisted PLWHA in achieving and maintaining housing stability, increasing access to care and services, and avoiding homelessness.

Now, eight years after adopting the *Alameda Countywide Homeless and Special Needs Housing Plan*., HCD has commissioned the AHNA to update our understanding of housing and housing-related service needs of PLWHA in Alameda County. Relying on consumer and community input, the expertise of persons knowledgeable about housing and PLWHA, and a variety of data sources, this AHNA assesses current conditions and offers policy and program options to address identified needs.

Framework. This is a challenging time to assess need and then plan access to housing for PLWHA. Available federal funding, the changing demographics of the PLWHA population, and advances in AIDS treatment affect the planning and provision of AIDS housing and services. PLWHA who are successfully taking anti-retroviral therapies experience significantly improved health. The HIV/AIDS housing system now must plan for the needs of people who are healthier and living longer, not just those severely ill and dying. Stable housing is extremely important, if not essential, to successful and consistent engagement in medical care and treatment.

A new National HIV/AIDS Strategy calls for: 1) increasing the percentage of clients with permanent housing, 2) supporting case management and clinical services that work toward increasing access to non-medical supportive services (e.g., housing), and 3) consideration of additional efforts to support housing assistance and other services that enable PLWHA to obtain and adhere to HIV treatment (The White House Office of National AIDS Policy, 2010).

Needs Assessment data. To accomplish its objectives the AHNA turned to multiple resources to understand current needs and develop a list of program and policy recommendations for HCD's consideration. In addition to primary data collection methods such as focus groups and surveys, the needs assessment relies on secondary data in the form of administrative and epidemiological statistics that the county produces as well as a review of the literature, including AIDS housing needs assessments and/or plans undertaken in other jurisdictions. Put another way, the data sources on which the AHNA relies include both pre-existing data as well as original data derived specifically for this project. The AHNA uses this multi-method approach to increase the likelihood that we have as much data as possible with which to work, including from data sources potentially contradicting one another. Toward the end of this report we will have the opportunity to bring the findings together and discern the degree to which they are in agreement with one another.

AHNA collection of primary data includes:

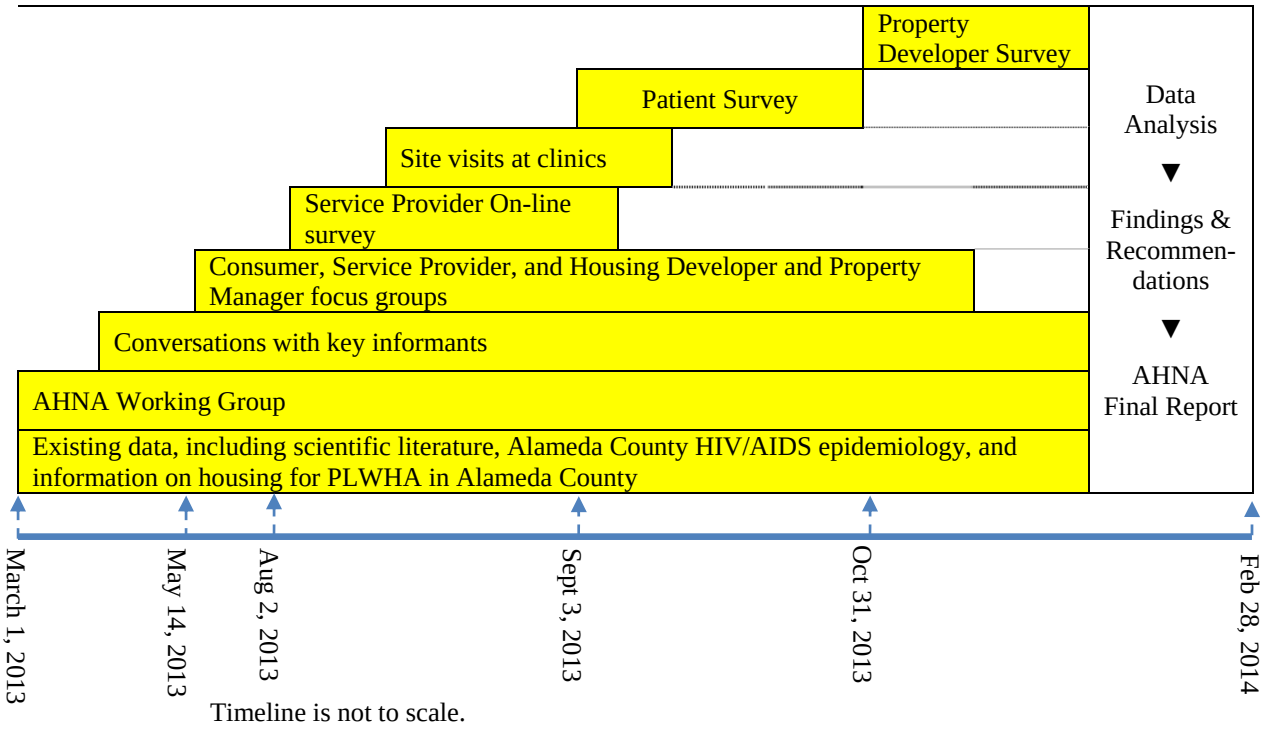
- ✓ Five focus groups
  - One conducted with HIV service providers
  - Three conducted with PLWHA – one group for the general population, one for women and another for Spanish-speaking PLWHA
  - One conducted with housing developers and property managers.
- ✓ On-line survey of 95 HIV service providers
- ✓ Survey of six housing developers and property managers
- ✓ Site visits followed by in-person surveys with 210 low-income patients at HIV/AIDS primary care sites
- ✓ Conversations with key informants on an as-needed basis; members of the AHNA Working Group served also as key informants

AHNA use of existing data includes:

- ✓ Academic, governmental, and popular press literature on housing, housing costs, HIV/AIDS, and homelessness
- ✓ Alameda County Public Health Department HIV/AIDS epidemiology
- ✓ Alameda County Public Health Department Office of AIDS Administration budget and service utilization information
- ✓ HCD budget and service utilization information on housing for PLWHA in Alameda County

Successive data collection methods are informed by results of previous methods. For example, perspectives provided by members of the AHNA Work Group and a variety of existing data have been of value in themselves and also in informing subsequent data collection strategies. As Chart 1 displays consumer, service provider, and developer and property manager focus groups; an on-line service provider staff survey; site visits; and a survey of low-income patients of HIV primary care clinics follow and build upon public health HIV/AIDS epidemiological and program use data, a variety of literatures, and insights of key informants.

Chart 1. Chronology of AHNA Data Types and Collection Strategies



Timeline is not to scale.

Our original structured data collection efforts began in May 2013 when we conducted our first focus group – this one for housing and other HIV service providers – and concluded in December 2013 with our last focus group, with AIDS Housing Developers and Property Managers. We conducted an on-line survey of housing and other service providers during August and September and a patient survey in September and October 2013.

Guide to the report. Following acknowledgements and the needs assessment's executive summary, this report is divided into an introduction, seven chapters, and a number of appendices.

- ✓ Following this Introduction, Chapter 1 continues with a presentation on the national context in which this "conversation" takes place.

- ✓ Chapter 2 describes the complicated and challenging situation of the Alameda County context. In the course of this presentation we address demography and epidemiology; income, housing costs, and housing; HIV/AIDS in combination with mental illness, abuse of alcohol and drug dependence, and homelessness and housing instability; HOPWA and other dedicated funding for housing for PLWHA; the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act and its Minority AIDS Initiative; and major changes guiding Alameda County's HIV/AIDS housing and service system today.
- ✓ Chapter 3 describes the methods that the AHNA employed to secure the variety of information needed to accomplish the needs assessment; these methods and their resulting data are presented in the following three chapters.
- ✓ Chapter 4 presents findings from five focus groups: one with service providers, three with consumers, and one with housing developers and property managers. The latter focus group is also informed by results of a survey of selected HIV/AIDS housing developers and property managers.
- ✓ Chapter 5 provides the results of an on-line survey of housing and other service providers.
- ✓ Chapter 6 presents findings from a survey of low-income HIV+ residents of Alameda County who are patients using publicly funded primary care clinics and one independent physician's office.
- ✓ Chapter 7 summarizes the findings from Chapters 4, 5, and 6 and offers recommendations on housing and housing development, services, collaboration, special issues, and additional data collection and research.
- ✓ The appendices provide back-up detail on a number of topics – from a list of HOPWA developments in the county to copies of the AHNA's survey instruments – beginning with a glossary to define acronyms and the technical meaning of certain terminology.

References

AIDS Housing of Washington. (1996). *Alameda County Multi-year AIDS Housing Plan.*

AIDS Housing of Washington. (2006). *Alameda Countywide Homeless and Special Needs Housing Plan.*

The White House Office of National AIDS Policy. (2010). *National HIV/AIDS strategy for the United States.*

Chapter 1: Housing for People Living with HIV/AIDS in the United States: An Orientation to Needs, Programs, and Funding

1.1 The National Context

> [Current AIDS housing research] demonstrates a direct and independent relationship between improved housing status and reduction in HIV risk behaviors. Homeless or unstably housed persons are up to six times more likely to engage in risk behaviors than stably housed persons with the same personal and service characteristics. Housing also increases access to antiretroviral medications, which lower viral load and reduce the risk of transmission. Among HIV/AIDS experts there is a growing consensus that HIV prevention strategies will not succeed without attention to housing status and other structural factors that shape or constrain individual behavior (National AIDS Housing Coalition 2013).

The AIDS epidemic has been with us for more than 30 years since the first cases were diagnosed in 1982.[1] Nationally, although the number of new infections remains constant at approximately 50,000 per year, the death rate has declined dramatically due to the advent and widespread use of new Highly Active Antiretroviral Therapy (HAART) medication regimes that involve multiple anti-retroviral drugs acting on different viral targets in an attempt to control HIV infection. As a result, more PLWHA are having longer lives and unlike in recent years many are not progressing to an AIDS diagnosis.

In this section, we present an overview of the HIV epidemic in the United States and its disparate magnitude in various communities (see Chapter 2 for more detail on Alameda County). We highlight emerging evidence that shows how housing serves as a public health intervention. In the realm of HIV prevention and treatment, the evidence is persuasive that stabilizing housing for people who are homeless is associated with improved treatment adherence and reduced risk behavior, and is an important tool both for increasing survival and reducing infections in the broader community (Leaver, et al. 2007).

[1] A project literature review appears as Appendix 3.

Finally, we explain how the federal government has funded distinct programs to address the clinical and supportive service needs of PLWHA and to increase the number of PLWHA who successfully maintain engagement in care and treatment.

The demographics of the HIV+ population have changed in major ways from the early days of the epidemic when AIDS was widely viewed as a gay, White, middle-class men's disease. Currently, African Americans in particular are disproportionately affected by new cases in the HIV/AIDS epidemic nationwide, as well as in Alameda County. Nationally, people of color have been shown to have less access to health care and worse health outcomes than Whites, due to factors such as poverty and racism (AIDS Housing of Washington 2006).

The highest rate of HIV prevalence nationally is among gay, bisexual, and other men having sex with men (MSM). New HIV infections among women are primarily attributed to heterosexual contact (84% in 2010) or injection drug use (16% in 2010). Women accounted for 20 percent of estimated *new* HIV infections in 2010 and 24% of those *living with* HIV infection in 2009. The 9,500 new infections among women in 2010 reflect a significant 21 percent decrease from the 12,000 new infections that occurred among women in 2008 (Centers for Disease Control 2013).

A continuum of services that includes diagnosis, linkage to care, retention in HIV medical care, and ongoing HIV prevention interventions is required to improve the survival of PLWHA and reduce transmission. However, fewer than one in five (17%) PLWHA has private insurance, and nearly 30 percent do not have any coverage (The Affordable Care Act and HIV/AIDS 2013). Federally-funded programs for HIV care and treatment services are limited in scope to ambulatory HIV care and treatment and support services; they do not include inpatient care and ambulatory care for other medical issues.

In July 2012, the White House released the first National HIV/AIDS Strategy for the United States with three major goals: to reduce HIV infections, to increase access to care and improve health outcomes and to reduce HIV-related health disparities. The National Strategy cites housing as a key structural intervention and calls for the integration of housing services with other services that PLWHA need. It also urges more interagency collaboration in response to the epidemic (U.S. Department of Housing and Urban Development Office of Community Planning and Development 2011). The Federal government's approach to implementing the National

HIV/AIDS Strategy covers an array of departments and agencies. Accomplishing the National Strategy's goals is described as requiring a more synchronized national response to the epidemic and increased coordination of HIV programs among federal agencies and state and local governments. Businesses, faith communities, philanthropy, the scientific and medical communities, educational institutions and PLWHA consumers are called upon to collaborate to achieve success and end the epidemic.

1.2 HIV/AIDS in Combination with Mental Illness, Substance Abuse and Homelessness/Housing Instability

While no single definitive data source is available, there is substantial evidence that PLWHA also experience homelessness/housing instability, mental illness and substance abuse in significant numbers. Co-occurring disorders are now more frequently evident than earlier in the history of the disease; mental illness and substance abuse diagnoses more often accompany new HIV diagnoses. And, as the HIV+ patient population ages, in large part because of the success of HAART, more medical conditions related to middle-age and aging require attention and treatment.

Mental illness and substance abuse. The HIV Costs and Services Utilization Study (HCSUS), the first major research effort to collect information, from 1994 to 2000, on a nationally representative sample of people in care for HIV infection, found that nearly 50 percent of adults being treated for HIV also have symptoms of a psychiatric disorder; this indicates a prevalence that is four to eight times higher than in the general population. Nineteen percent of patients studied showed signs of substance abuse, and 13 percent had co-occurring mental illness and substance abuse disorders (Bing, et al. 2001).

Homelessness/housing instability. While there are limited data on the number of homeless PLWHA, the U. S. Department of Housing and Urban Development (HUD) reports studies showing approximately half of all PLWHA will face homelessness or experience an unstable housing situation at some point during their illness (U.S. Department of Housing and Urban Development Office of Community Planning and Development 2011). In 2004, Dennis Culhane, a researcher who has worked extensively on homelessness, estimated that approximately three percent of the adult homeless population nationally is PLWHA (AIDS Housing of Washington 2006). If that statistic holds true today, and is applicable to the Alameda

County homeless population of 4,264 people, we would expect to find approximately 128 HIV+ individuals homeless at a point in time. The County's Homeless Count and Survey estimate for 2013 is 97 homeless PLWHA (a topic we explore further in Chapter 2) (Schatz, Halcon and Norris 2013).

1.3 Housing as Healthcare

For many low-income PLWHA, the cost of housing is prohibitive. According to the National Low Income Housing Coalition, the 2013 national housing wage is $18.79 per hour. While an individual would need to earn this wage full-time annually to afford a two-bedroom rental unit at the fair market rent, HUD reports that 91% of HOPWA clients have extremely low incomes that are below 30% of area median income (National AIDS Housing Coalition 2013). As we discuss in Chapter 2, rental challenges are much more severe in Alameda County.

Data from two major studies demonstrate investing in HIV housing reduces other public costs by improving the health of PLWHA and preventing new infections. In an AIDS Foundation of Chicago Housing for Health Partnership (CHHP) study, savings in avoidable health services more than offset the costs of the CHHP housing program (Sadowski, et al. 2009). Preliminary calculations from the multi-site, multi-agency Centers for Disease Control and Prevention (CDC) and HUD research collaboration known as the Housing and Health Study indicate that housing serves as a cost-effective health care intervention for PLWHA, with a valuable cost per quality-adjusted life-year (National AIDS Housing Coalition 2013).[2] Housing is in the same range of significance as HAART and other widely accepted health care interventions. Moreover, 95% of HOPWA clients with permanent housing are remaining stably housed and connected to HIV care and treatment.

According to the CDC, health is also affected by social determinants which substantively affect individual health. CDC explains that life expectancy and health status are attributed to social and economic factors (40%); health behaviors, such as alcohol use, injection drug use (needles), unprotected sex, and smoking (30%); and the physical environment (10%) – leaving only 20 percent to clinical care (Centers for Disease Control and Prevention 2010).

[2] The quality-adjusted life-year takes into account both the quantity and quality of life resulting from healthcare interventions. It is the arithmetic product of life expectancy and a measure of the quality of the remaining life-years.

Many people experience coinciding determinants of health, such as homelessness, language barriers, poverty and lack of social support. Often, it is not just *how* a person lives that can affect one's health, but also *where* the individual lives. Controlling for a person's age, gender, race/ethnicity, and education level, low socio-economic status neighborhoods are associated with poor overall health and an increased risk for death. Unhealthy or unstable living spaces are key physical environmental risk factors. The Alameda County Public Health Department is addressing these issues with its "Place Matters Policy Initiative" (Schaff, et al. 2013).

The social determinants of health complicate the ability of the medical care system to address personal as well as community health problems (National Association of Community Health Centers 2012). This can pose a challenge for the patient, the provider and the community.

- For the patient, social determinants adversely affect health care access and the patient's progress adopting healthy behaviors.
- For the provider, the social determinants of health make it more challenging to identify, assess, and treat a health problem; the scope of services necessary to adequately treat such patients may be much more intensive. For example, a poor HIV+ patient on HAART medications who is homeless or living in an unstable housing environment is a very different and more challenging patient – both medically and socially – than someone with the same medical conditions without these social constraints.
- With the health care system not addressing most social determinants, poor health outcomes tend to persist and reproduce poor health, health care disparities, avoidable utilization of expensive health care, and poor prevention efforts.

Important research also shows that, with housing, PLWHA can access health care, adhere to treatment regimens and reduce HIV risk behaviors.[3] A 2006 systematic review on the subject finds a "significant positive association between increased housing stability and better health-related outcomes" including "utilization of health and social services" (Aidala, et al.

[3] Employment income can also be of critical value for PLWHA. A new International Labor Organization study released ahead of the 2013 World AIDS Day states that employed PLWHA are almost 40 per cent more likely to adhere to HIV treatment than those who are unemployed. The report analyses the findings of 23 studies, involving more than 6,500 PLWHA, on the relationship between employment and HIV treatment. The main reason for this success is because employed individuals have regular financial means to pay for their related health services, medications and support, and to afford sufficient food (International Labor Organization 2013).

2005). Similarly, a longitudinal study commissioned by CDC and HUD finds that HOPWA rental assistance improves the health status of HIV+ clients. Housing status has also been shown in other studies to be one of the strongest predictors of health outcomes for PLWHA even after controlling for other factors such as substance abuse, mental health and receipt of medical and social services (U.S. Department of Housing and Urban Development Office of Community Planning and Development 2011).

1.4 Dedicated Funding for Housing and Services for PLWHA

On the national level, the federal government has responded with distinct programs to respond to the clinical and supportive service needs of PLWHA. There are two primary federal programs that fund housing and health programs specifically designed for PLWHA:

- Housing Opportunities for Persons with AIDS (HOPWA), a program of the U. S. Department of Housing and Urban Development (HUD), and the
- Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, a program of the Health Resources and Services Administration (HRSA) of the U. S. Department of Health and Human Services and the CARE Act's Minority AIDS Initiative (MAI) to address the disproportionate impact of HIV on minority populations.

Although on an annual basis through its Part A and MAI funding streams the Ryan White program brings in about twice as much funding as does the HOPWA program for housing and health (see Chart 1.1), both of these programs provide a significant amount of support to housing and health service programs for PLWHA in Alameda County (see Chapter 2 for details).

Chart 1.1. Federal Funding to Support Housing and Health of PLWHA

	2012-13*		2013-14**	
	Dollars (millions)	**Percent of total**	**Dollars (millions)**	**Percent of total**
Ryan White CARE Act Part A and MAI * **	**$632**	**67%**	**$651**	**66%**
HOPWA	**$315**	**33%**	**$330**	**34%**
Total	**$947**	**100%**	**$981**	**100%**

* Federal FY 2013 began October 1, 2012 and ended September 30, 2013.
** Federal FY 2014 began October 1, 2013 and will end September 30, 2014.
*** Estimated for 2013-2014

1.5 Housing Opportunities for Persons With AIDS (HOPWA)

HOPWA was established in 1992 to address the specific housing-related needs of PLWHA and their families. HOPWA is the cornerstone for the HIV/AIDS housing continuum available in most communities. The City of Oakland is the grantee for the HOPWA Eligible Metropolitan Area which includes Alameda and Contra Costa Counties. It contracts with the Alameda County Housing and Community Development Department to administer the HOPWA funding in Alameda County and integrate the HOPWA program with other related local planning efforts, such as HUD's Consolidated Plan and efforts of the Alameda Countywide Homeless Continuum of Care Council, the planning body that coordinates program funding and various services for homeless people in Alameda County. The primary projected outcomes of the HOPWA program are increased housing stability, decreased risk of homelessness and increased access to care for PLWHA.

HOPWA regularly gathers data from its grantees nation-wide to measure their progress towards achieving housing stability (U.S. Department of Housing and Urban Development Office of Community Planning and Development 2011). HOPWA Highlights for program year 2010 address housing status, as well as income and health care.

• HOPWA-funded permanent housing developments, usually new construction or renovation by non-profit corporations, showed that 94 percent of the 25,230 assisted households achieved housing stability, and 92 percent of the 35,439 households receiving short-term/transitional housing achieved housing stability or reduced risk of homelessness.

• HOPWA-funded programs also documented that clients received comprehensive and complimentary services to improve their "quality of life": 93 percent of clients served had a housing plan for maintaining or establishing stable ongoing housing; 89 percent had contact with case manager/benefits counselor; 77 percent successfully accessed or maintained their qualification for a source of income; and 84 percent accessed and maintained medical care.

This housing stability and access to care was achieved for HOPWA-assisted households with limited income and frequently considerable risk of homelessness: 82 percent of households were extremely low income; 12 percent were very low income; and 6 percent were low income.

The National HIV/AIDS Strategy Goal 2, Objective 2-3 for 2015 is to increase the proportion of Ryan White Program clients with permanent housing to 86%. The California Office of AIDS shares this target (California Department of Public Health Office of AIDS 2013).

1.6 Ryan White Comprehensive AIDS Resources Emergency (CARE) Act and the Minority AIDS Initiative

The Ryan White CARE Act, enacted in 1990, was named after Ryan White, an Indiana teenager whose courageous struggle with HIV/AIDS and against AIDS-related discrimination and stigma helped to educate the nation. It represents the largest financial investment made by the federal government specifically for the provision of services for PLWHA. Ryan White funds are intended to help communities and states increase the availability of primary health care and support services, and increase access to care for underserved populations. There are over ten allowable core medical and sixteen support service categories that Ryan White can fund. One of the support service categories is Housing Services which includes emergency housing assistance, temporary/transitional housing programs and housing referral services. (See Chart 2.4 below, a matrix of housing programs funded in Alameda County, and fundable per federal regulations, under the Ryan White and HOPWA programs.) In 1999, as a result of African American community leaders and the Congressional Black Caucus declaring an HIV/AIDS state of emergency, the federal government responded with increased funding and outreach to stop the spread of HIV in African American communities through the Minority Aids Initiative (MAI) program. In 2000, the MAI was expanded to include Latinos, Native Americans and Asian and

Pacific Islanders (Alameda County Public Health Department Office of AIDS Administration 2013).[4]

Alameda County has received Ryan White funding since 1991 and HOPWA funding since 1992. The Alameda County Public Health Department Office of AIDS Administration administers the federally allocated Ryan White Part A and MAI funds in Alameda County, as well as the Ryan White Part B funds awarded to the county by the California state Office of AIDS (see Chart 1.2 below). Note that for both HOPWA and Ryan White, some of the funding is on a formula basis and some is competitive

The Collaborative Community Planning Council (CCPC) guides the service priorities and allocated uses for funding. The CCPC is the community planning body, mandated by federal law with members locally appointed, that designates which of the federally-approved service categories should be funded locally and allocates Ryan White Part A and MAI funds among them.

[4] Ryan White Program and Minority AIDS Initiative funds are distributed by HRSA to support HIV care and treatment services to uninsured and underinsured PLWHA. Ryan White programs are designated by law to be the payor of last resort for individuals seeking HIV care. The amounts of Ryan White funds are determined by national budget priorities and the number of HIV cases reported locally.

Chart 1.2. Ryan White Program Parts

The U.S. Department of Health and Human Services HIV/AIDS Program website (http://hab.hrsa.gov/abouthab/aboutprogram.html) explains that the Ryan White legislation created a number of programs, called Parts, to meet needs for different communities and populations affected by HIV/AIDS.

- Part A provides emergency assistance grants to the local governments of metropolitan areas that are disproportionately affected by HIV/AIDS to fund a variety of medical and support services that have contracts with the local government.
- Part B provides grants at a state level and is designed to improve the quality, availability and organization of AIDS support and healthcare services. A large proportion of Part B is also earmarked to fund state AIDS Drug Assistance Programs.
- Part C provides direct grants to individual organizations and outpatient care clinics for early intervention services and capacity development.
- Part D grants fund family-centered care involving outpatient care for women, infants, children, and youth with HIV/AIDS. They also improve access to clinical trials and other forms of AIDS research
- Part F provides funds for a variety of programs:
    - The Minority AIDS Initiative (MAI) provides funding to evaluate and address the disproportionate impact of HIV/AIDS on African Americans and other minorities.
    - The Dental Programs provide additional funding for oral health care for people with HIV.
    - The Special Projects of National Significance (SPNS) Program funds innovative models of care and supports the development of effective delivery systems for HIV care.
    - The AIDS Education and Training Centers (AETC) Program supports a network of 11 regional centers and several National centers that conduct targeted, multidisciplinary education and training programs for health care providers treating people living with HIV/AIDS.

1.7 The Affordable Care Act and Health Care Reform

The current sea change of health care reform holds out the hope that more PLWHA, especially HIV+ People of Color and those with low incomes, will gain access to and remain engaged in medical care and treatment to suppress their HIV viral load and improve their health. Increasing these numbers is important because we now understand that approximately 68 percent of PLWHA who remain in care continuously have suppressed viral-load. Currently, only 28 percent of all PLWHA have reached this goal. According to the CDC HIV continuum of care, also known as the Treatment Cascade, only 62 percent of PLWHA have been linked to a care provider and only 36 percent are engaged in regular care (HIV/AIDS treatment cascade helps identify gaps in care, retention 2012; Horn 2013). In California, only 50 percent of the state's estimated 130,000 Californians living with HIV/AIDS are in care, but 36 percent of the total has achieved viral suppression (California Department of Public Health Office of AIDS 2013).

Other innovative demonstration projects occur at the state level to address housing as health care. To meet the needs of homeless PLWHA and others, Housing Works' Chief Executive Officer Charles King advocated using Medicaid funds for supportive housing itself and not just related services. This proposal was included in New York's 1115 Medicaid waiver recently approved by the Centers for Medicare and Medicaid Services and described in "Housing as Health Care – New York's Boundary-Crossing Experiment" in the December 2013 New England Journal of Medicine (Doran, Misa and Shah 2013).

1.8 The Budget Control Act's FY 2013 Sequestration and FY 2014 Federal Funding

While the number of HIV/AIDS patients is increasing, HIV care services were reduced as a result of Sequestration, the automatic federal spending cuts in particular categories of outlays that went into effect on March 1, 2013. This is the conclusion of a survey conducted by *The AIDS Institute* of 131 AIDS organizations in 29 states and the District of Columbia on the impact of Sequestration and other budget cuts.[5] In the last year, overall federal funding for HIV/AIDS

[5] Seventy-nine percent of the programs surveyed reported an increase in the number of clients served. "This survey demonstrates that the severe cuts enacted by the Budget Control Act are having real, negative consequences on HIV/AIDS organizations and their patients across the nation," commented Carl Schmid, Deputy Executive Director of The AIDS Institute. "These budget cuts, coupled with an increasing number of HIV patients, have impacted their ability to provide timely, quality care and prevent future HIV infections" (The AIDS Institute 2013, 1).

programs was reduced by almost $380 million. Eighty-five percent of the organizations surveyed experienced funding reductions averaging 17 percent while at the same time seeing the demand for their services increase. Survey respondents reported that the decreased funding resulted in staff reductions and reduced patient services, including fewer prevention programs, longer times between appointments, increased clinic wait times, and less availability of HIV testing.

It was estimated that 60,000 households would be assisted by the HOPWA program in FY 2013, including 25,000 households continuing to receive permanent housing support and 35,000 households provided with short-term or transitional housing assistance. Due to Sequestration, HOPWA funding for FY 2013 fell to $315 million, a $17 million decrease from the previous year. As a result of Sequestration in FY 2013, 1,530 fewer households were expected to receive permanent housing and 1,640 fewer households would receive short-term assistance to prevent homelessness. Seventy-eight percent of those losing services, or 2,460 households that would be removed from the HOPWA program under Sequestration, were expected to be racial minority households (amfAR, The Foundation for AIDS Research 2013). Restoring most of that decrease for FY 2014, the budget agreement of January 2014 scales back the Sequester that seriously affected HOPWA and other major domestic programs last year and funds HOPWA at $330 million.

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Chapter 2: Housing for People Living with HIV/AIDS in Alameda County: Needs, Programs, and Funding

Alameda County's 2012 population of 1.5 million, up 7.7 percent from 2000, makes it the 7th most populous county in the state. The most recent U.S. Census data report that non-Hispanic Whites are 34 percent, Asian & Pacific Islanders 29 percent, Latinos 23 percent, Blacks 13 percent, and American Indians and Alaska Natives 1 percent of the county population. Females comprise 51 percent and males 49 percent of the population. Approximately 43 percent of the population five years and older speak a language other than English at home (U.S. Census Bureau 2012). Between 2000 and 2010, there was an increase in the number of Asian/Pacific Islanders and a decline in the number of Black/African Americans in Alameda County.

For purposes of this report, we define geographic regions for the county by assigning its cities and unincorporated areas as follows:

- North County: Albany and Berkeley
- Oakland
- Oakland Area: Alameda, Emeryville and Piedmont
- Central County: Ashland, Castro Valley, Cherryland, Fairview, Hayward, San Leandro, San Lorenzo,
- South County: Fremont, Newark, Sunol and Union City
- Tri-Valley: Dublin, Livermore and Pleasanton

We distinguish *Oakland Area* from *Oakland* for two reasons. First, for analytic reasons we want to avoid expanding the population coverage of the City of Oakland, already the residence of a solid majority of low-income HIV+ residents in primary care (59.9%; see Chart 6.69 in Chapter 6). Second we want to distinguish Oakland from neighboring cities which differ so substantially in terms of services availability.

The following sections of this chapter summarize highlights of HIV/AIDS epidemiological data for the country, state, and county. The chapter continues with a focus on income and homelessness factors, co-occurring mental health and substance abuse diagnoses, and dedicated funding and programs for housing for PLWHA.

2.1 HIV/AIDS Epidemiology

Chart 2.1 lists selected HIV/AIDS statistics for Alameda County, California and the United States.

Chart 2.1. New HIV Cases and People Living with HIV/AIDS: Alameda County, California and the United States

	New HIV/AIDS Cases	New HIV/AIDS Case Rate *	Persons Living With HIV/AIDS	Persons Living With HIV/AIDS Case Rate *
Alameda County[1]**	230	14.5	5,229[1]	339
California State[2]***	5,965	19.2	111,666	363
United States[2, 3]***	50,007	19.1	888,921	342

[1] Alameda County Public Health Department 2014.

[2] Center for Disease Control and Prevention, National Center for HIV/AIDS 2012.

[3] Centers for Disease Control and Prevention (2013). The 888,921 figure used for the national PLWHA count is based on diagnosed HIV infection. The 1.1 million figure, more frequently used in national HIV materials, is an estimated count which includes undiagnosed cases and adjustments for reporting delays in addition to diagnosed cases.

* The case rate represents the number of cases per 100,000 population.

** The new HIV/AIDS and PLWHA case count, as well as the PLWHA case rate, are for 2012 whereas the new HIV/AIDS case rate is a three year average for 2010-2012.

*** PLWHA cases reported and case rates are for 2010 whereas new HIV/AIDS cases reported and case rates are for 2011.

According to the Centers for Disease Control and Prevention (CDC), since the beginning of the epidemic, 1,700,000 individuals have been found to be HIV+ and 660,000 people have died from the disease, including more than 16,000 in 2010 (National Minority Action Council Newsletter 2013; The Kaiser Family Foundation 2013).[1] For males, high risk behaviors and reported modes of transmission have been identified as same-sex contact, intravenous drug use (IDU), heterosexual contact and other/unknown. For females, heterosexual contact, IDU and other/unknown are their major risk factors and transmission modes.

The most recent epidemiological data available suggest the prevalence of HIV nation-wide continues to be greatest among gay, bisexual, and other men who have sex with men (MSM)

[1] Since an estimated 18% of Americans living with HIV are unaware of the status, the actual HIV+ figure is over 2,073,000 (The Kaiser Family Foundation 2013).

(Johnson, et al. 2013). Although MSM represent only 2 percent of the U.S. population, they account for more than 60 percent of *new* infections and half of all PLWHA. Rates of new HIV diagnoses among MSM are more than 44 times greater than rates among other men.

Nationally, disparities among racial/ethnic minority populations are significant. Blacks/African Americans and Latinos/Hispanics have a disproportionate share of new HIV infections, relative to their size in the total population, accounting for approximately 50 percent of all new infections in 2009. Blacks/African Americans have the *highest* rate of new HIV infections. There are more than 510,000 Blacks/African Americans living with HIV in the United States. According to the Kaiser Family Foundation, "national household survey data found that 2 percent of Blacks in the U.S. were HIV positive, higher than any other group" (The Kaiser Family Foundation 2013).[2]

The CDC reports that Hispanics account for an estimated 19 percent of PLWHA (220,400 persons) and an estimated 21 percent of new infections in the United States each year.[3] The rate of new HIV infections among Hispanic men is almost three times higher than that among White, non-Latino men, and the rate of new HIV infections among Hispanic women is more than four times that of White, non-Latina women (Sanchez 2013).

One in four new HIV infections occurs in youth ages 13 to 24 years. About 12,000 youth in 2010, or approximately 1,000 per month, were infected with HIV. About 60 percent of all youth, with HIV do not know they are infected, are not getting treated, and can unknowingly pass the virus on to others (Centers for Disease Control and Prevention 2012). Young MSM (YMSM), ages 13-24 years, are especially at risk; they comprise the only risk group where new HIV infections are going up, with a 22 percent increase in recent years. Black/African American YMSM disproportionately account for 55 percent of new infections among YMSM overall (Mermin 2013).

The HIV/AIDS treatment cascade presents the numbers of PLWHA in the United States who receive and fully benefit from medical care (HIV/AIDS treatment cascade helps identify gaps in care, retention 2012). First developed, replicated, and published in 2011, the cascade shows that

[2] According to the Kaiser Family Foundation, in 2010, the 68.9 rate of new HIV infections per 100,000 for African Americans/Blacks was about 8 times that of Whites (8.7); Latinos/Hispanics had a 27.5 rate which was 3 times that of Whites.

[3] Approximately one in 50 Hispanics will be diagnosed with HIV during their lifetime (Centers for Disease Control and Prevention 2013).

along the different stages of the continuum of care, a decreasing number of PLWHA succeed and suppress their viral infection. For every 100 PLWHA, it is estimated that:

- 80 are aware of their HIV status.
- 62 have been linked to HIV care.
- 41 stay in HIV care.
- 36 receive antiretroviral therapy (ART).
- 28 adhere to their treatment and sustain undetectable viral loads.

The stark conclusions are that 20 percent of infected individuals nationally are not aware of their HIV, status and almost one out of two PLWHA aware of their status have failed to successfully link to and maintain care.

In California, only 50% of the state's estimated 130,000 Californians living with HIV/AIDS are in care, but 36% of the total has achieved viral suppression (California Department of Public Health Office of AIDS 2013).

In California, both HIV and AIDS rates have decreased (Bajko 2013), but the demographics of the newly diagnosed cases differ from earlier periods. Among Californians newly diagnosed with HIV infection in 2011, 40 percent were Latino/a, 33 percent were White, 20 percent were African American and 6 percent were Asian/Pacific Islander. California Latinos/as have almost double the proportion of new infections nationally. The newly infected group is also younger: Fifty percent under 35 years of age. Conversely, as PLWHA live longer post-diagnosis, overall the California PLWHA population is aging. People 40 years of age and older now account for 75 percent of PLWHA in California, with 43 percent of them over the age of 50. The California PLWHA population has larger percentages of Whites, Latinos/as and Asian/Pacific Islanders than the national PLWHA population (San Francisco Department of Public Health 2012). Males account for 87 percent of the California PLWHA total, 12 percentage points greater than the 75 percentage of male cases nationally, and 66 percent of California PLWHA are MSM compared to 43 percent nationally.

Within California, Alameda County ranks eighth for number of AIDS cases and sixth for number of HIV cases (California Department of Public Health Office of AIDS HIV/AIDS Surveillance Section 2012). Chart 2.2 displays the distribution of the 5,229 PLWHA in Alameda County as of December 31, 2012 – the most recent data available from the state – by race/ethnicity, gender, age,

mode of transmission, and region.[4] As is evident in Charts 2.1 and 2.2, the Alameda County HIV epidemic has some similarities as well as differences compared to the national and California figures. Case rates for African Americans, Whites and Latinos/as in Alameda County are similar to those in the United States and California. However, A/PI cases comprise a higher proportion of the Alameda County epidemic than in the nation.

The Alameda County Department of Public Health summarizes its findings related to characteristics of *new* HIV Cases for 2010-2012 as follows (Alameda County Public Health Department 2014):

- Both new HIV diagnoses and PLWHA in Alameda County are predominantly among male, African Americans, and MSM mirroring the national CDC findings described above.
- Between 2006 and 2012, overall HIV case rates declined steadily. They remained stable among males and declined substantially among females. There was a steady decline in case rates among African Americans.
- African Americans bear almost 10 times the burden of new HIV diagnoses compared to Asian/Pacific Islanders, 5 times the burden among Whites and nearly 4 times the burden among Latinos.[5]
- Adults 20-49 years old have the greatest burden of new HIV diagnoses. Since 2009, case rates among 20-29 year olds surpassed those for 30-39 year olds and 40-49 year olds.
- HIV burden is strongly related to neighborhood poverty. Alameda County rates of HIV diagnosis increase with every step of neighborhood poverty level. High poverty neighborhoods (where 30 percent or a higher percentage of households are in poverty) have three times the burden of new cases compared to low-poverty neighborhoods (i.e., those with fewer than 10 percent of households in poverty).
- Most of the new cases of HIV in Alameda County are in the Oakland and Central County areas and concentrated in the cities of Oakland, Hayward, San Leandro and Berkeley.

[4] For additional information and details about the demographic breakdown on new HIV cases and PLWHA in Alameda County, see Murgai (State of the HIV Epidemic in Alameda County 2013, July 24). While there are no AHNA data on mode of transmission, as we see in Chapter 6 the prevalence of alcohol dependence and drug abuse among low-income Alameda County PLWHA in primary care is widespread and significant in its association with homelessness and housing instability.

[5] We emphasize the salience of the heavy burden of HIV/AIDS in the Alameda County African American community.

Chart 2.2. People Living with HIV/AIDS in Alameda County, 2012[6]

	PLWHA 2012	
	Number	Percent
Race/Ethnicity		
African American	2,297	43.9%
White	1,684	32.2%
Latino/a	878	16.8%
Asian/Pacific Islander	219	4.2%
Other/Unknown	151	2.9%
Total	5,229	100%
Gender		
Male	4,202	80.4%
Female	961	18.4%
Transgender	66	1%
Total	5,229	100%
Age Groups		
Under 19	37	0.7%
20-29	381	7.3%
30-49	2,321	44.4%
Over 50	2,488	47.6%
Unknown	2	0%
Total	5,229	100%
Modes of Transmission		
MSM	3,095	59.2%
MSM & IDU	301	5.8%
Heterosexual Contact	985	18.8%
IDU	480	9.2%
Other/Unknown	368	7.0%
Total	5,229	100%
City / Region		
Oakland	2,930	56.0%
Area Around Oakland (Alameda, Emeryville, Piedmont)	350	6.7%
North County (Berkeley, Albany)	422	8.1%
Central County (Hayward, San Leandro, Castro Valley, San Lorenzo, Ashland)	943	18.0%
South County (Fremont, Union City, Sunol)	373	7.1%
Tri-Valley Area (Livermore, Dublin, Pleasanton)	211	4.0%
Total	5,229	100%

[6] Alameda County eHARS data as of June 30, 2013.

Young MSM of color, have slightly higher HIV rates compared to young White MSM. As with overall HIV cases in Alameda County, new HIV diagnoses among youth are concentrated in Oakland and the Central County areas.

The number of people living with AIDS is now larger than the number of those living with HIV only in all groups as defined by sex, race/ethnicity, age group and mode of transmission (Murgai, State of the HIV Epidemic in Alameda County 2013, July 24). These descriptive data about PLWHA in Alameda County serve as the backdrop for the AHNA.

2.2 Income and Housing

Alameda County has a vibrant housing real estate market and a well-developed housing stock. At the same time housing has presented a serious challenge to many county residents. For a population of 1.5 million, the County has 582,500 housing units, as of 2010, with a 53.4 percent homeownership rate (U.S. Census Bureau 2010). In 2010, there were 253,900 renter-occupied apartments, an increase of 7.1 percent from 2000 (U.S. Census Bureau 2000). During the period from 2000 to 2010, the population increased by 4.6 percent (U.S. Census Bureau 2010; U.S. Census Bureau 2000).

For 2008-2012, the median household income in Alameda County was $71,516, but in the same time period 13.5 percent of the population had an income below the federal poverty level (FPL) during the previous 12 months (Alameda County 2012).[7] For California, during the same period, the median household income was $61,400, and 15.3% of the population had an income below the FPL. Nationally, the figures were $53,046 and 14.9% (U.S. Census Bureau 2014). Recent work on the actual cost of living suggests that the FPL fails adequately to address actual costs of living, however.[8] Replacing the FPL with a measure termed "Self-Sufficiency Standard for California" suggests that for 2014, for a single adult with no children the Self-Sufficiency Wage is $27,994

[7] According to a recent report from the Brookings Institution, using a *95/20 ratio,* in 2012 Oakland had the seventh greatest income inequality among the 50 largest cities in the United States. The 95/20 ratio measures "the income at which a household earns more than 95 percent of all other households, divided by the income at which a household earns more than only 20 percent of all other households." For Oakland that figure was 12.7 (Berube 2014).

[8] The Insight Center for Community Economic Development puts its critique of the FPL this way (Insight Center for Community Economic Development 2014): "The Federal Poverty Guidelines are "frozen" at the level of a basket of goods and services adequate for families in the 1950s, and updated only for inflation. They do not reflect rapidly increasing costs, such as health care and taxes or "new" costs such as child care; nor do they reflect local differences in the cost of basic goods and services."

annually ($13.25 hourly), and the proportion of Alameda County households falling below the Self-Sufficiency Standard is 29.2 percent (Insight Center for Community Economic Development 2014).

Neither the minimum wage ($8.00 per hour) nor the hourly value of a full SSI benefit expressed as an hourly income figure ($5.21 per hour) approaches the Alameda County Self-Sufficiency Wage discussed above.[9] Following the policy suggestion for an *affordable* housing expenditure one should expend no more than 30 percent of income on housing costs, the individual with a "self-sufficiency wage" should spend less than $669 per month for rent or mortgage. For an SSI recipient the comparable monthly figure is no more than $263 per month for housing.

Housing costs are quite high The March 2012 cost of living index in Alameda County was 132.2, considered high in comparison with the U.S. average index of 100 (City-data.com 2003-2013). According to the U.S. Census, the 2012 median monthly cost for existing renter-occupied units in Alameda County was $1,265, and since then housing costs have risen substantially. In Alameda County, the average asking price for someone newly renting in Fourth Quarter 2014 was $2,133, a figure that continues to increase as the cost of housing in San Francisco and other neighboring counties has soared (Said, Bay Area rents, home prices up sharply 2013). In 2013, according to a recent report, the median cost of housing in Oakland rose 16 percent over the previous year, with a 99.5 percent occupancy rate (Said, Winter drop hardly makes a dent in hot S.F. market 2014). Other reports claim a vacancy rate of approximately 3 percent (Federal Reserve Bank of San Francisco 2013). The Post, a local Oakland newspaper, reported in late 2013 that Oakland was second only to San Francisco in the high cost of market rentals then on the market (The Post 2013). In 2012 the federally prescribed "fair market value" of a studio apartment was $980 and heading higher. A studio apartment at fair market rent costs 70 percent of the monthly full-time minimum wage, and exceeds the entire value of an SSI check by 12 percent.

Frequent news stories suggest that migration to Alameda County from San Francisco is on the rise. Because of in-migration and large economic trends that affect Alameda County, pressure on the housing stock in the county has magnified in recent months and years.

[9] In California the maximum SSI cash benefit for an individual is $877 per month. The SSI cash benefit includes a "cash-out" for Food Stamps, making SSI recipients ineligible for additional benefits from the SNAP program – called CalFresh in California (Graves 2014).

There is, simply, a shortage of affordable housing in the county. It is very difficult to secure housing on a low-income budget.[10]

In part because of these social statistics, for the 2008-2012 period, almost 33 percent of Alameda County renter-occupied housing units with incomes less than $35,000 were forced to spend more than 30 percent of their income on housing costs, while only 7.8 percent of households earning $50,000 or more did so (U.S. Census Bureau 2008-2012). And the county's January 2013 point-in-time homeless count yielded an estimate of 4,264 people living in a shelter, on the street, or in another place not meant for human habitation (Aspire Consulting 2013). Additional numbers of individuals were not shelter-less but were doubled-up or couch-surfing.

2.3 HIV/AIDS in Combination with Mental Illness, Substance Use and Homelessness/Housing Instability

A large number of PLWHA have histories of homelessness, mental illness, and/or abuse of alcohol or other drugs.[11]

Mental illness. The OAA reports that, in FY 2012–2013, 13.5% of the 2,491 unduplicated clients at OAA-funded primary care clinics participated in Ryan White Part A- and MAI-funded mental health services during the year (Waltrip 2014).[12]

Alcohol and other drug use. Estimates of the extent of abuse of alcohol or other drugs among PLWHA are limited by current data collection protocols and by the documented tendency people have to underreport this issue. For FY 2012-2013, the OAA reports that 222 (8.9%) unduplicated clients participated in Ryan White Part A- and MAI-funded substance abuse services (Waltrip 2014).[13] This OAA report contains information regarding PLWHA who were infected through IDU. These data, however, neither convey current use or abuse of alcohol or other drugs nor

[10] At a California Budget Project 2014 workshop session on "Laying the Foundation: How Can State Policy and Investments Best promote Access to Affordable Housing?" one member of the panel of speakers commented that, unlike in a number of other states, there is a critical [housing] supply problem in California (Shoemaker 2014).

[11] See Appendix 13 for additional, relevant information from the literature review.

[12] Alameda County Behavioral Health Care Services' mental health and substance use treatment and recovery programs do not track information related to HIV/AIDS, and use different eligibility criteria than Ryan White.

[13] The Oakland Transitional Grant Area 2013 HIV/AIDS Needs Assessment finds that substance use service organizations are sparse in large sections of Oakland (Facente Consulting 2013).

describe possible associations with homelessness or unstable housing. To the extent that alcohol and other drug problems may be current, some individuals with these problems will need housing resources that are both age-appropriate and address their alcohol- and drug-using behavior with clear and consistent "clean and sober" or alternatively *low threshold*, *harm reduction*, and/or *housing first* policies.[14]

Homelessness. Every other year, EveryOne Home, a local non-profit affordable housing advocacy organization, conducts a county-wide survey and count to assess the dimensions of homelessness within Alameda County. For 2013, the count estimates that there are 97 homeless PLWHA in the county, a small, statistically insignificant increase from 2001 and a number at just above two percent of the homeless population. The 2011 data had noted a shift among PLWHA from mostly sheltered, including emergency shelter and transitional housing, to mostly unsheltered. This trend continued in 2013 with 74% of homeless PLWHA being unsheltered. While the numbers of PLWHA has shifted over time, from a high of 157 in 2003 to a low of 60 in 2011, the proportion of the homeless population with HIV/AIDS has remained between one and three percent of the overall homeless population since the first Alameda County homeless count (Aspire Consulting 2013). Both homelessness and HIV/AIDS affect people of color disproportionately. In particular, African Americans constitute a higher proportion of PLWHA and people who are homeless than of the general population of Alameda County (AIDS Housing of Washington 2006).

In 2006, Alameda County adopted the EveryOne Home Plan to end homelessness over the next ten years in the county. Proposing a Housing First strategy, the plan aims to move homeless individuals and families directly into permanent, independent, stable housing rather than through multiple levels of interim or transitional housing. Once housing is obtained, then other issues that may affect the household can and should be addressed. Housing first incorporates what is termed a *low threshold* approach to ending homelessness.

