

AIDS Housing and Service Systems Integration (AHSSI) Initiative Final Report

Prepared by:
AIDS Housing of Washington
2014 East Madison, Suite 200
Seattle, WA 98122
(206) 322-9444

www.aidshousing.org

Advisory Council Members

Roger Anderson

Veteran's Administration

Joan Clement

Madison Clinic, Harborview Medical Center

Cathy Cochran

Washington State Department of Social & Health Services

Lynn Davison

Common Ground

Barbara Deming

King County Department of Adult & Juvenile Detention

Terry Elizabeth Edwards

Consumer

Theresa Fiaño

HIV/AIDS Program, Public Health – Seattle & King County

Michael Hanrahan

HIV/AIDS Program, Public Health – Seattle & King County

Jeffrey B. Henderson

Community Member

Bill Hobson

Downtown Emergency Service Center

Cassandra Jackson

Seattle Mental Health

Clark Kimerer

Seattle Police Department

Chuck Kuehn

Lifelong AIDS Alliance

Paul Lambros

Plymouth Housing Group

Michael Lee

Community Member

Daniel Malone

Downtown Emergency Service Center

Adimika Meadows

AHW Board

Peter Mourer

King County Housing Authority

Farrel Oglesby

Consumer

Alex O'Reilly

City of Bellevue Human Services Division

Alan Painter

City of Seattle Human Services Department

Cynthia Parker

City of Seattle Office of Housing

Ali Phoenix

Lifelong AIDS Alliance

Rubén Rivera

Therapeutic Health Services

Tom Rooney

Community Member

Katherine Roseth

Porchlight Housing Center, Seattle Housing Authority

Bill Rumpf

City of Seattle Office of Housing

Pam Sacks

Division of Alcohol and Substance Abuse

Debbie Thiele

King County Housing Authority

Dennis Torres

University of Washington, Seattle HIV Prevention Trials Unit

Karina Uldall

HIV/AIDS Research Project (HARP)

Patrick Vanzo

King County Department of Community and Human Services

Kim von Henkle

City of Seattle Human Services Department

Sally Wolf

AHW Board

Kurt Wuellner

Northwest Family Center

AIDS Housing of Washington

Donald Chamberlain

Director of Technical Assistance

Amanda Klein

Systems Integration Coordinator

Betsy Lieberman

Executive Director

Ginny Plata

Executive Team Coordinator

David Wertheimer

Kelly Point Partners

Carol Wilkins

Corporation for Supportive Housing

The AIDS Housing and Service Systems Integration (AHSSI) Initiative and Final Report were funded by the City of Seattle Human Services Department through its federal Housing Opportunities for Persons with AIDS (HOPWA) formula award.

The substance and findings of this work are dedicated to the public. The author and publisher are solely responsible for the accuracy of the statements and interpretations contained in this publication. Such interpretations do not necessarily reflect the views of the Government.

Table of Contents

Executive Summary	i
Addressing Systems Fragmentation and Defining Gaps and Barriers	1
Developing a Model for an Integrated Continuum of Housing and Services Tailored to Meet the Needs of the Target Population.....	1
Integrated Permanent Housing and Services (IPHS) Pilot Project	1
Intensive outreach and engagement services.....	3
Low-barrier, pre-recovery housing options.....	3
Varying pathways of transition to permanent housing.....	3
Model fluidity that incorporates relapse and multi-directional movement.....	4
Culturally competent services	5
How Did We Get There? Identifying the Target Population, the Problem, and Promising Practice Models.....	6
The AHSSI problem statement	6
Definition of AHSSI target population	6
Identification of promising practice models.....	7
Development of Working Agreements and Stimulation of Cross-System Dialogue.....	9
Purpose of working agreements	9
AHSSI working agreements.....	10
Stimulation of cross-system dialogue	11
Identification of Housing Sites and Expanded Housing Stock	12
Unresolved Issues and Problem Areas.....	13
Systems disconnection and fragmentation	13
System capacity and housing availability	14
Dwindling resources in a difficult economic climate.....	14
Information sharing and confidentiality	15
What Needs to Happen Next.....	16
Provide top-down support for integration	16
Designate funds for collaborative activities	17
Create additional system-level working agreements.....	18
Tackle community acceptance issues.....	18
Educate for and about the value of integrating housing and support service resources.....	18
The AIDS Housing and Service Systems Integration (AHSSI) Model.....	19
Background and Problem Statement.....	19
Why we needed AHSSI.....	19
The emergence of the AHSSI initiative	19
Description of the AHSSI Model.....	21
Goals.....	21
The AHSSI structure	21