[14] The San Francisco Department of Public Health Direct Access to Housing program describes itself as a *low threshold* program that "accepts single adults into permanent housing directly from the streets, shelter, acute hospital or long-term care facilities. Residents are accepted into the program with active substance abuse disorders, serious mental health conditions, and/or complex medical problems" (San Francisco Department of Public Health 2005). According to the National Alliance to End Homelessness, "Housing First is an approach to ending homelessness that centers on providing people experiencing homelessness with housing as quickly as possible – and then providing services as needed" (National Alliance to End Homelessness 2014).

2.4 Dedicated Funding for Housing for PLWHA in Alameda County

As previously described, Alameda County's current HIV/AIDS housing and service system is supported primarily by two federal programs:

- HUD's Housing Opportunities for Persons With AIDS (HOPWA) program and the
- Ryan White CARE Act, a program of the Health Resources and Services Administration (HRSA) of the United States Department of Health and Human Services (HHS) and the CARE Act's Minority AIDS Initiative (MAI).

Both the HOPWA and Ryan White programs have as eligibility requirements written confirmation of an HIV diagnosis and proof of residency in Alameda County. Both programs also serve low-income individuals. The Ryan White program has an income limit of 300 percent of the federal poverty level while the HOPWA program has an income limit of 400 percent of the federal poverty level. Chart 2.3 displays the limits in terms of percent of poverty level and income. While the income limits appear to go high, two factors should be kept in mind. First, as we have discussed above, housing costs are very high in Alameda County. Second, the incomes of many PLWHA making use of the Ryan White and HOPWA programs are far from the program income limits. Persons relying on SSI, for example, are, respectively, at 30.5 and 22.9 percent of the Ryan White and HOPWA program limits.

Chart 2.3. Ryan White and HOPWA Program Eligibility for Individuals

	Ryan White Program	**HOPWA Program**
Income limit	**300% of Federal Poverty Level**	**400% of Federal Poverty Level**
Income limit in dollars for one person, 2013	$34,470	$45,960
Percent of program FPL limit received by an SSI recipient with the SSI maximum grant	30.5%	22.9%

Beyond those requirements, different programs may have additional different requirements specific to their focus. For example, PI requires a one-year-long residency in a leased apartment prior to enrollment in or to be eligible for the PI program and receipt of the PI rental subsidy. EHA requires written documentation of a threatened eviction in order to provide a payment of late rent to the landlord to prevent an eviction. And, as noted above, S+C serves individuals who are homeless.

Chart 2.4 displays eligible and current uses of HOPWA funding as well as Ryan White housing and other service programs currently funded and not currently funded in Alameda County.

2.5 HOPWA

As the largest city in the federally-designated metropolitan area that includes both Alameda and Contra Costa Counties, the City of Oakland serves as the local HOPWA grantee and contracts with the Alameda County Housing and Community Development Department for HOPWA administration in Alameda County. The Oakland Eligible Metropolitan Area (EMA) has received a HOPWA formula allocation since 1992. These funds are allocated between Alameda County and Contra Costa County proportionally based on the percentage of AIDS cases reported in the two counties; this averages out to approximately 25 percent for Contra Costa County and 75 percent for Alameda County. In Alameda County, HCD routinely solicits proposals for designated uses of HOPWA funds through a competitive Request for Proposals (RFP) process. Interested housing developers and housing service providing agencies apply to HCD for HOPWA funds through this process. Since the introduction of this funding into the county, HCD has used HOPWA to fund permanent housing with services and a variety of support service programs such as case management and mental health and substance abuse services. From 2008-2012, the five-year period, for which the most recent data are available, HCD allocated annually an average of 54 percent of the total funds available, after administrative costs and some technical assistance reserves, to development of new permanent housing units and 46 percent to services for PLWHA.

The HIV/AIDS housing system last developed a comprehensive HIV/AIDS housing plan in 1996 with the *Alameda County Multi-Year HIV/AIDS Housing Plan*, and completed an update to that plan in 1998. As a part of its implementation, Alameda County developed two new programs, Project Independence (PI) and Eden I & R's AIDS Housing and Information Project (AHIP). AHIP has been funded since then through the county's HOPWA allocation; PI was supported under a federal HOPWA competitive grant program from 1996 to 2012 and is now funded with HOPWA Permanent Supportive Housing dollars. Descriptions of the PI program and AHIP appear on pages 33 and 35 below.

- HCD has been awarded multiple three-year renewals of a HOPWA Special Project of National Significance (SPNS) grant for PI to provides partial or shallow rent subsidies,

support service coordination and accessibility improvements to PLWHA who are at risk of homelessness. For FY 2013-2014, the PI budget totals $543,396.

- HOPWA began funding AHIP in 1997. AHIP is a project of Eden I & R and provides services that include an attended phone line to provide housing search and other information to service providers and consumers, distribution of housing information to an e-list of service providers and others, and push-out to bring housing access information into shelters and other environments.

HCD also administers the HUD-, but not HOPWA-, grant-funded S+C program which includes a set-aside service for PLWHA. S+C is designed to provide housing and supportive services on a long-term basis for homeless people. To be eligible, an individual must also have a diagnosis of HIV/AIDS and/or disabling serious mental illness and/or chronic alcohol or drug addiction.[15] See the S+ C program description on page 36 for more information.

In Alameda County, HCD uses HOPWA formula funds for the development of transitional and permanent housing, as well as related services. Some of this development is for supportive housing where services are flexible and primarily focused to maintain housing stability. This approach is also referred to as the Housing First model which provides housing upfront and offers help for illnesses and addictions. This concept is different from the traditional model which typically stipulates requirements such as sobriety before a person receives housing. By 2014, HOPWA had provided funding for the development of 201 units of permanent housing since 1992. (See Appendix 5 for a list of these HOPWA units throughout the county.) At present, HOPWA has several multi-year service contracts funding temporary/transitional housing at Crossroads/EOCP with approximately $900,000, permanent housing at Walker House/Yvette A. Flunder Foundation with $447,958 and the Alameda Point Collaborative with $311,585, and housing referral services at AHIP/Eden Information & Referral with $350,009. See Chart 2.4 on page 34 for details on current HOPWA and Ryan White Program Care Act programs funded in Alameda County.

[15] HOPWA guidance is provided by the *Title 24: Housing and Urban Development. Code of Federal Regulations (CFR) Part 574: Housing Opportunities for Persons With AIDS*, initially published in December 1992. These regulations provide information regarding the HOPWA program, including formula entitlements, competitive grants, use of grant funds, grantee and sponsor responsibilities, grant administration, and other federal requirements.

Project Independence

Partial or shallow rent subsidy programs are often operated as tenant-based rental assistance, like the Housing Choice Voucher Program, or Section 8, but with a critical difference.[1] Tenants with Section 8 pay a fixed 30 percent of their income for housing costs, with the Section 8 program making up the difference between that amount and the actual rental cost. Section 8 programs do not provide or coordinate any support services. Partial rent subsidy programs pay a fixed dollar amount per month to help augment what the tenant can pay. Alameda County has operated Project Independence, a partial rent subsidy program for PLWHA since 1996.

Project Independence, which provides partial rent subsidies, support service coordination, and accessibility improvements to people living with HIV/AIDS who are at risk of homelessness, was recommended in the 1996 *Alameda County Multi-Year AIDS Housing Plan*. The program's funding, from the U. S. Department of Housing and Urban Development's (HUD) Housing Opportunities for Persons with AIDS (HOPWA) Special Projects of National Significance (SPNS) program, has subsequently been renewed four times in 1999, 2002, 2005, and 2009, each time for a three-year period. Alameda County's Project Independence program is now funded under the HOPWA Permanent Supportive Housing funding stream.

The goal of Project Independence is to prevent homelessness and increase housing stability. The Alameda County Department of Housing and Community Development serves as the Grantee/Lead Agency. Three community-based organizations – the AIDS Project of the East Bay, Tri-City Health Center and the Yvette A. Flunder Foundation (formerly known as the Ark of Refuge) – function as the "Hub" agencies that serve clients. These agencies conduct outreach and determine client eligibility, coordinate housing inspections and accessibility assessments and modifications, and provide shallow rent subsidies as well as service coordination and refer clients to services needed to maintain independent, permanent housing.

Eligible clients are adults diagnosed with HIV or AIDS who meet the HUD Very Low Income (no more than 50% of Area Median Income or AMI) requirement and have a lease on an apartment or house in Alameda County that meets HUD rent and habitability standards. Priority is given to households with extremely low-incomes (no more than 30% of AMI). Clients may not receive any other ongoing government housing subsidy, and they must be willing to participate in services as needed for independent living.

Monthly rent subsidies, ranging from $184 to $446 depending on income, household size and unit size, are intended to stabilize participants' housing situations. These subsidies are for use in permanent housing, and there is no time limit for participation. For FY 2013-2014, Project Independence anticipates providing an average of $341 per month in rental assistance to approximately 120 households.

Two evaluations of Project Independence, the first in 2002 and a second in 2006, document its support for residents and their families and "attest to its success in meeting its objective of helping low income HIV+ individuals and their families maintain housing stability."[2]

[1] See the U.S. Department of Housing and Urban Development website for information on the Housing Choice Voucher Program: http://portal.hud.gov/hudportal/HUD?src=/topics/housing_choice_voucher_program_section_8.
[2] United States Interagency Council on Homelessness, http://usich.gov/usich_resources/solutions/explore/project_independence Accessed January 7, 2014.

Chart 2.4. HOPWA Entitlement Grant and CARE Act Housing Programs and Other Services Currently Funded and Not Funded in Alameda County*

	Clinical Care and Support Services	Housing Assistance			Housing Development	Other Housing-Related Activities
		Housing Referral Services	Short-term or Emergency Housing Assistance	Long-term Housing Assistance		
Eligible uses of HOPWA entitlement grant funds	*Primary medical care, mental health treatment, and others; support services enhancing access to care, including case management, meals/nutritional support, transportation; early intervention services to link HIV+ people into care. The priority use for HOPWA funds should be housing and housing related services.*	*Assessment, search, placement, and advocacy services*	*Emergency Housing Assistance (hotel vouchers, eviction prevention, short-term rental assistance); emergency shelter stays, short-term residential treatment, temporary assisted living, master*	*Permanent, independent, and supportive housing; long-term assisted living; master leasing; long-term tenant-based rental assistance (1)*	*Acquisition, rehabilitation, new construction*	*Technical assistance and resource identification*
HOPWA, currently funded by entitlement grant funds in Alameda County		**AHIP/Eden I&R**	Temporary / transitional housing : **Crossroads/East Oakland Community Project**	Permanent housing: **Walker House/YAFF** **Alameda Point Collaborative**	Acquisition, rehabilitation, new construction: **Various projects**	
Ryan White CARE Act programs currently funded in Alameda County	Primary medical care, substance abuse treatment, mental health treatment, and others; support services enhancing access to care, including case management, meals/nutritional support, transportation; early intervention services to link HIV+ people into care		Emergency Housing Assistance (hotel vouchers, eviction prevention, moving costs, first- and last-month's rent, security deposit, and other short-term rental assistance) currently at	Not Allowed	Not Allowed	Not Allowed
Ryan White CARE Act options not currently funded in Alameda County		Assessment, search, placement, and advocacy services	Emergency shelter stays, short-term residential treatment, temporary assisted living			

*From U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau (2001). Housing Is Health Care -- Implementation of the HAB [HIV/AIDS Bureau] Policy, p22. Both HOPWA and Ryan White CARE Act formula and competitive funds support programs in Alameda County. Project Independence, a separate HOPWA grant only for long-term housing assistance, is not funded under the HOPWA entitlement grant and not included in this chart.

AHIP

Established in 1997 with HOPWA funding, Eden I&R's AIDS Housing and Information Program (AHIP) provides intensive, one-on-one client services to PLWHA in Alameda County seeking housing and other resources. The AHIP Coordinator works with clients both over the phone and in person.

AHIP maintains a centralized database of permanent AIDS-dedicated housing, transitional housing beds, housing subsidies, and other market rate and below market rate housing, as well as social and health-related services for PLWHA and their families. AHIP offers this information to reduce the burden on PLWHA to call multiple agencies, housing developers, and service providers located throughout Alameda County. Clients receive current information on subsidized housing waiting lists from Eden I&R's housing and resource database, shelter bed availability, and eligibility requirements (i.e., income, health status, etc.) for services from different healthcare providers and social service agencies.

The AHIP phone line is open Monday through Friday, 9:00 A.M. to 4:00 P.M.. Information on AHIP services is distributed at AIDS Service Organizations (ASOs) sites, the monthly Alameda County HIV Case Management meetings and community workshops in the form of public announcements, flyers and brochures.

The AHIP Coordinator also distributes housing applications to clients when visiting multiple ASOs, such as the East Oakland Community Project, Highland Hospital Adult Immunology Clinic, AIDS Project of the East Bay (APEB) and Women Organized to Respond to Life-Threatening Diseases (WORLD), at least one time each month. The AHIP Coordinator partners with onsite case managers and peer advocates to alert clients to AHIP scheduled visits and schedule clients to meet with the AHIP Coordinator.

In FY 2012-2013, AHIP provided:

- 2,205 subsidized and market rate housing referrals and 576 referrals to various other services, in response to more than 1,119 phone calls, from 639 PLWHA and their family members
- Roving Housing Assistance to 411 PLWHA through monthly visits to four to six AIDS Service Organizations throughout the county
- Monthly "Available Housing Updates" to 14 AIDS service organizations through Eden I&R's monthly Housing Subscription
- One housing-related training to nine Service Providers

Shelter Plus Care

Shelter Plus Care (S+C) is a program designed to provide housing and supportive services on a long-term basis for homeless persons and their families who previously resided in places not intended for human habitation, in emergency shelters or in transitional housing, if they were on the streets or in an emergency shelter the night before they entered transitional housing. Eligibility criteria also require a diagnosis of a disabling serious mental illness, and/or HIV and related disorders, and/or chronic alcohol or drug addiction.

The program allows for a variety of housing choices, and a range of supportive services funded by other sources, in response to the needs of the hard-to-reach homeless population with disabilities. S+C participants receive support services through a network of local service agencies.

Program grants are used for the provision of rental assistance payments through four components:

- **Sponsor-based Rental Assistance (SRA):** Specific units, ranging from single room occupancy to three bedrooms, scattered throughout Alameda County.
- **Project-based Rental Assistance (PRA):** Specific two, three and four bedroom units located at Alameda Point and Lorenzo Creek Apts.
- **Single-Room Occupancy (SRO):** Specific one-room units located at the Harrison Apartments in Oakland.
- **Tenant-based Rental Assistance (TRA):** A certificate provided to an S+C participant by a contracted Public Housing Authority. A TRA holder, with the help of their service coordinator, is responsible for locating housing in Alameda County with an owner willing to accept S+C as a subsidy.

There are two agencies in Alameda County that administer S+C Programs:

- **The Alameda County Housing and Community Development Department (HCD) in partnership with the Oakland, Alameda City, and Alameda County Housing Authorities**
- **The City of Berkeley Housing Department. (The Berkeley Housing Authority is not involved with the S+C Program.)**

Specific S+C grants may have additional or more restrictive requirements to qualify, such as being chronically homeless or having a specific one of the qualifying disabilities. In general, applicants must meet all of the following criteria:

- **The applicant must be able to document that they are disabled due to a severe mental illness, chronic drug or alcohol dependence, or HIV/AIDS.**
- **The applicant must be receiving services at an S+C designated agency, and homeless according to one of the following definitions:**
    - Residing in an emergency shelter;
    - Sleeping on the streets or in a vehicle or some other public place; or
    - Currently residing in transitional housing following a stay in a shelter or on the streets prior to entering the transitional housing program.
- **The applicant must be low income according to HUD guidelines (no more than 50% of Area Median Income or AMI which is currently $31,250 per year for a single adult).**
- **The applicant must be willing to participate in case management services, and able to live safely in their own apartment.**

Services provided by S+C Service Coordination Agencies include:

* Assistance submitting applications and locating housing	* Job training	* In-home support services
* Traditional/non-traditional mental health services	* Transportation assistance	
* Alcohol/drug treatment and recovery housing search	* Financial management	* Independent living skills

Currently, the HCD S+C program has more than 500 housing units or approximately 5.1 million dollars for housing units available countywide. A minimum of 69 units are allocated for PLWHA. With permission to over-lease with available funds, HCD S+C program currently subsidizes more than 500 households at any one time. HCD has a sub-contract with the City of Berkeley so that the City of Berkeley S+C Program administers 15 of the 69 units allocated for PLWHA. For FY 2012-2013, the City of Berkeley S+C Program has approximately 212 housing units or 3.1 million dollars for S+C housing units available in Berkeley. With permission to over-lease with available funds, the City of Berkeley S+C program subsidizes a total of approximately 250 households at any one time.

2.6 Ryan White Comprehensive AIDS Resources Emergency (CARE) Act and the Minority AIDS Initiative

The Ryan White CARE Act supports services in order to reduce utilization of more costly inpatient care, increase access to care for underserved populations, and improve the quality of life of those affected by the epidemic.

Alameda County administers Ryan White CARE Part A and Part B funds through the OAA. Federal guidelines require that the local use of CARE Act Part A funds be guided by a Ryan White planning council comprised of consumers, providers, and advocates. In Alameda County, the Collaborative Community Planning Council (CCPC) serves as the planning council body that determines service category priorities and funding allocations for CARE Act Part A and MAI funding. The OAA funds the operation of the CCPC and administers the CARE Act funding,

The OAA provides leadership, resources, and guidance in coordinating and facilitating the delivery of HIV health and prevention Ryan White Program and MAI services throughout Alameda County, and works closely with the CCPC and community partners to achieve local HIV public health goals. The OAA is required to complete regular needs assessments, the most recent of which was conducted in 2013, to determine the current needs of the community, and the Ryan White planning council must set priorities and allocate resources based on the needs assessment and Ryan White guidelines (Facente Consulting 2013).

The CCPC is charged with determining how to allocate Ryan White Part A and MAI funds in Alameda County according to the needs illustrated by local epidemiological surveillance data and regular needs assessments. Using this information the CCPC determines which Ryan White Services Categories should be funded and how to distribute the available funds amongst the Service Categories. For the MAI funds, the CCPC also determines the local priority population. The OAA then solicits competitive bids from potential contractors to provide services to meet the needs identified by the CCPC.

In late 1998, the Alameda County Board of Supervisors unanimously passed a resolution declaring a State of Emergency due to the prevalence of HIV/AIDS in the African American community. It was the first local government in the United States to declare a regional disaster because of HIV. The declaration was aimed to draw attention to the seriousness of the issue and to help develop new resources to address the situation (California Healthline 1998). Recently, for the MAI

component of its Part A funding, Alameda County released a FY 2013-14 Request for Proposals to enhance available HIV-related health and support services for Young Men of Color Who Have Sex with Men (YMSM) and Women of Color in Alameda County.

OAA housing service categories allowed by HRSA include:

- Emergency Housing Assistance (EHA) that provides tenant-based rental assistance to prevent eviction, first- and last-month rental or security deposit assistance to promote move-in, and help with moving expenses. For FY 2012-2013, the OAA reports that 192 unduplicated clients received Ryan White Part A- and MAI-funded emergency housing assistance services (Waltrip 2014).
- Transitional or short-term housing with a tenancy no longer than two years; not currently funded by the OAA.
- Housing Referral Services that include assessment and housing search, placement and advocacy services; not currently funded by the OAA.

The OAA has developed Standards of Care for EHA, Housing Referral Services and Short-Term Housing Assistance to describe a required level of service delivery standards for each funded service category and the quality of service delivery expected to enhance the lives of PLWHA.

For FY 2012-2013, Alameda County had available $4,167,229 of Part A funds, $358,763 of MAI funds and $1,156,823 of Part B funds to provide care and treatment and support services for PLWHA. HOPWA funds may be used for a range of housing activities, including permanent housing. In 1999, HRSA clarified that Ryan White funds could be used for housing referral services, and short-term or emergency housing that is necessary to gaining access to medical care, but not permanent rental or ownership housing. In 2005, HRSA introduced a new Ryan White program requirement stipulating that at least 75 percent of client service funding must be spent on core medical care and treatment services, which included medical case management, mental health and substance abuse services, and no more than 25 percent on support services which include EHA, Housing Referral Services and Short-term Housing (Ryan White HIV/AIDS Treatment Modernization Act of 2006 2006). Housing, one of the support services, receives an allocation less than 5 percent of the total funds available.[16]

[16] See also Housing is Health Care: A Guide to Implementing the HIV/AIDS Bureau Ryan White CARE Act Housing Policy, funded by the U.S. Department of Health and Human Services Health Resources and

Chart 2.5 notes how much of these funds were allocated to the relevant service categories for FY 2013-12 and FY 2013-14. Because the prevalence of mental health problems, alcohol dependence and drug abuse among low-income Alameda County PLWHA in primary care is widespread and significant in its association with homelessness and housing instability, amounts allocated for those services are included.

Chart 2.5. Ryan White CARE Act Funding for Emergency Housing Assistance, Mental Health Services, and Substance Abuse Services, FY 2012-13 and FY 2013-14

	Part A Allocation ($)	Part B Allocation ($)
FY 2012-2013*		
Emergency Housing Assistance	195,573	30,000
Mental health services	497,627	48,121
Substance abuse treatment services	289,754	0
FY 2013-2014**		
Emergency Housing Assistance	124,682	5,796
Mental health services	404,328	27,505
Substance abuse treatment services	241,210	0

*Funds expended by end of fiscal year

**Funds allocated at beginning of fiscal year. Due to the State Office of AIDS change of the term of its fiscal year for the future, FY 2013-2014 Part B allocation was shortened to 9 months.

2.7 Major Changes Guiding Alameda County's HIV/AIDS Housing and Service System Today

Several changes at the national and state level influence the current context for HIV/AIDS housing and services in Alameda County.

Changes in the allowed uses of HOPWA and Ryan White Program funds**.** With its current HRSA application for Ryan White funds for FY 2014-2015, the OAA has requested a waiver to the "75/25 percent" regulation described above. If granted, more support services, including housing, could be locally funded.

Services Administration, HIV/AIDS Bureau, which provides the most comprehensive overview available of the overlapping and different housing services funded by HOPWA and the Ryan White CARE Act (U.S. Department of Health and Human Services Health Resources and Services Administration HIV/AIDS Bureau 2001).

2011 State of California elimination of more than 400 redevelopment agencies statewide**.** As of 2012, most of the property taxes that provided funding to redevelopment agencies was channeled to the state, counties and school districts for other purposes. Additionally, state bond funds that had served to fund affordable housing are virtually depleted (Stivers 2014). Such funding is no longer available to support the development of new affordable housing units which could be occupied by PLWHA and others. Also, the state no longer permits cities and counties to require housing developers to practice "inclusionary zoning" housing by providing a set proportion of affordable rental units for low- and moderate-income people (Said, Governor vetoes bill on affordable housing rental 2013).

Integration of planning efforts. In recognition of the similarity in issues and programs between various federal programs, including HOPWA, Consolidated Plans, Continuum of Care, and Ryan White, the *National HIV/AIDS Strategy* has placed a renewed emphasis on integrating local planning efforts.

The 1996 *Alameda County Multi-Year HIV/AIDS Housing Plan* was a success in terms of reorienting and increasing AIDS housing resources. The Sponsoring Agencies for the 2006 *Alameda Countywide Homeless and Special Needs Housing Plan* included Alameda County Behavioral Health Care Services, Housing and Community Development Department, Public Health Department Office of AIDS Administration, and Social Services Agency, Alameda Countywide Homeless Continuum of Care Council, City of Berkeley Health and Human Services Department, City of Berkeley Housing Department, City of Oakland Community and Economic Development Agency, and City of Oakland Department of Human Services (AIDS Housing of Washington 2006). However, some of the systems change that the 2006 Plan contemplated for cross-departmental cooperation between related branches of local government has not yet been achieved, especially the coordination of housing resources. Housing funding continues to be handled separately in both OAA and HCD, though progress has been made in sharing information, developing common monitoring protocols and implementing a three-year Memorandum of Understanding to re-orient HOPWA funding for housing operations and Ryan White CARE Act funding for medical care and treatment services.

In addition, the HIV/AIDS housing and service system in Alameda County, like other communities in the country, faces a growing population with stable or declining resources. Since

the introduction of anti-retroviral medications in 1996, PLWHA are living longer and healthier lives. As new infections continue, though, lengthening life spans mean there are greater numbers of PLWHA than ever before. Other complicating factors affecting PLWHA locally as well as nationally include the co-occurrence of problems associated with alcohol and other drug use and mental illness, the increase of middle-age and geriatric medical conditions, and continued stigma as well as racism, sexism and poverty. Even among PLWHA who successfully manage their HIV through medication regimens and treatment adherence, medical conditions and medication side-effects may make full engagement in the labor force impossible and hence severely limit income.

The HOPWA housing system and the Ryan White care and treatment system have evolved over time in response to the issues, regulations, and resources available to address their primary issue. During the AHNA, distinctions between these two different systems were evident when estimating the size of the homeless and unstably housed populations involved and the housing-related resources available to them. In trying to answer the question *who is homeless?*, each system tracks housing and homeless status differently. The homeless services system maintains two different homeless definitions, one of which, "chronic" homelessness among single adults, has been defined very specifically by HUD. The HIV/AIDS health systems, on the other hand, usually only record housing status/homelessness information once—at the first service contact of the year, or if it comes up as a service-related issue during the year—and base it on a working, rather than technical, definition of homelessness. Therefore information between the systems is neither directly comparable nor uniformly available.

These differences extend to housing and services activities as well. For example, HOPWA funds "permanent housing," based on a definition established by HUD's Office of HIV/AIDS Housing, while the Ryan White program funds "short-term housing" using the definition established by the HIV/AIDS Bureau of the Health Resources and Services Administration (HRSA).

While these housing programs are similar in intent and function—and in some cases HOPWA and Ryan White fund the same providers—the goals and objectives of these programs are not the same. As a result, even within a single system, programs are using different concepts, names and regulations for similar activities. This is just one among many gaps and inconsistencies between systems that confuse consumers and make systemic collaboration the exception, at this point, rather than the rule.

Addressing and overcoming these kinds of administrative challenges that have consequences for homeless and unstably housed PLWHA seeking stable housing would indubitably streamline their efforts and increase their odds of success.

2.8 Summary

In this chapter, we have reviewed select demographic data for the overall Alameda County population and comprehensive HIV/AIDS epidemiological data on the local level to shed light on the diversity of our community and the extent of its HIV/AIDS epidemic. There has been discussion of the major co-occurring diagnoses of substance use/abuse and mental illness and their intersection with homelessness among PLWHA. Finally, we provided overviews of the major government-funded housing and related service programs for PLWHA in Alameda County that serve the people described above.

In subsequent chapters, we will hear the voices of PLWHA in Alameda County – many of whom are engaged in primary care at community HIV medical practices and others who participated in various AHNA focus groups. And we will also learn from the contributions of affordable housing developers and property managers as well as staff who provide housing assistance and other HIV services who participated in AHNA focus groups and surveys.

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Chapter 3: Original Data Collection – Needs Assessment Design and Methods

3.1 Introduction

In order to comprehend the extent of need for housing and related services among low-income PLWHA residing in Alameda County we turned to a variety of data sources, both original (or primary) data and existing (or secondary) data. Secondary data include existing literature (see the discussion in Chapter 1 and Appendix 3), including numerous recent AIDS housing needs assessments and/or plans from other jurisdictions (see Appendix 16), budget data, number and characteristics of Ryan White CARE Act clients, Public Health Department AIDS epidemiological information (see especially Chapter 2), and a variety of Alameda County housing cost, income, and poverty rate data. This chapter provides an overview of the methods used to design and implement original data collection for the AHNA.

We engaged in six kinds of original data collection activities as noted below (additional details appear in Chapters 4, 5, and 6). The *n* = usage indicates the number of consumers, service providers, patients, or housing developers/property managers involved in that activity.

1. One focus group with housing and other service providers (n=10)
2. An on-line survey of housing and other service providers (n=95)
3. Three focus groups with clients/consumers: one with men and women conducted in English (n=9); one with women conducted in English (n=10), and one with men and women conducted in Spanish (n=9).
4. A survey of low-income PLWHA in primary care (n=210) designed to generalize to 2,631 low-income Alameda County PLWHA in primary care.
5. One focus group with housing developers and property managers (n=15 individuals representing 9 agencies) and an associated survey (n=6 of the agencies)
6. Interviews and/or other communications with key informants (n = 14, plus numerous informal conversations with site managers and other clinic staff)

3.2 Housing and Other Service Provider Focus Group

Construction and goal of the first focus group. The housing and other service provider focus group included 10 service providers suggested by AHNA and HCD staff and Work Group members. The ten individuals work at a variety of HIV/AIDS and other programs spread across the county and serve a population diverse in terms of gender, race, ethnicity, language, and sexual orientation (see Chart 4.1 for participant names and affiliations). Despite working with such a diverse population of clients the focus group was not intended necessarily to be *representative* of a broader community of service providers. That function was left to the on-line survey of service providers. Instead, this focus group provided the AHNA with its first opportunity to listen to the concerns of key players who provide services to PLWHA in Alameda County.

Recruitment of participants. AHNA and HCD staff and Work Group members identified 20 individuals to invite to participate in this 2-hour-long focus group for HIV housing and other HIV service providers. AHNA extended invitations by email and selected a date and time that worked best for the largest number of interested individuals.

Focus group guide. Focus group questions asked about homelessness and unstable housing among clients, personal and system barriers preventing clients from entering into and remaining in stable housing, and resources available to attend to clients' needs (see Appendix 15). The focus group also addressed strategies for program improvement. Finally, focus group participants discussed the questions they would like to see posed in an on-line survey of service providers and to clients in focus groups or as part of the patient survey.

Amenities. Beverages and snacks were provided for participants.

Confidentiality. AHNA staff indicated that our perspective was to acknowledge the names of individuals participating in this focus group but not to attribute statements to specific individuals. Given the relatively large number of people present in the focus group we felt that we could not provide assurance that anything said would not be repeated by others in the room, unless the group agreed to its own rule of confidentiality. The group did come to such an agreement.

Preparation. Individuals invited to the group were told by email that during the focus group we would ask participants to comment on questions such as the following concerning the situation in Alameda County:

1. What is the estimated percent of your PLWHA clients who are homeless, in unstable housing situations, or in need of better housing?
2. What barriers prevent clients from making progress toward entering and remaining in stable housing?
    a. Are there particular services needed to make stable housing possible (or likely)?
    b. What resources are available for attending to the needs of persons who, in their current housing situation, are at risk of housing instability or homelessness because of substance abuse relapse or other factors?
    c. What is needed to help clients avoid dropping out of primary care?
3. New medications continue to change survival rates of PLWHA. What have the implications been in terms of the demographics of your clients and in their housing and services needs?
4. Which current programs are most successful, somewhat successful, or not helpful in assisting PLWHA in Alameda County in getting into and remaining in appropriate housing?
5. How could current programs be improved?
6. What new programs need to be created and/or implemented in Alameda County?

Data record and analysis. AHNA staff took transcript-like notes during the focus group, recording as close to actual words used as possible. Following the meeting the notes were transcribed into a Word document that could be reviewed by staff. R. Speiglman, Mosmiller, and Brooks examined the transcript in order to construct guides for subsequent focus groups and AHNA survey instruments for other data collection activities. At time of analysis, the transcript was used once again to identify major themes that emerged.

Statistical inference. We do not infer any perspectives to a larger group of service providers based on this focus group.

Findings. Findings are summarized in Chapter 4.

3.3 PLWHA Client/Consumer Focus Groups

Focus group guides. The first guide, for the focus group of men and women conducted in English, was constructed based on information provided at the housing and service provider focus group and was supplemented by questions posed by members of the Work Group. Slight edits were made to the guide following each of the first two sessions, both to follow-up on points made in the previous focus group and in recognition of the distinctive demographic characteristics of the next group(s). The questions are reproduced in Appendix 15. The three consumer focus groups were designed to yield an overview of consumer areas of concern, secure contextual material for interpreting consumer survey responses, and develop an initial list of recommendations to address policy and system issues. These three focus groups also guided us in specifying questions for the consumer survey.

Development of Spanish language focus group guide. Following AHNA's revision of the guide in English for the Spanish language focus group, a bilingual, bicultural specialist knowledgeable about HIV/AIDS and Alameda County developed the Spanish version in consultation with AHNA staff for accuracy of meaning.

Focus group guide. Focus group questions asked about kind of current residence, number of and reasons for moves in the last three years, experiences of and reasons for homelessness, and sources of assistance in finding housing. We also asked whether particular demographic and other characteristics helped or hurt in securing good housing situations; how current residence affects daily life, including ability to keep up with treatment and treatment appointments; receipt of housing subsidies and emergency housing assistance; help from case managers and others to remain housed; and presence on housing wait lists. We asked which subsidy and HIV/AIDS housing programs participants knew about and which had aided their being housed, what kind of housing is preferred, and experiences of discrimination.

Participant incentives; amenities. Following completion of each consumer focus group, participants were provided $25 cash to pay for transportation or other costs of participation. Beverages and snacks were provided for participants.

Recruitment of participants. Work Group members and other service provider colleagues helped identify and invite PLWHA to participate in two-hour consumer or client focus groups.

Participant confidentiality and consent. Participants were not asked to sign an informed consent document in part because, for reasons of confidentiality, we did not wish to retain a record of participants' identities. AHNA staff stressed that we would not use anybody's name in the project report, or anywhere. As with the housing and service provider focus group, each consumer focus group agreed to keep the conversation confidential. At the same time AHNA staff reminded participants not to say anything that could cause trouble for them.

Data record and analysis. AHNA staff took transcript-like notes during each focus group, recording as close to actual words used as possible. Following the meeting the notes were transcribed into a Word document that could be reviewed by staff. In the case of the Spanish-language focus group, the transcript was prepared in Spanish and then translated into English. R. Speiglman, Mosmiller, and Brooks examined the transcripts in order to construct subsequent focus group guides and AHNA survey instruments for later data collection activities. At time of analysis, the transcript was used once again to identify major themes that emerged.

Statistical inference. We do not infer any perspectives to a larger group of consumers based on these three focus groups. At the same time, AHNA staff took particular note and prepared a cross-tabular analysis of similar comments that emerged from more than one consumer focus group.

Findings. Findings are summarized in Chapter 4.

3.4 Housing Developer/Property Manager Focus Group

Construction of focus group guide and survey instruments. This focus group was the final data collection activity of the AHNA. As a result questions were the product of both a developing picture of the housing challenges of low-income PLWHA in the county as well as new inquiries about the efforts of housing developers and property managers and the challenges they faced. In part because AHNA staff members were not conversant enough in matters of development to efficiently facilitate the group, this focus group was co-facilitated by the Deputy Director of HCD and the first author of this report. In light of the many questions that we wished to pose but the limited time available for the group, we supplemented oral questions with those that could relatively easily be answered in a short survey instrument to be completed by participants following the focus group.

Focus group topics ranged from inquiries about the demand for AIDS housing and referral processes to the assessment of new residents and development of service plans, reasons for denying housing to applicants, degree of residential stability among residents, financing HOPWA unit operations, property management, implications for building and program, and changes desired in the HOPWA program.

Survey questions addressed screening applicants for housing, written and unwritten policies on several topics, turnover, wait lists, staffing, and operating costs.

Appendix 9 displays both the questions used to guide the focus group and the survey distributed at the conclusion of the Focus Group.

Recruitment of participants. A representative from each of the largest HOPWA housing developers in Alameda County and from one housing policy organization was invited to participate in the two-hour focus group by the HCD Deputy Director and asked, when appropriate, to have a property manager working with residents accompany them. Since in several cases AHNA staff were not known to the developers (and vice-versa) HCD's Deputy Director initiated the invitation process by sending emails to invitees. AHNA and HCD staff followed-up to encourage a substantial participation rate. Ten of the eleven organizations invited to participate did so. One or more staff persons representing agencies responsible for the development of 89 percent of current HOPWA units participated in the focus group. Hence the focus group comments are taken to reflect experiences and perspectives of virtually all of the housing providers who have HOPWA units in Alameda County.

Amenities. As this session took place at the beginning of the work day, beverages and breakfast were provided for participants.

Participant confidentiality. No confidentiality was suggested, but participants were encouraged as necessary to speak "off the record" and told that, since their HOPWA funder was present, their remarks would not have administrative repercussions.

Data record and analysis. AHNA staff took transcript-like notes during this focus group, recording as close to actual words used as possible. Following the meeting the notes were transcribed into a Word document that could be reviewed by staff. R. Speiglman and Mosmiller

examined the transcript for accuracy. At time of analysis, the transcript was used once again to identify major themes that emerged.

Statistical inference. We do not use statistical techniques to project the perspectives shared to a larger group of developers or property managers based on this focus group. At the same time, since developers and property managers associated with the vast majority of HOPWA units participated in the focus group findings take on a certain degree of meaning beyond individual statements from individual participants.

Findings. Findings are summarized in Chapter 4.

3.5 On-Line Survey of Housing and Other Service Providers

Construction of survey instrument. The on-line survey instrument was the product of a lengthy list of questions of interest to the AHNA which were vetted by the Work Group and further limited to fit into a reasonable length of time for self-administration on-line. The instrument is summarized in Chapter 5 and reproduced in Appendix 7. The survey of HIV/AIDS housing and service administrative and line staff was designed to identify staff areas of system concern and secure recommendations to address system challenges and programmatic/system changes. These data were expected to be of value themselves but also to prove helpful in developing questions for the patient survey.

Recruitment of participants. Respondents were a convenience sample of service providers working in a wide range of services and at many different agencies. With the assistance of Work Group members, AHIP, several other individuals active in HIV services, and a review of HIV services directories, AHNA staff identified 197 individuals to invite by email to participate in the on-line survey. AHNA staff followed-up to promote a substantial participation rate. Chapter 5 provides additional details about follow-up and reports that 95 individuals, representing 37 agencies provided enough information to be considered survey participants.

Incentive. The names of individuals completing the survey were entered into a raffle for one of three gift vouchers valued at $75 at a restaurant of the winner's choice.

Participant confidentiality. Survey instructions included the information that all responses would be kept confidential.

Data record and analysis. The on-line survey software produced an Excel spreadsheet that we imported into SPSS software for analysis.

Statistical inference. The 95 participants collectively report almost 1,000 years of employment in the HIV/AIDS field. That figure leads us to take quite seriously the analytical findings from this survey. Nevertheless, we neither sought to determine how many individuals are in the *universe* of service providers to whom findings might generalize nor to ascertain in what ways participants in the on-line survey resemble or differ from the larger group. Thus, participants do not necessarily represent in a statistical sense the full group of service providers. Accordingly our findings simply reflect the perspectives of 95 individuals. That said, this is a large and very significant group of survey participants.

Findings. Findings are summarized in Chapter 5.

3.6 Survey of Low-Income Alameda County PLWHA in Primary Care

Population of interest. The population of interest for the AHNA includes all low-income, HIV+, non-institutionalized adult and emancipated youth (that is, persons responsible for their housing) residents of Alameda County.[1] In light of the high prevalence of undiagnosed HIV disease, short of a large-scale survey associated with random HIV testing, there is no way to locate, survey, and collect information on a representative sample of the broad population that includes both those who do and who do not know their HIV status.

Given the resources available to the AHNA, we determined that the most productive approach to locating members of this population to learn about consumer needs and barriers to housing and services would involve surveying English- and Spanish-speaking patients at Ryan White-funded HIV clinics in the county.[2] As described further in Chapter 6, we conducted interviews at nine of the eleven Ryan White-funded primary care clinic sites in the county. We supplemented this

[1] We exclude "institutionalized" individuals since they are not connected to the housing market. Individuals in-hospital or incarcerated for a relatively brief period remain in the population of interest and, depending on what day they are hospitalized or jailed, have an equal opportunity to be recruited for survey.

[2] As noted in Chapter 2 individuals are eligible for Ryan White services if under 300 percent of the Federal Poverty Level. Especially in a locale such as Alameda County with its high cost of living, even persons at 300 percent of the FPL may have difficulty finding affordable housing.

strategy by also surveying patients of a physician who is known to have a private practice with the largest number of HIV+ patients in Alameda County. This approach leaves out four groups of low-income HIV+ adults or emancipated youth residing in Alameda County: 1) those using Ryan White clinics but not speaking English or Spanish, 2) those not in primary care in Alameda County, 3) those who are patients of other private physicians' offices or group practices – including the Kaiser system, and 4) those securing care through the Veterans Administration health system.[3] This survey frame provides access to the majority of known HIV+ adults residing in the county and to an unknown – but larger – percent of *low-income* HIV+ adults in primary care.

Construction of survey instrument. The patient survey was the product of each previous data collection activity. In order to field an instrument that could be completed within about 20 minutes, with input from HCD staff and the Work Group, AHNA staff deleted about one-half of the questions we would have liked to pursue. Chapter 6 describes the contents of the survey instrument, which is reproduced in Appendix 10 (English) and Appendix 11 (Spanish).

Pilot test of the English version of the survey instrument and translation of the English language survey instrument into Spanish. Following testing by AHNA staff and HIV+ friends of staff, the English version of the survey instrument was pilot-tested by five HIV+ individuals recruited at Ryan White-funded clinics. Problem questions were discussed by staff and revised as needed. A bilingual AHNA consultant knowledgeable about HIV/AIDS and the Alameda County translated the instrument into Spanish. The translation was then reviewed by three Spanish-speaking AHNA staff for possible misunderstandings. Several potential problems were discussed with the translator, and the final wording resolved, depending on the outcome of the conversation.

Recruitment of participants. Managers at each clinic or physician office serving as a survey locale (listed in Chart 6.1) agreed to have front-desk staff inform all English- or Spanish-speaking HIV+ patients residing in Alameda County that they were eligible on that day to participate in an AIDS housing survey that offered a $15 food voucher gift card as an incentive.

[3] We investigated possible opportunities to survey out-of-care, low-income PLWHA but did not succeed in identifying such times and places. For example, we expected that there might be numbers of out-of-primary-care PLWHA making use of needle exchange or support group services. But both needle exchange and support group service providers explained that very few of their HIV+ clients were not in primary care.

As the first step in gaining patients' consent to participate, the patient survey recruitment flyer (reproduced in Appendices 10 and 11) was provided to eligible patients by front-desk staff, and/or provided to patients by AHNA interview staff for patients' reading, or read by interview staff to patients. Among other items communicated were the purpose of the AHNA (to help county administrators plan to address the housing needs of PLWHA in Alameda County) and that options were for patients to complete the survey on their own or to have an AHNA staff member read the questions and record their answers. Survey participants were also told that the survey is confidential, that they could stop the survey at any time or skip any questions that made them uncomfortable, and that those who complete the survey would receive a $15 gift card. The survey instrument was then administered as soon as possible to patients who indicated an interest in proceeding with it (virtually all individuals with whom interview staff met). Rarely, a patient had to wait for a few minutes, until an interviewer and a private interview space became available. The instrument cover sheet details the dual process of determining patient eligibility (resides in Alameda County and is either HIV+ not diagnosed with AIDS or HIV+ diagnosed with AIDS) and securing patient consent (see Appendices 10 and 11). We were careful not to record the names of any survey participants. Surveys (n=210) took place between September 3 and October 25, 2013.

Data entry and analysis. AHNA staff created a data entry template using Excel to convert hard copy survey responses into digital format. The template provided checks on valid answer choices and skips as appropriate. A random sample of five percent of survey instruments was double-data-entered to verify data entry accuracy. Accuracy was determined to be virtually 100 percent, necessitating no further examination of the data entry effort. When data entry was completed the Excel spreadsheet was imported into SPSS software for analysis.

Statistical inference. We conducted surveys at the ten sites on from one to eight days per site, departing after we had surveyed our target for each site. Patients who asked to be interviewed – or who wanted to connect a friend with the survey – but were not seeing a clinician on the days we were present, were told that they were not eligible for the survey. This process yielded a random sample of patients at each site. Analysis weights were used to adjust the sample data to represent better the patient population countywide. In this process we weighted the sample to reflect the PLWHA population by patient visit frequency, clinic share of patients in the county-

funded system, number of duplicated clients in OAA clinic reports, patient age, and patient location in the county. Necessary adjustments were made to control for differences in clinic use that might affect the probability of any particular individual being available for survey. The weighting procedures are described in Chapter 6 and Appendix 13. The resulting analysis weights allow us, using the responses from the 210 patients who were surveyed, to produce estimates of demographic, housing, and other characteristics for the population of 2,631 low-income HIV+ patients residing in Alameda County in primary care at the nine county-funded clinics plus one private physician's office.

As noted above Chapter 6 describes the contents of the survey instrument. The chapter also provides additional details about patient recruitment, handling of missing data, and survey findings.

Individuals Not within the Patient Sample Frame. AHNA resources permitted patient survey effort at nine of eleven Ryan White CARE Act-funded clinics. The survey did not extend to two Ryan White-funded clinics with small patient populations – Asian Health Services and Lifelong East Oakland as well as several other clinic sites that serve low-income HIV+ residents of Alameda County, such as Kaiser Oakland, Kaiser Hayward, Santa Rita County Jail, and the Veterans' Administration. Finally, in this regard, we administered the survey at only one private physician's office, albeit the one believed to have the greatest number of HIV+ patients. On the basis of the information that follows, we conclude that our patient sample appears to well-represent the county-wide low-income HIV+ population in primary care.

Kaiser staff informed us that its HIV+ patient panel for Hayward and Fremont is 414 patients, an estimated 70 percent of whom are below the Federal Poverty Level.[1] We have no other information about that patient cohort, including no data on housing instability or homelessness. And we have no information about the Kaiser Oakland patient population.

The VA serves 83 HIV+ Alameda County Veterans, 82 of whom are men. The vast majority are African Americans, followed by Latinos. Most are older than 50.[2] The VA has case managers who help these clients find housing, and there are federal funds to support housing for homeless

[1] Information as of late January 2014

[2] Information provided end of January 2014

veterans (National Coalition for Homeless Veterans). From this limited information we assume that VA patients are somewhat better off in terms of housing than is the patient population which we surveyed.

The patient populations at the two Ryan White clinic settings that we did not survey – Asian Health Services and Lifelong East Oakland – appear, with two exceptions, to have characteristics very much like those among the population we did survey. The exceptions are that Asian Health Services clients are more likely to report that they are Asian or Pacific Islanders and the Lifelong East Oakland clients are disproportionately 50 or older. In both cases, as in our population estimates, men predominate over women, and most patients reside in Oakland.

- Asian Health Services. As of November 2013, Asian Health Services provided primary care medical services to 24 PLWHA (17 Asian or Pacific Islanders, 4 African American, 2 White, 1 Latino/a). Men account for 79 percent of the patients. Fifty-eight percent of the clients are 30-49 years of age, 37 percent are over 50, and 4 percent between 20-29 years. Seventy-nine percent of the AHS patients reside in Oakland.[3] One or two members of this patient population are reported to experience homelessness at any point in time, with several others in unstable housing.

- Lifelong East Oakland. Lifelong Medical Care - East Oakland provides HIV primary care to 28 patients at its clinic at Foothill Square in East Oakland (76% African-American, 7% White, 7% Latino/a). Men account for 61 percent of the patients. Forty-six percent are 50 years of age or older, 36 percent are between 30 and 49 years old, 18 percent are in their 20s. Seventy-one percent are reported to live "in or around" Oakland.[4] Two of the 28 patients are homeless and two are living with others in an unstable living situation.

HIV+ inmates at Santa Rita Jail may, both before they are taken into custody and upon release, make use of Ryan White-funded primary care clinic services. Thus, they are in our sample frame. However, we believe it worth a moment to reflect on particular housing circumstances about this population noted by current and former discharge planning staff at Santa Rita. From

[3] Information provided early January 2014

[4] Information provided early January 2014

the staff members' perspective, when HIV+ inmates receiving HIV treatment at the jail depart the jail, they face substantial challenges both in securing housing and in remaining in the care of a physician.[5] Three subpopulations particularly are noted as having housing problems: certain sex offenders whose residence location is severely limited by state law, re-entry individuals with a gun charge or violent criminal record who most affordable housing programs will not accept, and transgender women.[4]

Because of survey language limitations as well as limited numbers of refuges in the clinic populations, we focus on the situation of HIV+ Burmese refugees, a refugee group in the community for several years. Burmese refugees in many respects resemble the population surveyed at Ryan White clinics, and it is reported that the most of the cohort of 15 HIV+ Burmese refugees served by Community Health for Asian Americans secure primary care at one of the clinics where we conducted the patient survey.[6] Most are men and in the 30-49-year age cohort. The majority reside in Oakland. The prevalence of homelessness and unstable housing situations is substantial. Five of fifteen are homeless or couch surfing. Two others share leases with another family but reside in exceedingly crowded conditions. Five live in subsidized housing. Barriers to housing include inability to pass a credit check and lack of enough monthly income to qualify for a rental (landlords require income of three times the monthly apartment rental cost).

3.7 Communications with Key Informants

Throughout the AHNA – from project design to focus group guide and survey instrument construction, to data analysis; from understanding benefits programs to gaining a working knowledge of housing funding streams; program managers and administrators, policy analysts, advocates, and a variety of stakeholders provided us with valuable information. On occasion we made appointments to sit down for quasi-scripted interviews with individuals to benefit from their knowledge. On other occasions we exchanged emails, asking specific questions, made a

[5] Information provided in December 2013

[4] For information on housing restrictions for sex offenders see (California Sex Offender Management Board, 2011).

[6] Information about the Burmese population was received at the end of January 2014.

phone call to get a question answered, or posed a question to someone who had just chaired a meeting we had observed.

In the end, each key informant helped by providing a *key* to understanding the environment we were studying. Insights from these informants are rarely specifically discussed in the report, but they affect many aspects of the report and our interpretation of findings.

3.8 Limitations

All data collection was cross-sectional; that is, at one point in time. We did not look at change in any one person's status – for example, a patient's housing status – or his or her perspective on a topic. This limits our ability to speak of *causality*. As we discuss further in Chapter 6, for example, we can only speculate that income level or mental health problems may *explain* homelessness or unstable housing status rather than the reverse – that homelessness or unstable housing may explain income level or mental health or that the association may be spurious. Nevertheless, as we will discuss in chapters to come, a variety of *associations* among characteristics and statuses are suggestive for purposes of considering refinement to policies or programs.

Concerning low-income HIV+ patients in Alameda County, the needs assessment did not employ a comparison group, so we cannot, for example, contrast level of need among low-income HIV+ residents of Alameda County against the needs of other low-income residents.

Finally, as we note above, we can speculate about, but do not know, the situation of members of the population of interest who were not in our sample frame. Low-income, HIV+ Kaiser members or veterans receiving services at a VA clinic may have experiences different, for example, from other low-income HIV+ patients who make use of Ryan White clinics.

3.9 Summary and Guide to Next Chapters

The next three chapters display findings from the several kinds of data collected. Chapter 4 reviews findings from service provider, consumer, and property developer and property manager focus groups. Chapter 5 examines results from the on-line survey of housing and other service providers. Chapter 6 considers findings from the patient survey. Those chapters, and this one,

are informed by input from the key informants (n = 14), plus numerous conversations with site managers and other clinic staff.

References

California Sex Offender Management Board. (2011, September). *Homelessness among California's registered sex offenders: An update.* Retrieved from http://www.casomb.org/docs/Residence_Paper_Final.pdf

National Coalition for Homeless Veterans. (n.d.). *Grants*. Retrieved February 24, 2014, from http://nchv.org/index.php/service/service/grants/

Chapter 4: Service Provider, Consumer, and Developer and Property Manager Focus Groups

4.1 Service Provider Focus Group

The first of the five focus groups described in Chapter 3 was with housing and other service providers. Taking place early in the needs assessment process, this focus group was organized for May 14, 2013, at the AIDS Ministry Office of the Allen Temple Baptist Church Family Life Center in Oakland. Ten individuals, representing nine programs, participated in person. One additional individual sent a written communication. Chart 4.1 lists names and affiliations of the participants.

Chart 4.1.
Participants at Housing and Other Service Providers Focus Group

Darice Bridges, Eden I & R - AIDS Housing & Information Project (AHIP)
Rosa Davis, Crossroads / East Oakland Community Project
Liam Galbreth, East Bay Community Law Center
Evelyn Guerrero -Valencia and Gloria Preciado, Tri-City Health Center
Felecia Greenly, Women Organized to Respond to Life Threatening Diseases (WORLD)
Kenny Hall, Yvette A. Flunder Foundation
Yani Hyman, AIDS Project of the East Bay (APEB)
Alex Williams, East Bay AIDS Center (EBAC) Downtown Youth Clinic (DYC); also shared from a written communication from EBAC colleague Monica Espiritu
Tiffany Woods, Tri-City Health Center TransVision Program

Focus group participants discussed clients' personal challenges as well as program and system barriers to housing for PLWHA. Their comments make it evident that a combination of personal and other barriers restrict clients' progress entering into and remaining in stable housing. Chart 4.2 summarizes the opinions voiced at the focus group. Access to housing is limited because of housing prices, insufficient number of rental subsidies, restrictions on individuals lacking required legal residency documents, and inadequate transitional housing arrangements. Additional and more intense services are required to promote residential stability once individuals are housed.

Chart 4.2. Service Provider Perspectives on Housing Barriers

Category: Program and system barrier	Comment or solution
▪ Problems of access to affordable housing ▪ Rental costs always rising ▪ SSI is not enough for a room rental or an SRO, making housing impossible, even to qualify for Project Independence	• Need more housing • In light of the general lack of affordable housing, need for three times the amount of funding for rental assistance • Need senior housing supported by other subsidy programs • Need deposit assistance • There is so much paperwork in applying for housing! That is a barrier in itself.
▪ There are problems finding housing for people without legal residency documents who are not HOPWA-eligible	
▪ Problems with HUD regulations, especially Section 811 (Supportive Housing for Persons with Disabilities) and Section 202 (Supportive Housing for the Elderly)	• [Nothing added, but in the subsequent Developer / Property Manager focus group it was noted that Section 811 will not allow the housing facility to pay for service coordination or case management]
▪ Lack of affordable transitional housing for people waiting for Shelter Plus Care	• Walker and Concord House do not work for PLWHA
▪ Housing stability	• Need utility and other housing subsidy resources • Need more bonded money management representative payee services
▪ Crisis case management services are the norm	• Need comprehensive case management, not crisis case management, with caseload size limits at every agency • Need dedicated housing-specific case management to help people stay housed
▪ Rapid re-housing is good, but after that?	• Aftercare is needed; there has to be a case management piece
▪ Other needed services	• Need more life skill classes • Need support through education
▪ Information and referral	• AHIP has useful resources, but if there is not money for rent, housing cannot be secured • 211 agency volunteers need understanding so they do not frustrate clients
▪ Landlord-tenant relations	• Need better dynamics between landlords and tenants: fair housing, decisions not made on the basis of discrimination
▪ Lack of information sharing, communication, networking, training and service coordination since discontinuation of previous regular meetings of all the HIV housing service providers that were convened by HOPWA and the OAA	• The East Bay Regional Case Managers' Meeting is getting very effective • Need restoration of dedicated staff time to support inter-agency collaboration and service coordination
▪ Other organizational/institutional suggestions	• Consider a return to a housing commission • Need leadership from the Office of AIDS Administration

As a result of the personal, program, and system problems, focus group participants offered the following comments about particular groups of PLWHA that they serve:

Youth. Because of minimum-wage incomes, youth fail to qualify for much housing. Accordingly, much of their housing is transient. Youth, who may have been kicked out of parents' or family home for sexual orientation or HIV, often turn to couch surfing. Most youth at the Downtown Youth Clinic [generally, individuals under age 30] have experienced or currently experience transient housing. It is important to stabilize them before that pattern becomes a permanent trend. Fifteen to 20 percent of the youth need housing assistance in a year.

Transgender clients. Half of transgender clients are in unstable housing, and the other half are stable "for a minute." They are out of care staying in motel rooms. Some used to stay at the Harrison Hotel where the previous property manager would call the client's off-site case manager if there was a problem, but the current property manager just documents violations and then evicts residents. The clients are not allowed to reside there again at a later date. Transgender clients last at Crossroads for only one or two days because of the animosity of other residents. Because of severe limitations in Alameda County, transgender clients are now routinely referred to San Francisco.

Supplemental Security Income benefits. Rents are too high for HIV+ clients with SSI assistance. In Project Independence, clients are not allowed to pay more than 90% of their income for rent. It is hard to find a place within the Fair Market Rent range for someone relying on SSI.

Women. Making three times the amount of the rent (first- and last-month's rent plus a security deposit or move-in costs) – to make rent affordable – is hard for women. If a woman's income is $840 a month, and the rent is $750 a month, then something has to fall off. She has to turn to another agency to help with the rent.

Eviction histories. Clients have problems with their previous eviction records and lengthy legal appeals. Previous evictions may prevent them from having access to HOPWA and subsidized housing. It is tedious to get those evictions off the record.

4.2 Consumer Focus Groups

Between June and August 2013, we conducted focus groups with three groups of PLWHA: one for the general population in English, one for women in English, and one for the general population in Spanish (see Chart 4.3).

Chart 4.3. Client/Consumer Focus Groups

	Client/Consumer Focus Group 1	Client/Consumer Focus Group 2	Client/Consumer Focus Group 3
Gender	7 Men and 2 Women	Women only	5 Men and 4 Women
Race/ethnicity	7 African American 2 Latino/a	9 African American 1 Latina	9 Latino/a
Language	English	English	Spanish
Date	June 18, 2013	July 12, 2013	August 8, 2013
Number of participants	9	10	9

Consumers echoed many of the concerns voiced by service providers but also offered numerous personal stories that both expanded on the already identified challenges and added new ones. Consumers spoke about challenges of finding housing but went into detail about the particular problem of needing to purchase numerous credit checks (see Chart 4.4). They talked about residing in violent and in drug-using neighborhoods, mentioning in particular the limitation on their ability – because of lack of safety – to invite friends and family to visit and the challenge of being in recovery in such neighborhoods. Consumers also described both the difficulty of having to endure multiple moves because of environment problems and the severe limitation of feeling that they could not move for fear of losing a critical rental subsidy. They objected to poor construction and poor upkeep, inattention from management, discrimination experienced by Latino/as, and challenges in locating housing for households with children, with persons with disabilities, and with re-entry household members. Finally consumers described challenges in trying to secure emergency housing assistance and their lack of comprehension as to how housing authorities – and the overall affordable housing system – function.

Chart 4.4. Experiences and Concerns Voiced in Consumer Focus Groups

	Client/Consumer Focus Group 1 General English Speakers	Client/Consumer Focus Group 2 Women English Speakers	Client/Consumer Focus Group 3 General Spanish Speakers
Housing challenges – access and options	• Credit checks are a problem; each costs $35; it is a struggle to maintain your credit during housing search		• Multiple credit check costs in housing search are unreasonable
	• One person: I have no credit	• Hard to find a place due to low income and poor credit history	• Constantly rising rent is a problem • It is very hard to find housing and benefits
	• Moved twice in last 3 years because of drugs in buildings		• Multiple moves in past 3 years • On-going need for better or different housing
	• If my place had staff at night I could work night shift, improve my income		• Housing problems make it hard to work
	• A lot of turnover in terms of property managers; each wants to do an inspection; then they don't do anything		• Cheap materials, broken household components only attended to when annual inspections takes place
Race/ethnicity & immigration status and housing			• 7 of 9 participants experienced discrimination because they are Latinos/as • Lacking legal residency documents is a problem. • Latinos/as are the "last group considered for anything"
Other challenges in securing housing	• If you are on disability, you have fear of applying for another place • If I move, I would lose my subsidy • I can't move because of Shelter Plus Care	• Challenge in moving because of subsidy for two participants.	
		• More people in household a challenge, especially if children • Stereotypes among landlords in Fremont. • Felony, other convictions • Health or disability, including HIV+	

	Client/Consumer Focus Group 1 General English Speakers	Client/Consumer Focus Group 2 Women English Speakers	Client/Consumer Focus Group 3 General Spanish Speakers
Housing environment	• Section 8 apartment: 2 ½ years of torture because of neighbor parties all night	• Lack of peace due to neighbor & neighbor kids, drug-related fighting among neighbors	• Violence and/or gangs a problem
		• Violence, gangs a challenge in terms of stopping family and friends from visiting	• Because of violence, fear of inviting guests over
		• Place is a dump outside	• Location of housing close to industry bad for health
	• East Oakland is a hindrance for those fighting addictions and other issues • Moved four times because of noise and mildew		• Cockroaches, mold, rats, second-hand smoke, and smell from drugs all reported as problems; management inattentive
Received emergency housing assistance	[Topic not raised]	• Yes for three participants. Another three tried but were denied assistance.	• Seven participants needed and received EHA. But people also reported getting the run-around.
Challenge keeping track of where you are on housing / subsidy wait lists	• No understanding why HUD [Housing Authority?] switches status from disabled to non-disabled • There is a special needs section in each housing authority, but no access; we're shut out	• Yes	• Yes • Lack of response from Section 8
Know about PI	Not asked	2	2
Know about S+C	Not asked	3	4
Know about HOPWA	Not asked	2	3
Know about Housing Auth Mainstream Voucher	Not asked	2	3
Know about Section 8	Not asked	10	7

4.3 Housing Developer and Property Manager Focus Group

The AHNA Housing Developer and Property Manager Focus Group was convened on October 31, 2013 with 15 representatives from nine housing developers, one provider of transitional housing and emergency shelter, and one community organization and staff from HCD and the AHNA. In addition to the focus group, six of the larger housing developers completed a follow-up survey instrument. Chapter 3 of this report provides additional detail on the organization of the focus group. Appendix 9 provides a copy of the survey instrument referenced here, the focus group guide, and a list of focus group participants. Highlights of their responses are mentioned below.

The purpose of this focus group was to ask the people overseeing HOPWA units about what they are seeing "on the ground" and the housing needs of PLWHA in Alameda County.

Participants were encouraged to share their personal stories, to provide agency-level information and to reflect on the larger picture – the system of HIV housing and care and treatment in Alameda County and its overall functioning.

This section of the report follows the major topics that were discussed by participants.

The demand and need for AIDS housing in Alameda County. Participants concurred that the need is great. The size of the units was one key factor. One East Oakland development, with one-bedroom units, reported that their wait list is 6-8 years long, and they sometimes receive several applications per day. Others agreed that there is a high demand for one-bedroom and studio units but little demand for two-bedroom units which are very hard to fill. One agency recently took almost 60 days to fill a two-bedroom vacancy. Another had a two-bedroom unit that was both a HOPWA and Shelter Plus Care unit, and it took about six months to fill. Family units are also harder to fill. Regarding congregate living or family units, it was noted that, if people can independently get together in advance and meet the income qualifications, then there is no problem. Otherwise, agency matchmaking of potential residents is extremely difficult.

The location of future AIDS housing was another key issue. The majority of HOPWA units are in Berkeley and Oakland with very few or no units in Castro Valley, Fremont, Livermore and the Tri-Valley or the Tri-City areas (see Chart 6.69 below). The HOPWA housing in Oakland is

widely distributed with units in Downtown and East Oakland but none in West Oakland. The proposal was made that it makes most sense to put units in those areas where there are service providers, and the only community HIV clinic south of Fairmont Hospital is in Fremont. Since only one agency has developed a few units of senior housing for PLWHAs who are living longer, more planning is required to meet the increased needs for units for seniors.

Participants complained about the shortage of Section 8 units, and some stressed that more transitional or temporary housing is needed, especially because clients are on waiting lists for permanent housing for so long. If clients are in temporary housing situations but have to move, where can they go in the time before they move to the top of a waiting list?

How do you find PLWHA to move into your housing units? Some agencies rely on the routine (e.g., annual) opening of their waiting list to gather applications. Others use marketing plans to flyer agencies that serve PLWHA, letting people know there are HOPWA units, and reach out to HIV service providers and case managers through Eden I & R. Marketing in different languages is key.

Since HOPWA applicants could also qualify to get on lists for non-HOPWA units, there was discussion as to whether there should be a centralized waiting list maintained by HCD. It was noted that the HCD Shelter Plus Care program has a central waiting list. Participants favored a centralized wait list of HOPWA-eligible clients so that agencies would call one phone line to fill a vacancy. Any centralized waiting list would have to be compliant with the relevant HUD requirements. In order for referrals to be suitable, applications need to clearly identify the qualifications of clients. To place people in housing that is appropriate, any centralized waiting list would have to include an assessment of client need. For example, regarding Section 811 properties, the applicant has to qualify as disabled, so you cannot discriminate against a PLWHA just because the next available unit is not a HOPWA unit. For some other existing centralized waiting lists, the biggest problem is locating and contacting applicants if they are homeless or living in different places. Difficulties processing an application can result in vacancies and loss of income for developers and delays for clients.

If someone comes to you for housing and there is a six year wait, or you have no space, what do you do? If your waitlist is open, new applications can be accepted. If not, applicants are referred

to Eden I & R AHIP/2-1-1, or to other programs. The downside for applicants is that they have to call each housing site, developer, or program and complete a separate application for each site's waitlist. (This is another good reason for a centralized waiting list. While there are many reservations and complications, it would be of great benefit for the consumer.) There was general appreciation for the services provided by Eden I&R AHIP/2-1-1 (see Chapter 2 for details on AHIP activities).

What kind of housing assessment happens before PLWHA are referred to you? Do you receive eligible referrals? Participants acknowledge that sometimes unqualified applicants contact their agencies and are turned down. There was discussion regarding the quality of life and housing stability, and whether or not PLWHA require support services, case management, or property management involvement beyond services provided to other low-income persons. Some participants commented on the prevalence of mental health issues with clients having a HOPWA case worker but none for mental health issues. A few housing developments provide on-site case management services that address mental health issues. Some residents need more medical services, and transportation difficulties are common. It seems that the system cannot address the multiple issues that people may have. Some clients have pressing alcohol, drug and mental health issues in addition to HIV/AIDS. In general, when a client's service provider does not go into the unit or is not fairly active on the property, a lot more problems result. In that case, property management does more. Sometimes, at move-in, property managers are successful at establishing relationships with service providers. But, if there is less willingness by service providers to subsequently participate in a high level of service delivery, the resident's behavior can deteriorate and threaten their housing stability. Housekeeping issues can be rooted in mental health issues. Residents can start to lose housing for those reasons. When considering new applicants, it is very worthwhile to try to get a picture from their service provider as to how much time the service provider will spend on-site and in the unit, as opposed to being only an off-site service provider.

There was discussion of the *optimal level* of services for PLWHA residents with varying degrees of need. Participants stressed the importance of clients being linked to medical, mental health, substance abuse services, and transportation. Funding is needed to provide case management

and support services and/or property management involvement beyond the level of services provided to other low-income persons.

Resident service plans could stipulate that when people first move in that there be a certain number of home visits by their HIV primary care clinic case manager that may decrease over time. There are advantages also for service providers to engage in resident meetings to help residents combat isolation and link with the larger community. Essentially, these clients are no different from other low-income clients.

But, after some clients are settled in, mental health and loneliness issues that were overlooked take hold. That leads to turnover and a loss of housing. To prevent such outcomes these clients need hands-on support.

Many service providers and coordinators have huge caseloads, so once property management spots a problem, connecting the provider to clients is often a lengthy process. Sometimes, because the service providers' average caseload is so large, residents can start to dissemble even when they are housed.

It was discussed whether the co-occurrence of special needs was affected by funding specialization. If the Affordable Care Act (ACA or "Obamacare") improves the coverage of medical care, there may be a greater focus on the mental health and substance abuse issues that sometimes accompany HIV/AIDS. It was noted that all the funding streams erroneously treat PLWHA as if all of them have the same needs and require identical services. It is not just the services, but the coordination of services that is challenging. Sometimes, the property manager, wielding the threat of eviction because of residents' behavior, assumes the role of a service broker or coordinator. One of the problems identified is that HUD does not allow Section 811 housing development funding to support service coordinators even if many, or all, of the housing units are HOPWA-funded. It would be helpful if HOPWA funded needed service coordinator positions. The collaboration between the medical case manager and on-site service coordinator can be critical and regularly focuses on linkage to medical care and substance abuse. The service coordinator at a housing facility would need to be immersed in care issues, insuring the resident is getting to care appointments, and have a wide knowledge of substance abuse and mental health issues, in order to be effective. Some on-site service coordinators are in-house staff; others work

with an outside agency on a Memorandum of Understanding (MOU). They can troubleshoot and conduct interventions but not provide ongoing care. Some agencies have MOUs with external programs to provide on-site services.

There was a brief discussion of harm reduction and clean and sober housing. It was argued that the need was greater for housing that focuses on homelessness, mental health and substance abuse issues than for re-entry housing or clean and sober housing. Managing the client's risks is important, so there is less injury to the person while they use alcohol or other drugs. Some clients cannot succeed in clean and sober housing.

What are common reasons for denying housing to applicants? Are there factors that are not regulation-based? Primary reasons identified were: the client not meeting requirements set by the unit's funder and the client's sex offender status, history of violent criminality or arson, and a record of evictions. Applicants who do not meet Section 8 requirements are denied Section 8 housing. The developers have an appeal process in which they can consider special situations. Some developers use this process routinely on the special needs units because typically there is a credit issue or eviction in the client's history. For some issues, special needs populations require more consideration and assistance. There was a call for services to address past credit issues and evictions to promote clients' ability to qualify for Section 8 and other housing.

The most common reason for an eviction is the non-payment of rent, followed by non-compliance with the lease terms regarding housekeeping, hoarding, clutter and following property rules. Several participants proposed that some residents need a payee service to maintain their housing and to prevent evictions. There is no county-wide payee program. In Oakland, the Harrison Hotel and St. Mary's Center have one for their clients. Alameda County Behavioral Health Care offers one for some clients. And, in Berkeley, BOSS offers payee services for current and former clients. HOPWA client participation would have to be voluntarily. But, if a resident misses paying rent twice in a row, it was stated that the property manager has the leverage to require the client's involvement in this kind of payee service in order for them to stay housed.

Regarding resident turnover, some thought the population is more stable now, in part because it is an aging population. Some stated that regular low-income communities, even if layered with

some special needs clients, are fairly stable. The inclusion of homeless clients can decrease stability.

What is the cost of financing the operation of HOPWA units? How do you cover those costs? Participants said this was difficult to estimate because their developments include so many Shelter Plus Care, Section 8, or other-funded units. In order to insure the presence of service coordination, developers need to receive at least the same income from HOPWA units that they receive for an "average" unit. One program absorbed the cost of a medical case manager because they deemed the services necessary for their residents. Even though the thinking was that operating costs for a HOPWA unit were higher than those for an "average" unit, participants were not easily able to quantify the costs. Some HOPWA housing, such as transitional units, provides many supportive services. Other projects use external services funded by other sources. The need for a roving case manager was discussed. HOPWA was urged to increase funding for service coordination and for medical case management.

It is challenging that HOPWA funds development but not enough subsidies. Development is great, but it is really important to look at ways to sustain existing units. It was proposed that HOPWA fund project-based vouchers and/or operating subsidies linked to HOPWA units. Another idea was to provide some amount of funding for services based on the number of HOPWA units.

What kinds of assistance do HOPWA tenants need that they do not receive from property management or off-site service providers? Participants said this varied depending on the kind of housing development. For some, with high functioning residents, there is minimal involvement needed or provided. If there is a problem, property management staff usually know how to contact the resident's off-site case manager. HIV/AIDS medications can cause cognitive issues which can lead to rent payment problems. If there are these kinds of issues, the property manager can change operating procedures to accommodate the resident; for example, by invoicing monthly so the resident does not have to solely rely on their memory.

Several participants encouraged a policy for mandatory case manager visits to their clients in HOPWA housing sites on a regular basis. There is no monitoring and sometimes a client is not seen for six months. Property managers conduct unit inspections 30 days after the client moves

in. With special needs residents, they can ascertain whether the client is having difficulty living independently. Subsequently, property managers know when residents are at risk of being evicted. To prevent eviction, there is a need for a system to coordinate case managers, service providers, property owners and property managers.

Most participants indicated that they did not have, but needed, additional service coordinators at their sites. Medical case managers at Ryan White medical facilities do not visit clients in their homes. It was suggested that a HOPWA-funded service coordinator or case manager could fill this gap, ensure there is linkage to care, substance abuse and mental health services, make sure the client is on track, and coordinate with the medical case manager. There was discussion and differences of opinion as to whether additional staff was needed or better integration and coordination of existing staff would be sufficient.

How important are HOPWA development funds in light of all the other funding, such as Redevelopment, that have been lost? Should HOPWA spend more funds on services or fund development? The group answer was to continue funding development, in light of the need for more AIDS housing. It was also stated that there is a need for an operating subsidy linkage for HOPWA units. HOPWA is now funding some predevelopment and is increasing the amount of development funding per unit from $100,000 to $150,000 which the participants appreciated because their operating costs have increased over the years. Participants stated that it was critical to have predevelopment dollars, especially since there was no longer Redevelopment Agency funding

What would make HOPWA work better? Participants suggested combining service dollars with units for HOPWA and providing funds for project-based vouchers for HOPWA units. They favored having an operating subsidy tied to each unit and would comply with additional administrative and paperwork requirements. It was suggested to investigate whether the Affordable Care Act might cover HOPWA case management and other housing-related HOPWA services.

4.4 Highlights from the Survey of Developers and Property Managers.

Most topics of significance had also been mentioned during the focus group and are not repeated here. The few additional finding are:

1) One of the developers states they have 11,000 names on their waiting list.

2) The ratio of property managers to residents ranges from 1:24 to 1:80.

3) All developers report that they have monolingual Spanish-speaking or bilingual Spanish-English-speaking staff to serve clients, but only three of the six sites that responded to the survey provide printed materials in Spanish.

4) Three estimates for monthly costs for operating a HOPWA unit were provided, ranging from $590 to $1,012 per month.

4.5 Summary

There is no conflict among the perspectives from the three types of focus groups. Each stipulated that the need for affordable housing and/or for rental subsidies is considerable. We heard about greater need for (different) transitional housing from service providers as well as developers/property managers. Service providers and housing developers/property managers stress the need for additional case management and/or service coordination services.

Comments about the challenges of credit and eviction records were widespread.

Service providers and developers/property managers addressed the need for payee services and senior housing as well as less burdensome housing application procedures, including perhaps a centralized waiting list approach.

Consumers were additionally concerned with housing and neighborhood quality, discrimination against Latino/as, and limitations on moving once certain subsidies are provided.

Developers and property managers asert that new developments ought to be sited near service providers.

Finally, developers/property managers suggest that the Affordable Care Act may serve to cover HOPWA case management costs.

Chapter 5: On-Line Survey of Housing and Other Service Providers

The third form of data that the AHNA collected consists of 95 on-line survey responses completed by housing and other service providers at 37 agencies across Alameda County.[1] Our primary objectives in collecting on-line survey responses were to learn what housing and service providers view as the most pressing needs of PLWHA, the personal and program barriers to addressing those needs, what systems are working, and what improvements and new approaches are needed.

In this section of the report we describe the on-line survey design and elaborate beyond the Chapter 3 materials on method, report the survey participant characteristics, and display results deemed most important.

5.1 On-line Survey Design and Method

Survey content. The survey included 46 questions (some with multiple parts) and required approximately 45 minutes to complete. The survey is reproduced in Appendix 7. Questions address HIV work experience and current work responsibilities of the respondent; information about the agency for which the respondent works; information on the survey participant's clients such as their housing situations, rental assistance or subsidy needs, greatest personal and program barriers faced, services needed, and characteristics of the clients who are most difficult to house; the most serious gaps in the housing continuum; resources available and how clients gain access to them; and solutions to problems identified by the survey respondent. Question types include multiple choice where only one answer could be selected, checkbox where multiple answers could be selected, fill in the blank, ranking, and combination questions utilizing more than one question type (e.g. multiple choice followed by fill in the blank).

Survey administration. On August 2, 2013, AHNA staff emailed housing and service providers a brief introduction to the AHNA, a request that they assist the needs assessment by participating in the survey, and an individualized link to the online survey. The link in the email redirected the respondent to the welcome page of the on-line survey, hosted by www.fluidsurveys.com. The welcome page provided additional details including how to begin, pause, resume at a later

[1] These 37 agencies include at least 39 sites.

date, and submit the online survey. AHNA staff estimated that the survey would take 20-30 minutes to complete, but median completion time was 45 minutes.[2]

AHNA staffing. Needs assessment staff were assigned to test the on-line survey prior to its going live, as well as send out invitation emails and reminder emails and help troubleshoot. There were a limited number of respondents who required technical assistance, which AHNA staff provided as needed.

Housing and service provider perspective. With one exception, all survey data are self-reported and not validated from any other source. We discuss the exception under Missing Data below.

Sample. The on-line survey was intended to provide an opportunity for staff at a range of facilities and organizations in Alameda County to share their insights on the housing needs of their clients with HIV/AIDS. To achieve this, AHNA compiled a comprehensive list of agencies and then staff contacts at each agency. The list included agencies that provide services supported with Ryan White or HOPWA program funding to PLWHA in Alameda County as well as agencies known to serve ten or more HIV+ clients in a 12-month period or agencies where the number of HIV+ clients served is equal to or greater than 10 percent of all clients served in a 12-month period.

Recruitment. At each agency, we identified staff who likely had substantial contact with HIV+ clients – preferably at least five in a 12-month period. Individuals recruited for participation were asked to let AHNA staff know of colleagues who might also be interested in participating, and generally those additional people were invited to participate. This happened in only a few cases. Not knowing how widespread interest in participating would be, and not knowing at which agencies individuals invited to participate might delegate participation responsibility to selected other staff, we determined to make our invitation list inclusive rather than exclusive, and invited 197 individuals at 56 agencies to participate. The survey was open from August 2 through September 27, 2013. Three raffle prizes (vouchers to local restaurants), to promote interest in the survey and express thanks for participation, were announced at the beginning of the survey and awarded once it closed.

[2] The on-line survey program calculation of length of time to completion included any periods of time during which the participant was inactive with the survey program and, hence, ranged from 6 minutes to over 17 hours.

Participation rate. AHNA staff sent up to three follow-up emails to encourage invitees to participate. By the close of business on September 27th, 103 individuals had entered some information into the on-line survey instrument. Those responses that addressed only the respondent's background and the agency's activities, skipping the questions concerning characteristics and needs of clients, were judged incomplete and omitted from the final results. On this basis, information from 95 survey participants (48% participation rate), representing 37 agencies (77% participation rate) is included for analysis.

Participation per agency ranged from one to 14 staff members or service providers. The number of participants per agency was not necessarily in direct relationship to agency size or number of HIV+ clients. Accordingly we considered whether weighting individual responses down by the number of participants per agency was required. We also investigated whether to weight up by number of HIV clients respondents had seen in the past year. Neither approach had a significant impact on test variable results concerning client characteristics. As a result all findings are presented unweighted.

Missing data. The survey was voluntary. Additionally, participants were allowed to skip any questions they did not wish to answer. Certain text fields were required, but only if the respondent had already clicked the corresponding multiple choice or checkbox field. Some respondents did not answer all questions so some data are missing. When more than one individual from an agency participated in the survey, and one or more respondents left information about the agency blank, we used information from other respondents to code agency type and other characteristics.

Chart displays. Chart titles in this chapter identify the corresponding survey instrument page number from which the data are derived, which can be found in full in Appendix 7. Chart numbers may be utilized two times – to present findings in both tabular and graphic format (see 5.6a and 5.6b, for example) – but the text may not specifically refer to both formats. Since findings do not refer to service providers as a whole, table headers refer to *n* – the sample – rather than to *N* (a reference to the *population* of housing and service providers).

5.2 Survey Participant Characteristics

Survey participants (or respondents) bring a wealth of experience and wide breadth of perspective to the survey. One-quarter (27.4%) of respondents are case managers, and most of

the rest provide direct services to clients (Chart 5.1). Another 22.1% are administrators, many of whom also have direct client contact.

Chart 5.1. Respondent Job Title (Survey p. 7)

	Number	Percent
Case Manager	26	27.4
Administrator	21	22.1
Medical Staff	15	15.8
Clinician/Therapist	9	9.5
Community Health Worker	9	9.5
Program Coordinator	8	8.4
Staff Attorney	2	2.1
Housing and Resources Specialist	1	1.1
Health Education Specialist	1	1.1
HIV Tester/Counselor	1	1.1
Other	2	2.1
Total	95	100.0

Note: Administrator category includes one data technician. Medical staff includes physicians, nurse practitioners, physician assistants, nurses, and medical assistants. Other includes one board member and one research project staff person.

Chart 5.2 displays the wide range of services that respondents as well as the agencies for which they work provide, grouping them topically. Two-thirds (67.6%) of the 95 survey participants report that their agency provides housing referral services, and 28.4 percent of the participants say that they themselves provide that service. Other service areas provided by a majority of the agencies include HIV prevention, access to health care benefits, mental health, women's services, transgender services, youth services, and food or food vouchers. This table examines topical areas rather than techniques such as case management or information and referral that respondents and agencies might employ in working in any number of these service areas.

Eight of ten respondents indicated that the agency for which they work is a non-profit (Chart 5.3). Others work at county, federal, or for-profit agencies. Chart 5.4 displays information on length of time that 89 of the 95 survey participants have worked in the HIV field. Over 70 percent have worked in the field for 6 years or more, many of them for over 20 years. Total service for all respondents equals more than 980 years of work.

Chart 5.2.
In what area(s) does your agency and do you personally provide service (Survey p. 4)

Service type	Agency provides service		Respondent provides service	
	Number	Percent	Number	Percent
Housing referral	25	67.6%	27	28.4%
HIV prevention	23	62.2%	30	31.6%
HIV testing	18	48.6%	19	20.0%
Needle exchange	4	10.8%	7	7.4%
Women's services	21	56.8%	20	21.1%
Transgender services	19	51.4%	21	22.1%
Youth services	19	51.4%	16	16.8%
Immigration/refugee services	14	37.8%	4	4.2%
Services for immigrants without documents	13	35.1%	10	10.5%
Access to health care benefits	23	62.2%	20	21.1%
Mental health	22	59.5%	24	25.3%
Substance abuse	18	48.6%	20	21.1%
Primary medical care	16	43.2%	13	13.7%
Food or food vouchers	19	51.4%	15	15.8%
Transportation voucher	17	45.9%	16	16.8%
Access to emergency financial assistance – food	17	45.9%	20	21.1%
Access to emergency housing assistance (first/last month's rent, eviction assistance)	16	43.2%	14	14.7%
Access to housing subsidies	16	43.2%	10	10.5%
Access to emergency financial assistance – utilities	13	35.1%	15	15.8%
Access to cash assistance and income benefits (CalWORKs, GA, SSI, SSDI, etc.)	16	43.2%	13	13.7%
Landlord - tenant disputes	8	21.6%	7	7.4%

Other services specified by fewer respondents but not displayed in the table include vocational training, GED classes, dental, eye, laboratory, pharmacy, ADAP services, shelter and transitional housing, subsidized housing, and housing and services for homeless persons. Probably a number of additional respondents would have mentioned housing services had they been prompted to do so.

Chart 5.3. Agency Sector by Number of Agencies and Number of Respondents (Survey p. 3)

	Agencies		Respondents	
	Number	Percent	Number	Percent
Not-for-profit	31	83.8	82	86.3
Federal and county	4	10.8	8	8.4
For-profit	2	5.4	5	5.3
Total	37	100.0	95	100.0

Chart 5.4a. What is the total amount of time you have personally delivered one or more of those [HIV] services throughout your career? (Survey p. 7)

Survey instrument options	Number of staff persons participating in survey	Percent distribution of survey participants	Midpoint number of years for those staff	Total number of work years (product of Col 2 and Col 4)
Less than 1 year	4	4.5%	.5	2
1-2 years	12	13.5%	1.5	18
3-5 years	12	13.5%	4.0	48
6-10 years	23	25.8%	8.0	184
11-20 years	25	28.1%	15.5	388
Over 20 years	17	19.1%	20.0	340
Total	89	100.0%		980

We conservatively assume that those working over 20 years worked exactly 20 years; thus the total number of years is an underestimate.

Chart 5.4b. What is the total amount of time you have personally delivered one or more of those [HIV] services throughout your career? (Survey p.7)

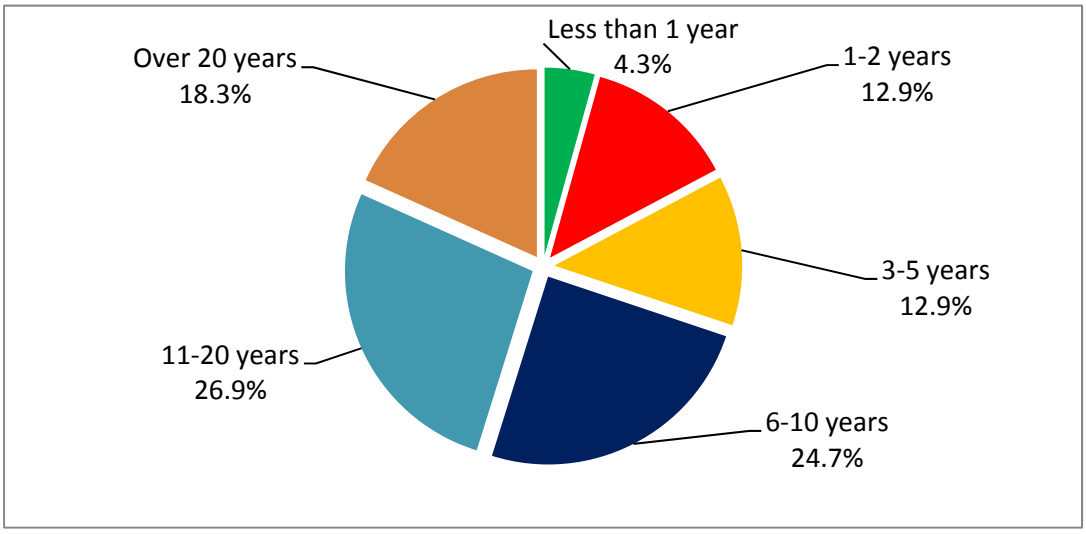
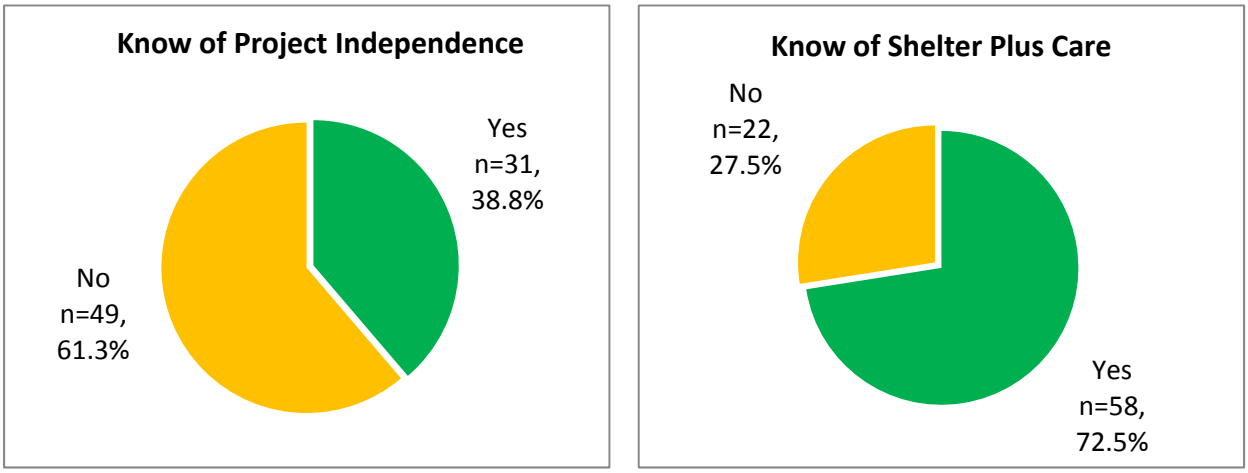


Chart 5.5 notes that 72.5% of respondents indicate that they know about the S+C Program, but only 38.8% know about PI (see Chapter 2 for information about these programs).

Chart 5.5.
Knowledge of Project Independence and Shelter Plus Care Programs (Survey p.19)



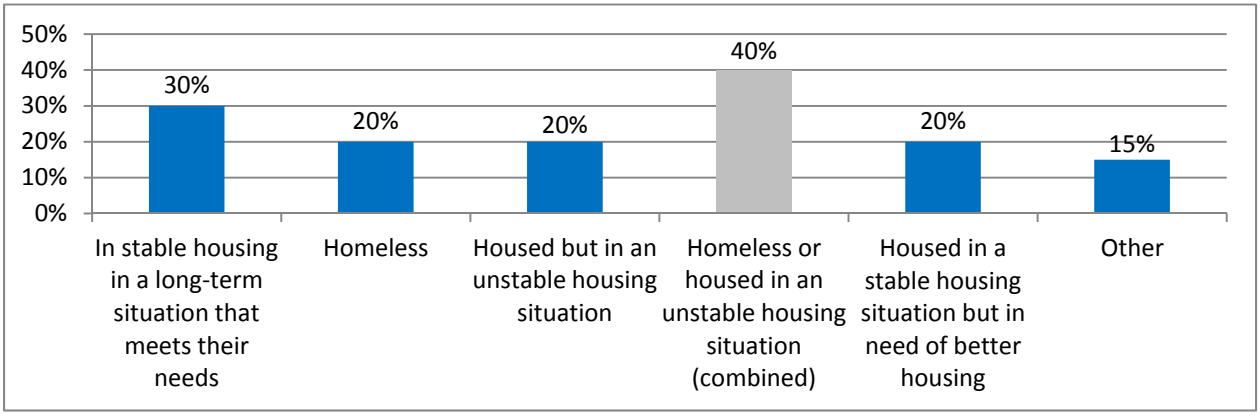
5.3 Information about Clients

Seventy-eight survey participants describe clients' housing status. Chart 5.6 displays the median – or mid-point – value of their estimates. Respondents indicate that the largest group of clients is stably housed in a place that meets their needs, but this accounts for only 30 percent of clients. Twenty percent are thought to be homeless, and another 20 percent are estimated to be housed but in an unstable housing situation. Note that the medians do not necessarily add to 100 percent.

Chart 5.6a.
What percent of your PLWA clients are . . . Percents to add up to 100% (Survey p. 9)

	In stable housing in a long-term situation that meets their needs	Homeless	Housed but in an unstable housing situation	*Homeless or housed in an unstable housing situation (combined subtotal)*	Housed in a stable housing situation but in need of better housing	Other
n respondents	75	78	72	*72*	72	7
Median (midpoint estimate)	30%	20%	20%	*40%*	20%	15%

Chart 5.6b.
What percent of your PLWA clients are . . . Percents to add up to 100% (Survey p. 9)



As displayed in Chart 5.7, 25 respondents contributing to this question report that their homeless clients are likely to be doubled-up or couch-surfing (68.7% very common or moderately common), staying in a shelter (61.0%), living outside or in a car (53.6%), and residing short-term in a hotel or motel (44.9%). Just under one-quarter (23.6%) of homeless clients are thought to be in Santa Rita jail, and over one-third (37.4%) make use of a variety of other options.

Chart 5.7.
Thinking only about your homeless clients, where do they commonly live? (Survey p. 9)

	Double-up or couch-surf without a lease		In a shelter		Street, car, under a bridge, structure not meant for habitation, homeless camp		Short-term in a hotel or motel, without tenancy rights		Santa Rita Jail		Somewhere else	
	n	Percent	n	Percent	n	Percent	n	Percent	n	Percent	n	Percent
Very common	12	47.0%	11	47.8%	7	32.6%	6	24.1%	2	10.4%	2	18.2%
Moderately common	5	21.7%	3	13.1%	5	21.1%	5	20.7%	3	13.2%	3	19.1%
Very or moderately common (combined, subtotal)	*17*	*68.7%*	*14*	*61.0%*	*12*	*53.6%*	*11*	*44.9%*	*5*	*23.6%*	*5*	*37.3%*
Somewhat common	7	26.7%	6	27.5%	7	33.0%	11	44.0%	10	44.2%	2	14.5%
Not common at all	1	4.6%	3	11.6%	3	13.3%	3	11.2%	7	32.2%	6	48.1%
Total	25	100.0%	24	100.0%	22	100.0%	24	100.0%	22	100.0%	13	100.0%

Other comments included: Assisted Living, with family, in own apartment unit, on BART trains and in BART stations, in parks, in monastery, on streets, in recovery programs, in transitional housing, in hospital, at the San Francisco Airport, in substance abuse treatment programs, with friends, and with whom they can date for the night [a reference, we believe, to trading sex for shelter].

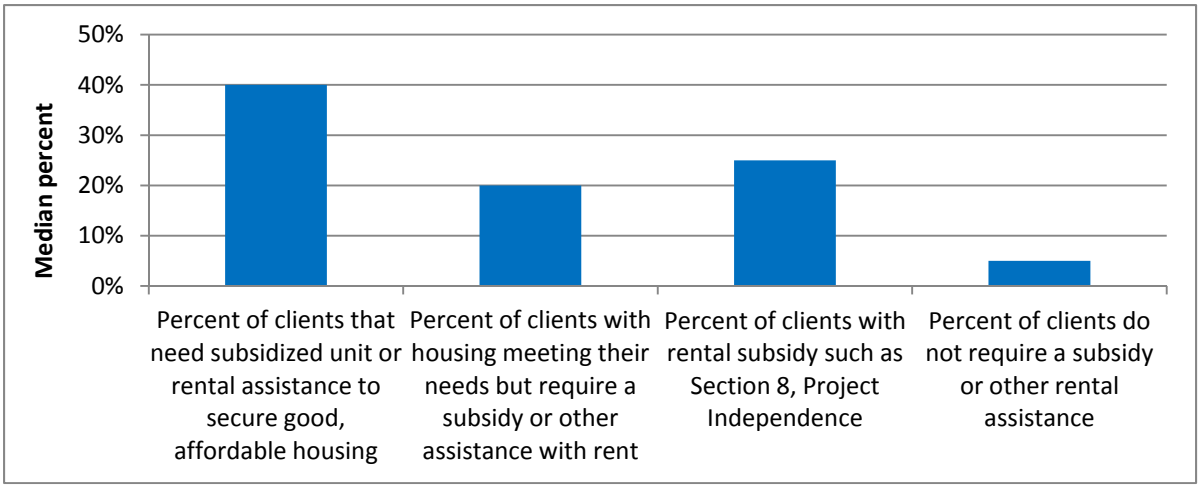
Addressing the situations of housed clients with tenancy rights but assessed to be unstably housed, respondents said it was very common or moderately common for their clients to rent apartments or houses with partners, friends, spouses, and/or children; reside alone in a rental; and share a rental with other individuals (results not displayed in chart form).

Chart 5.8 finds that many clients need a rental subsidy, both those who require a subsidy to secure housing (median 40%) and those with housing that meets their needs but who require a subsidy to remain securely housed (median 20%).

Chart 5.8a. Need for and Receipt of a Rental Subsidy (Survey p. 12)

	Percent of clients that need subsidized unit or rental assistance to secure good, affordable housing	Percent of clients with housing meeting their needs but require a subsidy or other assistance with rent	Percent of clients with rental subsidy such as Section 8, Project Independence	Percent of clients do not require a subsidy or other rental assistance
n respondents	60	62	65	48
Median	40%	20%	25%	5%

Chart 5.8b. Need for and Receipt of a Rental Subsidy (Survey p.12)



The survey asks for opinions about personal as well as program and system barriers to stable housing. Respondents confirmed the relevance of a wide variety of suggested personal barriers that prevent clients from making progress toward gaining access to stable housing (Chart 5.9). Most prevalent are characteristics associated with income and finances. Over 90 percent of respondents indicate that insufficient monthly income and lack of current employment are either extremely or moderately significant personal barriers. Poor credit history trails only somewhat (59.5% extremely significant; 25.0% moderately significant), and history of previous evictions – many if not most associated with financial challenges – are thought to affect three-quarters of clients (44.6% extremely significant; 30.1% moderately significant).

Respondents believe that behavioral health problems are very widespread among their HIV+ clients with housing challenges. Slightly more respondents name mental health problems as extremely significant (57.5%) as opposed to alcohol (40.0%) and other drug (50.0%) use. The

combined reports on extremely and moderately significant barriers are essentially equal (79.3% mental health, 79.1%, other drugs, 78.8% alcohol).

Two-thirds of respondents (65.0% and 63.1%) mention barriers associated with reentry from jail or prison and other criminal record problems as extremely or moderately significant. Social resources among immigrants and newcomers, family/partner/roommate problems, client motivation, and physical disability are also seen as broadly relevant. Household characteristics are seen as least problematic.