What AHSSI Accomplished	24
Major outcomes of the AHSSI initiative.....	24
How to Make Best Use of This Report.....	27
Replicating the AHSSI initiative in Other Jurisdictions	27
Conduct local research and data analysis.....	27
Define problem areas	28
Identify target populations	29
Describe resources	29
Tailoring Integration Activities to Different Local Jurisdictions	30
Identify the “right” stakeholders and systems.....	30
Demonstrate to stakeholders the value of their involvement.....	31
Assemble key stakeholders in working groups.....	32
Engage stakeholders in strategic planning.....	33
Clearly define action steps	33
Evaluate outcomes and accomplishments.....	34
Potential Problem Areas: What to Watch Out For.....	36
Systems inertia.....	36
System defensiveness or hostility	36
Turf issues	37
Cross-system “cultural” conflicts.....	37
Community opposition.....	37
Resource limitations.....	38
Lack of funding opportunities.....	38
Loss of momentum.....	38
Defining Your Own Next Steps.....	40
Appendices.....	A-1
Appendix I: Sample Advisory Council Invitation Letter.....	A-1
Appendix II: Sample Advisory Council Minutes	A-3
Appendix III: Final Problem Statement.....	A-7
Appendix IV: Pilot Project Needs Assessment Overview & Summary	A-10
Appendix V: Cultural Competence: Preamble, Definitions, Measures, & Bibliography	A-16
Appendix VI: Best Practice Models	A-19
Appendix VII: Blank Working Agreement Template	A-21
Appendix VIII: Sample Meeting Evaluation Form	A-25
Appendix IX: Sample Final Meeting Self-Evaluation Form.....	A-26
Appendix X: Bibliography & Online Resources	A-27
Appendix XI: Glossary	A-30

Executive Summary

Stable housing is fundamental to success in the lives of our citizens. This is particularly true for individuals struggling with problems and illnesses that threaten health and make the tasks of daily living even more challenging. Without a home, stress levels increase, further compromising already fragile immune systems. Individuals are exposed to challenging shelter environments or the chaos of life on the streets. Essential nutritional needs are easily neglected or forgotten. Complex treatment regimens become more difficult to monitor and are frequently derailed. Appointments with health care and human service providers are more likely to be missed or not scheduled at all. Outreach workers are less likely to be able to find their clients in order to offer ongoing support and treatment. In short, for people living with HIV/AIDS, stable housing is a cornerstone of quality health care.

In July 2001, AIDS Housing of Washington launched an ambitious initiative to address a growing problem in Seattle/King County, Washington: increasing numbers of multiply diagnosed people with HIV/AIDS who were falling through the cracks of the existing housing and services continuum. This initiative, called AIDS Housing and Service Systems Integration (AHSSI), consisted of an 18-month planning effort to develop and test more effective solutions for people with HIV/AIDS who are homeless or at risk of homelessness, have histories of mental illness, chemical addiction, and/or other chronic health problems, and have criminal justice involvement.

AHSSI's two main goals were to increase permanent, affordable housing resources for individuals and families with HIV/AIDS, and to promote integration of supportive service options for difficult-to-serve people with HIV/AIDS. AIDS Housing of Washington's development staff took responsibility for the identification and creation of permanent housing units, identifying a total of up to 36 potential units. As of the end of the initial grant period, 14 units were already occupied or ready for tenants.

With the help of an advisory council of 35 key stakeholders (including consumers, advocates, and specialists in the fields of HIV/AIDS services, homelessness, primary care/public health, mental health, substance abuse/chemical dependency, housing and housing development, and financial supports/entitlements), AIDS Housing of Washington staff and consultants undertook a range of activities to meet the integration objectives of the initiative.

The AHSSI Advisory Council was the starting point for cross-system dialogue, as its members, with a diverse range of roles and affiliations, contributed their perspectives on the issues related to the target population and the many existing system-level gaps and barriers that prevent these individuals from accessing housing and support services. The Advisory Council and the AIDS Housing of Washington staff/consultant team developed a formal "problem statement," examined a number of promising practice models, and collected and reviewed national and local data to define a specific target population for the AHSSI initiative.

Based on this work, the group proposed the creation of the Integrated Permanent Housing and Services (IPHS) project, a model targeting post-incarcerated individuals who are homeless (or chronically homeless), HIV-positive, and active abusers. IPHS combines a broad and intentional continuum of housing and support services linked to client progression through stages of recovery with a high degree of flexibility that incorporates an understanding of relapse in substance use

disorders as part of the recovery process. This unique model will build cross-systems capacity to engage and house clients through a flexible continuum that integrates intensive outreach-based case management, two levels of new “pre-recovery” housing, and streamlined access to medical care, mental health and substance abuse treatment, support services, recovery-oriented housing, and other permanent housing resources in the community.

The IPHS pilot seeks to demonstrate that this continuum can increase positive housing outcomes, expand service linkages, and decrease jail episodes for people with co-occurring HIV and substance use disorders. Just before the conclusion of the AHSSI process, one of the participating agencies received notification of \$1.3 million in funding for the IPHS pilot. Application for this new funding was made with the help of AIDS Housing of Washington and the AHSSI Advisory Council.