Chart 5.9. From your experience, what <u>personal</u> barriers prevent clients from making progress toward <u>gaining access to stable housing</u>? (Survey p. 12)

	Extremely significant		Moderately significant		Somewhat significant		Not al all significant		Total	
	n	%	n	%	n	%	n	%	n	%
Income and finances										
Insufficient monthly income	77	87.5%	8	9.1%	1	1.1%	2	2.3%	88	100.0%
Lack of current employment	53	63.1%	24	28.6%	3	3.6%	4	4.8%	84	100.0%
Poor credit history	50	59.5%	21	25.0%	9	10.7%	4	4.8%	84	100.0%
History of previous evictions	37	44.6%	25	30.1%	15	18.1%	6	7.2%	83	100.0%
Behavioral health/										
Mental health problem	50	57.5%	19	21.8%	15	17.2%	3	3.4%	87	100.0%
Use of other drugs	43	50.0%	25	29.1%	14	16.3%	4	4.7%	86	100.0%
Use of alcohol	34	40.0%	33	38.8%	12	14.1%	6	7.1%	85	100.0%
Criminality										
Recently released from jail or prison	31	37.3%	23	27.7%	19	22.9%	10	12.0%	83	100.0%
Other criminal record	26	34.2%	22	28.9%	19	25.0%	9	11.8%	76	100.0%
Social resources										
Lack of social resources among immigrants without authorization / documents	28	34.1%	24	29.3%	17	20.7%	13	15.9%	82	100.0%
Lack of social resources among others new arrived from outside the County	24	30.0%	20	25.0%	22	27.5%	14	17.5%	80	100.0%
Family/partner/roommate problems	21	25.9%	19	23.5%	27	33.3%	14	17.3%	81	100.0%
Lack of client motivation	20	24.7%	26	32.1%	27	33.3%	8	9.9%	81	100.0%
Physical disability	17	20.5%	23	27.7%	29	34.9%	14	16.9%	83	100.0%
Household characteristics										
Larger family size	9	11.1%	18	22.2%	29	35.8%	25	30.9%	81	100.0%
Being single	8	10.0%	16	20.0%	22	27.5%	34	42.5%	80	100.0%
Having young children	8	10.3%	18	23.1%	30	38.5%	22	28.2%	78	100.0%

5.4 Program and System Perspectives

Charts 5.10-5.12 specify program and system factors that challenge the search for appropriate housing by clients who are homeless or in emergency, temporary or short-term shelter or housing. Almost universal are long waits for rental subsidies (98.8% extremely or moderately significant; Chart 5.10). Closely following, and related, are that rental assistance isn't enough to

pay for a decent place (89.5%) and lack of housing in safe neighborhoods (84.4%). Additional challenges include application processes that are too difficult (78.5%) and service provider lack of information about available subsidies or affordable housing or how to gain access to both subsidies and housing (65.5%). Finally, respondents report that stigma because of HIV/AIDS (59.7%) and limitations on overnight visitors (47.3%) serve as a barrier to housing,

Chart 5.11 summarizes responses to a more pointed question about system barriers. Most often noted is lack of sufficient housing affordable to lower-income people (94.0% extremely or moderately significant). Next are cumbersome referral procedures or lack of such arrangements (77.0%), lack of services for people without documentation for legal residency (63.7%), and agencies' difficulty communicating with each other (65.4%). Homophobia (62.1%) and racism (59.8%) significantly outpace sexism (39.7%) and ageism (34.7%).

Chart 5.12 approaches these questions in a slightly different way, summarizing responses to the question, "What are the most serious gaps in the HIV/AIDS housing continuum in Alameda County?" Two-thirds (62.5%) of those responding to this question list affordable housing in the community as one of three most serious gaps. Next most prevalent in terms of response are permanent supportive housing (46.3%), transitional housing (32.5%), and Section 8 subsidies (31.3%).

Chart 5.10. What are the greatest other barriers that clients who are homeless or reside in temporary, emergency, or short-term shelter or housing face in finding appropriate housing? (Survey p. 13)

Significance	Long waits for housing subsidies		Rental assistance isn't enough to pay for a decent place		Lack of housing in safe neighborhoods		Clients' lack of information about what housing is available or how to gain access to it		Application process that is too difficult		Service provider lack of information about available subsidies or affordable housing or how to gain access to them		Stigma because of HIV/AIDS status		Housing program limitations on overnight visitors (friends, relatives, children)	
	n	Percent	n	Percent	n	Percent	n	Percent	n	Percent	n	Percent	n	Percent	n	Percent
Extremely significant	75	92.6%	53	69.7%	47	61.0%	40	49.4%	31	39.2%	22	28.9%	24	31.2%	17	23.0%
Moderately significant	5	6.2%	15	19.7%	18	23.4%	28	34.6%	31	39.2%	27	35.5%	22	28.6%	18	24.3%
Extremely or moderately significant (combined, subtotal)	80	98.8%	68	89.5%	65	84.4%	68	84.0%	62	78.5%	49	64.5%	46	59.7%	35	47.3%
Not at all significant		0.0%	2	2.6%	1	1.3%	1	1.2%	3	3.8%	6	7.9%	12	15.6%	12	16.2%
Somewhat significant	1	1.2%	6	7.9%	11	14.3%	12	14.8%	14	17.7%	21	27.6%	19	24.7%	27	36.5%
Total	81	100.0%	76	100.0%	77	100.0%	81	100.0%	79	100.0%	76	100.0%	77	100.0%	74	100.0%

Chart 5.11. How significant is each of these system barriers in preventing clients from entering into and remaining in stable housing? (Survey p. 17)

	Extremely significant		Moderately significant		Extremely or moderately (combined, subtotal)		Somewhat significant		Not al all significant		Total	
	n	Percent	n	Percent	n	Percent	n	Percent	n	Percent	n	Percent
Lack of sufficient housing affordable to lower-income people	73	88.0%	5	6.0%	78	94.0%	3	3.6%	2	2.4%	83	100.0%
Cumbersome referral structure or lack of such arrangements	41	52.6%	19	24.4%	60	77.0%	13	16.7%	5	6.4%	78	100.0%
Lack of services for people without documentation for legal residency	35	45.5%	14	18.2%	49	63.7%	16	20.8%	12	15.6%	77	100.0%
Agencies' difficulty communicating with each other	29	37.2%	22	28.2%	51	65.4%	22	28.2%	5	6.4%	78	100.0%
Homophobia	20	27.0%	26	35.1%	46	62.1%	16	21.6%	12	16.2%	74	100.0%
Racism	27	35.1%	19	24.7%	46	59.8%	22	28.6%	9	11.7%	77	100.0%
Sexism	10	13.7%	19	26.0%	29	39.7%	26	35.6%	18	24.7%	73	100.0%
Ageism	8	11.1%	17	23.6%	25	34.7%	30	41.7%	17	23.6%	72	100.0%

Others specified include: lack of skills and expertise by agency case managers / inability to stay in contact with clients, language barriers, payee and money management, serophobia, Transphobia, and violence and crime.

Chart 5.12. What are the most serious gaps in the HIV/AIDS housing continuum in Alameda County: What is in most short supply compared to the need? Please select the three most serious gaps. (Survey p. 17)

	n	% of those responding to question
Most serious gap: Affordable housing in the community	50	62.5%
Most serious gap: Permanent supportive housing	37	46.3%
Most serious gap: Transitional housing	26	32.5%
Most serious gap: Section 8 housing subsidies	25	31.3%
Most serious gap: Tenant-based certificates for people with mental illness, substance abuse, and/or AIDS, such as those provided by Shelter Plus Care	23	28.8%
Most serious gap: Emergency shelter	21	26.3%
Most serious gap Emergency financial assistance for move-in and eviction-prevention	19	23.8%
Most serious gap: Priority for Section 8 certificates for persons with disabilities	14	17.5%
Most serious gap: Information and referral	8	10.0%
Most serious gap: Site-specific, supportive housing such as provided by Shelter Plus Care at the U.A. Hotel in Berkeley and the Harrison Hotel in Oakland	4	5.0%
Most serious gap: Shallow rental subsidy program such as Project Independence for PLWHA	2	2.5%

Response to a question about possible challenges for clients residing in permanent or long-term housing or housing programs are also informative. Chart 5.13 conveys the following perspectives on extreme or moderate significance, in descending order of respondents' attribution of significance:

- Rental costs are not affordable
- Insufficient housing availability in safe neighborhoods
- Lack of harm reduction policy and/or clean and sober requirement too demanding
- Inconvenient location of medical and other services in terms of transportation
- Language limitations among housing providers or property managers
- Housing program limitations on overnight visitors

Chart 5.13. For clients residing in permanent or long-term housing or housing programs, what are the greatest barriers your agency's clients face in staying stably housed? (Survey p. 14)

	Rental costs not affordable		Lack of housing in safe neighborhoods		Lack of harm reduction policies on the premises or clean and sober requirements that are too demanding		Location of medical and other services inconvenient in terms of transportation		Language limitations among housing providers or property managers		Housing program limitations on overnight visitors (boyfriends, girlfriends, children)	
	n	Percent	n	Percent	n	Percent	n	Percent	n	Percent	n	Percent
Extremely significant	57	71.3%	40	51.3%	21	26.3%	13	17.1%	12	16.0%	15	20.0%
Moderately significant	13	16.3%	23	29.5%	28	35.0%	30	39.5%	21	28.0%	14	18.7%
Extremely or moderately significant (combined, subtotal)	70	87.5%	63	80.8%	49	61.3%	43	56.6%	33	44.0%	29	38.7%
Somewhat significant	5	6.3%	12	15.4%	23	28.8%	25	32.9%	24	32.0%	28	37.3%
Not at all significant	5	6.3%	3	3.8%	8	10.0%	8	10.5%	18	24.0%	18	24.0%
Total	80	100.0%	78	100.0%	80	100.0%	76	100.0%	75	100.0%	75	100.0%

5.5 Policy Perspectives

Many of the findings noted above reflect current local, state or federal policy. In this section of the report we note respondents' explicit comments on local policy. Chart 5.14 displays responses to the question, "Would a centralized housing referral system be useful." Over three-quarters (78.4%) of respondents say "Yes."

Chart 5.14.
Would a centralized housing referral system be useful? (Survey p. 21)

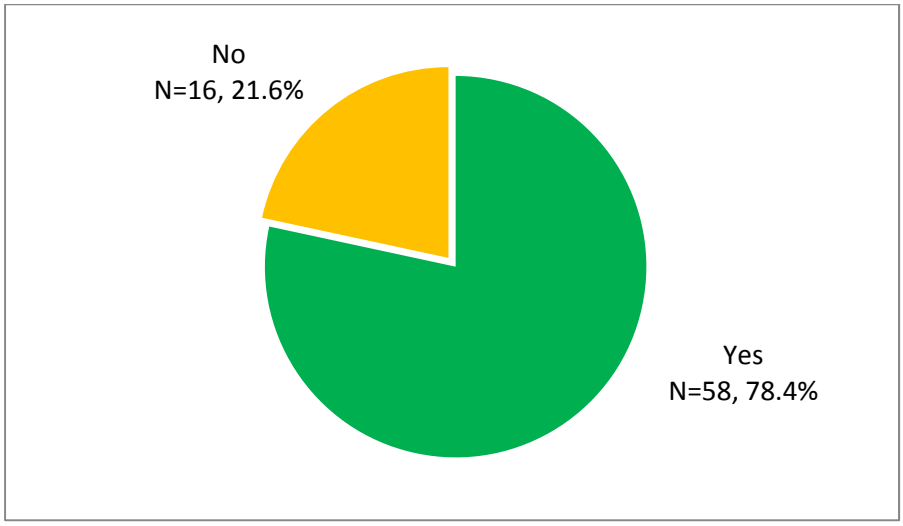


Chart A8.1 in Appendix 8 expands on the perspectives of those with substantial interest in a centralized waiting list/referral system. Responses note the contribution to accuracy and savings of staff and consumer time that such a program would yield, suggest content that might be disseminated, and mention the value of both 2-1-1 and Santa Clara County's Health Trust program that might serve as a models.

Chart 5.15 addresses the question of whether, in light of longer life-expectancy for PLWHA, eligibility criteria for permanent supportive housing should be modified. One-third of respondents say "Yes," but 43.4% indicate that they don't know.

Chart 5.15. Should eligibility criteria for permanent supportive housing be modified in an era of longer life expectancy? (Survey p. 21)

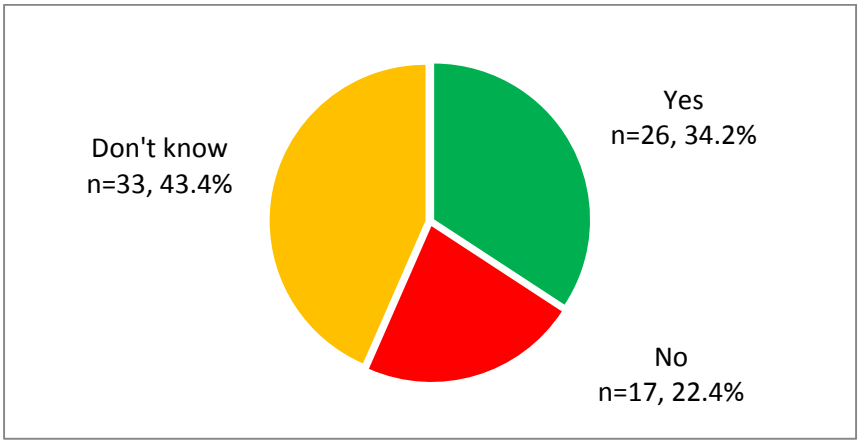


Chart A8.2 displays suggestions for criteria and raises several practical and ethical concerns. Nearly half of those who commented (9 out of 22 people) expressed the desire for increased

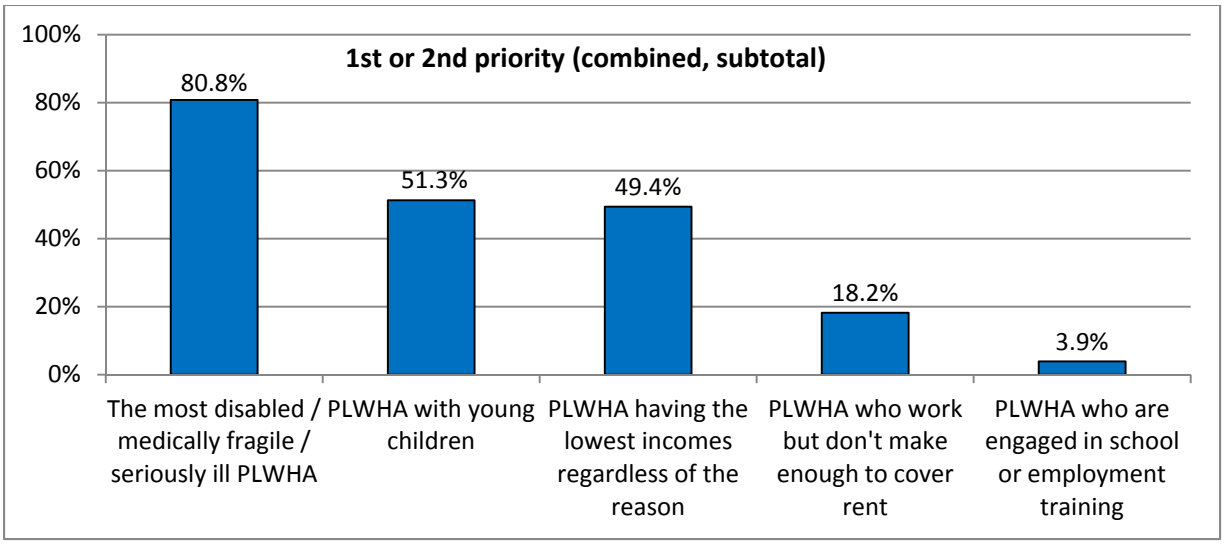
and/or new forms of housing subsidies due to longer life expectancy. Other comments included recommendations on changes to policy and suggestions for how to prioritize subsidy recipients.

In Chart 5.16, we consider respondents' perspectives about possible prioritization and allocation of limited housing resources. Four out of five (80.8%) respondents believe that first or second priority ought to be for the most disabled, medically fragile, and/or seriously ill PLWHA. Half (51.3%) say that PLWHA with young children ought to be prioritized. But that percent is indistinguishable from the proportion indicating that housing should go to PLWHA with the lowest income, regardless of reason.

Chart 5.16a.
We are interested in your thoughts about the prioritization and allocation of limited housing resources available to PLWHA. Who should be first in line? (Survey p. 20)

	The most disabled / medically fragile / seriously ill PLWHA		PLWHA with young children		PLWHA having the lowest incomes regardless of the reason		PLWHA who work but don't make enough to cover rent		PLWHA who are engaged in school or employment training	
	N	Percent	N	Percent	N	Percent	N	Percent	N	Percent
1st priority	60	76.9%	4	5.1%	9	11.7%	5	6.5%	1	1.3%
2nd priority	3	3.8%	36	46.2%	29	37.7%	9	11.7%	2	2.6%
1st or 2nd priority (combined, subtotal)	63	80.8%	40	51.3%	38	49.4%	14	18.2%	3	3.9%
3rd priority	6	7.7%	15	19.2%	20	26.0%	21	27.3%	15	19.7%
4th priority	2	2.6%	11	14.1%	14	18.2%	24	31.2%	25	32.9%
5th priority	7	9.0%	12	15.4%	5	6.5%	18	23.4%	33	43.4%
Total	78	100.0%	78	100.0%	77	100.0%	77	100.0%	76	100.0%

Chart 5.16b.
We are interested in your thoughts about the prioritization and allocation of limited housing resources available to PLWHA. Who should be first in line? (Survey p. 20)



We conclude this section of the report by summarizing respondents' comments on what works well for them with Project Independence and Shelter Plus Care as well as what could be improved to make these two programs more useful to clients and to themselves as staff.

Although only a minority of respondents knows of the PI program, those who do know about it speak of its value, note the need for more PI subsidies, and offer suggestions for program improvement (Chart A8.3). Among other critiques, one respondent appeared to be calling for a deep subsidy rather than a shallow rent subsidy program. Two note the need for greater investment in program marketing. And one believes that the prerequisite of being housed is incorrect.

More respondents know about S+C, and comments on S+C are more complex. Five of the 31 service providers responding note that the program works well (Chart A8.4). Others call for program expansion, more housing options, easier access and eligibility, and more opportunities to turn project-based into tenant-based vouchers. Three individuals criticize what they understand to be the requirement of remaining homeless while on the S+C waitlist. And a few respondents express concern about program accountability and possible favoritism.

5.6 Summary

Input from housing and other service providers represents a broad array of service areas and reflects many work-years in HIV services. Findings cover a range of topics, including:

- Despite the collective years of work in this area, many service providers do not know about Project Independence and/or Shelter Plus Care; some of those who know of the programs suggest program expansion and other changes, call for stronger marketing, and criticize the eligibility criteria that clients remain homeless to qualify for S+C
- 40 percent of clients are estimated to be homeless or in an unstable housing situation
- Many clients are in need of a rental subsidy, either to secure housing or to ensure that they will remain stably housed
- Barriers to stable housing include personal as well as program and system challenges
- Personal barriers include:
    - Financial problems associated with insufficient monthly income and lack of employment, poor credit history, and history of previous evictions
    - Behavioral health problems such as challenges with mental health as well as with alcohol and other drugs
    - Re-entry from jail or prison and criminal records
    - Lack of social resources among immigrants and newcomers to the area
- Program and system barriers include:
    - Lack of sufficient affordable housing
    - Long waits for rental subsidies
    - Rental subsidies that are not large enough
    - Lack of housing in safe neighborhoods
    - Lack of access to subsidized housing for people without required residency documents
    - Lack of permanent supportive housing and transitional housing capacity
    - Referral procedures and housing applications that are too cumbersome and/or complicated (need for a centralized system)
    - Service providers' lack of information about available subsidies, affordable housing, and how to gain access
    - Racism, homophobia, and stigma because of HIV/AIDS

Chapter 6: Patient Survey Data

The fourth and in many ways most critical form of data that the AHNA collected consisted of surveys of 210 low-income HIV+ Alameda county residents who were patients receiving primary healthcare at clinics across the county. To advance the AHNA, our primary objectives with respect to the patient survey were three-fold: (1) to understand the characteristics of two subgroups of the low-income, HIV+ population in care: those with and without stable housing, (2) to investigate whether those with stable housing benefitted from services that the unstably housed group failed to secure, and (3) to illuminate the type and location of housing needed for the population.

In this section of the report we elaborate on the survey design and method introduced in Chapter 3, report survey participant characteristics, and continue with countywide estimates of demographic and other characteristics of the population of low-income PLWHA in primary care, the current prevalence of homelessness and unstable housing among that population and the demographic and other characteristics of the homeless and unstably housed population as distinct from the population that is stably housed. We then examine services the stably housed population receives that may distinguish that subgroup from those who are homeless or unstably housed and conclude with observations about where, and in what types of housing, members of the population desire to reside.

6.1 Survey Design and Method

Survey content. The survey included 77 questions (some with multiple parts) and required about 20 minutes to complete. The survey instrument was available in English and in Spanish. Both versions are reproduced, in Appendices 10 and 11. Questions addressed demographics (age, gender, race/ethnicity, language), household composition, personal support, residence locality, sexual orientation, health status including mental health and alcohol and drug use, income, services utilization, criminal justice history, housing history, housing status, rental subsidy, housing costs, knowledge of rental subsidy programs, housing wait list status, housing preference, and housings services – including both those found helpful and those not received.

Self- or staff-administered. Patients had the option to complete the survey on their own (59% did so), have a needs assessment staff member go over the questions and mark down the patient's answers (33% elected this approach), or a combination (8%).

AHNA staffing. Needs assessment staff were assigned to particular clinics, depending on clinic schedules for seeing HIV+ patients. Survey staff – including two Caucasian men, one African American man, one Latina woman, and one Latino man – were scheduled for particular clinics in order to meet the English and Spanish language needs of each clinic's patients. We were not prepared to conduct interviews in other languages and did not want to rely on telephone translation services for such a delicate process. However, on three occasions patients utilizing American Sign Language expressed interest in participating and had an ASL interpreter with them at the time of their clinic visit. We included them in the survey.

Patient perspective. All survey data are self-report. That is, the data derive from personal recollection and perspective and are not validated from any other source.

Missing data. Survey participants were told that they could skip any questions that made them uncomfortable or that they did not wish to answer (see survey instrument cover page, Appendices 10 and 11). A few did intentionally skip some questions, saying that they did not want to disclose particular information or, on occasion, that they did not have the information required to answer a question (Question 36 about the dollar amount of housing assistance received proved to be a challenge for several participants). Several participants who self-administered the survey mistakenly skipped one or more questions. When AHNA staff received the completed survey from people self-administering it, we quickly reviewed the instrument to determine if questions had been skipped. On many occasions missed questions were then completed. On other occasions staff could not determine if a question was inappropriately skipped before the participant departed, and missing data resulted.

Sample. The survey was intended to provide a point-in-time snapshot of the experiences and statuses of the whole Alameda County population of low-income PLWHA residents of Alameda

County in primary care.[1] To accomplish this, surveys took place among a random sample of patients drawn from nine of the eleven primary care clinic sites in Alameda County in which Ryan White Care Act funds support the treatment of low-income PLWHA plus the private practice office of Anthony Jones, MD.[2] Patient survey participation by clinic is displayed in Chart 6.1. Chart 6.1a also reports the annual census of patients, by clinic. Since a patient might utilize primary care at more than one clinic in the course of a year, the 3,313 total is a *duplicated* client count. The *unduplicated* client count across all sites is 2,631. Thus our AHNA sample of 210 represents eight percent of the (unduplicated) population of interest. Survey participant characteristics are displayed in Charts 6.2 through 6.8.

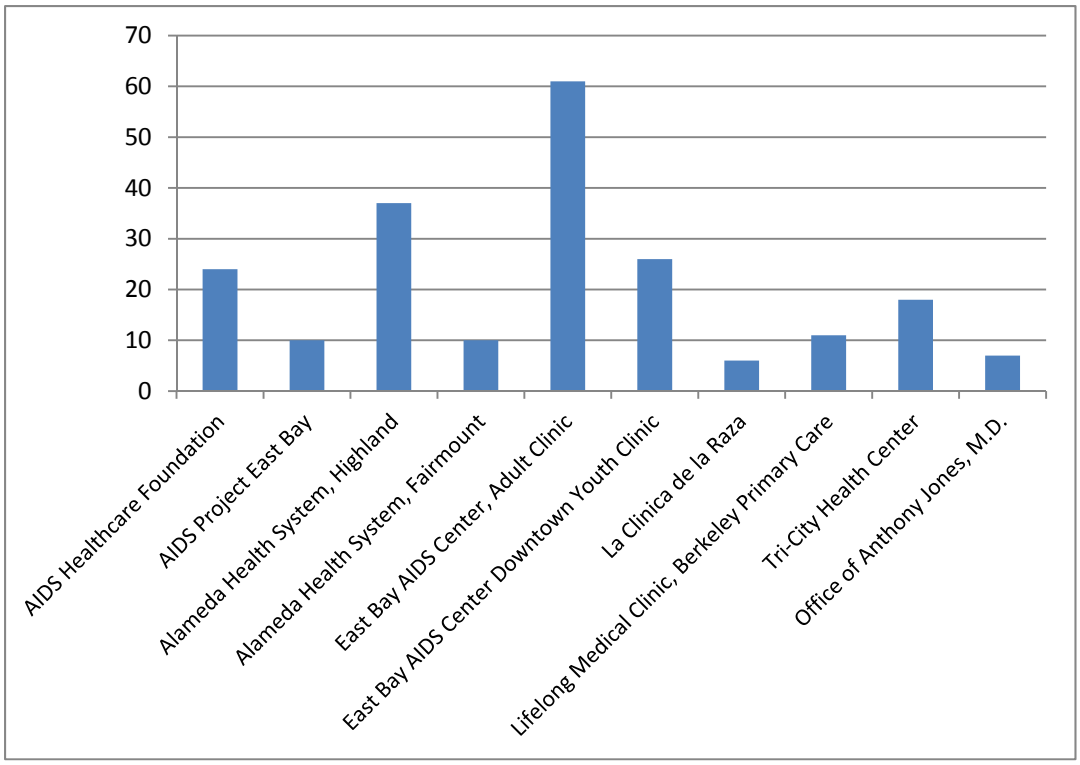
Chart 6.1a. AHNA Survey Sample and County Clinic Census, by Site

Primary Care Clinic	AHNA Sample	Alameda County PLWHA using each clinic (duplicated count)
AIDS Healthcare Foundation, Oakland	24	296
AIDS Project East Bay, Oakland	10	377
Alameda Health System, Highland, Oakland	37	886
Alameda Health System, Fairmount, San Leandro	10	
East Bay AIDS Center Adult Clinic, Oakland	61	890
East Bay AIDS Center Downtown Youth Clinic, Oakland	26	
La Clinica de la Raza, Oakland	6	243
Lifelong Medical Clinic, Berkeley Primary Care	11	193
Tri-City Health Center, Fremont	18	288
Dr. Anthony Jones, Oakland	7	140
Total	210	3,313

[1] As described in Chapter 3, the sample does not include the low-income HIV+ population that secures healthcare from Asian Health Services, Lifelong East Oakland, the Veterans' Administration - Oakland, Kaiser Oakland and Hayward, or private medical practices other than that of Anthony Jones, MD.

[2] For these purposes we defined as a clinic all Ryan White-funded sites or sub-sites in the county. For patient recruitment purposes Alameda Health Systems was considered two sites – the Highland and the Fairmont campuses. And the East Bay AIDS Center (EBAC) was considered two sites – its Downtown Youth Clinic and the EBAC adult clinic. Because of the small population of PLWHA seen at Asian Health Services (AHS) and Lifelong East Oakland, we did not conduct interviews at those sites. According to the Office of AIDS Administration, AHS serves 0.6 percent of annual (duplicated) primary care patients at Ryan White clinics in the county. Comparable OAA figures for Lifelong East Oakland are not available.

Chart 6.1b. AHNA Survey Participants by Site



Analysis weights. Comparing the raw demographic data from the *sample* of 210 individuals with the Office of AIDS Administration (OAA) demographic data on the countywide *population* of primary care patients, we learned that our sample was not fully representative of the patient population in several ways. Through the use of analysis weights, we adjust the sample data to represent better the patient population countywide and report estimates of housing and other characteristics for the *total number of unduplicated patients*. To produce characteristics estimates for the countywide low-income HIV+ patient population, the following five weighting steps were undertaken:

- HIV/AIDS patients use clinic services with differing frequency. Those who make more frequent clinic visits were more likely to be encountered on an interview day. Accordingly the data from frequent clinic patients were adjusted downward.
- Younger patients, under age 30, were oversampled to permit analyses for the younger age group. In order to represent the distribution of the larger population by age, data for the under-30 group were adjusted downward to bring their numbers back into the proper proportion of the whole population.

- The number of patients interviewed at each clinic was weighted up to represent the clinic's share of the total duplicated number of HIV patients engaged in care.
- To address the fact that some patients appear to use more than one clinic during the course of a year, a weighting was made to account for the number of duplicated clients in OAA clinic reports.
- Clinic patients come from all areas of Alameda County, but a disproportionate number of interviewed persons report living in Oakland. The data were adjusted so that cities of residence appear with the same relative frequency as reported by OAA in statistics for the total clinic patient population.

For additional details on the weighting procedures, see Appendix 13. While the patient survey participants were weighted to represent the overall group of PLWHA utilizing Ryan White-funded primary care services (that is, low-income individuals), the population estimates do not well represent the *broader* countywide population of individuals with HIV. In particular they do not reflect the characteristics and needs of middle- and higher-income residents.[3]

Chart displays. Chart titles include the survey instrument question number(s) from which the data are derived, which can be found in full in Appendix 10 and Appendix 11. We do not repeat question numbers in subsequent charts making use of the same question. Titles also indicate whether data are unweighted – based on responses from the 210 people surveyed – or weighted; that is, providing estimates of characteristics of the larger population numbering 2,631.

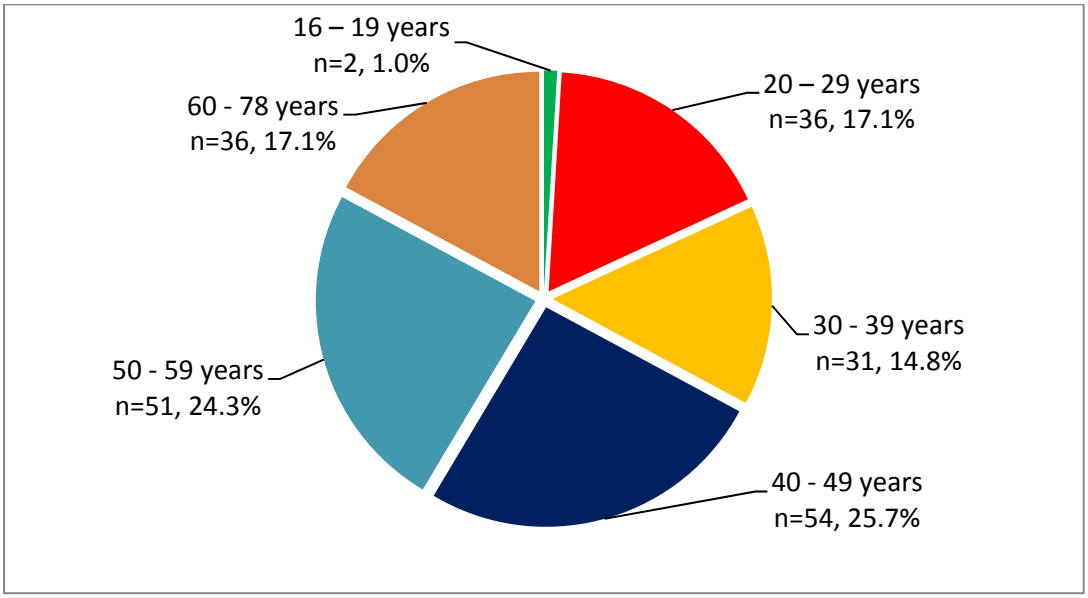
Chart numbers may be utilized more than once – to present findings in both tabular and graphic format (see, for example, Charts 6.13a and 6.13b) – but the text may not specifically refer to both formats. In Section 6.2 findings refer to PLWHA sampled for and participating in the patient survey. Hence charts make use of the symbol *n* for *number* in referring to the *sample size*. Subsequent sections of this chapter present characteristics estimates for the *population* and accordingly rely on *N* for *estimated number* in the population.

[3] Neither do these estimates necessarily mirror epidemiological data on the overall HIV+ population in the county. Thus, the characteristics presented in this chapter may differ, for example, from those in Chapter 2 that make use of countywide epidemiological information.

6.2 Survey Participant Characteristics (unweighted)

Survey participants range in age from 16 to 78, with a mean age of 45.5 years (median age 47.3 years). Seventy percent describe their gender as male, 25.7% female, and 4.3% transgender (all or male to female). Participants include gay men (40.5%), heterosexual women (22.9%), heterosexual men (15.7%), bisexual men (12.9%), transgender persons (4.3%) and other or missing (3.8%). Over half the survey participants (58.1%) say they are Black or African American, and 15.2% report they are White or Caucasian. One-quarter (26.2%) report that they are Latino or Hispanic (some of this 26.2 percent also report that they are Black, African American, and/or White or Caucasian). Three-quarters (77.6%) of participants speak only English. Another 8.6 percent speak English and Spanish, 8.1 percent Spanish only, and 3.8 percent English and another language. While 85.2 percent of participants have English as their only language or speak English well or very well, 11.9 percent do not speak English that well. Charts 6.2 through 6.8 summarize these characteristics.

Chart 6.2. Survey Patients' Age (Question 1 (Q1[4]) , unweighted)



[4] Henceforth all question numbers in Chart titles will be referred to as "Q" followed by the number.

Chart 6.3. Survey Patients' Gender (Q2, unweighted)

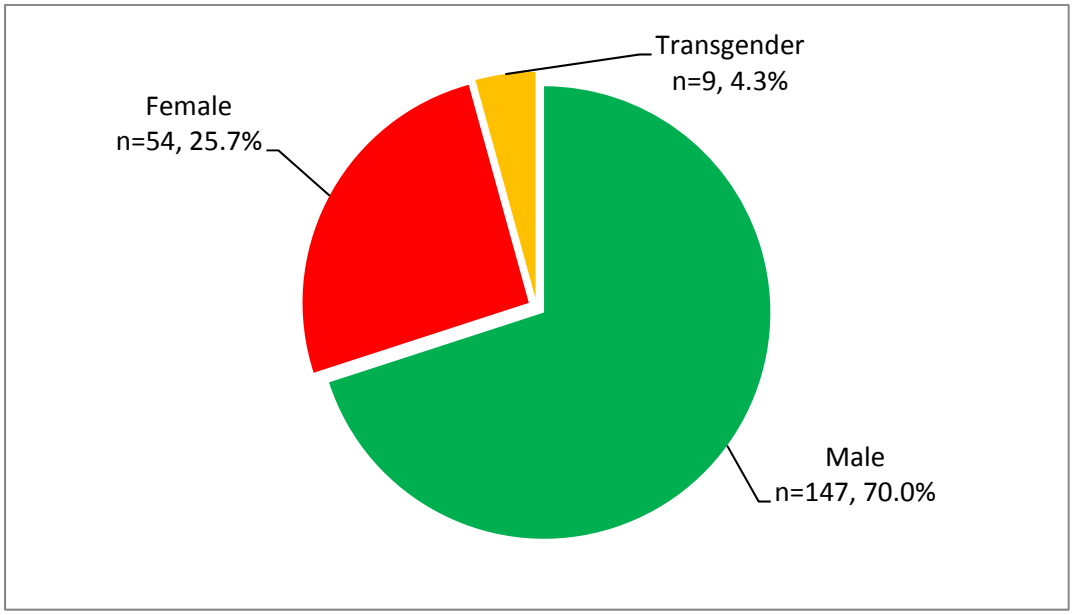


Chart 6.4. Survey Patients' Gender and Sexual Orientation (Q2, 3, unweighted)

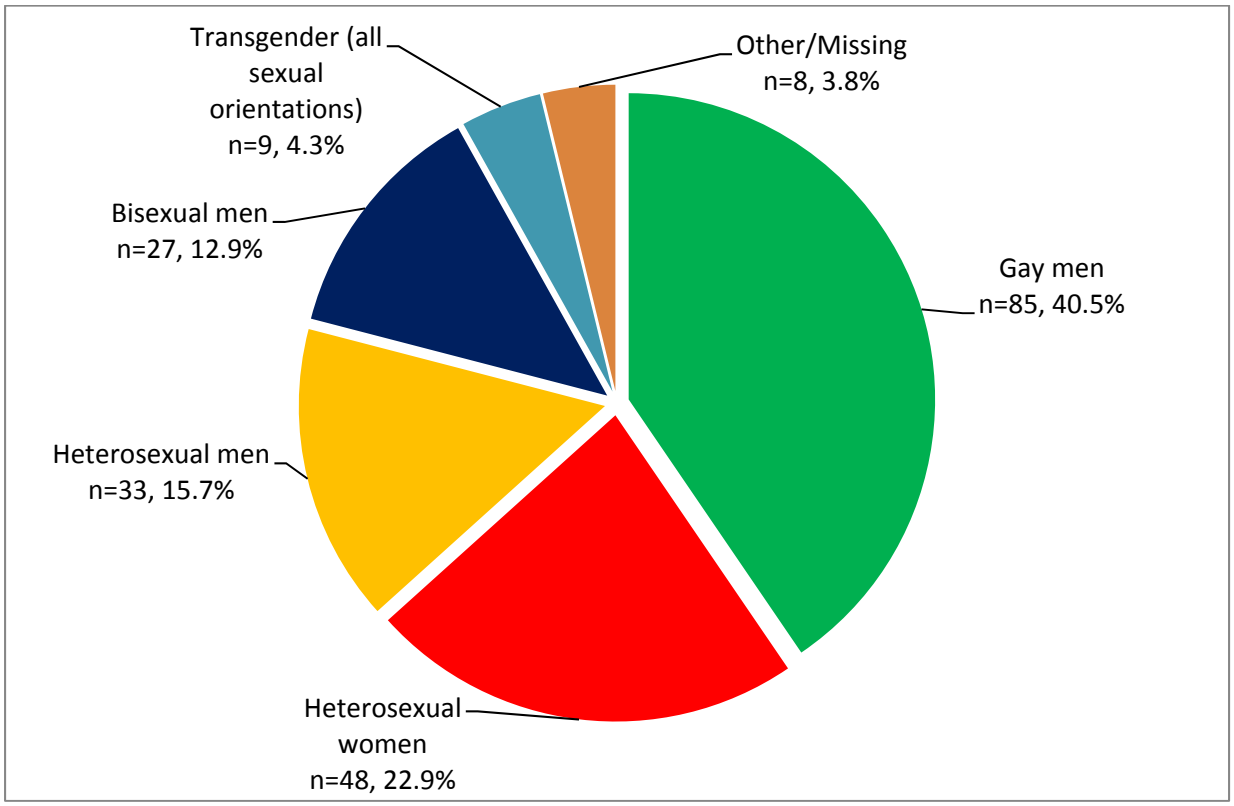


Chart 6.5. Survey Patients' Race (Q5, unweighted)

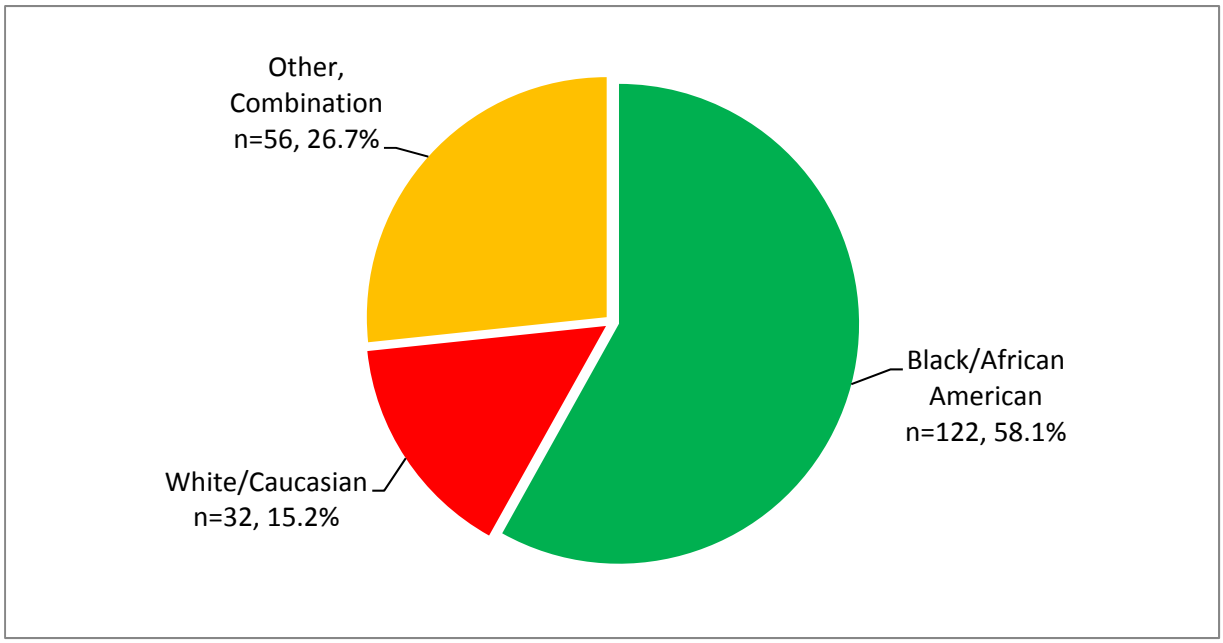


Chart 6.6. Survey Patients' Latino/Hispanic Ethnicity (Q4, unweighted)

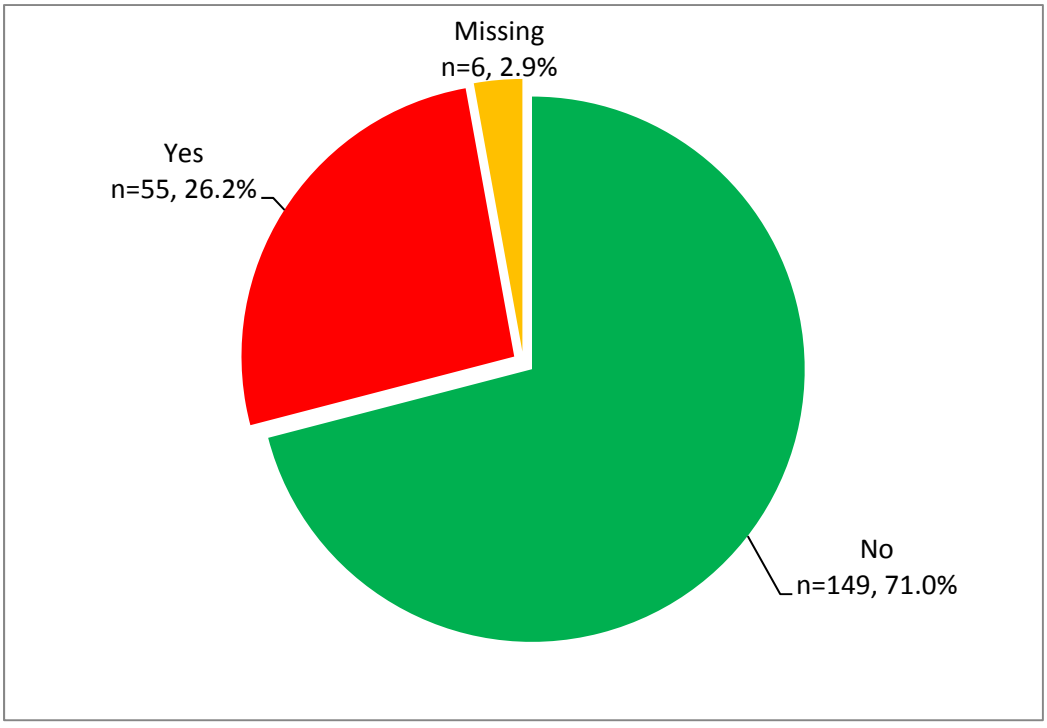


Chart 6.7. Survey Patients' Language(s) Spoken at Home (Q6, unweighted)

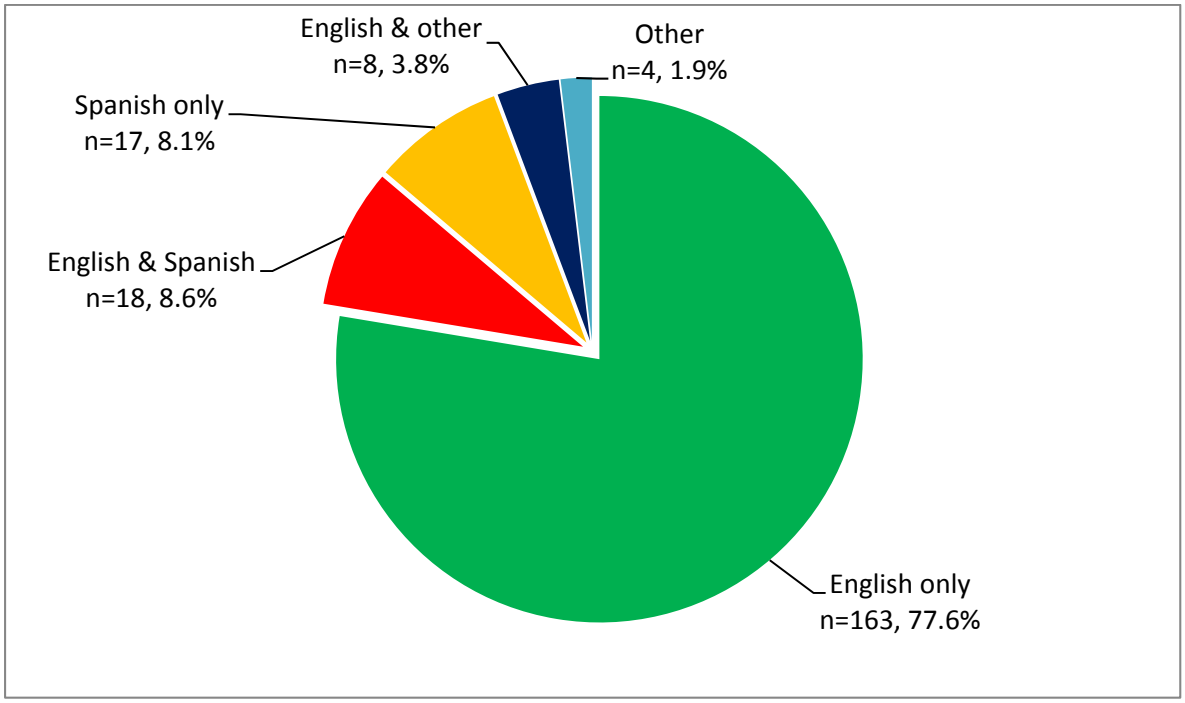
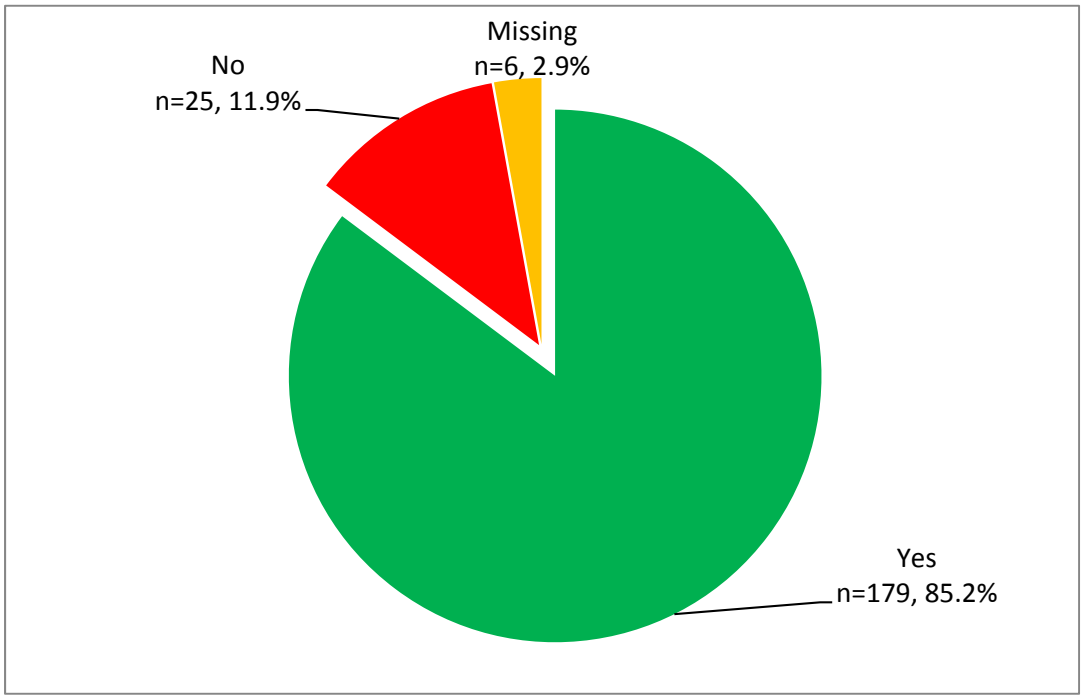


Chart 6.8. Survey Patients' English Language Skill:
English Only Language or Speak English Well or Very Well (Q6, Q7, unweighted)



6.3 Countywide Estimates from Patient Survey (weighted)

In the pages below we first provide estimates of demographic and other key characteristics of the countywide population of low-income HIV+ individuals in primary care (Section 6.4). Second, we estimate the current, point-in-time prevalence of homelessness and unstable housing as well as stable housing among that population (Section 6.5). Third, we describe the demographic and other characteristics that distinguish the population that is homeless or unstably housed from the rest of the population (Section 6.6). Fourth, we look at the situation of the younger patient population (Section 6.7). Fifth, we examine predictors of homelessness and unstable housing (Section 6.8). Sixth, we consider whether the stably housed population receives services unavailable to those who are homeless or unstably housed (Section 6.9). Next, we examine stated housing needs for the population (Section 6.10). In a final section we discuss these findings and draw conclusions (Section 6.11).

We refer to the statistics in these sections as *estimates* as they are based on responses from 210 individuals weighted-up, or projected, to characterize the entire patient population of 2,631 people. So, while the numbers and percents concerning the 210 sampled survey participants are precise, the numbers and percents in this report section are instead computed estimates. The larger the number of participants surveyed in any subgroup, the more confident we are that the resulting population estimate for that subgroup is accurate. Consider, for example, the estimate of 17 white women that we present in Chart 6.13a. The number 17 is the product of surveys of three white women (out of the 210 individuals surveyed). Had we happened to interview one more, or one fewer, white women the figure presented in Chart 6.13 would have increased or decreased by about one-third (depending on the particular weighting applied to each individual woman surveyed). Accordingly, findings such as this one we consider *unstable*.

We do not present statistical significance levels in this report. However, we note that for population estimates this large – certainly when speaking of the larger subgroups such as men versus women or recipients of SSI versus non-recipients – *statistically significant* differences are routine. At the same time, differences that are *important for policy and program administration purposes* may be fewer in number. What we mean is that while a difference of a few percentage points may be significant in a statistical sense, a larger difference may be required to attract the attention of policy-makers and program administrators.

With but a few exceptions, charts in these sections do not include estimates for the relatively small percent of the population for whom survey participants did not or could not provide information that we could code for analysis. Therefore, with but a few exceptions these "missing" cases are left out of the estimates that we display. Charts 6.33 and 6.34 represent exceptions, where rows for "missing" are visible. We do this because the relatively large amount of missing data suggests, first, that the estimates for the named categories may be particularly unstable and, second, to indicate where survey participants may have had a difficult time providing information.[5] In other charts the existence of missing data is visible by noting the difference between a chart's total number and the 2,631 people for whom we wish to generate estimates. For example, while Charts 6.10 and 6.11 provide estimates for a total of 2,631 people, Chart 6.12 totals only 2,563. Based on responses to Question 4 we were not able to generate estimates for Latino/Hispanic ethnicity for 68 people in the population.

For survey questions the "missing" number may be the result of intentional or unintentional skips. We believe that some survey participants were confused by the Question 4-5 combination (Latino/Hispanic ethnicity; race). For Question 3 (sexual orientation; Chart 6.14) missing information may reflect survey participants' lack of ability to categorize themselves or their unwillingness to share their characterization.

We also note that rounding may result in percents that do not add exactly to 100.0 percent or to total population estimates that do not add to 2,631. Chart 6.13, for example, totals 2,632.

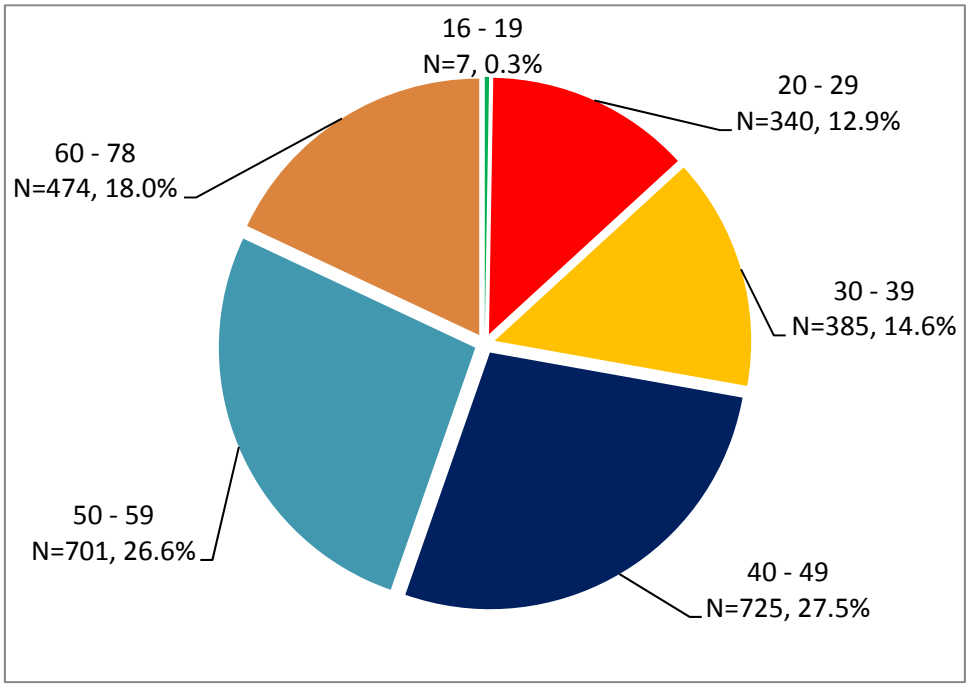
6.4 Population Characteristics

Relying on the weighting procedures described above, in this section of the report we generate *estimates* of the characteristics of the countywide population of low-income patients using either Ryan White-funded clinics in Alameda County or the private Oakland medical service of Dr. Anthony Jones. To simplify language below, in this chapter we refer to this population as *low-income PLWHA* or, even less wordy, *the population*. As in Chart 6.2 above, patient age ranges

[5] In a short survey that does not provide for follow-up questions or qualitative data collection and analysis, it is not unusual to confront questions that particular survey participants find difficult. This reality represents one of the limitations of a needs assessment such as this. For further discussion of limitations, see Chapter 3.

from 16 through 78 (Chart 6.9). The largest segments of the population are in the 40-49 and 50-59 decades. Mean age is estimated to be 46.9 years (median 47.9 years).

Chart 6.9. Age (Q1, weighted)



We estimate that almost three-quarters (71.6%) of the patient population is male, 23.1% female, and 5.3% transgender (Chart 6.10). We conclude that more than half (57.1%) of patients are Black or African American, 15.5 percent White, and 27.4 percent Other or a combination of racial categories (Chart 6.11). In a separate question survey participants were asked to indicate whether they identify as Latino or Hispanic. Our population estimate is that 29.1 percent so identify (Chart 6.12). Chart 6.13 displays our estimate that there are relatively few White females in this population (that is, 17) but a larger number of Black women (442) than would be anticipated by looking only at the independent percents on gender and race.[6]

[6] We estimate that 57.1% of the members of the patient population are Black (Chart 6.11) and that 23.1% are women Chart 6.10). Multiplying these estimates, 57.1% x 23.1%, or 13.2% of the population, ought to be Black women. In fact the best estimate is instead 16.8% (result not displayed).

Chart 6.10. Gender (Q2, weighted)

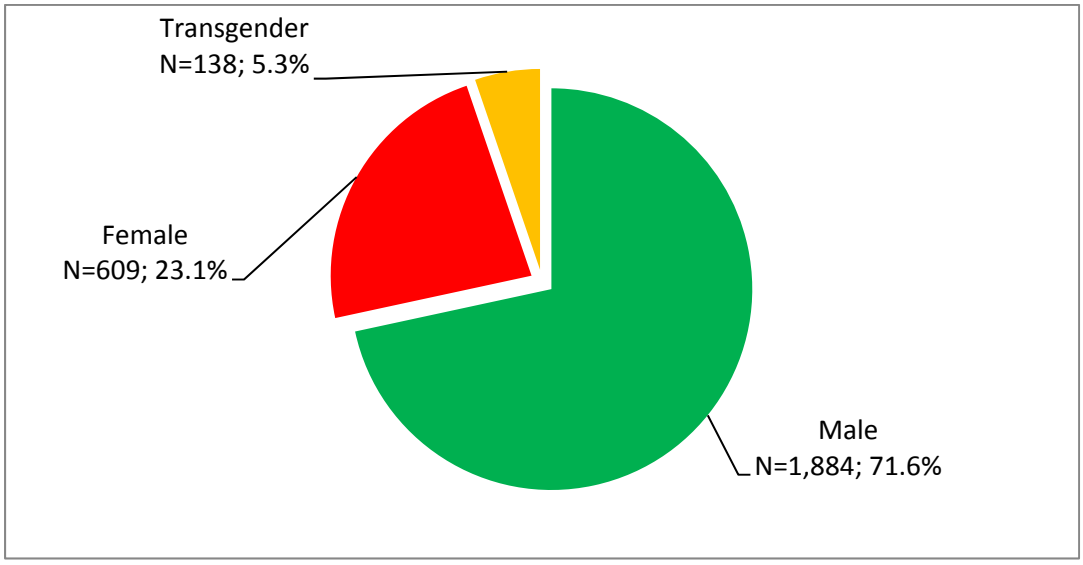
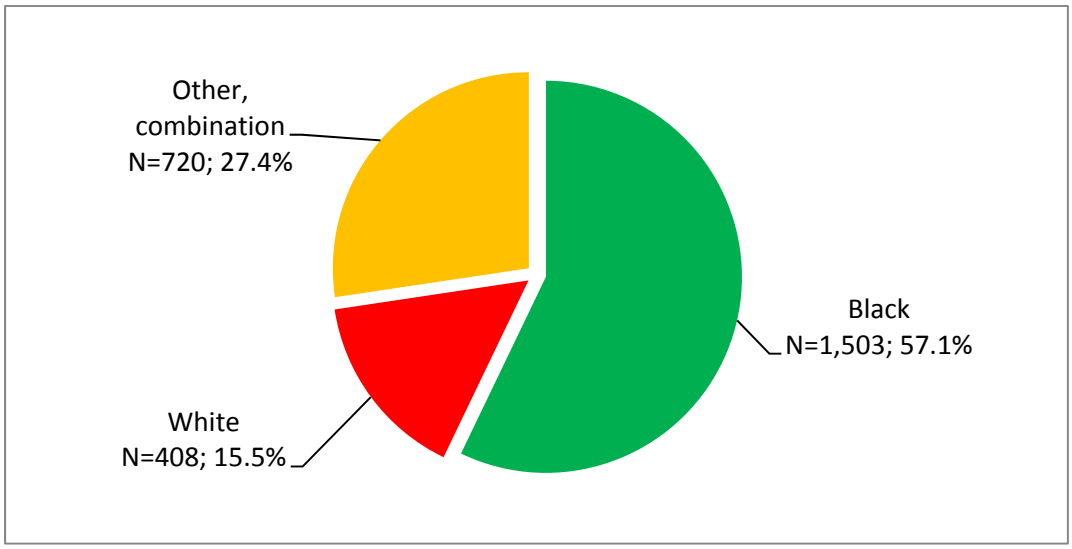


Chart 6.11. Race (Q5, weighted)[7]



[7] Note: Two-thirds (67%) of survey patients in the Chart 6.11 "Other, combination" group are categorized Latino / Hispanic in Chart 6.12.

Chart 6.12. Latino/Hispanic Ethnicity (Q4, weighted)

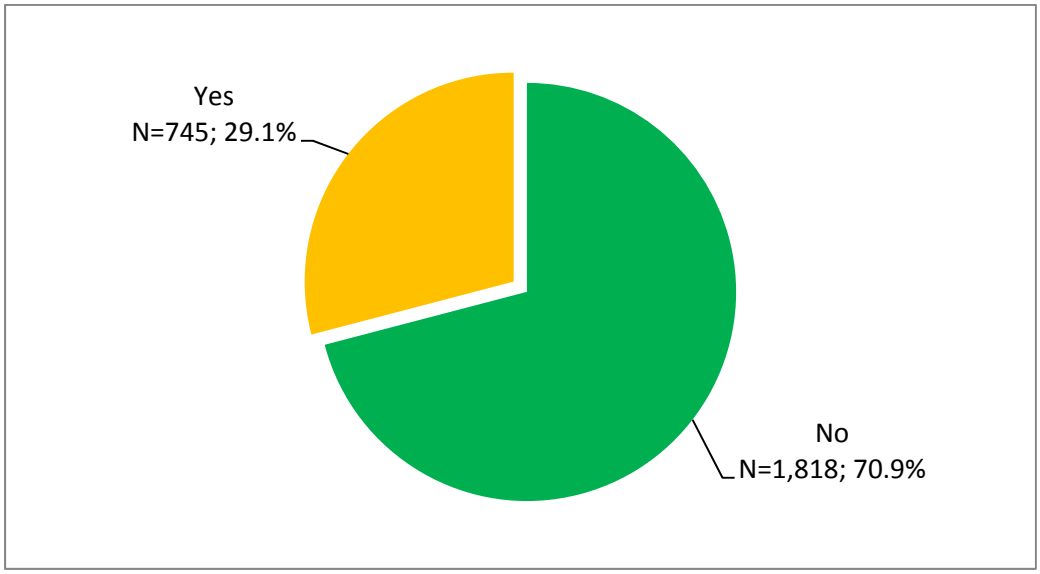
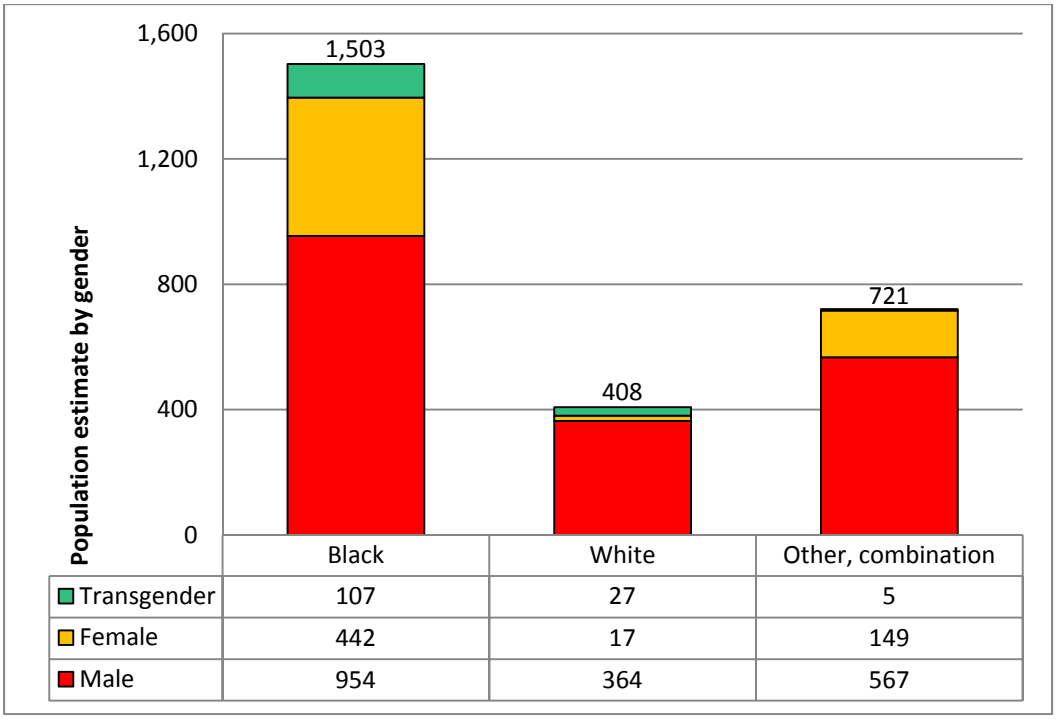


Chart 6.13a. Race by Gender (Qs 10, 11, weighted)

Race		Gender			
		Male N = 1,885 71.6%	Female N = 608 23.1%	Transgender N = 139 5.3%	Total N = 2,632 100%
Black	Count, weighted	954	442	107	1,503
	% within Black	63.5%	29.4%	7.1%	100.0%
White	Count, weighted	364	17	27	408
	% within White	89.2%	4.2%	6.6%	100.0%
Other, combination	Count, weighted	567	149	5	721
	% within Other, combination	78.6%	20.7%	.7%	100.0%

Chart 6.13b. Race by Gender (Qs 10, 11, weighted)



In Chart 6.4 we describe the low-income PLWHA population as comprised of people with diverse sexual orientations. Chart 6.14 displays our best estimate for the larger patient

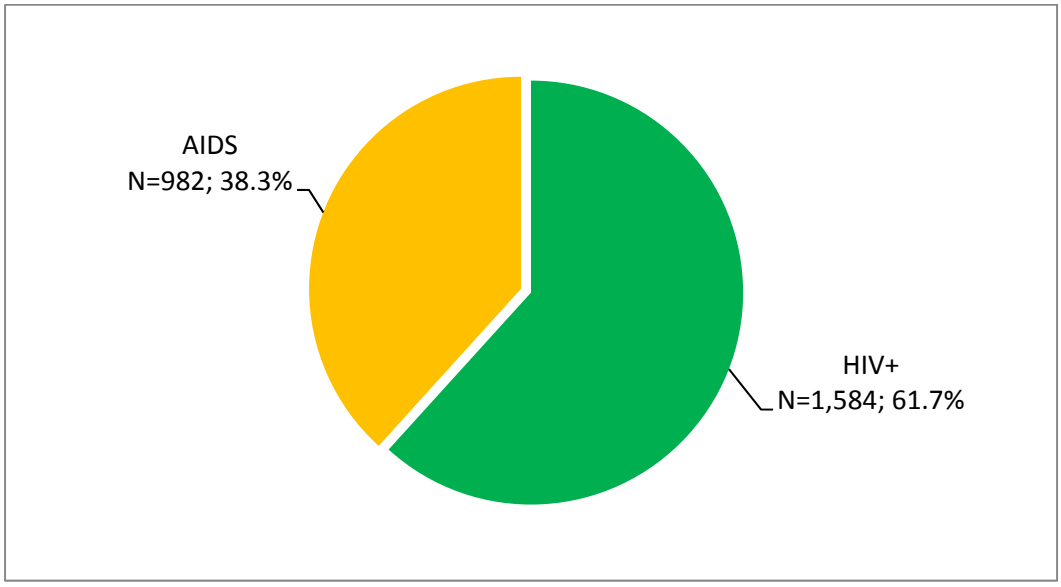
population. Major subgroups include gay men (38.3% of the population), heterosexual women (22.2%), heterosexual men (18.5%), bisexual men (15.2%), and transgender individuals (5.3%).[8]

Chart 6.14. Gender and Sexual Orientation (Qs 2, 3 weighted)

	Number N = 2,599	Percent 100.0%
Men having Sex with Men (MSM)		
Gay men	995	38.3%
Bisexual men	395	15.2%
Subtotal	1,390	53.5%
Heterosexual women	577	22.2%
Heterosexual men	480	18.5%
Transgender male to female (all sexual orientations)	138	5.3%
Other	14	0.5%

Chart 6.15 estimates that just over one-third (38.3%) of the low-income PLWHA population has an AIDS diagnosis.

Chart 6.15. HIV/AIDS Status (Screening Question, weighted)



[8] Several survey participants appeared to be confused by or to hesitate with Question 3: "Do you consider yourself [please select one answer] Gay male / Bisexual / Lesbian / Heterosexual (Straight) / Other? After a moment of thought almost all participants provided an answer. We do not know if responses to Question 3 are more (or less) reliable than to other survey questions.

More than half (54.1%) of low-income PLWHA reside in a single-person household (Chart 6.16). Almost one-quarter are in a household with only his or her spouse (22.6%). Another 12.7 percent reside with children (and a spouse or not), and 10.6 percent share a household with adult children or other adults. Chart 6.17a and b highlight the association between gender and household type. Our estimates suggest that 90.6 percent of transgender members of the population reside alone. Women are substantially more likely to reside with minor children, compared to men and transgender members of the population (respectively 28.1%, 8.7%, and 0%).

Chart 6.16. Household Type (Qs 9-14, weighted)

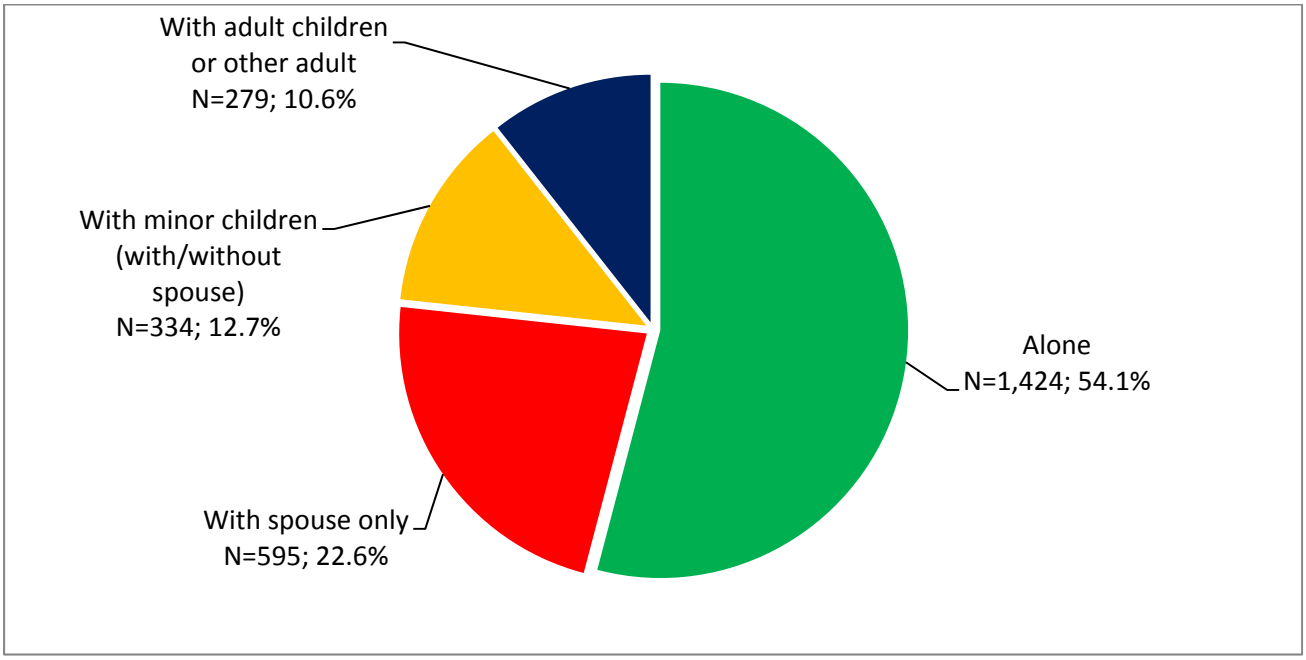
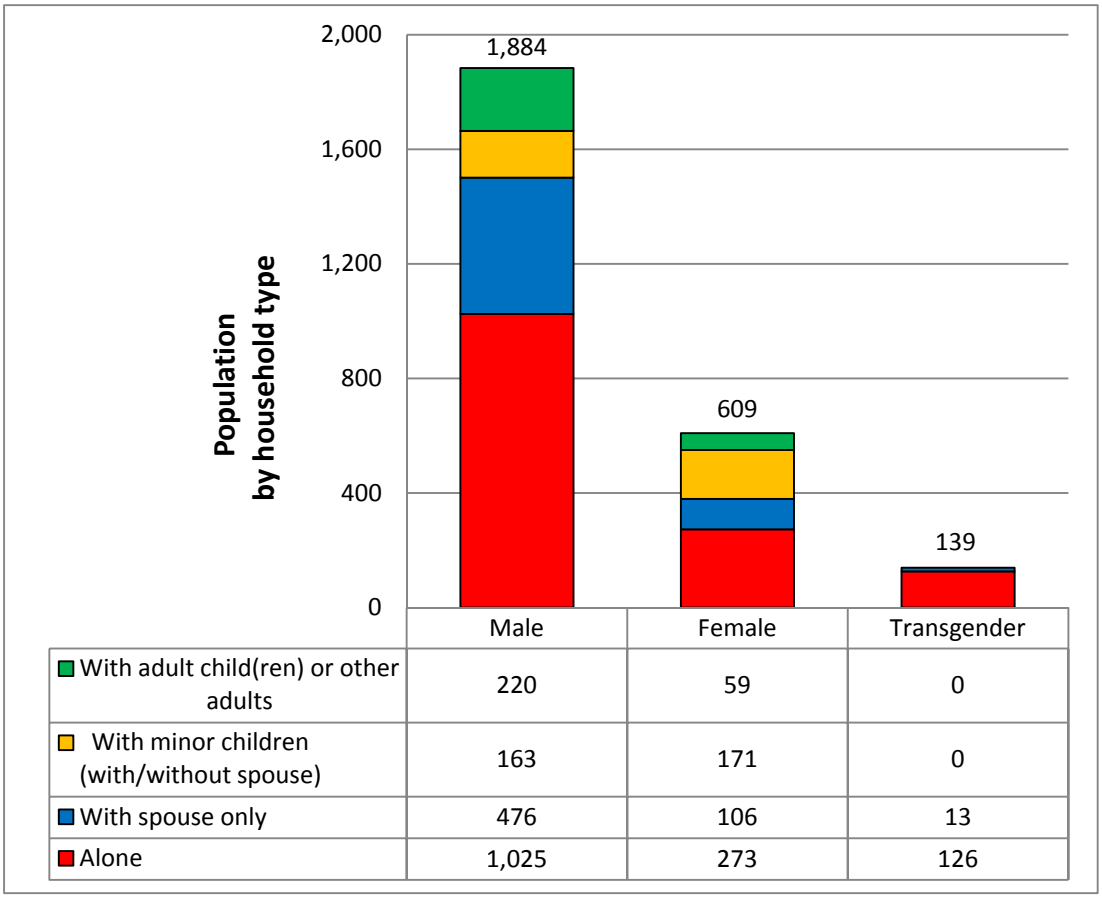


Chart 6.17a. Gender by Household Type (weighted)

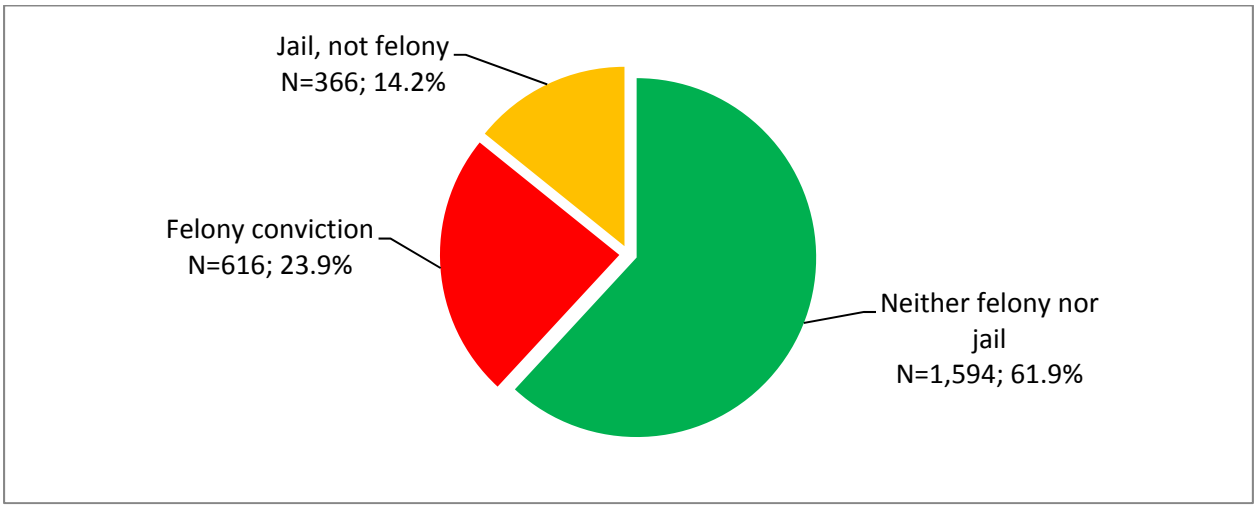
Gender		Household type: Alone N = 1,424 54.1%	With spouse only N = 595 22.6%	With minor children (with/without spouse) N = 334 12.7%	With adult child(ren) or other adults N = 279 10.6%	Total N = 2,632 100%
Male	Count, weighted	1,025	476	163	220	1,884
	% within Male	54.4%	25.3%	8.7%	11.7%	100.0%
Female	Count, weighted	273	106	171	59	609
	% within Female	44.8%	17.4%	28.1%	9.7%	100.0%
Transgender	Count, weighted	126	13	0	0	139
	% within Transgender	90.6%	9.4%	.0%	.0%	100.0%

Chart 6.17b. Gender by Household Type (weighted)



Three of five (61.9%) patients have neither a felony conviction nor have served a sentence in a county jail or state or federal prison since age 18 (Chart 6.18). Almost one-quarter (23.9%) have a felony record. Another 14.2 percent do not have a felony record but have served jail time since age 18. Only half a percent of the population is estimated to have a felony sex offense on their record (finding not presented in chart).

Chart 6.18. Criminal Justice History (Qs 74-77, weighted)



The majority (58.2%) of the patient population has a monthly income below $1,051 per month for the adults in their household who share money and share paying the bills (right column of Chart 6.19a). Individuals in the population with the largest incomes are less likely than others to reside in single-person households, are much more likely to share expenses with at least one additional adult, and are much less likely to receive a rental subsidy (data not displayed in a chart). In terms of income source, the largest group of the population (33.1%) derives income from only SSI and/or SSDI (Chart 6.20). The second-largest group (24.5%) has income only from work. One in seven (14.1%) members of the population receives income from a source other than work or SSI/SSDI.[9] One in nine (10.7%) has income from both SSI/SSDI and from work, and almost as many (9.2%) report no income source. Looking back at patients' monthly income totals (Chart 6.19), the majority of the largest group – those in the $701 - $1,050 range – secure that income only from SSI and/or SSDI (56.7% of that group; data not displayed). Another 16.6% of the group has income from both SSI/SSDI and work. Looking at the next

[9] Sources include: state or private disability insurance, Social Security or other retirement, unemployment insurance, General Assistance, CalWORKs, and veterans' benefits.

largest group, those with income between $1,051 and $1,750, we find that one-third (34.8%) has income only from work, 20.8 percent has income only from SSI/SSDI, and 21.5 percent from a source other than work or SSI/SSDI (data not displayed).

Chart 6.21 displays the relationship between AIDS diagnosis and likelihood of receipt of SSI and/or SSDI. As noted in this chart, 47.1 percent of the population has an SSI and/or SSDI income. We estimate that 42.6% of the low-income HIV+ population without AIDS has the SSI/SSDI benefit. The subgroup with AIDS is about 27 percent more likely to have the benefit; that is, 54.2 percent do have SSI and/or SSDI income.

In Chart 6.22 we estimate that 40.1 percent of the population with no criminal justice history receive SSI and/or SSDI, as do 55.5 percent of those without a felony record but with a jail history and 65.4 percent of those with a felony history. Irrespective of an AIDS diagnosis, among patients without a criminal justice history equal proportions are estimated to have SSI/SSDI. But among patients with either form of a criminal justice history, persons with AIDS are 40 percent more likely to have SSI and/or SSDI assistance (not presented in a chart).

An examination of Charts 6.23a, b and c suggests that patients with AIDS tend to have slightly lower incomes compared to those without AIDS. The major distinction appears in the Chart 6.23a column designating income from $1,051 to $1,750. While 25.8% of those *without* an AIDS diagnosis are found with incomes within that range, half the proportion (13.2%) of those *with* an AIDS diagnosis are in that income range.

Chart 6.19a. Monthly Income (Q23, weighted)

	Number	Percent	Cumulative Percent
None	115	4.4	4.4
$1 - $350	111	4.2	8.6
$351 - $700	230	8.7	17.3
$701 - $1,050	1,077	40.9	58.2
$1,051 - $1,750	559	21.2	79.5
$1,751 - $3,000	277	10.5	90.0
$3,001 - $5,000+	159	6.1	96.0
Missing	104	4.0	100.0
Total	2,631	100.0	

Chart 6.19b. Monthly Income (weighted)

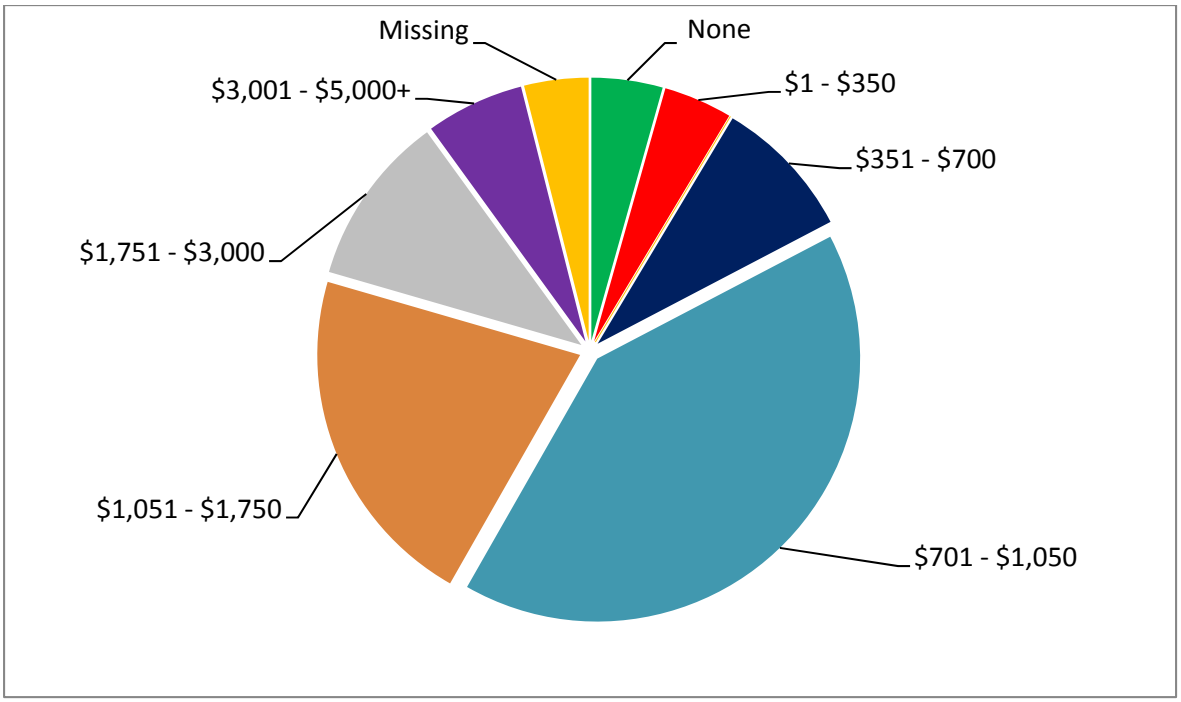


Chart 6.20a. Income Source (Qs 21, 22, weighted)

	Number	Percent
Income from SSI/SSDI only	865	33.1
Income from work only	641	24.5
Income only from a source other than work or SSI/SSDI	369	14.1
Income from work and SSI/SSDI	274	10.5
No income source	241	9.2
Income from work and from a source other than work or SSI/SSDI	108	4.2
Income from SSI/SSDI and a non-work source	109	4.1
Income from work, SSI/SSDI and from another source	5	.2
Total	2,611	100.0

Chart 6.20b. Income Source (weighted)

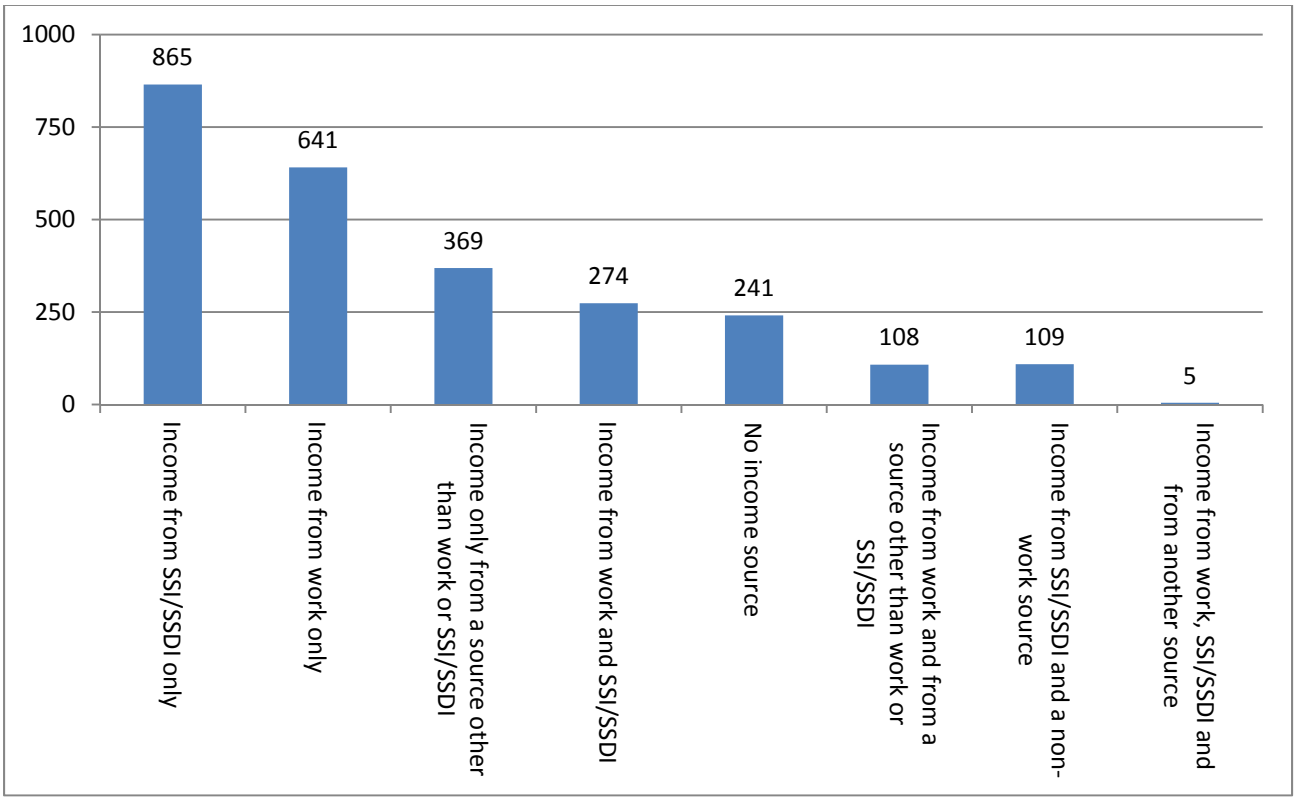


Chart 6.21a. HIV/AIDS Diagnosis by SSI or SSDI, or Both (weighted)

Diagnosis		SSI or SSDI, or both		
		No	**Yes**	**Total**
		N=1,359 52.9	N=1,208 47.1%	N=2,567 100%
HIV+	Count, weighted	909	675	1584
	% within HIV+	57.4%	42.6%	100.0%
AIDS	Count, weighted	450	533	983
	% within AIDS	45.8%	54.2%	100.0%

Chart 6.21b. HIV/AIDS Diagnosis by SSI or SSDI, or Both (weighted)

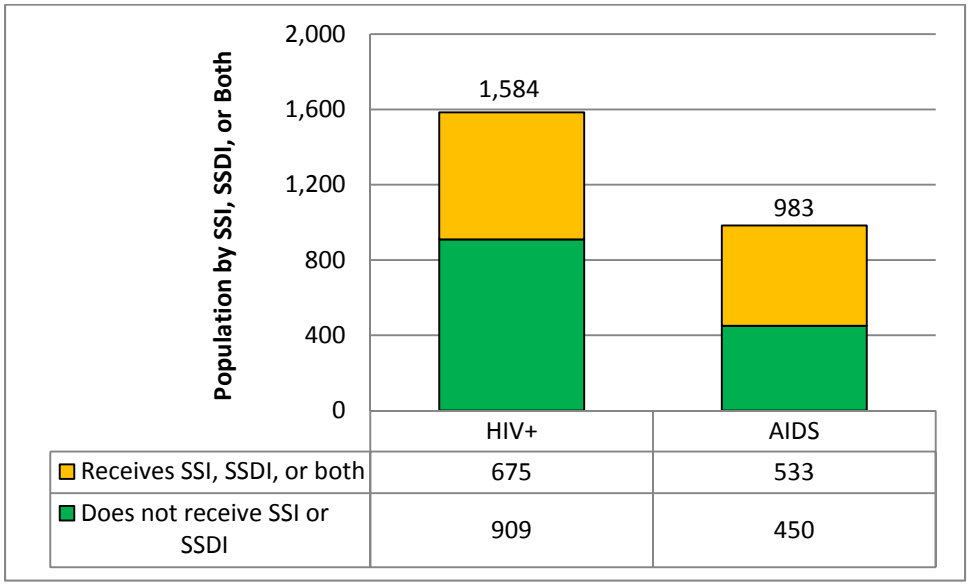


Chart 6.22a.
Criminal Justice History by Receipt of SSI and/or SSDI (weighted)

Criminal justice history		SSI or SSDI, or both		
		No	Yes	Total
		N=1,331 51.7%	N=1,245 48.3%	N=2,576 100%
Neither	Count, weighted	955	639	1,594
	% within Neither	59.9%	40.1%	100.0%
Felony conviction	Count, weighted	213	403	616
	% within Felony conviction	34.6%	65.4%	100.0%
Other jail	Count, weighted	163	203	366
	% within Other jail	44.5%	55.5%	100.0%

Chart 6.22b.
Criminal Justice History by Receipt of SSI and/or SSDI (weighted)

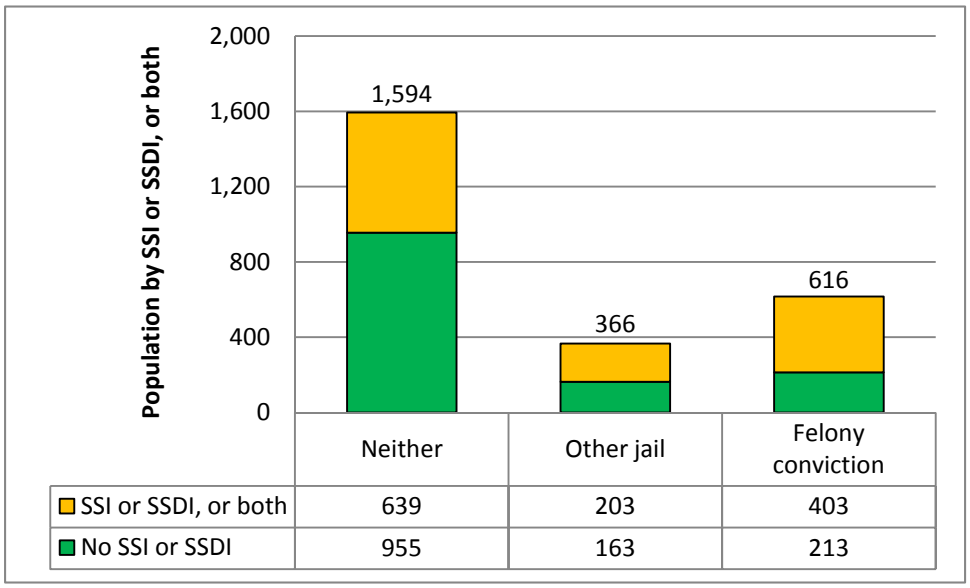


Chart 6.23a. HIV/AIDS Diagnosis by Monthly Income (weighted)

			Income								
			0 None	1 - 350	351 - 700	701 - 1,050	1,051 - 1,750	1,751 - 3,000	3,001 - 5,000+	Missing	Total
Diagnosis	**HIV+**	Number	74	77	112	623	409	159	59	71	1584
		% within HIV+	4.7%	4.9%	7.1%	39.3%	25.8%	10.0%	3.7%	4.5%	100.0%
		% within Income	64.3%	69.4%	48.7%	60.4%	75.9%	57.6%	37.1%	68.3%	61.7%
		% of Total	2.9%	3.0%	4.4%	24.3%	15.9%	6.2%	2.3%	2.8%	61.7%
	AIDS	Number	41	34	118	409	130	117	100	33	982
		% within AIDS	4.2%	3.5%	12.0%	41.6%	13.2%	11.9%	10.2%	3.4%	100.0%
		% within Income	35.7%	30.6%	51.3%	39.6%	24.1%	42.4%	62.9%	31.7%	38.3%
		% of Total	1.6%	1.3%	4.6%	15.9%	5.1%	4.6%	3.9%	1.3%	38.3%
Total		Number	115	111	230	1,032	539	276	159	104	2,566
		% of Total	4.5%	4.3%	9.0%	40.2%	21.0%	10.8%	6.2%	4.1%	100.0%

Chart 6.23b. HIV/AIDS Diagnosis by Monthly Income (HIV+ only)

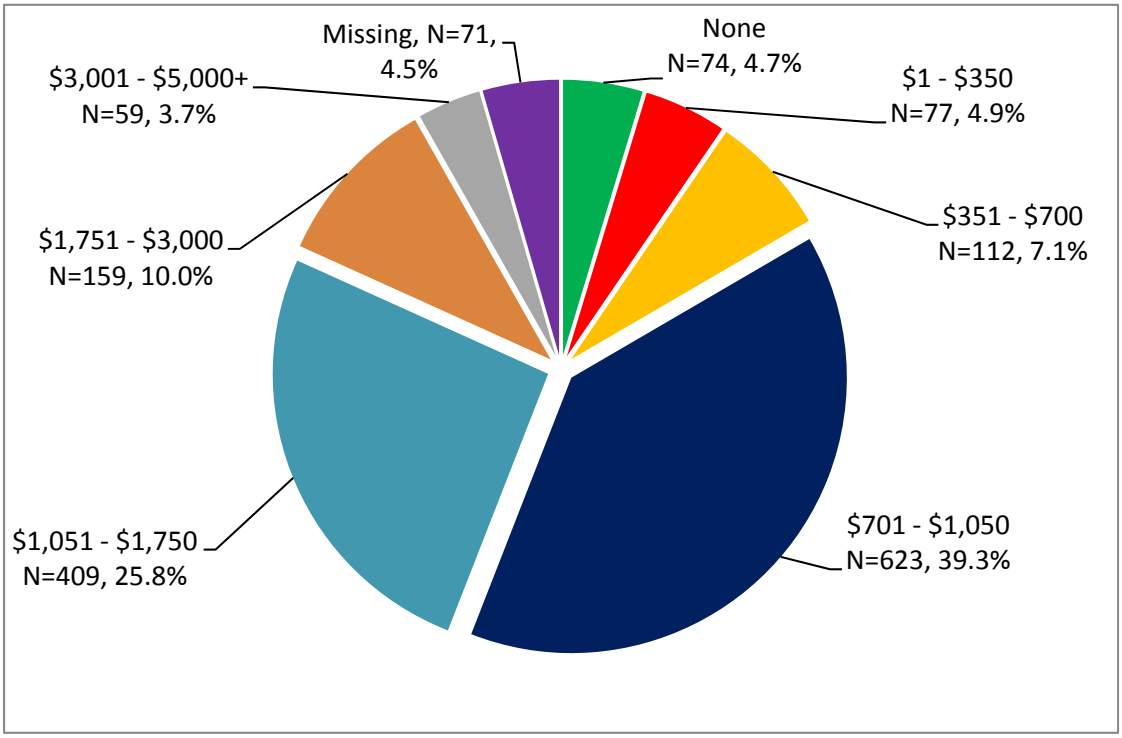
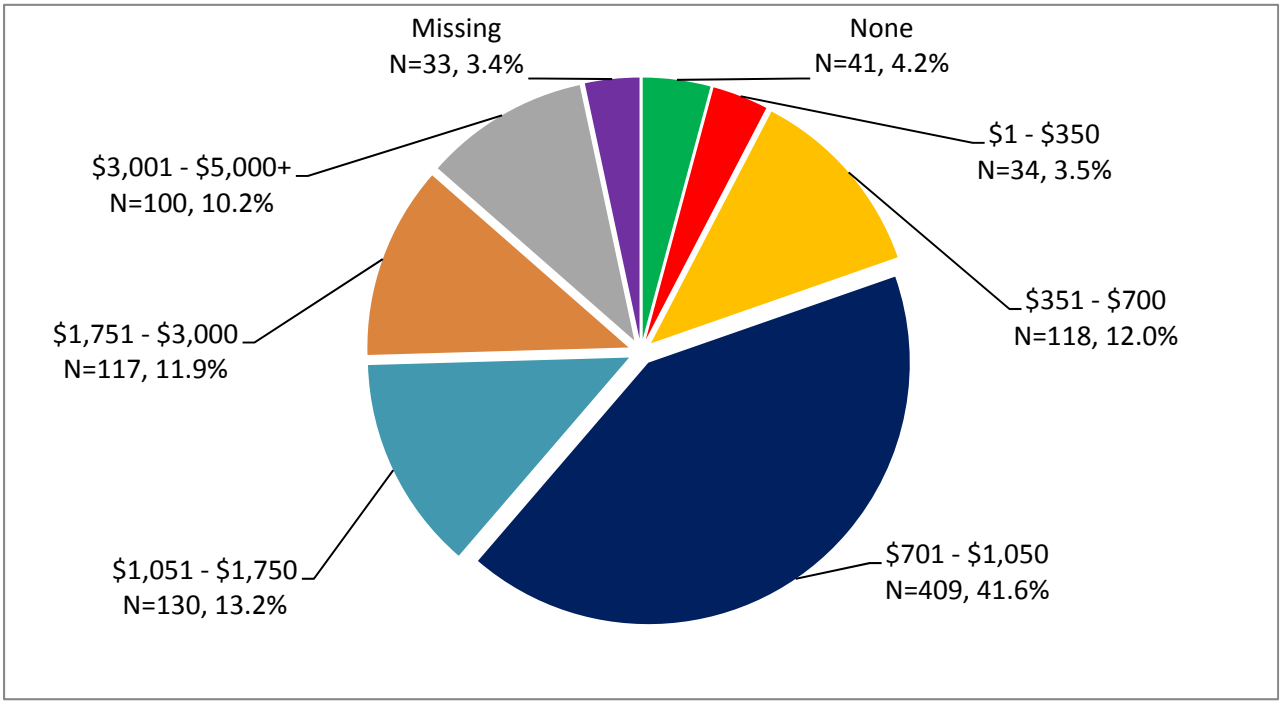


Chart 6.23c. HIV/AIDS Diagnosis by Monthly Income (AIDS only)



In some cases patients' income is supplemented by food stamps (now known as SNAP or, in California, CalFresh (we rely on *SNAP/Food Stamps* or *SNAP* for our charts). Recipients of SSI have a somewhat reduced value of SNAP included in their monthly SSI allocation. This policy does not extend to those with SSDI but does affect those receiving both forms of income. Chart 6.24 displays our estimates of the number and percent of the population receiving SNAP as a benefit included in, and separate from, the SNAP cash value that is received in individuals' SSI checks. Altogether we estimate that 263 individuals, 10.0 percent of the population, receive SNAP benefits outside of SSI cash assistance. Charts 6.25-6.27 examine the association of selected demographic characteristics with receipt of SNAP benefits. Women are 24 percent more likely to receive SNAP benefits compared to men (Chart 6.25). Blacks are 52 percent more likely to receive SNAP benefits than are Whites (Chart 6.26). And non-Latinos are 86 percent more likely than are Latinos (Chart 6.27).

Chart 6.24. Receipt of SNAP/Food Stamps (weighted)

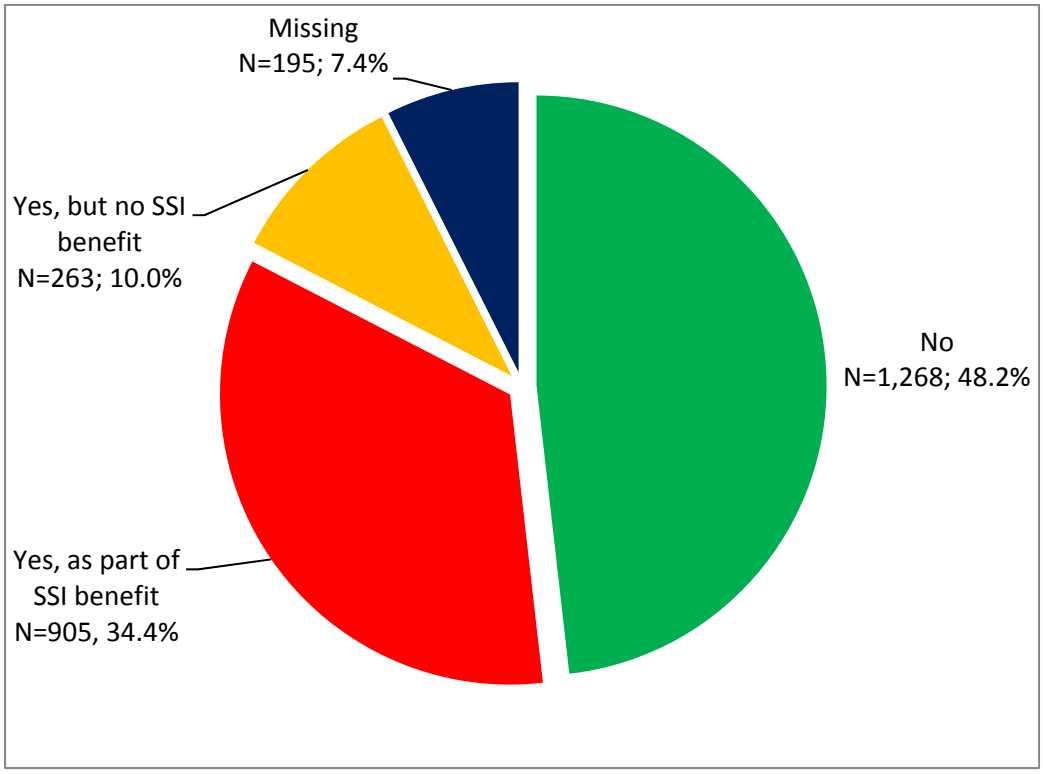


Chart 6.25a. Gender by Receives SNAP or Food Stamps (weighted)

Gender		Receives SNAP		
		No	Yes	Total
		N=1,415 54.8%	N=1,168 45.2%	N=2,583 100.0%
Male	Count, weighted	1,081	763	1,844
	% within Male	58.6%	41.4%	100.0%
Female	Count, weighted	297	312	609
	% within Female	48.8%	51.2%	100.0%
Transgender	Count, weighted	37	93	130
	% within Transgender	28.5%	71.5%	100.0%

Chart 6.25b. Gender by Receives SNAP or Food Stamps (weighted)

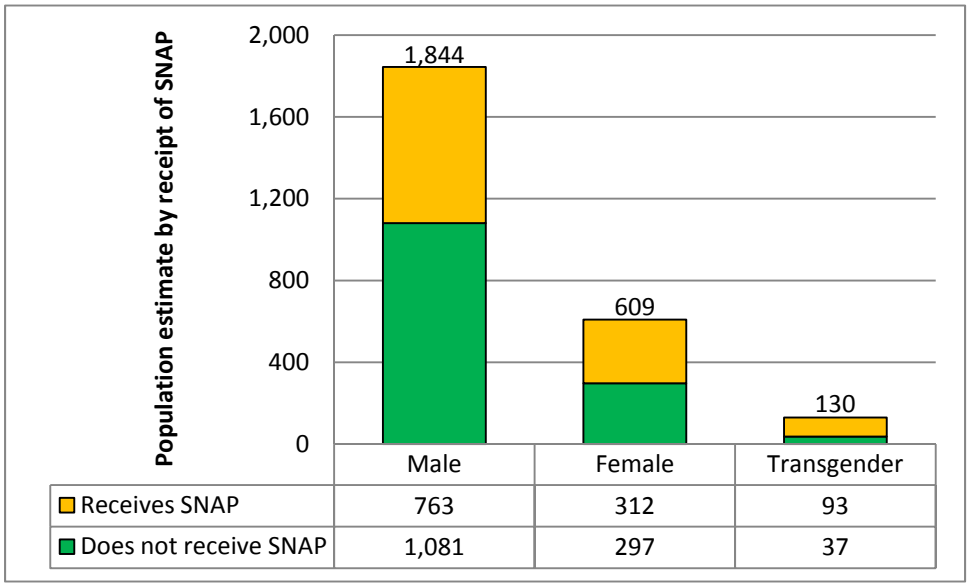


Chart 6.26a. Race by Receives SNAP or Food Stamps (weighted)

Race		Receives SNAP		
		No	Yes	Total
		N=1,415 54.8%	N=1,167 45.2%	N=2,582 100.0%
Black	Count, weighted	675	799	1,474
	% within Black	45.8%	54.2%	100.0%
White	Count, weighted	258	143	401
	% within White	64.3%	35.7%	100.0%
Other, combination	Count, weighted	482	225	707
	% within Other, combination	68.2%	31.8%	100.0%

Chart 6.26b. Race by Receives SNAP or Food Stamps (weighted)

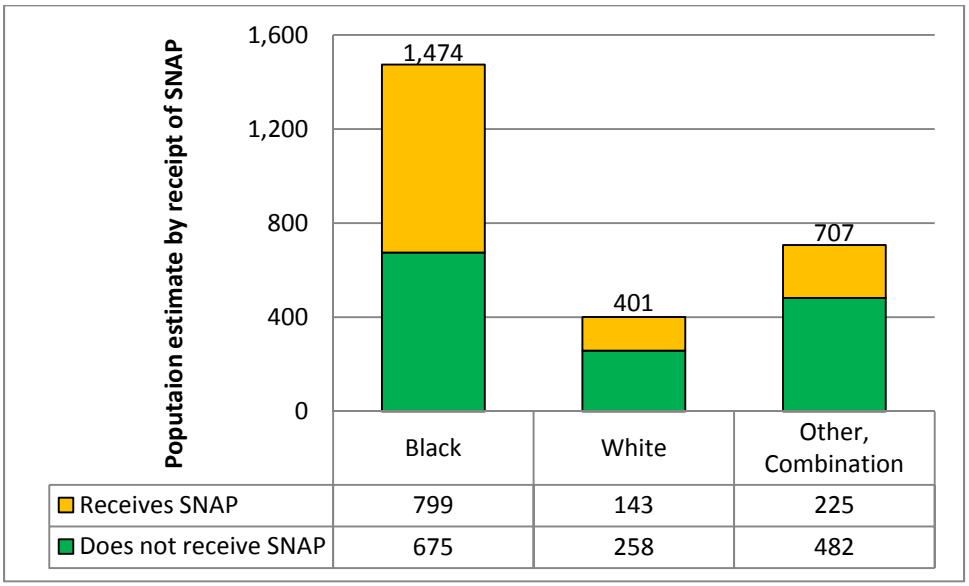
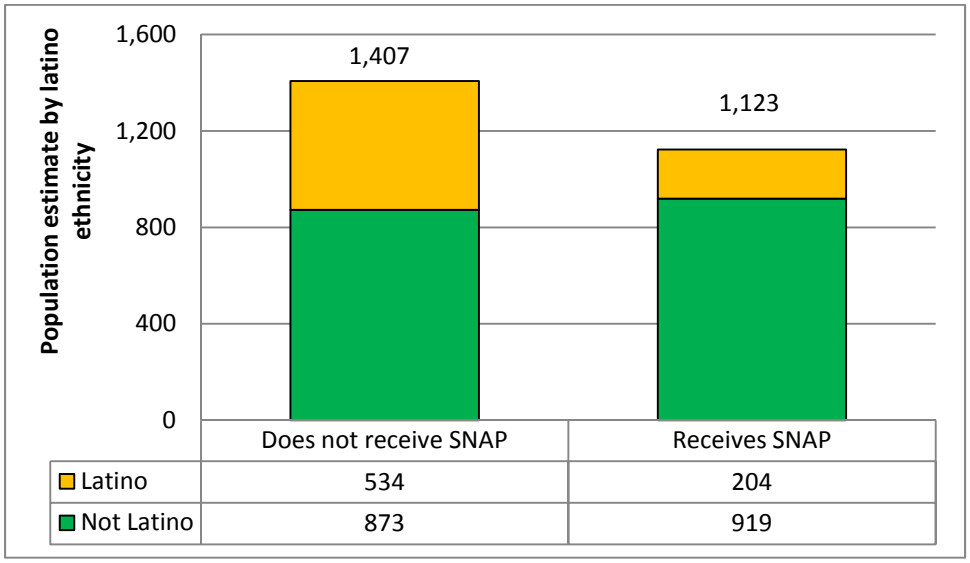


Chart 6.27a.
Latino Ethnicity by Receives SNAP or Food Stamps (weighted)

Latino		Receives SNAP		
		No	Yes	Total
		N=1,407 55.6%	N=1,123 44.4%	N=2,530 100.0%
No	Count, weighted	873	919	1,792
	% within Yes	48.7%	51.3%	100.0%
Yes	Count, weighted	534	204	738
	% within No	72.4%	27.6%	100.0%

Chart 6.27b.
Latino Ethnicity by Receives SNAP or Food Stamps (weighted)



6.5 Housing and Housing Stability

The patient survey examines current housing as well as housing experience for the past three years. From survey participants' report of current housing we categorize members of the population as stably housed (83.5%), as homeless (7.2%), or as unstably housed (9.2%) and then use these categories in subsequent estimates (see Chart 6.28). In several subsequent analyses we combine the homeless and unstably housed populations into one category: *homeless or unstably*

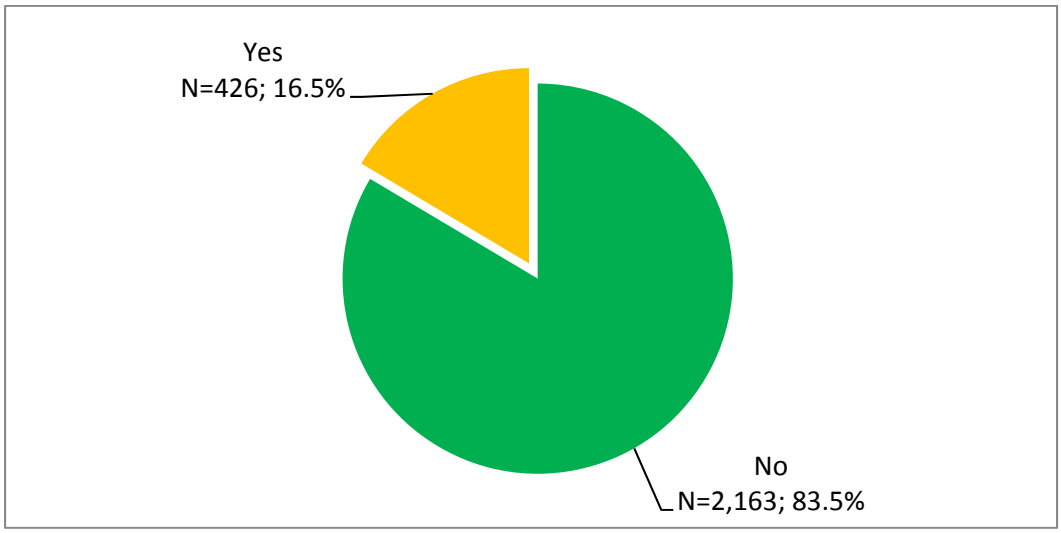
housed. As summarized in Chart 6.29, we estimate that 16.5% of the population is homeless or unstably housed at a point in time.

Chart 6.28. Current Housing (Q28, weighted)

	Number	Percent
Stably housed		
Private rental	1,321	51.0
Shared place, pays rent	510	19.7
Permanent subsidized housing	194	7.5
Condo, mobile home or house, owned	128	4.9
Board and care, nursing home	10	0.4
Subtotal	2,163	83.5
Unstably housed		
Transitional housing	42	1.6
Shared place, no rent	147	5.7
Temporarily doubled-up	43	1.7
Hotel or motel, agency paid	7	0.3
Subtotal	239	9.2
Homeless		
Garage, abandoned building, bus/train/BART station, outside, in car, on streets	101	3.9
Emergency shelter	86	3.3
Subtotal	187	7.2
Total*	2,589	100.0

*Information for an estimated 43 people is unknown.

Chart 6.29. Currently Homeless or Unstably Housed (weighted)



Current housing is not the only housing status variable of interest. The patient survey also inquires about eviction, homelessness or unstable housing, and number of moves in the previous three years, and about difficulty paying rent in the previous three months. Eviction, previous homelessness or unstable housing, and difficulty paying rent may be associated with patients who are at risk of on-going or future housing instability. Multiple moves may be a risk factor for homelessness or unstable housing or, alternatively, a characteristic of someone who is literally moving toward a better housing situation.

Despite the fact that 83.5 percent of the population resides in what we term a stable housing situation (Charts 6.28 and 6.29), housing challenges are widespread within this population. We estimate that one in seven (13.9%) patients has had an eviction in the previous three years – virtually all for inability to pay rent (Chart 6.30). Over four in ten (41.5%) have been homeless or resided in unstable housing in the same three-year period (Chart 6.31). One out of five (19.8%) has moved three or more times in that three-year period (Chart 6.32). And three in ten have had trouble paying rent (or mortgage) in the last three months (Chart 6.33). We estimate that almost one-half (45.2%) of the population has been homeless or unstably housed in the past three years and/or is homeless or unstably housed currently (see Chart 6.51).

Chart 6.30. Eviction in Previous 3 Years (Qs 43-44, weighted)

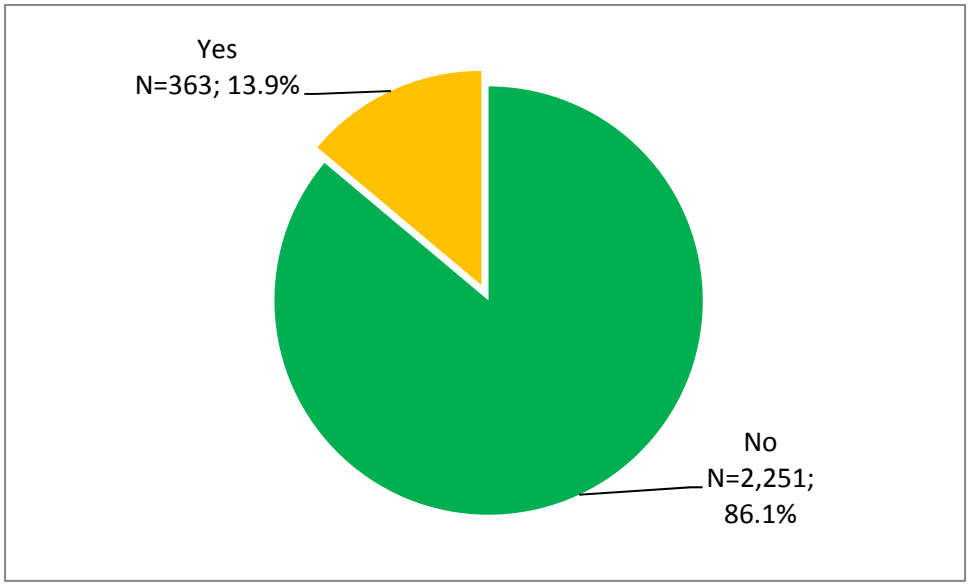


Chart 6.31.
Homelessness or Unstable Housing in Previous 3 Years (Q35, weighted)

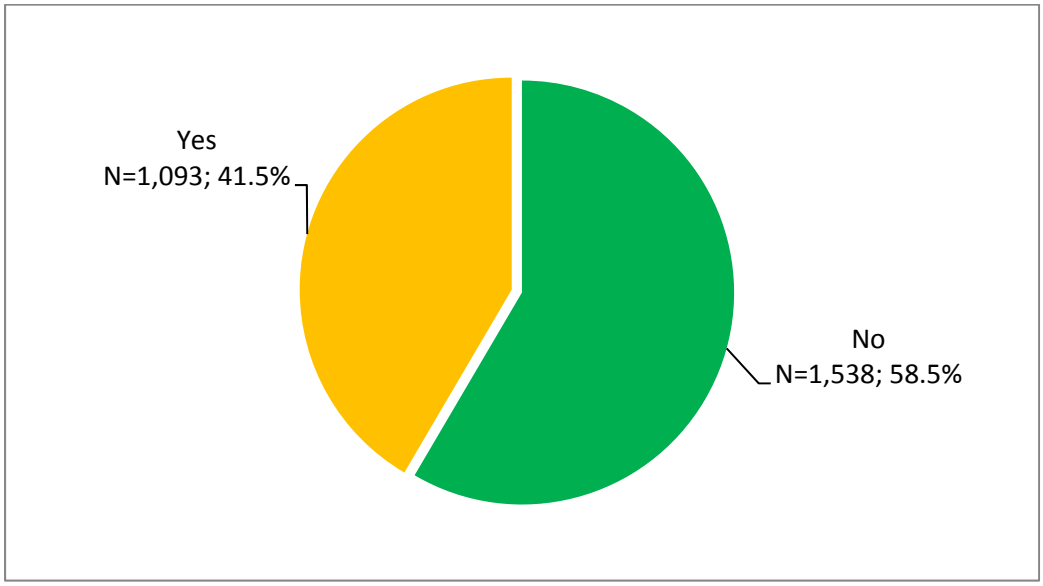


Chart 6.32. Three or More Moves in Previous 3 Years (Q42, weighted)

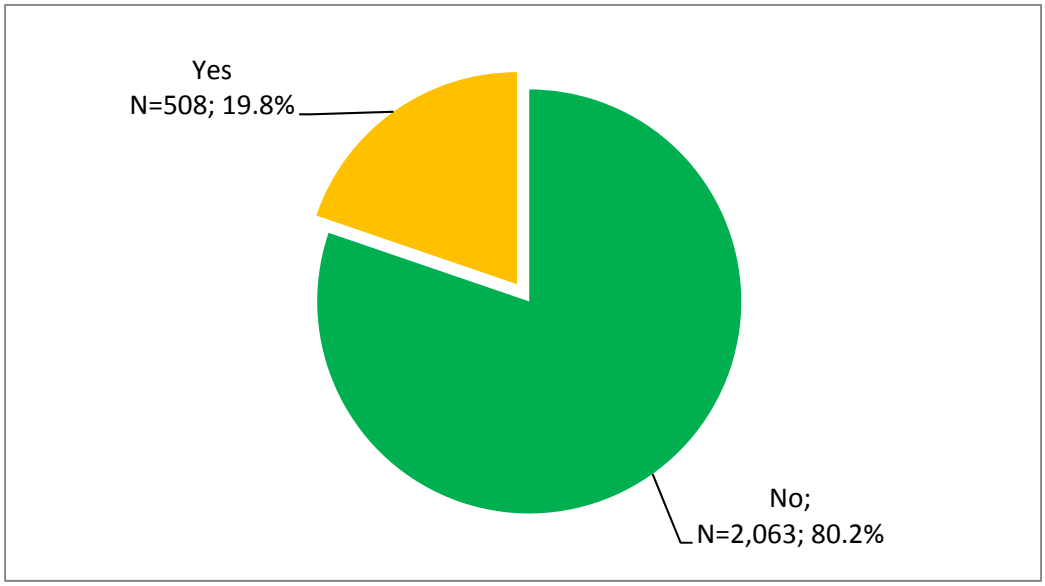
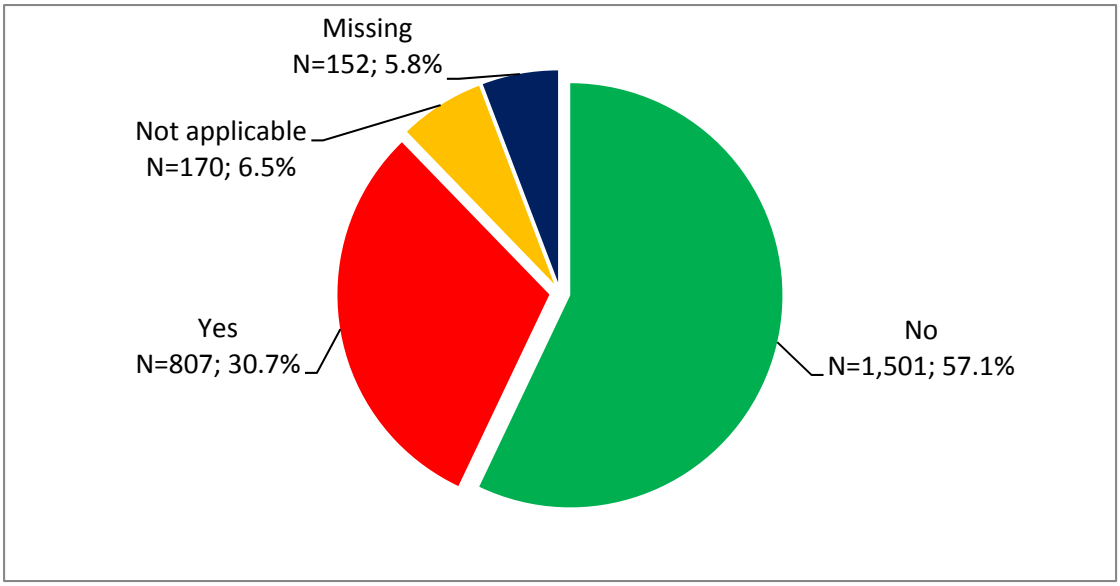


Chart 6.33. Problem Paying Rent in Previous 3 Months (Q37, weighted)



Along another dimension of possible housing instability, the survey inquires about housing and neighborhood problems. In the case of housing problems, we ask whether the survey participant's housing has any of eleven problems (kitchen, heat, plumbing, mold/mildew, water leaks, and others). The neighborhood question had a higher threshold in that is asks if the participant has considered moving because of any of nine neighborhood problems (examples include drug activity, violence, stigma because of HIV status, gangs, and harassment). While we

estimate that two-thirds (62.7%) of patients report no housing problem, the other one-third report from one to seven problems (Chart 6.34). Even though it was a more stringent question – asking participants to respond only if they had considered moving because of a neighborhood problem – and although 11 percent of participants did not answer the question, 33.8 percent (100% - 55.2% - 11.0%) reported one or more problem (Chart 6.35).

The number of problems would be expected to vary with housing status, and Chart 6.36 displays the average number of problems by whether or not population members are currently stably housed. In terms of problems with housing, those currently homeless or unstably housed reported 2.5 times the number of problems that those stably housed report: 1.6 versus 0.6. The situation is reversed concerning neighborhood problems. Low-income PLWHA who are stably housed have one-third more the number of neighborhood problems of patients who are homeless or unstably housed: 1.1 versus 0.8 (Chart 6.36).

Chart 6.34.
Number of Problems with Current Housing (Q32, weighted)

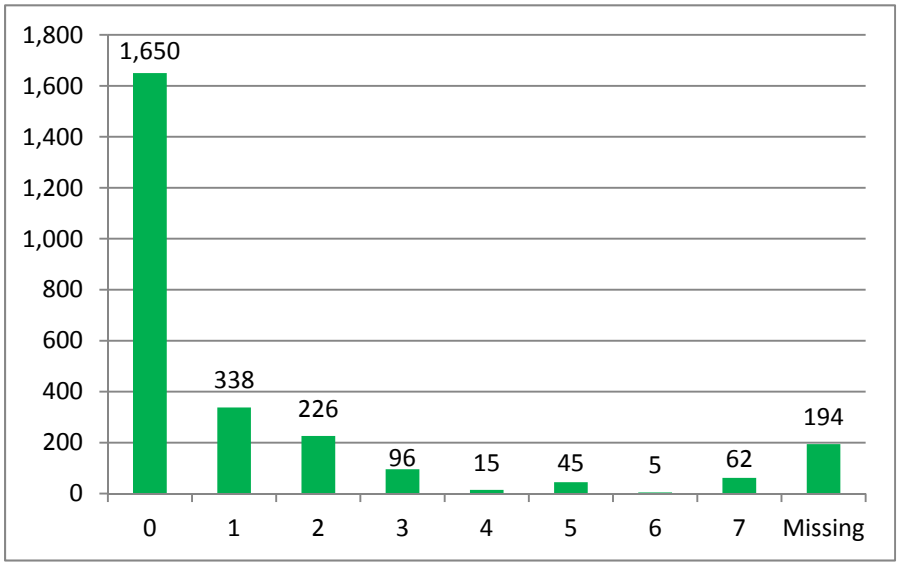


Chart 6.35. Number of Problems with Current Neighborhood (Q33, weighted)

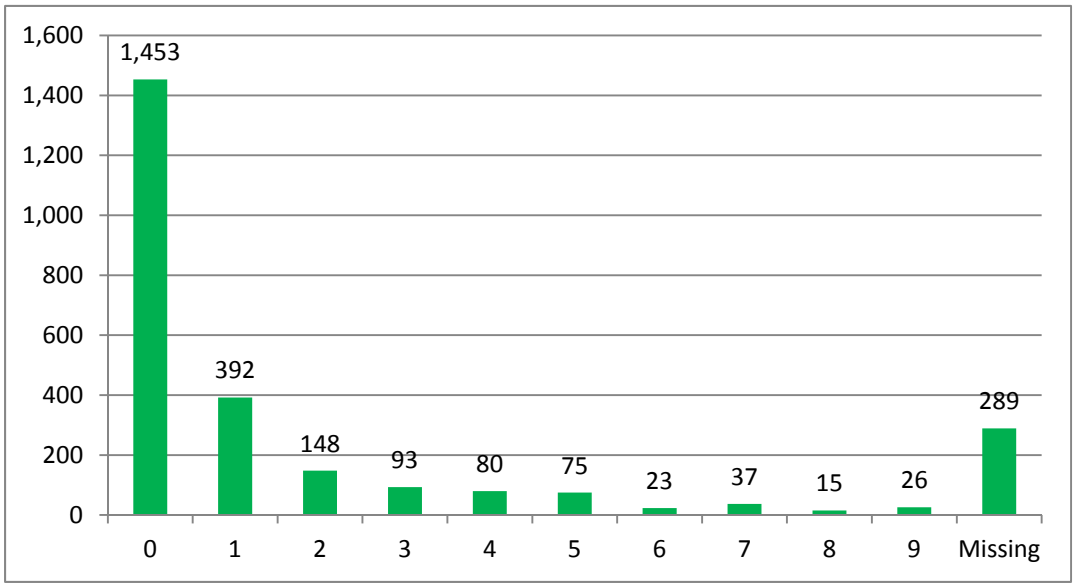
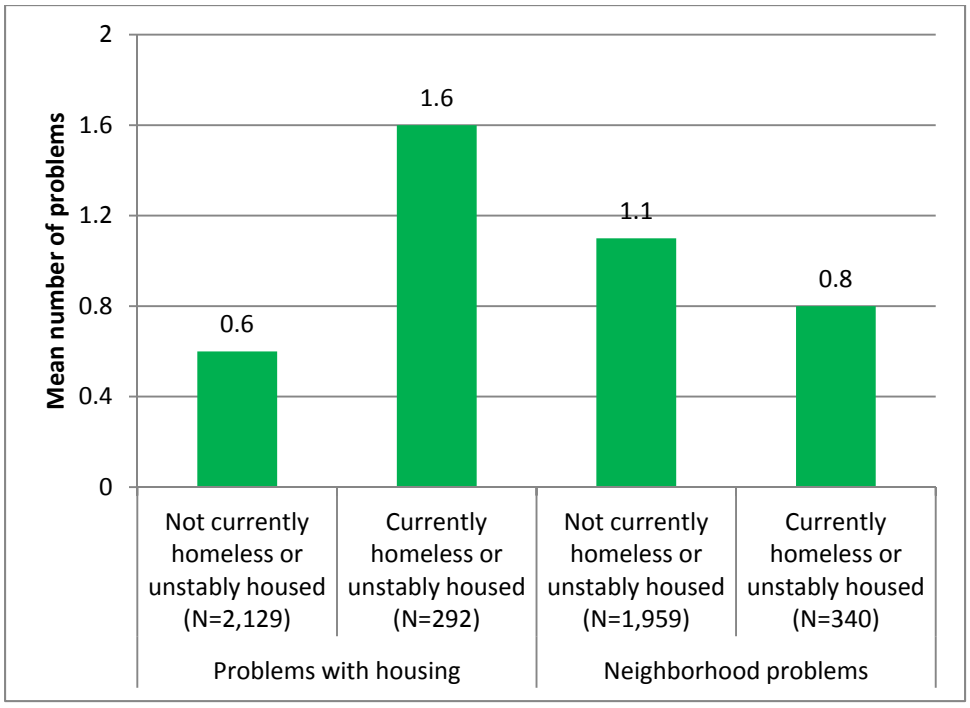
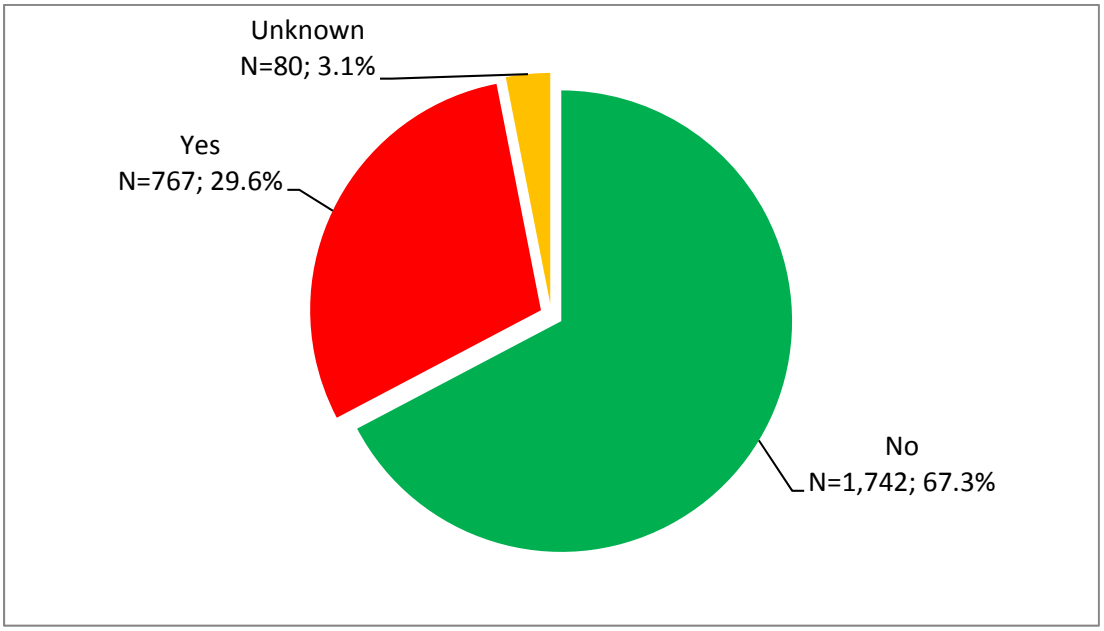


Chart 6.36. Mean Number of Housing and Neighborhood Problems by Housing Status (weighted)



Not surprisingly, we find a relationship between housing problems and receipt of rental assistance. We estimate that 29.6 percent of low-income PLWHA receive a rental subsidy or other financial assistance (hereinafter, rental subsidy) (Chart 6.37).

Chart 6.37. Receipt of Rental Subsidy (Qs 35, 36, 38, weighted)



While 36 percent of those with none or one problem receive a rental subsidy, the proportion drops by one-half (to 17.0%) among those reporting two or more problems (Chart 6.38). This finding suggests that – as mandated by program regulations – clients may not use a subsidy to rent a unit that fails to meet housing quality standards. However, a similar relationship does not hold for neighborhood problems. Although we estimate that 27.4 percent of patients who report no neighborhood problems receive a rental subsidy, between 37.8 and 42.1 percent of patients in neighborhoods with one or more problems report a subsidy (Chart 6.39). The next section of the report examines rental subsidies in greater detail.

Chart 6.38a.
Number of Housing Problems by Receipt of Rental Assistance (weighted)

Number of housing problems		Rental Assistance		
		No	Yes	Total
		N=1,590 67.5%	N=766 32.5%	N=2,356 100.0%
None	Count, weighted	1,016	572	1,588
	% within None	64.0%	36.0%	100.0%
One	Count, weighted	209	119	328
	% within One	63.7%	36.3%	100.0%
Two or more	Count, weighted	365	75	440
	% within Two or more	83.0%	17.0%	100.0%

Chart 6.38b.
Number of Housing Problems by Receipt of Rental Assistance (weighted)

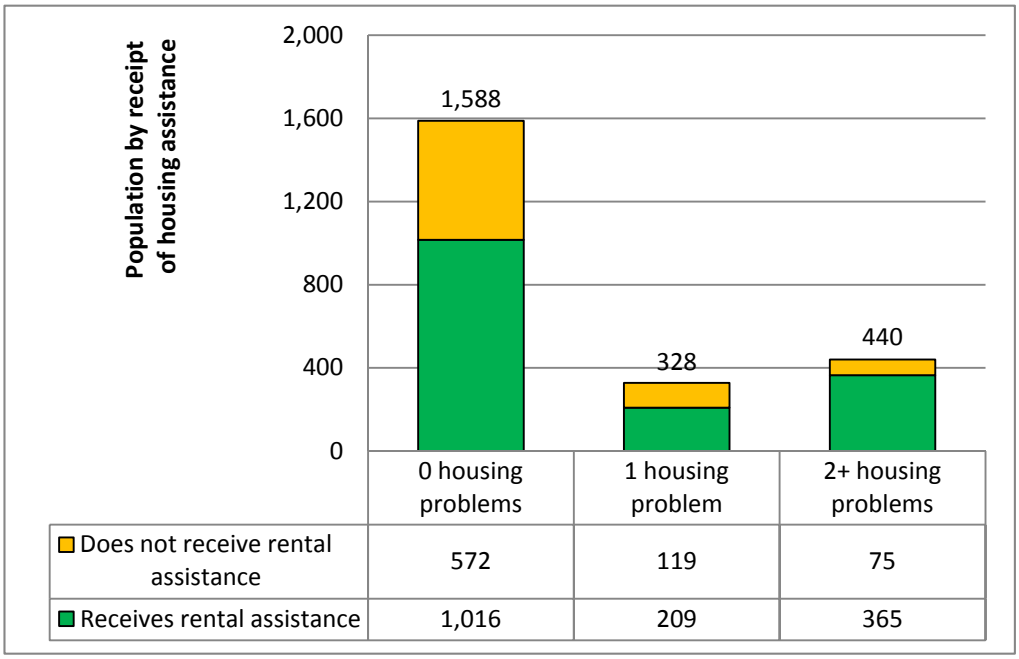
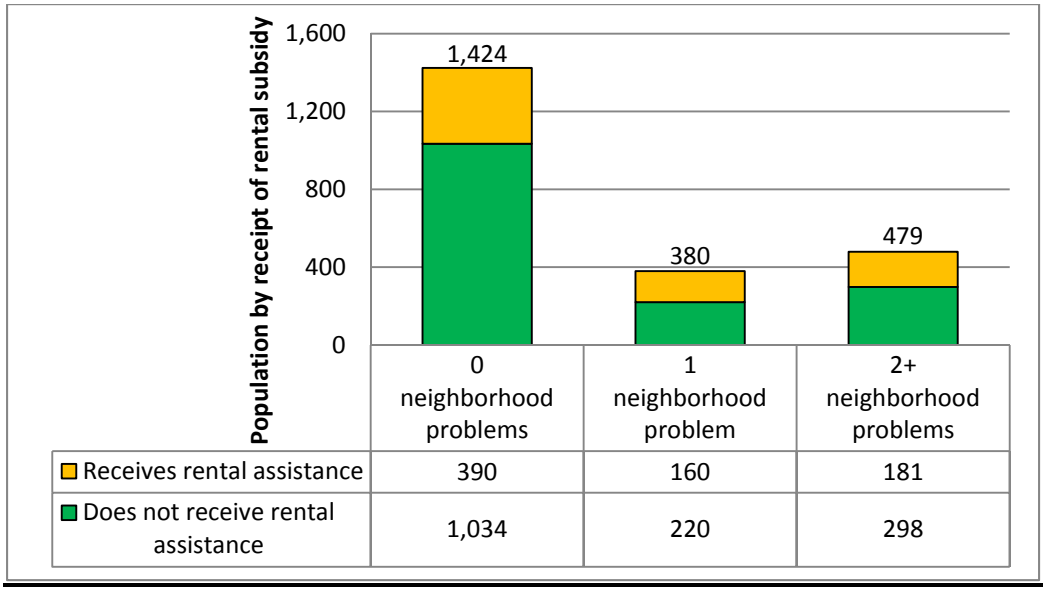


Chart 6.39a.
Number of Neighborhood Problems by Receipt of Rental Subsidy (weighted)

Number of neighborhood problems		Rental Assistance		
		No	Yes	Total
		N=1,552 68.0%	N=731 32.0%	N=2,283 100.0%
None	Count, weighted	1,034	390	1,424
	% within None	72.6%	27.4%	100.0%
One	Count, weighted	220	160	380
	% within One	57.9%	42.1%	100.0%
Two or more	Count, weighted	298	181	479
	% within Two or more	62.2%	37.8%	100.0%

Chart 6.39b.
Number of Neighborhood Problems by Receipt of Rental Subsidy (weighted)



6.6 Characteristics Associated with Homelessness or Unstable Housing

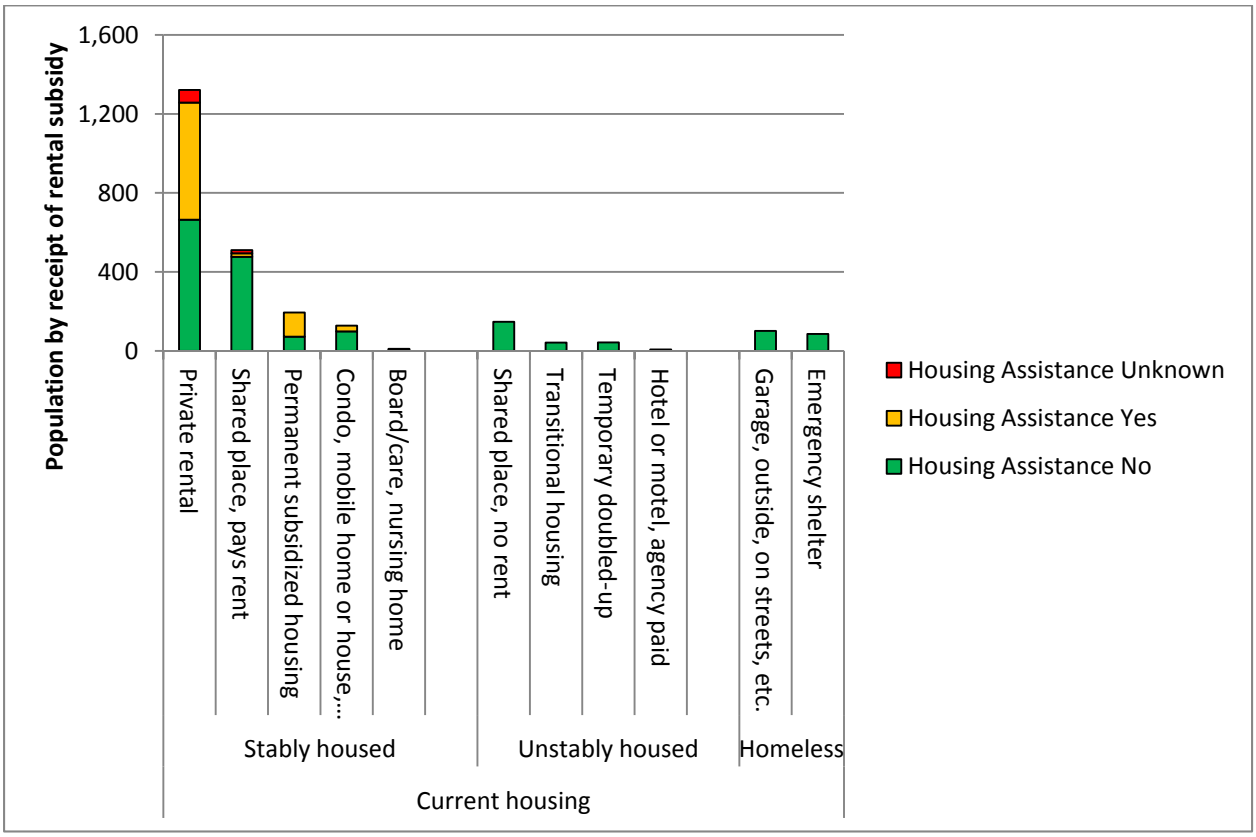
Chart 6.40 records the overlay of rental subsidy by housing type. Two-thirds (62.9%) of those in permanent subsidized housing receive a subsidy, as do 44.9 percent of those residing in private rental housing. These relationships are expressed graphically in Chart 6.40b, which groups the low-income HIV+ population by those stably housed, unstably housed, and homeless.

Chart 6.40a. Current Housing by Receipt of Rental Subsidy or Assistance (weighted)

Housing Type	Rental Subsidy				Total
	No	Yes	Unknown	% Yes*	
Private rental	664	593	64	44.9	1,321
Shared place, pays rent	476	18	16	3.1	510
Permanent subsidized housing	72	122	0	62.9	194
Condo, mobile home or house, owned	99	29	0	22.7	128
Board & care, nursing home	5	5	0	0	10
Shared place, no rent	147	0	0	0	147
Transitional housing	42	0	0	0	42
Temporarily doubled-up	43	0	0	0	43
Hotel or motel, agency paid	7	0	0	0	7
Garage, abandoned building, bus / train / BART station, outside, in car, on	101	0	0	0	101
Emergency shelter	86	0	0	0	86
Total	1,742	767	80	29.6	2,589

* In light of the unknowns, percent yes (yes/(no + yes + unknown)) is a minimum.

Chart 6.40b. Current Housing by Receipt of Rental Subsidy (weighted)



We now examine the personal characteristics and other conditions that are associated with stable as opposed to unstable housing or homelessness. First we consider demographic characteristics.

Chart 6.41 suggests that younger, low-income PLWHA are less likely to be homeless or unstably housed (7.8%), compared, at the other extreme, to the 30-49-year-old sector of the population (19.6% homeless or unstably housed).[10]

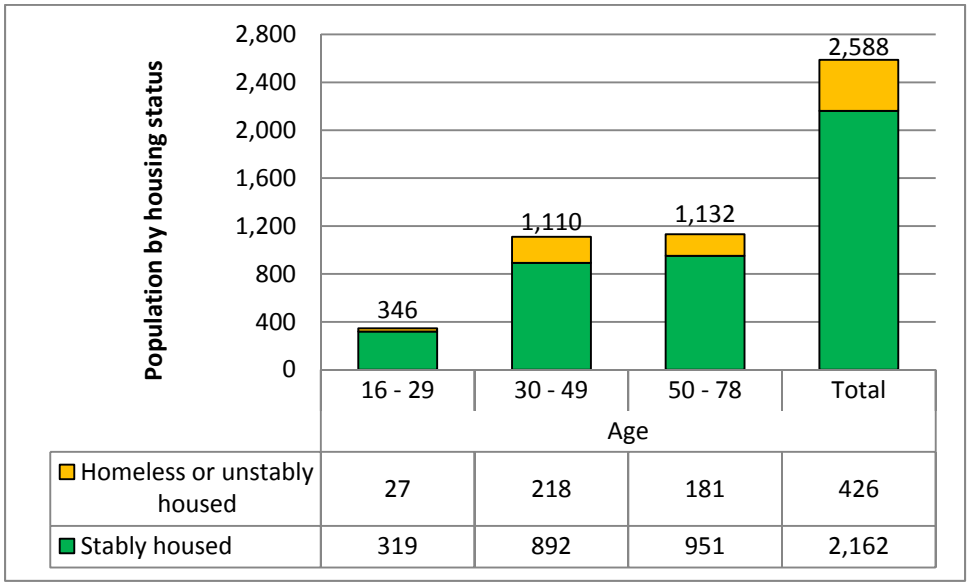
By a small margin Whites are more likely than Blacks to be homeless or unstably housed (data not presented by chart), but, given their predominance among the low-income HIV+ population in primary care, Blacks nevertheless account for two-thirds (67.4%) of those who are homeless or unstably housed (Chart 6.42).

Chart 6.41a. Age by Current Housing Status (weighted)

		Current Housing Status		
		Stably housed	Homeless or unstably housed	Total
Age		N=2,162 83.5%	N=426 16.5%	N=2,588 100.0%
16 - 29	Count, weighted	319	27	346
	% within 16-29	92.2%	7.8%	100.0%
30 - 49	Count, weighted	892	218	1,110
	% within 30-49	80.4%	19.6%	100.0%
50 - 78	Count, weighted	951	181	1,132
	% within 50-78	84.0%	16.0%	100.0%

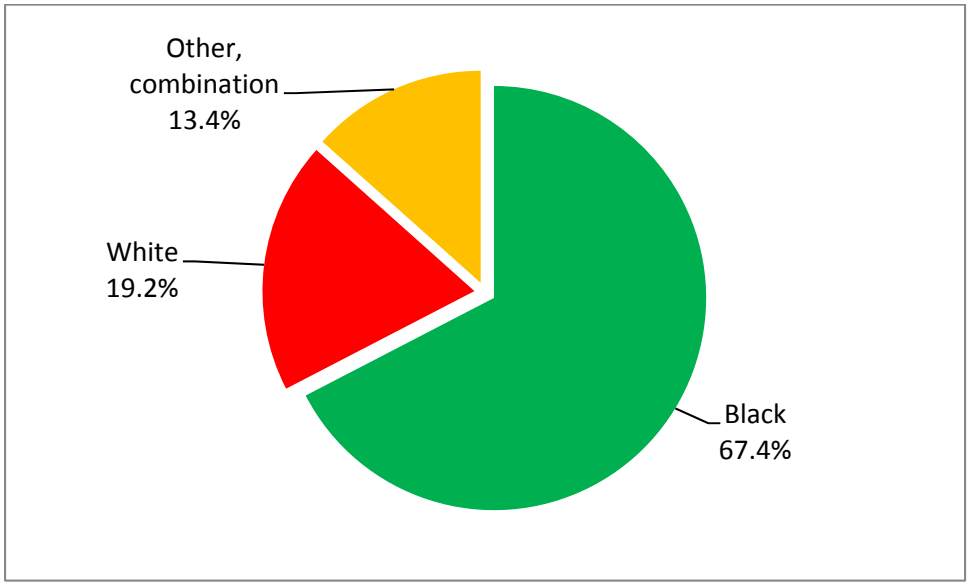
[10] One colleague noted, "It takes a while to burn your bridges."

Chart 6.41b. Age by Current Housing Status (weighted)



	16 - 29	30 - 49	50 - 78	Total
Homeless or unstably housed	27	218	181	426
Stably housed	319	892	951	2,162

Chart 6.42.
Currently Homeless or Unstably Housed by Race (weighted)



Persons diagnosed with AIDS are much more likely to be homeless or unstably housed than are members of the HIV+ only population (20.8% versus 11.6%; see Chart 6.43).

Chart 6.43a.
HIV+/AIDS Diagnosis by Current Housing Status (weighted)

Diagnosis		Current Housing Status: Stably housed N=2,142 84.9%	Homeless or unstably housed N=381 15.1%	Total N=2,523 100.0%
HIV+	Count, weighted	1,386	182	1,568
	% within HIV+	88.4%	11.6%	100.0%
AIDS	Count, weighted	756	199	955
	% within AIDS	79.2%	20.8%	100.0%

Chart 6.43b.
HIV+/AIDS Diagnosis by Current Housing Status (weighted)

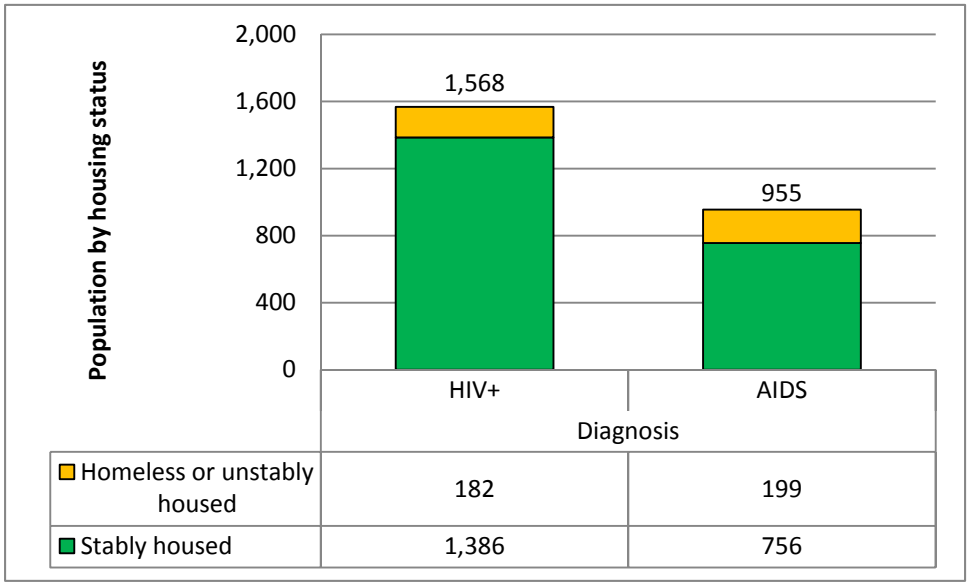
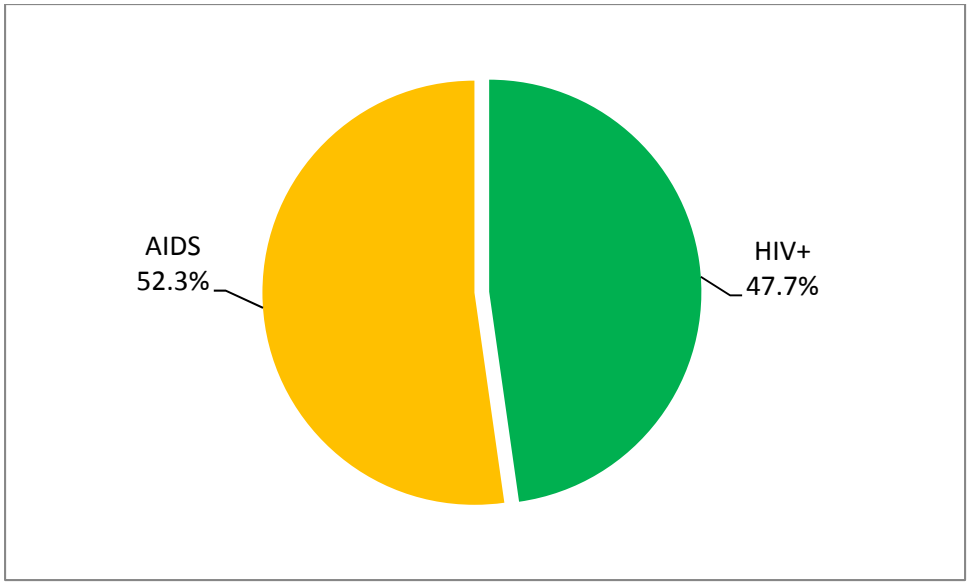


Chart 6.43c.
Currently Homeless or Unstably Housed by HIV+/AIDS Diagnosis (weighted)



As displayed in Chart 6.44, gay and bisexual men are the majority within the low-income PLWHA population that is homeless or unstably housed. It is transgender members of the population and bisexual men who are *most likely* to be homeless or unstably housed (respectively 43.8% and 26.3%) compared to gay men (15.1%), heterosexual men (14.8%), and heterosexual women (9.4%) (see Chart A17.1 in Appendix 17). Some characteristics of the bisexual and transgender populations may prove helpful in interpreting these findings. Bisexual men report the lowest score for medical problems (mean of 3.5 compared to 4.0 for gay men, 4.3 for heterosexual men, and 5.5 for heterosexual women). At the same time bisexual men have spent by far the most time on the streets in the past 12 months (mean 49.9 days compared to 16.5 days for heterosexual women, 14.2 days for heterosexual men, and 7.1 days for gay men).[11]

[11] Given the small numbers in the sample (and the population), and the instability of related findings, we do not pursue a similar discussion about the transgender population.

Chart 6.44a. Currently Homeless or Unstably Housed by Gender and Sexual Orientation (weighted)

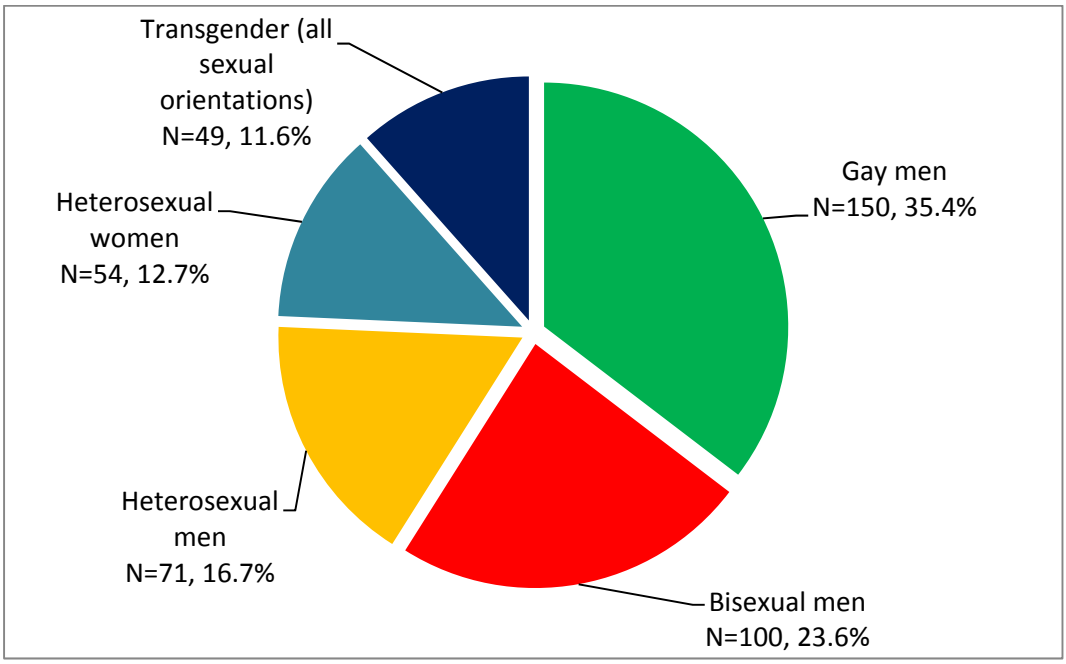
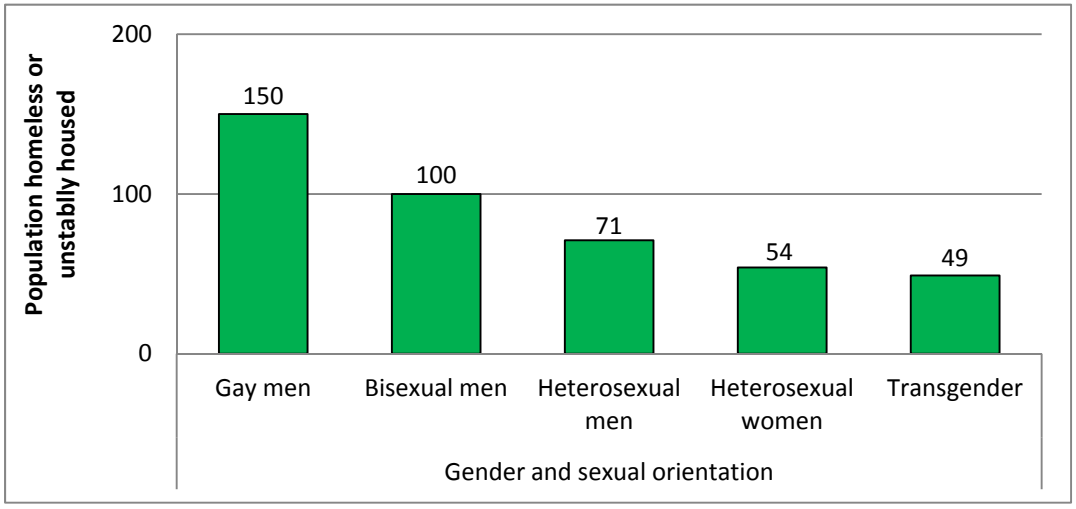


Chart 6.44b.
Gender and Sexual Orientation by Current Housing Status (weighted)



Three-quarters (76.8%) of the population that is homeless or unstably housed are people living alone (Chart 6.45a), and, compared to those in other household types, people living alone are much more likely to be homeless or unstably housed (Chart 6.45b).[12]

Chart 6.45a.
Currently Homeless or Unstably Housed by Household Type (weighted)

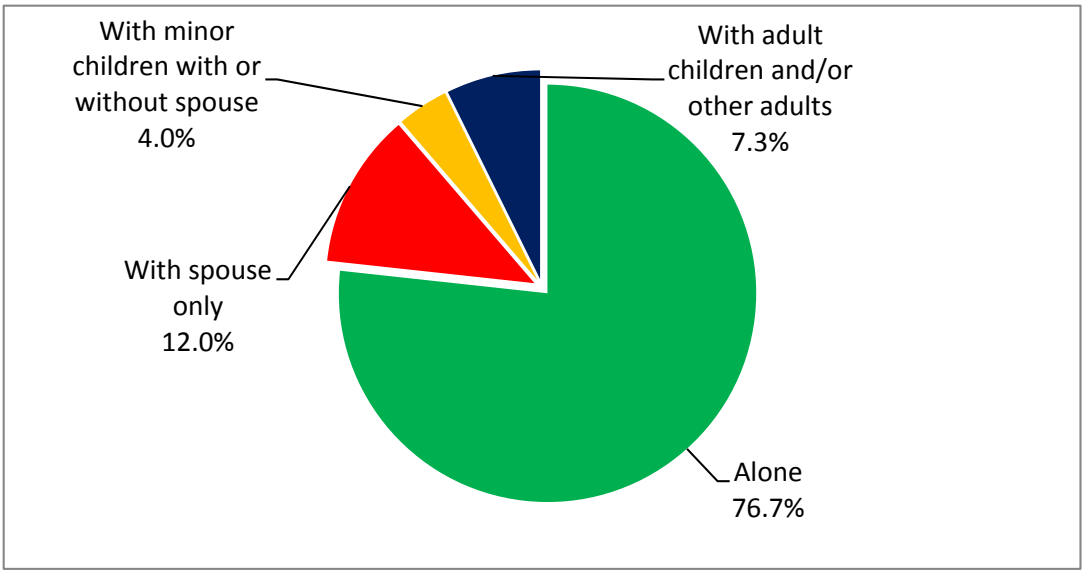
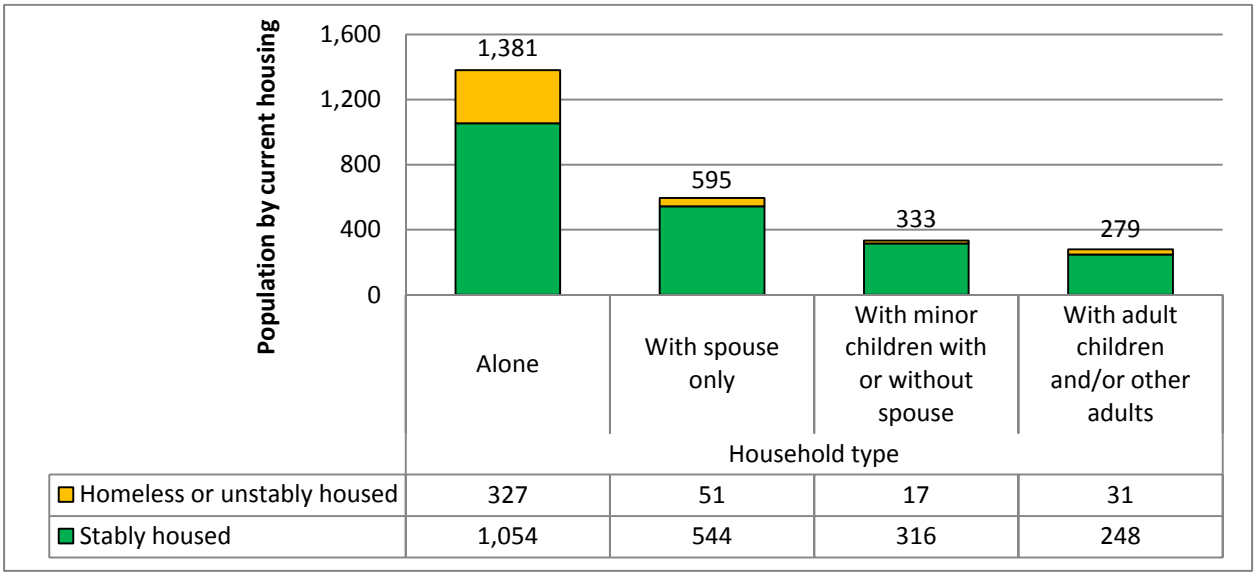


Chart 6.45b. Currently Homeless or Unstably Housed by Household Type (weighted)



	Alone	With spouse only	With minor children with or without spouse	With adult children and/or other adults
Homeless or unstably housed	327	51	17	31
Stably housed	1,054	544	316	248

[12] Being homeless or unstably housed may result in being alone. And lack of other family members may result in greater challenges in securing housing; hence lead to homelessness or housing instability.

Members of the population with felony records or other jail histories are two-and-a-half times as likely to be homeless or unstably housed as those with no criminal history (respectively 26.1% and 27.3% versus 10.5%; Chart 6.46).

Chart 6.46a. Criminal Justice History by Current Housing Status (weighted)

Criminal justice history		Current housing status: Stably housed N=2,123 83.3%	Homeless or unstably housed N=426 16.7%	Total N=2,549 100.0%
Neither	Count, weighted	1,402	165	1,567
	% within Neither	89.5%	10.5%	100.0%
Felony conviction	Count, weighted	455	161	616
	% within Felony conviction	73.9%	26.1%	100.0%
Other jail	Count, weighted	266	100	366
	% within Other jail	72.7%	27.3%	100.0%

Chart 6.46b. Criminal Justice History by Current Housing Status (weighted)

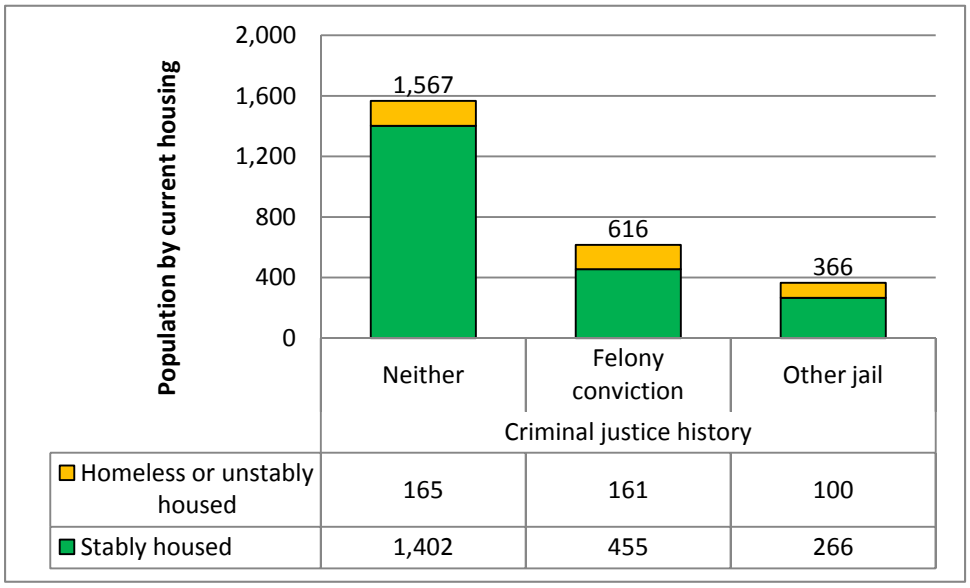


Chart 6.47 examines the relationship between income and housing status. A consistent trend is evident for much of the population. While we estimate that over half (56.5%) of the population with no income is homeless or unstably housed, that percent drops by almost 20 points (to 37.8%) for those with income in the $1 - $350/month range and continues on a downward slope

until, for the group with an income between $1,051 and $1,750, only 3.2% are estimated to be homeless or unstably housed.[13]

The next chart examines the relationship between receipt of SSI and/or SSDI and housing status (Chart 6.48). We estimate among the population without SSI and/or SSDI benefits 14.1 percent are homeless or unstably housed. Among SSI/SSDI recipients, that proportion jumps by one-third to 18.9 percent. Controlling for income level does not erase this effect. In Chapter 7 we recommend that future research examine implications of this potentially counter-intuitive finding; that is, that a consistent income flow might be associated with greater housing instability.

Chart 6.49 considers whether SNAP, independent of SSI, is associated with reduced homelessness or unstable housing. We estimate that one in five (19.3%) SSI recipients is homeless or unstably housed.[14] Among members of the patient population not receiving SSI, we estimate that 15.5 percent of those not receiving SNAP are homeless or in unstable housing, but only 6.4 percent of those receiving SNAP have that housing status. As we note further in the discussion below, we do not conclude that receipt of SNAP protects individuals from homelessness. It may be that stable housing promotes access to SNAP as well as other benefits or that the salient aspect of SNAP, independent of SSI receipt, is the lack of a formal disability.

While we estimate that one in four (24.5%) low-income PLWHA without rental subsidy is homeless or in unstable housing, no recipient of a rental subsidy is currently homeless or residing in unstable housing (Chart 6.50).[15]

[13] We note that the small sample size makes findings for the *none* and *$1-$350* groups unstable.

[14] Note distinctions between Charts 6.48 and 6.49. Chart 6.48 uses the combined SSI and/or SSDI category. Chart 6.49 focuses only on SSI.

[15] For an estimated 81 members of the population rental subsidy is unknown to them, although based on current housing information that survey participants provide we determine it very likely that all 81 patients do, in fact, have a rental subsidy. This highlights the confusion that patients experience about whether or not they benefit from a rental subsidy, presumably an important economic fact to each.

Chart 6.47a. Monthly Income by Current Housing Status (weighted)

Monthly Income		Currently homeless or unstably housed: No N=2,164 83.6%	Yes N=425 16.4%	Total N=2,589 100%
None	Count, weighted	50	65	115
	% within Income	43.5%	56.5%	100.0%
$1 - $350	Count, weighted	69	42	111
	% within Income	62.2%	37.8%	100.0%
$351 - $700	Count, weighted	178	52	230
	% within Income	77.4%	22.6%	100.0%
$701 - $1,050	Count, weighted	875	175	1050
	% within Income	83.3%	16.7%	100.0%
$1,051 - $1,750	Count, weighted	541	18	559
	% within Income	96.8%	3.2%	100.0%
$1,751 - $3,000	Count, weighted	256	20	276
	% within Income	92.8%	7.2%	100.0%
$3,001 - $5,000+	Count, weighted	131	29	160
	% within Income	81.9%	18.1%	100.0%
Missing	Count, weighted	64	24	88
	% within Income	72.7%	27.3%	100.0%

Chart 6.47b. Currently Homeless or Unstably Housed by Monthly Income (weighted)

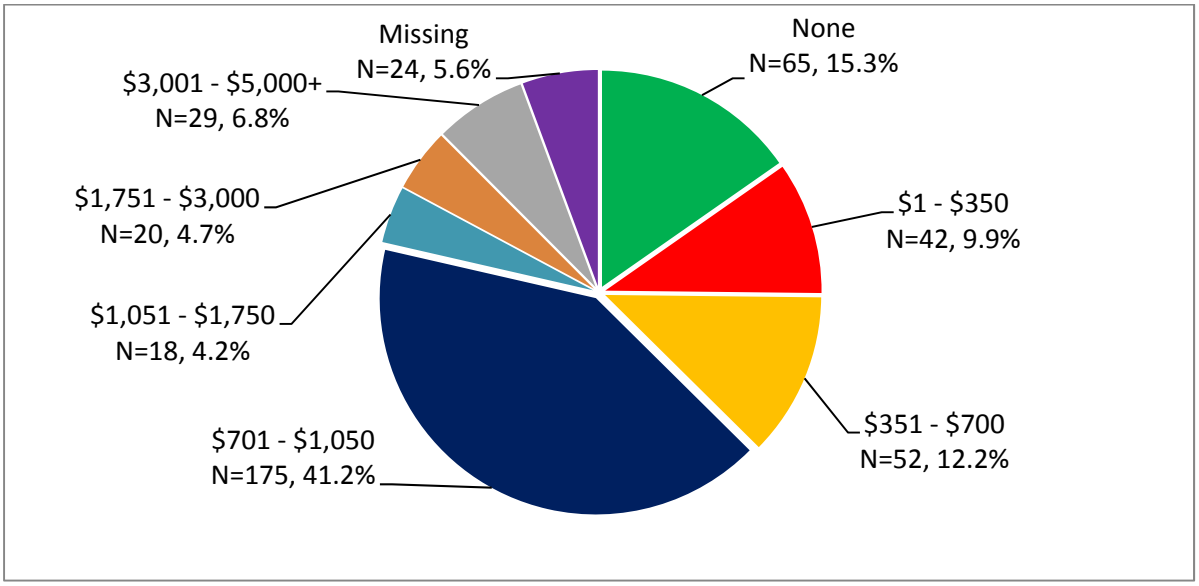


Chart 6.48.
Receives SSI and/or SSDI by Current Housing Status (weighted)

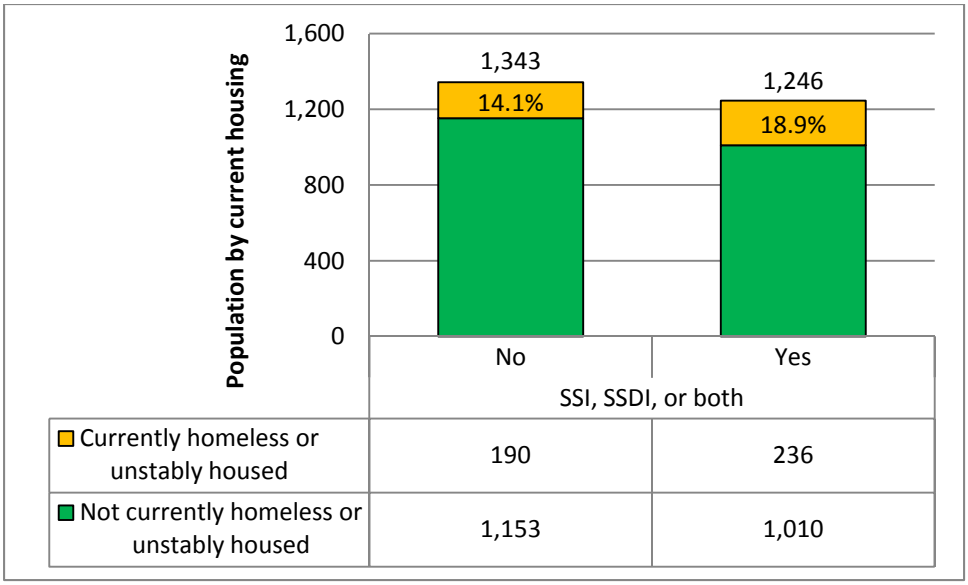


Chart 6.49.
Receives SNAP or Food Stamps by Current Housing Status (weighted)

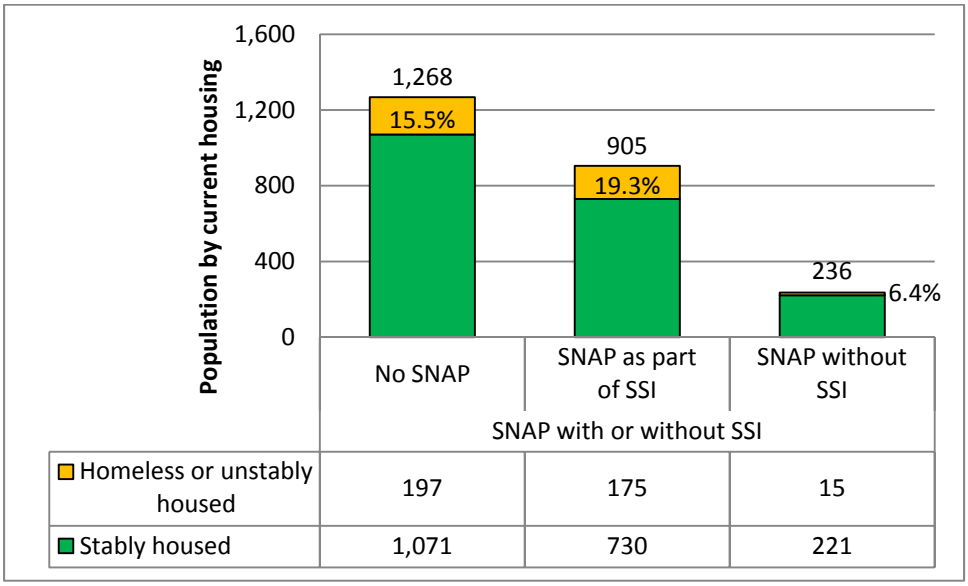


Chart 6.50. Receipt of Rental Subsidy by Current Housing Status (weighted)

Rental Subsidy	Currently homeless or unstably housed					
	No N = 2,163 (83.5%)		Yes N = 426 (16.5%)		Total N = 2,589 (100.0%)	
	N	%	N	%	N	%
No	1,315	75.5%	426	24.5%	1,741	100.0%
Yes	767	100.0%	0	0%	767	100.0%
Unknown	81	100.0%	0	0%	81	100.0%

We now consider the relationship between housing difficulties *in the previous three years* and *current* housing stability. Chart 6.51 displays the estimate that 31.8 percent of persons who were homeless or unstably housed in the past three years are currently homeless or unstably housed. This is six times the 5.2 percent rate of current homelessness or unstable housing among those stably housed in the past three years. The percent of the population homeless or unstably housed in the past three years and/or currently totals 45.2 percent. Both having been evicted in the previous three years (Chart 6.52) and having moved three or more times in that time period (Chart 6.53) more than double the probability of currently being homeless or unstably housed. Current homelessness or unstable housing is only slightly more prevalent among those with recent problems paying rent or mortgage (Chart 6.54).

Chart 6.51. Housing Past 3 Years by Current Housing Status (weighted)

Homeless, unstably housed situations, past 3 years		Current Housing Status		
		Stably housed N=2,162 83.6%	Homeless or unstably housed N=425 16.4%	Total N=2,587 100.0%
None	Count, weighted	1,417	78	1,495
	% within None	94.8%	5.2%	100.0%
1 or more	Count, weighted	745	347	1,092
	% within 1 or more	68.2%	31.8%	100.0%

Chart 6.52. Eviction Past 3 Years by Current Housing Status (weighted)

Eviction for any reason, past 3 years		Current Housing Status: Stably housed N=2,146 83.5%	Homeless or unstably housed N=425 16.5%	Total N=2,571 100.0%
No	Count, weighted	1,911	297	2,208
	% within No	86.5%	13.5%	100.0%
Yes	Count, weighted	235	128	363
	% within Yes	64.7%	35.3%	100.0%

Chart 6.53. Moved 3+ Times in Past 3 Years by Current Housing Status (weighted)

Moved 3+ times in last 3 years		Current Housing Status: Stably housed N=2,117 83.7%	Homeless or unstably housed N=412 16.3%	Total N=2,529 100.0%
No	Count, weighted	1,778	243	2,021
	% within No	88.0%	12.0%	100.0%
Yes	Count, weighted	339	169	508
	% within Yes	66.7%	33.3%	100.0%

Chart 6.54.
Problem Paying Rent or Mortgage Past 3 Months by Current Housing Status (weighted)

Problem paying rent or mortgage last 3 months		Current Housing Status: Stably housed N=2,125 87.2%	Homeless or unstably housed N=311 12.8%	Total N=2,436 100.0%
No	Count, weighted	1,309	165	1,474
	% within No	88.8%	11.2%	100.0%
Yes	Count, weighted	690	118	808
	% within Yes	85.4%	14.6%	100.0%
Not applicable	Count, weighted	126	28	154
	% within Not applicable	81.8%	18.2%	100.0%

From the perspective of a number of population characteristics, we examine the prevalence of particular housing problems – three or more moves in the last three years, homelessness or housing instability in the last three years, eviction in the last three years, and recent problems paying rent or mortgage. Chart 6.55 examines the relationship among these four measures of housing stability and the following associated characteristics.

Age. We note that the population with three or more moves appears to have a somewhat different array of resources compared to the total population. They are younger than the population as a whole (a mean of 42.3 years as opposed to 46.9 years).

Medical problems. We estimate that the lowest mean score for severity of medical problems, 3.8, is for the subgroup evicted within the last three years. Next-lowest is for individuals with three or more moves in the last three years – mean of 4.1. The group with current problems paying rent/mortgage has the largest mean number of medical problems: 4.7. The comparable figure for the population as a whole is 4.5.

Latino/a ethnicity. Latinos are more likely to have multiple moves, compared to others in this population (41.8% versus 25.9%). They are less likely to have been homeless or unstably housed in the last three years but more likely to report problems paying current rent/mortgage.

Income. Those moving three or more times in the past three years tend to have either smaller or larger incomes. Among those with monthly incomes up to $350, 24.8 percent have moved three or more times. Among those with incomes over $3,000, 32 percent have that history of moves (result not displayed).

People with lower current incomes are over twice as likely to have been evicted in the last three years, compared to those with incomes over $350 per month (24.8% versus 11.2%) and to have problems paying rent/mortgage in the last three months at almost double the rate of those with larger incomes (55.3% versus 29.4%).

Income from work. Patients with income from work are 1.7 times as likely to have moved three or more times (27.0% versus 15.5%). They are also more likely to have been homeless or unstably housed in the last 3 years (47.0% versus 38.5%) and evicted in the last three years (19.7% versus 10.3%).

Household type (not displayed). With the exception of households with minor children, 21 to 23 percent of all other household types moved three or more times within the last three years. Only six percent of households with minor children moved in that time period.

Gender/sexual orientation. Just under three percent of heterosexual men, 18.8 percent of gay men, 19.5 percent of heterosexual women, but 43.7 percent of bisexual men moved three or more times in the last three years. Bisexual and gay men are more likely than their heterosexual counterparts to have been evicted in the last three years.

Heterosexual women are least likely to have been homeless or unstably housed in the last three years but much more likely than heterosexual or bisexual men to have problems paying rent/mortgage in the last three months.

Alcohol dependence and/or drug abuse. Looking at patients with three or more moves in the last three years, patients who are alcohol dependent or abuse other drugs are four times as likely to have such moves as those without the alcohol/drug classification (46.5% versus 10.5%). They are also substantially more likely to have been homeless or unstably housed in the last three years and to have been evicted in that time period.

Mental health disability. Patients reporting a mental health disability are more likely to meet each of the four measures of housing instability compared to those without such disability reports.

SSI/SSDI. Patients with SSI and/or SSDI income are more likely to have been homeless or unstably housed in the last three years compared to those without that income source and disability designation (45.2% versus 38.1%). On the other three measures they are less likely to suffer housing problems.

Criminal history. Patients with felony convictions or other jail time are substantially more likely to have been homeless or unstably housed in the last three years compared to patients with neither criminal justice history (52.5% and 59.9% versus 34.2%). Patients with jail time but not felony histories are more likely to report an eviction in the last three years and problems paying rent currently.

Chart 6.55. Patient Characteristics by Three-year History of Moves, Housing Instability, and Eviction and Recent Difficulty Paying Rent (weighted)

Patient characteristic		Three or more moves last 3 years	Homeless or unstably housed last 3 years	Evicted last 3 years	Problem paying rent / mortgage last 3 months
Age (mean years)	Population 46.9 yrs	42.3 yrs	43.4 yrs	43.5 yrs	43.2 yrs
Medical Problems (mean number)	Population 4.5	4.1	4.5	3.8	4.7
Latino/a ethnicity	Yes	41.8%	34.8%	15.5%	38.3%
	No	25.9%	43.7%	13.7%	30.9%
Income	<= $350	24.8%	39.8%	24.8%	55.3%
	> $350	19.1%	41.3%	11.2%	29.4%
Income from work > $100 per month	Yes	27.0%	47.0%	19.7%	32.2%
	No	15.5%	38.5%	10.3%	33.1%
Gender / sexual orientation	Gay men	18.8%	40.5%	16.2%	41.0%
	Heterosexual men	2.7%	44.4%	11.3%	18.3%
	Heterosexual women	19.5%	36.6%	10.5%	42.9%
	Bisexual men	43.7%	42.7%	14.6%	14.2%
Alcohol dependence and/or drug abuse	Yes	46.5%	61.2%	20.2%	32.4%
	No	10.5%	34.4%	11.6%	32.6%
Mental health	Disability	28.5%	57.1%	18.3%	42.9%
	No disability	16.7%	35.8%	12.3%	28.8%
SSI/SSDI	Receives	15.8%	45.2%	10.5%	27.3%
	Does not receive	23.3%	38.1%	17.1%	37.1%
Criminal history	Neither felony nor jail	23.0%	34.2%	13.0%	34.7%
	Felony	13.9%	52.5%	10.9%	18.8%
	Other Jail	18.2%	59.9%	23.3%	39.4%

How recent previous housing instability was, and the particular type of previous housing instability, have strong relationships with current housing status. While we estimate that 8.5 percent of the population with no shelter stay in the last 12 months is currently homeless or residing in unstable housing, the comparable figure is seven times as great (61.9%) for people

who did have one or more days in a shelter (Chart 6.56). A similar relationship is found for members of the population with days living on the street in the past year (Chart 6.57).

Chart 6.56. Current Housing Status by Any Days in Shelter Past 12 Months (weighted)

Any days in shelter last 12 months		Current Housing Status: Stably housed N=2,162 83.5%	Homeless or unstably housed N=426 16.5%	Total N=2,588 100.0%
No	Count, weighted	2,014	186	2,200
	% within No	91.5%	8.5%	100.0%
Yes	Count, weighted	148	240	388
	% within Yes	38.1%	61.9%	100.0%

Chart 6.57. Current Housing Status by Any Days on Street Past 12 Months (weighted)

Any days on street last 12 months		Current Housing Status: Stably housed N=2,162 83.5%	Homeless or unstably housed N=426 16.5%	Total N=2,588 100.0%
No	Count, weighted	2,073	273	2,346
	% within No	88.4%	11.6%	100.0%
Yes	Count, weighted	89	153	242
	% within Yes	36.8%	63.2%	100.0%

6.7 Youth

We surveyed 38 patients under age 30, who represent 346 – or 13.2 percent – of the low-income PLWHA population. As displayed in Appendix 14, we estimate that almost three-quarters (73.9%) of the younger population is comprised of gay men, over twice the percent among the 30+ age population (33.2%). A smaller percent are Black (48.8% versus 58.4% among the 30+ age group), and a larger percent Latino/a (44.3% versus 267%). Youth are diagnosed with AIDS about one-third as often as are older members of the population (16.2% versus 41.7% among the 30+ group), and reports of medical problem severity are notably lower (mean 2.7 versus 4.7). Alcohol dependence or drug abuse is somewhat less prevalent (21.7% versus 27.3% among those

30+ years of age), and reports of a mental health disability are far less common (7.5% versus 30.0%).

The younger group is less likely to live alone (33.5% versus 57.2% for those 30+). A larger percentage live with minor children (23.1% versus 11.1%) or with other adults (21.7% versus 8.9%).

Members of the younger group are more likely than those 30+ to have experienced several kinds of housing problems in recent years:

- Eviction in the last three years (19.4% versus 13.1%)
- Three or more moves in the last three years (27.4% versus 18.6%)
- Homeless or unstably housed in the last three years (50.9% versus 40.1%)
- Any days on the street in the last year (13.9% versus 8.7%).
- Trouble paying rent or mortgage in the last three months (52.0% versus 29.5%).

Compared to the population 30 and older, a larger percentage of those under age 30 are *currently* stably housed (92.2% versus 82.2%), with fewer unstably housed (6.6% versus 9.6%), and almost none homeless. In their current place, we estimate that one-third (33.2%) of the younger age group has one housing problem, compared to 10.8 percent of the 30+ group. At the same time, a smaller percentage of the younger group reports two or more problems (11.9% versus 19.4%). Number of neighborhood problems is on average the same for both groups (mean 1.0).

The younger group receives rental assistance at half the rate of the 30+ group (16.1% versus 33.7%).

6.8 Predictors of Homelessness and Unstable Housing

In the course of this chapter we have discussed the problematic housing situation of people who:

1. Are currently homeless
2. Are currently unstably housed
3. Have been homeless or unstably housed at least once in the last 3 years
4. Have been evicted at least once in the last 3 years
5. Have moved 3+ times in the last 3 years
6. Have had a problem paying rent/mortgage in the last 3 months

An individual low-income HIV+ resident of Alameda County in primary care at a publicly-funded clinic could report none, one, or several of these situations. We want to understand how the characteristics of people with more of these housing experiences differ from those with fewer such experiences.

We took two steps to accomplish this. First, we assigned *difficult housing values* to each of the six problematic housing situations in order to create a homelessness – unstable housing score. Larger values are assigned to more problematic and/or more current situations, as follows:

1. Currently homeless (7 points)
2. Currently unstably housed (5 points)
3. In the last 3 years, homeless or unstably housed at least once (4 points)
4. In the last 3 years, evicted at least once (3 points)
5. In the last 3 years, moved 3+ times (1 point)
6. In the last 3 months, problem paying rent/mortgage (2 points)

In this sense, currently homeless is the most difficult situation because it involves no housing, and it is current. We assigned moved 3+ times in the last 3 years the fewest points in light of the fact that some moves may reflect steps toward stability. Other moves may reflect – and in fact be evidence of – instability.

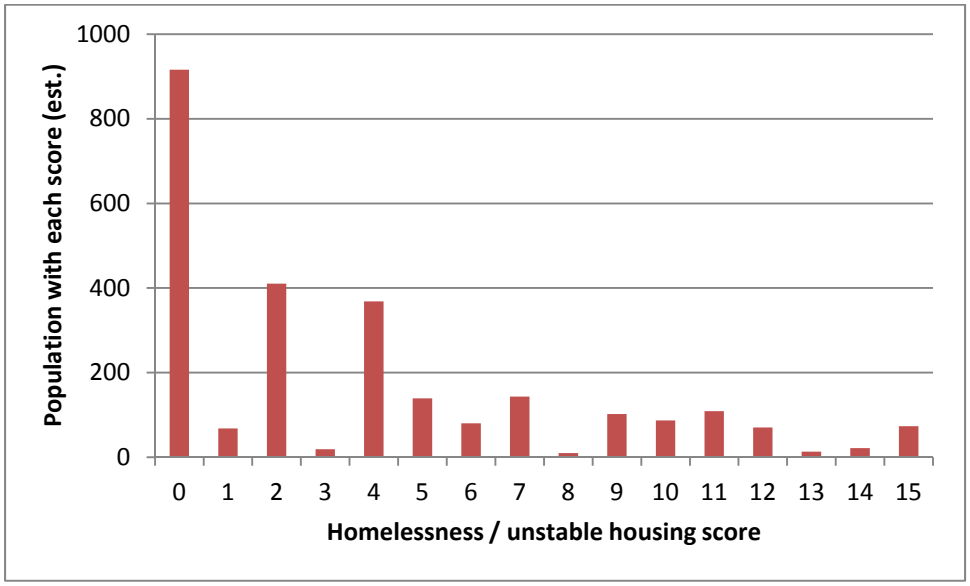
In theory, someone could have from 0 up to 17 points (one person could not currently be both homeless and unstably housed).

Applying these point scores to the estimated 2,631 persons in the population, we find the results summarized in Chart 6.58.

- About one-third of the population (916 individuals or 34.8%) is estimated to have had none of these situations, currently or in the last 3 years.
- Another one-third (32.9%) is estimated to have had a score of 1 through 4. They could have gotten that score, for example, by being homeless or unstably housed in the last 3 years (score of 4) or having been evicted one or more times in the last 3 years (score of 3), or having a problem paying rent/mortgage in the last 3 months (score of 2), or having moved 3+ times in the last 3 years (score of 1), or having moved 3+ times in the last 3 years and having had a problem paying rent/mortgage in the last 3 months (score of 4).

- The last one-third (32.4%) of the population is estimated to have 5 through 15 points. Either they report being currently homeless (7 points) or currently unstably housed (5 points) or having had multiple experiences with points totaling at least 5.

Chart 6.58. Distribution of Low-Income PLWHA in Primary Care by Homelessness / Unstable Housing Score (weighted)



Second, using a multivariate analytic technique known as weighted least squares regression, we examined the relationship among a number of potential factors and the homelessness – unstable housing score. This technique allows us to determine the relative impact of several characteristics simultaneously. Chart 6.59 summarizes the results. We find that a variety of personal characteristics – mental health disability, Black race, being a gay man, household type, criminal justice history, an AIDS diagnosis, alcohol dependence or drug abuse, ability to speak English well, and age under 30 – are associated with problems of homelessness and unstable housing.

Personal characteristics affect men and women differently in terms of their experience of homelessness and unstable housing.[16]

For men, a report of a mental health disability has the greatest impact on current and past three years of housing challenges. Such a report is, on average, associated with 3.5 points higher up

[16] The AHNA patient interviews did not include enough members of the transgender population to pursue a comparable analysis for that group.

the 17-point scale; that is, in the direction of a more problematic history of homelessness and housing instability. The next most powerful factors is race. Being Black (compared to the "Other" category) is associated with a 2.8 point increase on the scale; being White, with a 1.2 point drop on the scale. Both being a gay man (compared to another sexual orientation) and having alcohol and/or drug problems are each associated with a 2.5 point increase on the scale. For men, having a felony history, being bisexual, being under age 30, having a non-felony jail history, and living with a spouse (in contrast with living with minor children) also are associated with a more problematic housing history. These factors are additive, so a Black, gay man with a felony record would be likely to be high up the homelessness-unstable housing scale with 7.1 points out of a possible 17. Men who live alone or who live with adult children and/or other adults, but not a spouse, tend to have fewer problems with homelessness and/or housing instability.

The picture for women differs in many respects. Living with adult children and/or other adults, but not a spouse, is most strongly associated with a problematic housing history (7.3 points). The next most salient factor is reported mental health disability (6.3 points), followed by a non-felony jail history (6.1 points). Compared to women who do not speak English well, those who do are more likely to have histories of homelessness and/or housing instability (5.5 points). Other factors are an AIDS diagnosis (2.2 points), being Black (2.1 point), being under age 30 (1.6 points), and having a felony history (1.1 points).

In a cross-sectional study such as the AHNA, where individuals are not followed over time, we cannot discern the causal relationship between housing history problems and personal characteristics, if any. A mental health disability may, for example, make it more difficult to secure housing. And once housed such a disability may increase the likelihood of eviction for non-payment of rent or other reasons. At the same time, being homeless or unstably housed may exacerbate mental health problems. Alternatively, there could be other factors associated with both mental health problems and homelessness or housing instability.

Chart 6.59. Personal Characteristics and the Homelessness / Unstable Housing Scale, by Gender (weighted)

MEN	Number of points contributed to homelessness – unstable housing scale
Any report of mental health disability	3.5
Black (vs. Other – neither "White" nor "Black")	2.8
Alcohol dependence and/or drug abuse	2.5
Gay	2.5
Felony history (vs. no criminal justice history)	1.8
Bisexual	1.7
Under age 30	1.5
Non-felony jail history (vs. no criminal justice history)	1.2
Lives with spouse only (vs. lives with minor children, with or without spouse)	0.9
Speak English well	-0.7
Lives alone	-0.9
White (vs. Other – neither "White" nor "Black")	-1.2
Lives with adult kids and/or other adults, not spouse (vs. lives with minor children, with or without spouse)	-1.7

WOMEN	Number of points contributed to homelessness – unstable housing scale
Lives with adult kids and/or other adults, not spouse (vs. lives with minor children, with or without spouse)	7.3
Any report of mental health disability	6.3
Non-felony jail history (vs. no criminal justice history)	6.1
Speak English well	5.5
Diagnosed with AIDS	2.2
Black (vs. Other – neither "White" nor "Black")	2.1
Under age 30	1.6
Felony history (vs. no criminal justice history)	1.1

6.9 Service Receipt and Resource Access

The survey inquires about several kinds of programs and services that might assist low-income PLWHA. First we consider sources of a rental subsidy (Housing Authority, Shelter Plus Care, Project Independence, Ryan White emergency housing assistance, a rental subsidy, or another program). Chart 6.60 indicates that over half the population knows at most about one of these programs. A follow-up question inquired about whether survey participants are on waiting lists for the above-mentioned and other subsidized housing. As displayed in Chart 6.61, over three-quarters of the population (79.3%) is on no waiting list.

We would expect that people receiving a rental subsidy would, on the one hand, know of more such opportunities but, on the other, be on fewer wait lists. Chart 6.61, which explores these assumptions, finds that those homeless or unstably housed members of the population are two-and-a-half times as likely to be on a waiting list.

Fifty-six percent of homeless individuals – and 59.3% of those unstably housed – report being on no wait list for a rental subsidy slot. Among those on at least one wait list in these two groups, unstably housed individuals are more likely to be on more than one list.

Chart 6.60. Number of Sources of Rental Subsidy Known (Q40, weighted)

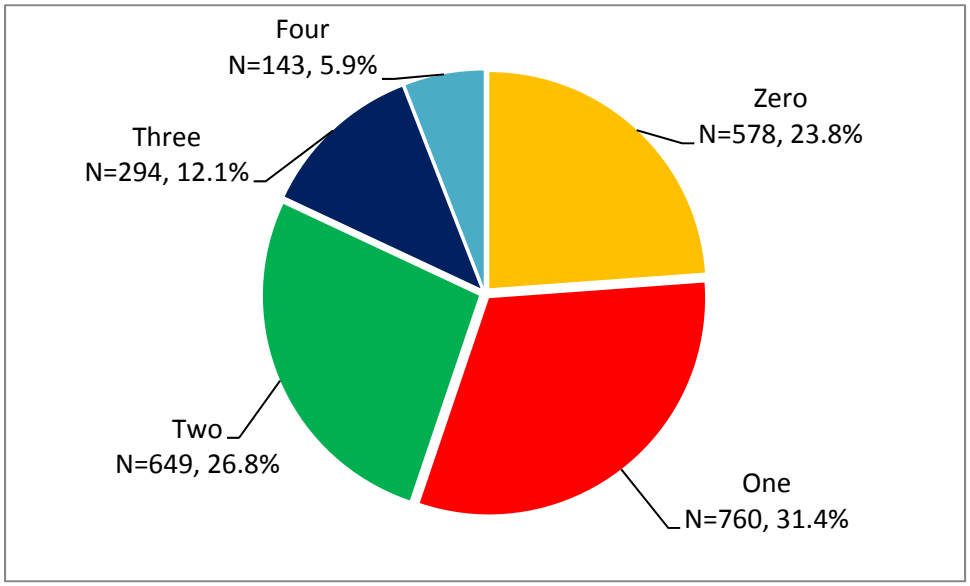


Chart 6.61. Number of Wait Lists by Current Housing (weighted)

On how many wait lists for rental subsidy?		Current housing: Stably housed N=1,990 100%	Unstably housed N=226 100%	Homeless N=141 100%	Total N=2,357 100%
None	Count, weighted	1, 656	134	79	1,869
	% within None	83.2%	59.3%	56.0%	79.3%
1	Count, weighted	208	24	46	278
	% within One	10.5%	10.6%	32.6%	11.8%
2	Count, weighted	94	44	0	138
	% within Two	4.7%	19.5%	.0%	5.9%
3+	Count, weighted	31	24	16	71
	% within Three+	1.7%	10.6%	11.3%	3.0%
At least one	Count, weighted	333	92	62	487
	% within At least one	16.7%	40.7%	44.0%	20.7%

Chart 6.62 summarizes which wait lists are reported to be used. Persons stably housed are most often on the Oakland Housing Authority wait list, followed by the Alameda County Housing Authority and Housing Authorities outside Alameda County. We estimate that very few are on wait lists for other city housing authorities, housing under construction, S+C, PI, and AIDS housing. Members of the homeless group report (limited) use of the Alameda County Housing Authority, housing authorities outside the county, Shelter Plus Care, and AIDS housing projects. They are not on Oakland Housing Authority wait lists. Nor are they on wait lists kept by housing authorities in other Alameda County cities or by Project Independence. The situation is somewhat different for persons who are unstably housed.

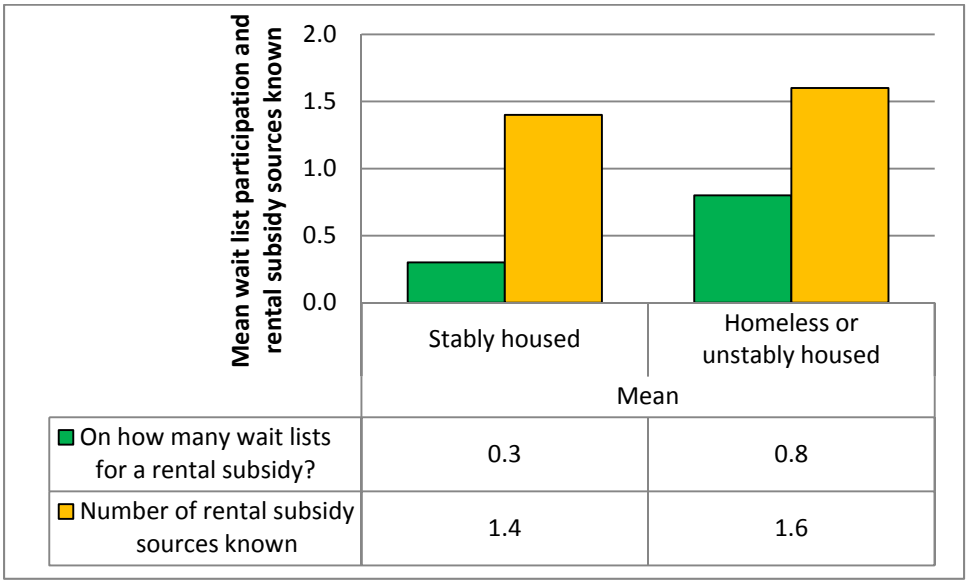
Chart 6.62. Wait Lists Used by Current Housing (weighted)

Wait list agency	Current housing		
	Stably housed	Unstably housed*	Homeless*
	Number of reports	Reported	Reported
Oakland Housing Authority	194	x	
Alameda County Housing Authority	145	x	x
Housing authority outside Alameda County	96	x	x
Other city housing authority in Alameda County	27	x	
Housing under construction	26		
Shelter Plus Care	22	x	x
Project Independence	22		
AIDS housing	5		x

* Small n limits value of listing number of reports

Overall, persons stably housed are on an average of 0.3 wait lists; people homeless or unstably housed are on 0.8 (Chart 6.63). Number of rental subsidy sources known is almost equivalent for the two groups.

Chart 6.63. Knowledge of Rental subsidy Programs and Wait List Participation by Current Housing Status (weighted)

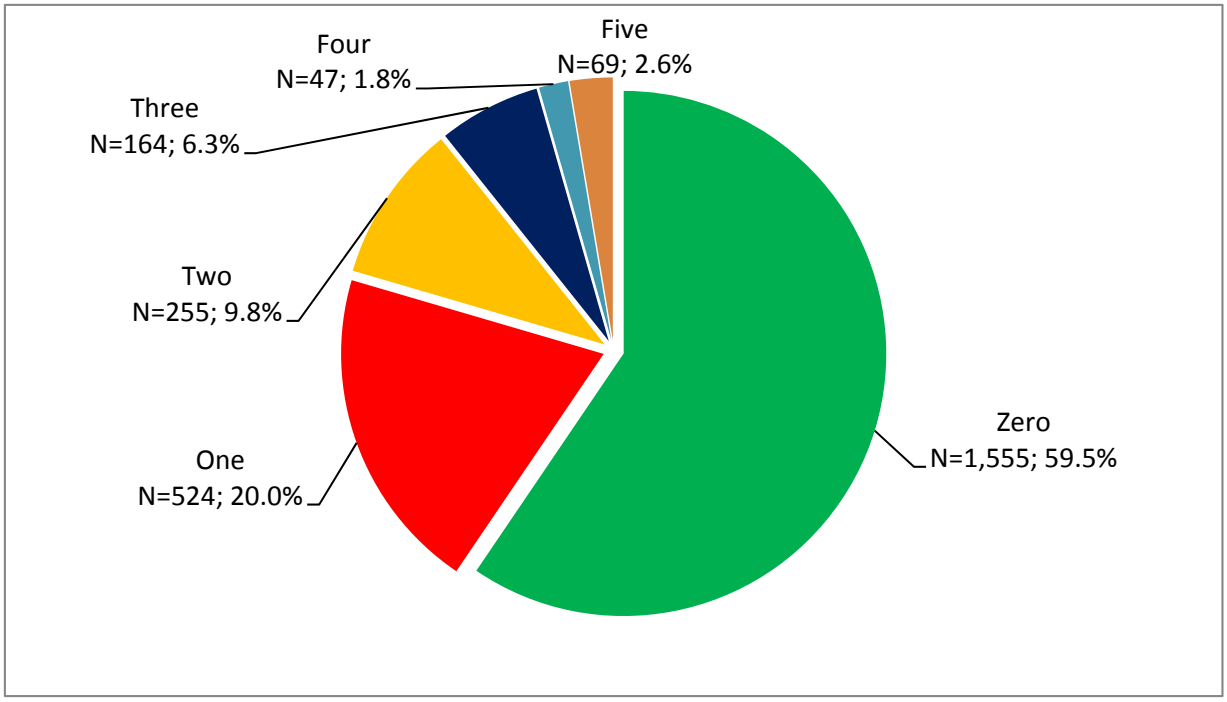


The survey asks participants whether each of four housing sources – or any other one – was helpful for getting into their current place:

- Help finding housing or referral services such as lists of apartments or houses that you might be able to afford
- Help filling out housing applications and other forms
- Assistance with moving, including 1st and last month's rent
- Assistance with landlords or property managers

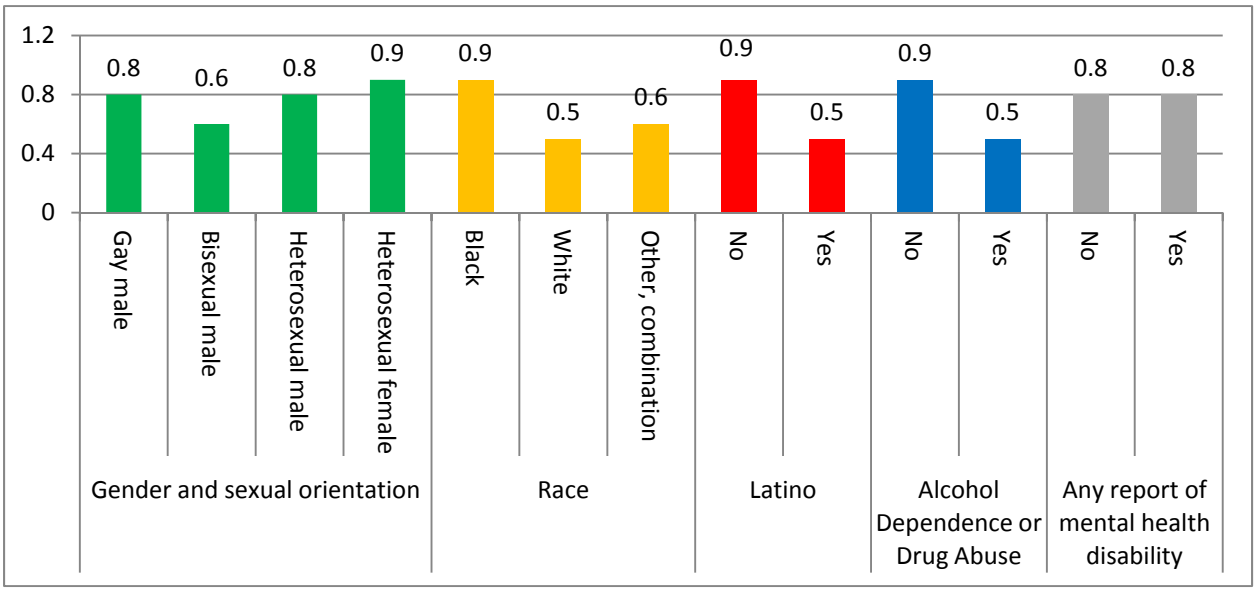
Three of five (59.5%) members of the population named no service (Chart 6.64).

Chart 6.64. Number of Services Received That Were Helpful to Get into Current Place (Q51, weighted)



Receipt of services found helpful is positively associated with sexual orientation and gender (heterosexual men and women, gay men), race (Blacks), non-Latino/a ethnicity, and lack of alcohol dependence and drug abuse (Chart 6.65). We find no effect for mental health disability.

Chart 6.65. Number of Helpful Services Received by Gender and Sexual Orientation, Race, Ethnicity, Alcohol Dependence or Drug Abuse, and Mental Health Disability (weighted)



We find that the low-income population in care reports a wide variety of problems in finding their current housing. Chart 6.66 displays most difficult problems faced in finding current housing by current housing status: stably housed, unstably housed, and homeless. Survey participants were asked to mark up to three answers. For each group, topping the list is cost of housing and/or insufficient monthly income. About one-third of each group also agrees on the importance of poor credit history. While credit history is second most important for stably and unstably housed groups, that concern falls behind criminal record for the homeless group. The 40.1 percentage of homeless persons with criminal records is over eight times the percentage for stably housed individuals. It is important also to take note of the salience of location of available housing, having pets, transportation problems, being single, and alcohol dependence/drug abuse.

Two-thirds of patients identify at least one needed housing service that they did not receive (survey participants were asked to mark all that apply). Again we present findings by current housing status (Chart 6.67). Topping the list for persons stably and unstably housed is assistance with moving, followed closely by help finding housing. For homeless persons, however, help finding housing is first, and help filling out housing applications and other forms edges out moving assistance. Assistance working with landlords and property managers is prevalent for all groups. And while essentially equal percents of stably and unstably housed persons express need

for clean and sober housing, among the homeless population it is the need for low-threshold or wet housing that prevails.

Chart 6.66. Most Difficult Problems in Finding Current Housing, by Current Housing Status (Q54, weighted)

	Current housing					
	Stably housed		Unstably housed		Homeless	
	N =	2,162	N =	239	N =	187
	Number of reports	Percent	Number of reports	Percent	Number of reports	Percent
Housing cost or lack of income	869	40.2%	118	49.4%	92	49.2%
Credit problems	755	34.9%	92	38.5%	66	35.3%
Location	365	16.9%	63	26.4%	52	27.8%
Pets	362	16.7%	46	19.2%	0	0.0%
Lack of employment	310	14.3%	69	28.9%	24	12.8%
Transportation	238	11.0%	20	8.4%	4	2.1%
Single	185	8.6%	5	2.1%	29	15.5%
Criminal record	101	4.7%	37	15.5%	75	40.1%
Immigration documents	79	3.7%	14	5.9%	0	0.0%
Previous eviction	71	3.3%	0	0.0%	0	0.0%
Large family	48	2.2%	0	0.0%	0	0.0%
Mental health problems	24	1.1%	13	5.4%	14	7.5%
Young children	17	0.8%	0	0.0%	0	0.0%
Child care	12	0.6%	0	0.0%	0	0.0%
Alcohol dependence or drug abuse	8	0.4%	0	0.0%	45	24.1%

Survey question 53 asks about resources that helped participant find housing the last time s/he moved into housing. Despite the fact that currently they are homeless, 44.1 percent of homeless persons were able to name at least one resource (Chart 6.68). For unstably housed persons 20.9 percent identified a resource. For stably housed subgroups, the figure was 33.8 percent. Among the homeless population most mentions are of 2-1-1 and/or AHIP and other materials from case manager or other service provider. Stably housed persons are most likely to mention web sites and lists from a housing authority.

Chart 6.67. Needed Housing Services Not Received (Q52, weighted)

Needed service	Current housing					
	Stably housed		Unstably housed		Homeless	
	Number	Percent	Number	Percent	Number	Percent
Assistance with moving, including 1st and last month's rent	842	38.9%	89	37.2%	46	24.6%
Help finding housing or referral services and lists of affordable apartments or houses	740	34.2%	68	28.5%	100	53.5%
Help filling out housing applications and other forms	484	22.4%	39	16.3%	50	26.7%
Assistance with landlords or property managers	375	17.3%	36	15.1%	21	11.2%
Clean and sober housing	177	8.2%	20	8.4%	7	3.7%
Wet housing	152	7.0%	7	2.9%	21	11.2%

Chart 6.68. Resources That Help Participants Find Housing (Q53, weighted)*

Needed service	Current housing							
	Stably housed N = 2,163		Unstably housed N = 239		Homeless N = 186		Total N = 2,588	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Any of these forms of help	731	33.8%	50	20.9%	82	44.1%	863	33.3%
Lists from Housing Authority	253	11.7%	8	3.3%	14	7.5%	275	10.6%
Bulletin boards	41	1.9%	5	2.1%	0	0.0%	46	1.8%
AC Housing Choice web site	15	0.7%	0	0.0%	0	0.0%	15	0..6%
Other web sites	323	14.9%	14	5.9%	0	0.0%	337	13.0%
2-1-1 and/or AHIP	229	10.6%	9	3.8%	58	31.0%	296	11.4%
Other materials from case manager or other service provider	179	8.3%	30	12.5%	62	33.2%	271	10.5%

* Survey participants could list more than one resource.

We estimate that two-thirds or more of the population reports no experience of unfair denial of housing (findings not displayed in a chart), with 4.8 percent estimated to have been denied housing because of HIV status.

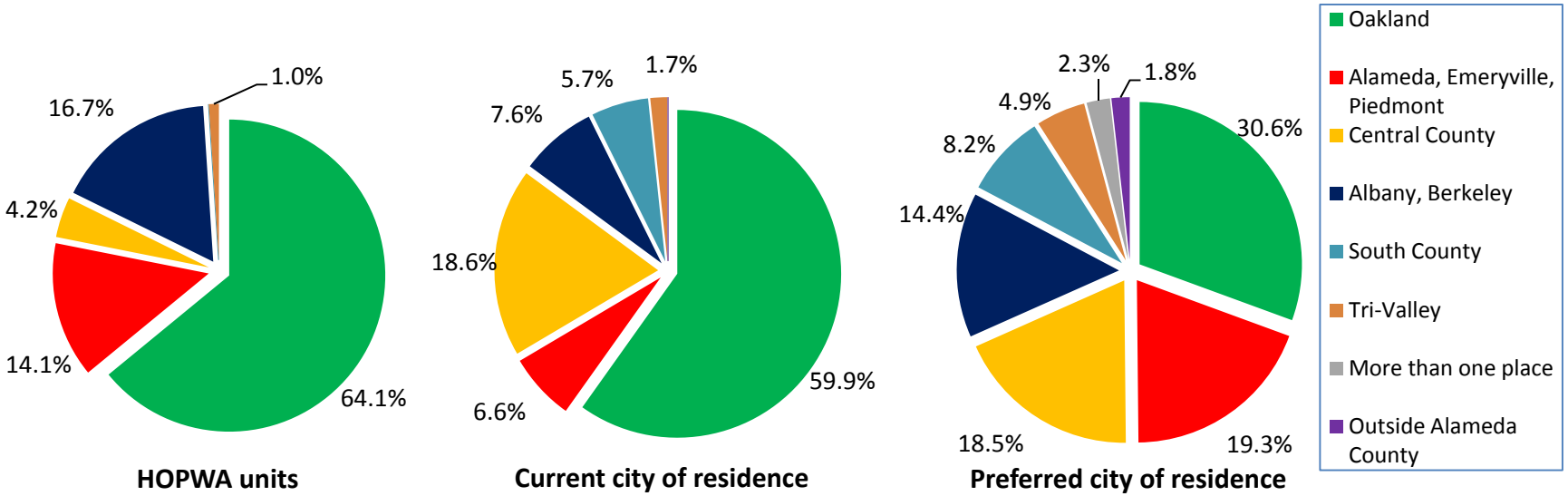
6.10 Housing Wants and Needs

Chart 6.69 displays three intersecting realities: The distribution of HOPWA units in the county, current city of residence of the low-income HIV+ population in care, and that population's preferred city of residence. While 59.9 percent of the population currently resides in Oakland, and 64.1 percent of all HOPWA units are in Oakland, only 30.6 percent of low-income PLWHA desire to live in Oakland. HOPWA units appear to be needed in every locality other than Central County and Oakland.

Chart 6.69a. Current or Planned HOPWA Units and Preferred Versus Current City of Residence (weighted)

HOPWA units		Current City of Residence	Number, weighted	Percent	Preferred City of Residence	Number, weighted	Percent	City of Residence Difference in % points
Number	Percent							
123	64.1	Oakland	1,567	59.9	Oakland	797	30.6	-29.3
27	14.1	Alameda, Emeryville, Piedmont	174	6.6	Alameda, Emeryville, Piedmont	502	19.3	12.6
8	4.2	Central County	487	18.6	Central County	482	18.5	-0.1
32	16.7	Albany, Berkeley	198	7.6	Albany, Berkeley	375	14.4	6.8
		South County	148	5.7	South County	214	8.2	2.6
2	1.0	Tri-Valley	44	1.7	Tri-Valley	128	4.9	3.2
		More than one place			More than one place	61	2.3	
		Outside Alameda County			Outside Alameda County	47	1.8	
192	100.0	Total	2,618	100.0	Total	2,606	100.0	

Chart 6.69b. Current or Planned HOPWA Units and Preferred Versus Current City of Residence (weighted)



Responses to a question about kind of housing preferred yield an array of first-choice selections, which vary by current housing situation (Chart 6.70). We estimate that the majority (55.1%) of stably housed individuals prefer a house or duplex, with another 26.1 percent desiring an apartment. Unstably housed individuals are about equally split between a house or duplex, on one hand, and an apartment on the other. Another 11.3 percent of unstably housed person prefer a room in a shared house. Homeless persons are even more diverse in their preferences, which, in addition to apartments and houses or duplexes include a room in a shared house (12.8%) as well as a room in a motel or hotel (11.2%).

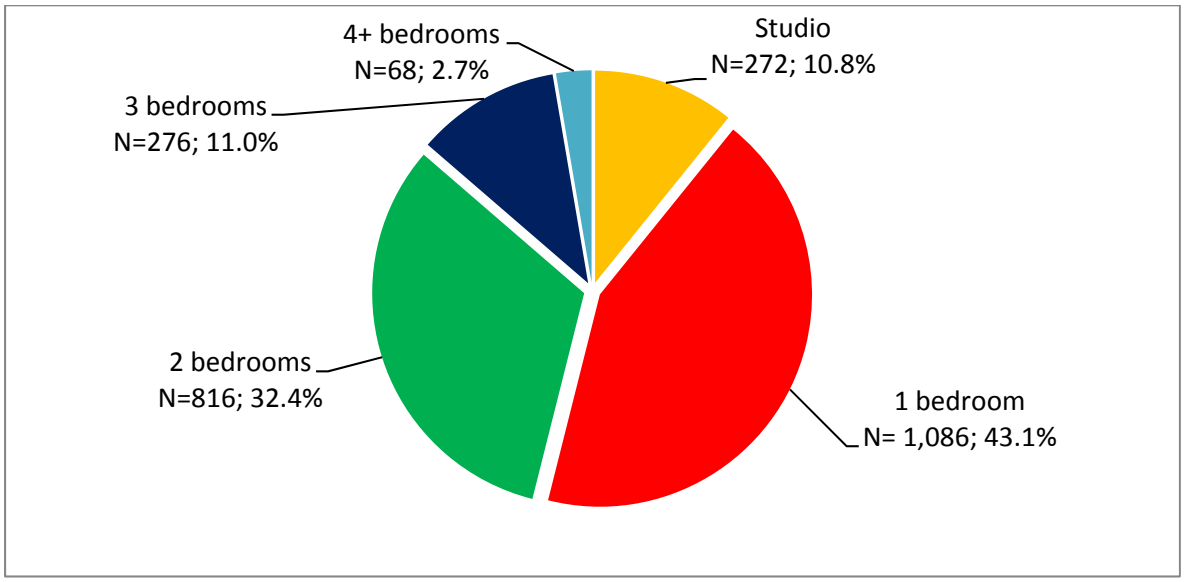
Chart 6.70. Preferred Kind of Housing (Q48, weighted)

Type of housing	Current Housing							
	Stably housed N = 2,162		Unstably housed N = 239		Homeless N = 187		Total N = 2,588	
	N	Percent	N	Percent	N	Percent	N	Percent
House or duplex	1,192	55.1%	91	38.1%	45	24.1%	1,328	51.3%
Apartment, modest sized building	334	15.4%	56	23.4%	65	34.8%	455	17.6%
Apartment, larger bldg.	232	10.7%	30	12.6%	30	16.0%	292	11.3%
Room in motel or hotel	76	3.5%	0	0.0%	21	11.2%	97	3.7%
Room in shared house	61	2.8%	27	11.3%	24	12.8%	112	4.3%
Permanent supportive housing	50	2.3%	10	4.2%	0	0.0%	60	2.3%
Halfway house	3	0.1%	0	0.0%	0	0.0%	3	0.1%
Missing, other	214	9.9%	25	10.5%	2	1.1%	241	9.3%

Very few members of the population want/need a studio (Chart 6.71). And there are many reasons why low-income HIV+ people in care might turn down a place to live (Chart 6.72).

These factors should be considered in the planning for housing options.

Chart 6.71. Number of Bedrooms Needed (weighted)



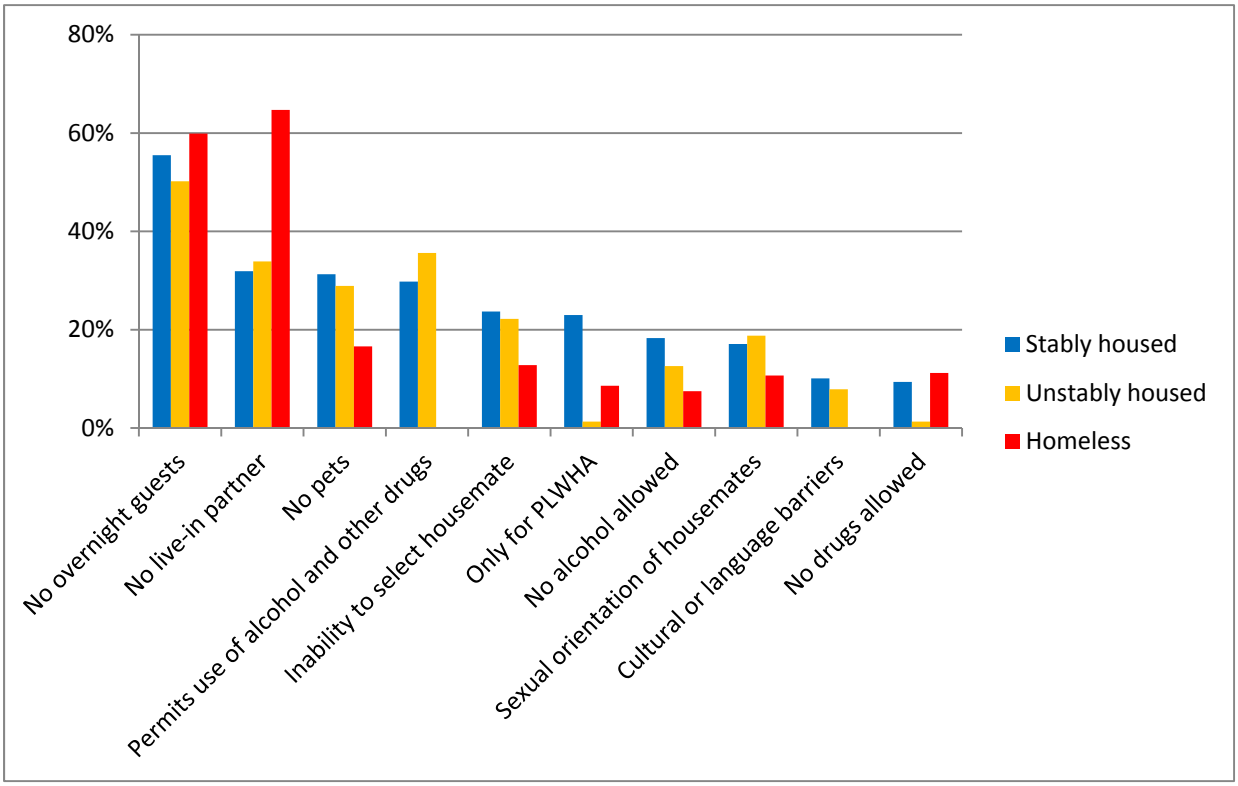
Across the three groups (stably housed, unstably housed, homeless), half or more might turn down housing that prohibited overnight guests. In terms of live-in partner, regulations prohibiting pets, and places that permit use of alcohol and other drugs, that figure drops to 29 to 36 percent for persons stably housed and unstably housed. While twice the percent of homeless persons compared with the other two groups are concerned about limitations on live-in partners, as a group they less often are concerned about the other issues. Findings concerning the homeless group are based on a small sample and should be interpreted very cautiously. Nevertheless, it is noteworthy that in most areas the homeless group expresses fewer concerns than does the rest of the population.

Chart 6.72a. Reasons People Might Turn Down a Place to Live (weighted)*

Rule	Current housing							
	Stably housed N = 2,162		Unstably housed N = 239		Homeless N = 187		Total N = 2,588	
	N	Percent	N	Percent	N	Percent	N	Percent
No overnight guests	1,200	55.5%	120	50.2%	112	59.9%	1,432	55.3%
No live-in partner	690	31.9%	81	33.9%	121	64.7%	892	34.5%
No pets	677	31.3%	69	28.9%	31	16.6%	777	30.0%
Permits use of alcohol and other drugs	645	29.8%	85	35.6%	0	0.0%	730	28.2%
Inability to select housemate	513	23.7%	53	22.2%	24	12.8%	590	22.8%
Only for PLWHA	497	23.0%	3	1.3%	16	8.6%	516	19.9%
No alcohol allowed	396	18.3%	30	12.6%	14	7.5%	440	17.0%
Sexual orientation of housemates	370	17.1%	45	18.8%	20	10.7%	435	16.8%
Cultural or language barriers	219	10.1%	19	7.9%	0	0.0%	238	9.2%
No drugs allowed	204	9.4%	3	1.3%	21	11.2%	228	8.8%

* Survey participants were asked to mark all that apply

Chart 6.72b. Reasons People Might Turn Down a Place to Live (weighted)*



* Survey participants were asked to mark all that apply

6.11 Summary

Based on surveys of 210 HIV+ individuals receiving care at ten clinics or physician offices in Alameda County, we estimate characteristics of 2,631 low-income, HIV+ residents of Alameda County in primary care in the County. From this patient survey we determine that recent and current homelessness and housing instability are widespread. We estimate that at a point in time seven percent of Alameda County's low-income, HIV+ population in primary care is homeless, and another nine percent is unstably housed. But beyond those statistics, a great many additional people have been without adequate housing – and likely are at risk for it in the future.

- 41% have been homeless or resided in unstable housing in the previous three years, and 32% of them are currently homeless or unstably housed, six times the rate of current homelessness or unstable housing among those stably housed in the past three years
- 45% of the population has been homeless or unstably housed in the past three years and/or is homeless or unstably housed currently.
- 14% have had an eviction in the previous three years, which is associated with more than double the rate of current homelessness or unstable housing
- 20% have moved three or more times in the previous three years, which is associated with more than double the rate of current homelessness or unstable housing
- 31% have had trouble paying rent or mortgage in the last three months.

Not surprisingly, eviction and problems paying rent/mortgage are associated with lower current income.

One in four patients without a rental subsidy is homeless or unstably housed.

Housing and neighborhood quality are problematic for many members of the population. One-third have considered moving because of a neighborhood problem, and that percentage is higher for individuals who are stably housed.

Receipt of SSI and/or SSDI is not associated with a higher rate of stable housing. In fact, recipients of SSI/SSDI are one-third more likely to be homeless or unstably housed than those without such benefits. Controlling for income level does not erase this effect.

Compared to others categorized by gender and sexual orientation, bisexual men have spent the most time on the streets in the past 12 months, and they are much more likely to have moved

three or more times in the previous three years. Bisexual and gay men are more likely than their heterosexual counterparts to have been evicted in the last three years. Heterosexual women are more likely to have problems paying rent/mortgage in the last three months.

Latino/as are more likely to have multiple moves in the previous three years.

Patients who are alcohol dependent or abuse other drugs are four times as likely to have three or more moves in the last three years and are more likely to be have been homeless or unstably housed and to have been evicted in that time period.

Patients reporting a mental health disability are more likely to report each of the four measures of residential instability.

Patients with felony convictions or other jail time are substantially more likely to have been homeless or unstably housed in the last three years. Patients with jail time but not felony histories are more likely to report an eviction in the last three years and to report problems paying rent currently.

Younger members of the HIV+ community are less likely to be homeless or unstably housed at a point in time. Nevertheless, factors associated with risk of homelessness and unstable housing are substantial. Persons under age 30 are more likely to report:

- Eviction in the last three years
- Three or more moves in the last three years
- Homeless or unstably housed in the last three years
- Any days on the street in the last year
- Trouble paying rent or mortgage in the last three months

And younger individuals receive rental subsidies half as often as do people in the 30+ age group.

A multivariate analysis in this chapter examines the relationship among several personal characteristics and a summary measure of current and recent homelessness and unstable housing. Many of the same personal characteristics are associated with problems of homelessness and unstable housing for both men and women.[17] But the relative strength of association across

[17] The AHNA patient interviews did not include enough members of the transgender population to pursue a comparable analysis for that group.

particular characteristics differs between the two genders. Mental health disability appears to have a very strong association with homelessness and unstable housing among both men and women, but the effect is especially strong for women. Women living with adult children and/or other adults but not a spouse are especially likely to have had problems with homelessness and/or housing instability. For men, the effect appears to be the opposite: those living with a spouse but not minor children are more likely to have histories of homelessness and/or unstable housing, but those living with adult children and/or other adults and those living alone are *less* likely to have had problems of homelessness and/or housing instability. For women and men both a felony history and a non-felony jail history are associated with greater number of problems with homelessness and unstable housing. For women speaking English well has a strong association with problems of housing and homelessness. For men it has the opposite effect. For both genders being Black is associated with a history of homelessness and/or housing instability. Age under 30 has a similar relationship for both genders. For women having an AIDS diagnosis is associated with homelessness and/or housing instability. For men alcohol dependence and/or drug abuse, being gay, and being bisexual are all associated with homelessness and/or housing instability.

Knowledge about the existence of rental subsidies and their sources is not widespread. Over half of the population knows at most about only one such program. And 59 percent of persons unstably housed are on no waiting list for a rental subsidy slot.

The perspective of the low-income HIV+ population in care is clear:

- Housing is unaffordable
- The location of affordable housing is problematic
- Personal credit problems are a problem

Needed services include:

- Assistance with moving
- Assistance finding housing
- Assistance with housing applications
- Assistance working with landlords and property managers

We conclude this chapter noting that the location of HOPWA housing units are not in parallel with the study population's preferred city of residence (Chart 6.69). From this perspective future units ought to be developed in the cities of Alameda, Albany, Berkeley, Emeryville, Piedmont, and, to a lesser degree, cities in Tri-Valley and South County. One-bedroom units are preferred over studios, and members of the study population express concern about a number of factors that might make a place unattractive to them (Chart 6.72).

Chapter 7: Recommendations

7.1 Introduction

This chapter collects the numerous needs voiced by AHNA participants and noted in previous chapters. We compile those expressions of need and suggestions for policy and program change into the recommendations in this chapter. We note that the recommendations also include input derived from analyses of survey results that were not available to AHNA participants when they shared their experiences and perspectives.

In conjunction with the National HIV/AIDS Strategy 2015 goals, the *California's Integrated HIV Surveillance, Prevention and Care Plan* has as Goal 2, Objective 2-3 to increase the proportion of Ryan White Program clients with permanent housing to at least 86 percent (California Department of Public Health, Center for Infectious Diseases, Office of AIDS, 2013). Alameda County should also consider adopting this goal to increase the proportion of Ryan White Program clients with permanent housing to at least 86 percent. Our survey of low-income HIV+ residents of Alameda County in primary care suggests that Alameda County is close to meeting this goal, with 83.5 percent in stable housing (Chart 6.28). At the same time, as we note in Chapter 6, substantial numbers of *currently* stably housed individuals report homelessness and/or housing instability in the last three years. Meeting the point-in-time objective of 86 percent in permanent housing may not be a guarantee of future or continued housing stability. We believe the recommendations below will support continued efforts to meet and surpass the current achievement in Alameda County and promote on-going housing stability for those currently housed.

We present the recommendations in six groups. We do not organize the proposal groups in any priority order relative to each other. **However, we emphasize one theme appearing in several recommendations: all affordable housing (both existing units and new developments), rental assistance, and housing service programs should be marketed in both Spanish and English and made accessible to persons speaking either language.**

In the recommendation area on future data collection and research, we specify actions that should be undertaken to address gaps in information. We conclude the chapter with final

thoughts on how these recommendations might guide HCD's HOPWA – and other – funding efforts to promote PLWHA's access to and maintenance of stable housing.

The six lists that follow (Sections 7.2 – 7.7) summarize the findings from previous chapters and are keyed to priority areas that we develop and reference as Priority 1 (P1) through Priority 11 (P11) in Section 7.8.

Finally by way of introduction to this chapter, we emphasize two points.

First, we recommend steps that, if taken, would require expenditures far beyond the size of the available HOPWA grant. Full implementation will require a combination of securing additional resources, whether from the identification of new income streams or contribution of resources from other county or city agencies, redirecting existing resources, and/or making difficult choices.

Second, and related to the first point, whatever priorities HCD adopts, we do not mean to suggest that HCD should necessarily be responsible for funding or operating all suggested programs. In some cases it will make sense for HCD to take on such responsibilities. In other cases HCD may bring new ideas to the local tables of planners and policy-makers and, as it is able, encourage other agencies to collaborate or otherwise follow HCD's lead. For example, the 3rd, 5th, and 8th bullets in Section 7.2 below offer suggestions that HCD might implement with respect to HOPWA-funded units. However, we would hope that through example appropriate changes be made to an array of affordable housing arrangements over which HCD has no control.

Given the enormous need in the low-income PLWHA community, whether through future needs assessments or other means, care should be taken to monitor closely and evaluate HOPWA-funded service programs to ensure that they are as productive as possible. As HCD has recognized, investments outside the housing arena may best be left to other county agencies. Nevertheless HCD should advocate that the needed services be funded and directed towards the PLWHA populations in need from HCD's perspective.

7.2 Housing Stock and Housing Development

- Subsidize operating costs and services needs associated with HOPWA-funded units with project-based vouchers or other mechanisms.
- Take the lead in developing and promoting city agency programs to improve housing standard inspections for PLWHA in non-subsidized housing (P1).
- Establish a centralized housing wait list for PLWHA applying for affordable housing units developed with HOPWA funds (P4).
- Provide low-threshold housing for PLWHA with a mental health disability and/or who abuse alcohol and/or other drugs, in collaboration with other Alameda County agencies or as a stand-alone HOPWA project (P5).
- Investigate making housing application procedures less complicated and cumbersome, and simplify them; use bilingual Spanish/English housing development descriptions and application forms.
- Develop a desktop computer software application to enable PLWHA to find any affordable housing application in the county; open the housing application file to complete it, and submit it.
- Address the dilemma of the temporary living situation for Shelter Plus Care applicants who qualify for Shelter Plus Care only if they remain homeless.
- Encourage HOPWA housing developers to postpone asking housing applicants on initial housing applications about past criminal convictions until after they determine whether or not the applicant meets minimum qualifications.
- Locate new HOPWA units in safe neighborhoods in cities where PLWHA desire to reside.
- Collaborate with cities and other entities to secure additional affordable units for PLWHA throughout the county.

7.3 Rental Subsidies

- Expand availability of deep rental subsidy assistance through Shelter Plus Care, Housing Authority mechanisms, and other programs, and add additional shallow rent subsidy slots as routes to stable housing; consider funding an additional Project Independence hub agency for increased outreach and accessibility (P2).

7.4 Services

- Provide education and training to HIV/AIDS housing and other service providers on the *availability of* and *how to access* rental subsidy and housing assistance programs such as HOPWA, PI, S+C, senior housing, Section 8 and other programs.

- Make use of bilingual Spanish/English social marketing and other tools so that PLWHA needing affordable housing and/or emergency housing assistance understand how Housing Authority programs, PI, S+C, and the overall affordable housing system function.

- Make use of or develop appropriate client/consumer bilingual Spanish/English marketing materials and strategies both within and outside of the traditional housing networks. Outreach through the health care sectors reaching PLWHA, such as the CCPC PLWHA Committee, the OAA Newsletter and/or other mechanisms, to publicize the *availability of* and provide information on *how to gain access to* rental subsidy and housing assistance programs such as HOPWA, PI, S+C, senior housing, Section 8 and other programs.

- Re-tool HCD's website so that HOPWA development, rental assistance and service programs are more visible for persons reading English as well as Spanish.

- Implement a fair housing testing program to determine whether housing service providers, providers of rental subsidies, and property managers are demonstrating bias against PLWHA with any of these characteristics: mental health disability, Black, gay, bisexual, criminal justice background, and under age 30. If bias is found take appropriate corrective action at the individual program level or, from a broader perspective, with introduction of new training programs or, if needed, new programs.

- Establish a pro-active outreach campaign to identify, find and offer housing assistance to homeless PLWHA – including those connected to services as well as those not connected. Consider prioritization of housing access for the most disabled/medically fragile/seriously ill and those with young children (P3).

- Establish and evaluate a pilot program for a voluntary county-wide payee service for PLWHA who would find it helpful to maintain housing stability and positive health outcomes (P6).

- Provide bilingual Spanish/English individual counseling to help consumers clean-up their credit records, and market the availability of that service. Consider providing bilingual Spanish/English credit record clean-up and other financial assistance services on-site at housing developments (P9).

- Ensure adequate funding for emergency housing assistance to prevent eviction through HOPWA or in collaboration with the OAA or other agencies, and publicize its availability (P7).

- Fund and support new, more intensive and comprehensive housing referral services, in addition to the information dissemination provided by AHIP, using the OAA Housing Referral Services funding category or another program as a model, to:
    - help PLWHA find appropriate available housing units in safe neighborhoods
    - negotiate and deal with landlords to move in
    - help PLWHA identify and gain access to financial resources for move-in costs, including access to EHA move-in funds, and

- conduct trainings for service providers about these new services (P8).

- Survey the PLWHA residing in HOPWA units to determine their level of need for and engagement with medical case management.

- Establish a special focus on serving the housing needs of the PLWHA re-entry population, including those with sex offense convictions.

7.5 Communication and Collaboration

- Require the establishment of a communication link between property managers and clinic-based medical case managers of HIV+ residents in primary care as an eviction-prevention strategy. This measure would increase the likelihood that residents, at risk of losing their housing, would be connected to services that would help them to maintain stable housing or secure more appropriate housing prior to eviction (P10).

- In conjunction with the OAA, convene HIV/AIDS housing meetings to provide input on planning issues, promote program and services coordination, and assist with the implementation of these recommendations (P11).

  - Regular meetings of all HOPWA and Ryan White Program housing and housing service providers

  - Regular meetings of HOPWA property managers and housing service providers.

- Integrate the development of HIV/AIDS housing and delivery of HIV/AIDS housing services for PLWHA onto the agenda of EveryOne Home.

7.6 Special Issues

- Improve access to housing and housing services for PLWHA households that include:
  - Gay men and heterosexual women (severe prevalence of problems paying rent/mortgage)
  - Bisexual men (severe prevalence of multiple moves and/or eviction histories)
  - PLWHA with criminal records (multiple moves, past homelessness or unstable housing, past evictions, and problems paying rent/mortgage)
  - PLWHA with mental health problems (multiple moves, past homelessness or unstable housing, past evictions, and problems paying rent/mortgage)
  - PLWHA with alcohol or drug problems (multiple moves, past homelessness or unstable housing, and pasts evictions)
  - PLWHA under age 30 (greater prevalence of evictions, recent moves, recent homelessness and unstable housing, days on the street in the last year, and trouble paying rent/mortgage, but half the rate of rental assistance, compared to those ages 30+)
  - Transgender PLWHA
  - Current and anticipated cohorts of immigrant and refugee PLWHA

- Latinos/as (multiple moves and problems paying rent/mortgage; especially men who do not speak English well are more likely to have a current or recent history of homelessness or housing instability); and PLWHA without required residency documents

- Expand or revise the biennial homeless count to incorporate questions about service connectivity and other characteristics in order to explain the extent of the overlap between the 2013 count estimate of 93 homeless PLWHA and the AHNA estimate of 187 homeless and 239 unstably housed individuals (plus an unknown number of homeless/unstably housed individuals outside the AHNA sample frame) and further investigate the service needs of homeless PLWHA.

7.7 Future Data Collection and Research

- Conduct future AHNAs every 3-5 years so that current needs can be more quickly identified and addressed. Different data collection elements of an AHNA process could be staggered across several years.

- In light of the small number of Transgender individuals in the patient survey, pursue additional data collection with this group.

- Investigate the housing needs of the following groups: PLWHA in-custody in the county, Asian/Pacific Islander PLWHA, immigrant and refugee (e.g., Burmese) PLWHA, and PLHWA who are veterans of the U.S. Armed Forces.

- Determine why the association between receipt of SSI/SSDI and problems of housing instability is so strong.

- Further explore the relationship among income source, income amount, rental cost, rental options, and residential stability.

- Explore the SNAP-homeless/unstable housing relationship further: does stable housing encourage SNAP application or continued receipt of SNAP? What role should service providers play in regard to on-going receipt of this and other benefits?

7.8 Conclusions

We would like to offer a comprehensive, prioritized list for HCD's *future* consideration. However, we note that the AHNA scope of work included neither outcome studies nor a cost-benefit analyses of *existing* HOPWA-funded services. Therefore we do not evaluate the effectiveness of existing services nor put them in priority order.

Nevertheless, we offer the following points as HCD considers next steps in its planning process to balance competing priorities for HOPWA and other funding for the development of

affordable, quality housing, rental subsidies, housing services, and communication and collaboration efforts. Funding and/or leadership are required to pursue each strategy.

Affordable, quality housing. Alameda County and its constituent cities need an adequate supply of good quality, affordable housing in safe neighborhoods, for both low-income PLWHA and others. Housing development and improved code enforcement would each promote this objective. We suggest the following be prioritized:

> P1. HCD take the lead in developing and promoting city agency programs to improve housing standard inspections for PLWHA residing in non-subsidized housing.

Rental subsidies. Rental subsidies such as those provided by Project Independence both let more households remain stably housed and, by virtue of housing inspections, upgrade the quality of the housing stock. We suggest the following be prioritized:

> P2. Expand the availability of deep rental subsidy assistance through Shelter Plus Care, Housing Authority mechanisms, and other programs, and add additional shallow rent subsidy slots as routes to stable housing; consider funding an additional Project Independence hub agency for increased outreach and accessibility.

Housing services. Even were there sufficient affordable, quality housing stock in safe neighborhoods with public transportation making health care and other services accessible, some PLWHA would still need assistance to secure and maintain stable housing. A variety of types of services are required – some for all PLWHA and some for different sub-groups. We suggest the following priorities:

> P3. Establish a pro-active outreach campaign to identify, find, and offer housing assistance to homeless PLWHA.
>
> P4. Establish a centralized wait list for PLWHA applying for affordable housing units developed with HOPWA funds.
>
> P5. Provide low-threshold housing for PLWHA with a mental health disability and/or who abuse alcohol and/or other drugs.
>
> P6. Establish and evaluate a pilot program for a voluntary county-wide payee service for PLWHA who would find it helpful to maintain housing stability and positive health outcomes.
>
> P7. Ensure adequate funding for emergency housing assistance to prevent eviction through HOPWA or in collaboration with the OAA or other agencies, and publicize its availability.
>
> P8. Fund and support new, more intensive and comprehensive housing referral services, in addition to the information dissemination provided by AHIP, to help PLWHA find

appropriate available housing units in safe neighborhoods, negotiate and deal with landlords to move in, identify and gain access to financial resources for move-in costs, including access to EHA move-in funds, and conduct trainings for service providers about these new services.

P9. Provide bilingual Spanish/English individual counseling to help consumers clean-up their credit records, and market the availability of that service. Consider providing bilingual Spanish/English credit record clean-up and other financial assistance services on-site at housing developments.

Communication and collaboration. The remaining two priority recommendations we stress to improve the delivery of services. We focus on two strategies to improve staff communications across agencies and, thereby, implementation of program and system improvements:

P10. Require the establishment of a communication link between property managers and clinic-based medical case managers of HIV+ residents in primary care as an eviction-prevention strategy.

P11. In conjunction with the OAA, convene HIV/AIDS housing meetings to provide input on planning issues, promote program and services coordination, and assist with the implementation of these recommendations.

The AHNA has identified 34 recommendations, some with multiple sub-parts, and above we highlight 11 of those recommendations.

- P1 and P2 could relatively quickly expand opportunities for *stable housing* and for *additional quality housing*.
- P7, P8, P10, and P11 would have the most immediate effect on *promoting continued stable housing for those currently in housing*. P6 would be directed at promoting *continued stable housing*.
- P9 involves an on-going effort not to be ignored.
- P3-P5 would *bring currently homeless or unstably housed individuals into stable situations*.

We believe it makes sense to pursue these strategies ahead of a substantial investment in developing *new* housing units. Certainly the 200 HOPWA-funded units of affordable housing either in operation on in development and dedicated to housing PLWHA in Alameda County are a great resource. At the same time, it is our understanding that each $150,000 of HOPWA funds invested in developing one additional unit of housing could instead, for example, fund shallow rent subsidies of $300 - $400/month for an additional 30 to 40 households for one year. A further complication is that with shallow rent subsidies or short-term rent subsidies some low-income PLWHA with high levels of need may not be able to secure a housing unit that meets

their needs on the market or remain stably housed once residing in a unit. At the same time Alameda County is not yet at the 86 percent goal mentioned at the onset of this chapter, and current trends in rental costs suggest that the situation may worsen. Compared to the addition of five new development units per year, strategies such as improving the housing stock may prove to have a more widespread impact.

Many of the recommendations address improvements to *information about* and *access to* housing. Hopefully this needs assessment will help inform a planning process that keeps the multi-faceted housing needs of PLWHA primary.

Reference

California Department of Public Health, Center for Infectious Diseases, Office of AIDS. (2013, August). *California's Integrated HIV Surveillance, Prevention, and Care Plan.* Retrieved February 27, 2014, from http://www.cdph.ca.gov/programs/aids/Documents/IntegratedPlan.pdf