Focused discussion of existing interagency linkages helped to identify problem areas and issues and promote the development of formal working agreements as well as other kinds of collaboration, integration, and service enhancement activities. With the assistance of AIDS Housing of Washington staff and consultants, working agreements are under development to enhance linkages between local correctional facilities and HIV/AIDS services, to promote increased housing opportunities for homeless families who do not qualify for AIDS-disabled housing, and to increase access to employment and recovery-oriented housing for people with HIV/AIDS and histories of involvement with the criminal justice system.

Other specific systems integration accomplishments of the AHSSI planning process included:

- Interfacing with the Seattle and King County Housing Authorities to promote increased attention to the housing needs of people with HIV/AIDS (especially those who are multiply diagnosed) and greater flexibility in the use of Section 8 vouchers
- Exploring strategies to create increased flexibility for tenant movement within HUD’s permanent homeless housing programs and allow at-risk tenants who have transitioned from these programs to mainstream housing to re-enter homeless housing if clinically necessary to prevent a return to homelessness
- Strategic discussions with the Northwest Family Center about opportunities to enhance existing case management services for homeless families living with HIV/AIDS
- Meetings with the providers of HIV/AIDS case management services to identify and address the specialized needs of the AHSSI target population
- Creation of a plan to ensure the delivery of culturally competent services to people in the target population
- Discussion with representatives of the publicly funded mental health and substance abuse treatment systems about the specialized service needs of people living with HIV/AIDS
- Identification of issues related to the needs of the target population that require additional educational efforts with policy makers, elected officials, and the agencies that fund housing and human services
- Cross-system discussions among the various funders of housing and service supports for people living with HIV/AIDS about the feasibility and desirability of creating a “funding collaborative” that would coordinate and integrate resource development and allocation procedures related to the target population of people with multiple problems who are living with HIV/AIDS.

Although the initial stage of the AHSSI initiative ended in December 2002, many of the issues and problem areas identified as a result of the initiative will be addressed in the coming months as

stakeholders continue to participate in integration efforts that were initially stimulated by AHSSI. This final report details some of the most promising strategies for facilitating increased integration of housing and support services on an ongoing basis.

Numerous gaps and barriers between and among systems continue to exist and have proven beyond the scope of the AHSSI initiative to address. Although some individuals face intense and complex sets of problems that make them seem virtually impossible to house, many of the stakeholders who at first doubted that solutions were attainable now find them within reach. Improvements realized and initiated through the AHSSI process have already touched the lives of individuals and families living with HIV/AIDS.

There are several concrete recommendations and action items contained in this report that represent the results of many hours of cross-system conversation and collaboration. In addition to these recommendations, it is important to acknowledge that the dialogue itself represents a significant process outcome. The AHSSI effort helped to make systems more aware of one other, and to identify key players in a variety of systems that each seek to address the needs of the same client population from different vantage points. The relationships created by the AHSSI project will remain one of its most valuable work products; these ongoing, cross-system contacts will continue to be central to the work of improving the lives of the most difficult-to-serve people living with HIV/AIDS and multiple associated problems in King County.

AIDS Housing of Washington is indebted to the large number of key informants and system stakeholders who were central to the AHSSI planning process. We thank them for their wisdom and guidance, and acknowledge that any errors or shortcomings in the report that follows belong to AIDS Housing of Washington alone, and not to any of our AHSSI partners. We wish to express particular gratitude and thanks to the many people living with HIV/AIDS who contributed to the AHSSI process. This includes the strong, diverse, and vocal consumer group that participated as regular members of the AHSSI Advisory Council as well as all the individuals who offered their wisdom and insight in informal conversations, focus groups, and consumer surveys.

Addressing Systems Fragmentation and Defining Gaps and Barriers

Developing a Model for an Integrated Continuum of Housing and Services Tailored to Meet the Needs of the Target Population

Taken as a group, not only does the AIDS Housing and Service Systems Integration (AHSSI) target population—HIV-infected individuals who remain difficult to house due to multiple issues in their lives—disproportionately draw resources from a range of systems that provide emergent care or incarceration, its members also remain significantly underserved, falling through the cracks in the existing housing and service support systems. They may be released from jail or prison without any formal linkages to the HIV/AIDS care system in place. Past evictions, criminal histories, and/or active involvement with illegal and legal substances may compromise or preclude eligibility for a variety of subsidized housing programs. These individuals may bounce among a range of survival services, including shelters, meal programs, drop-in and day health centers, public health clinics, etc. Problematic behaviors due to mental illness and/or substance abuse may result in specific individuals being barred from any of a number of these facilities. The existing housing and service continuum must evolve if it is to provide workable options for this population.

Integrated Permanent Housing and Services (IPHS) Pilot Project

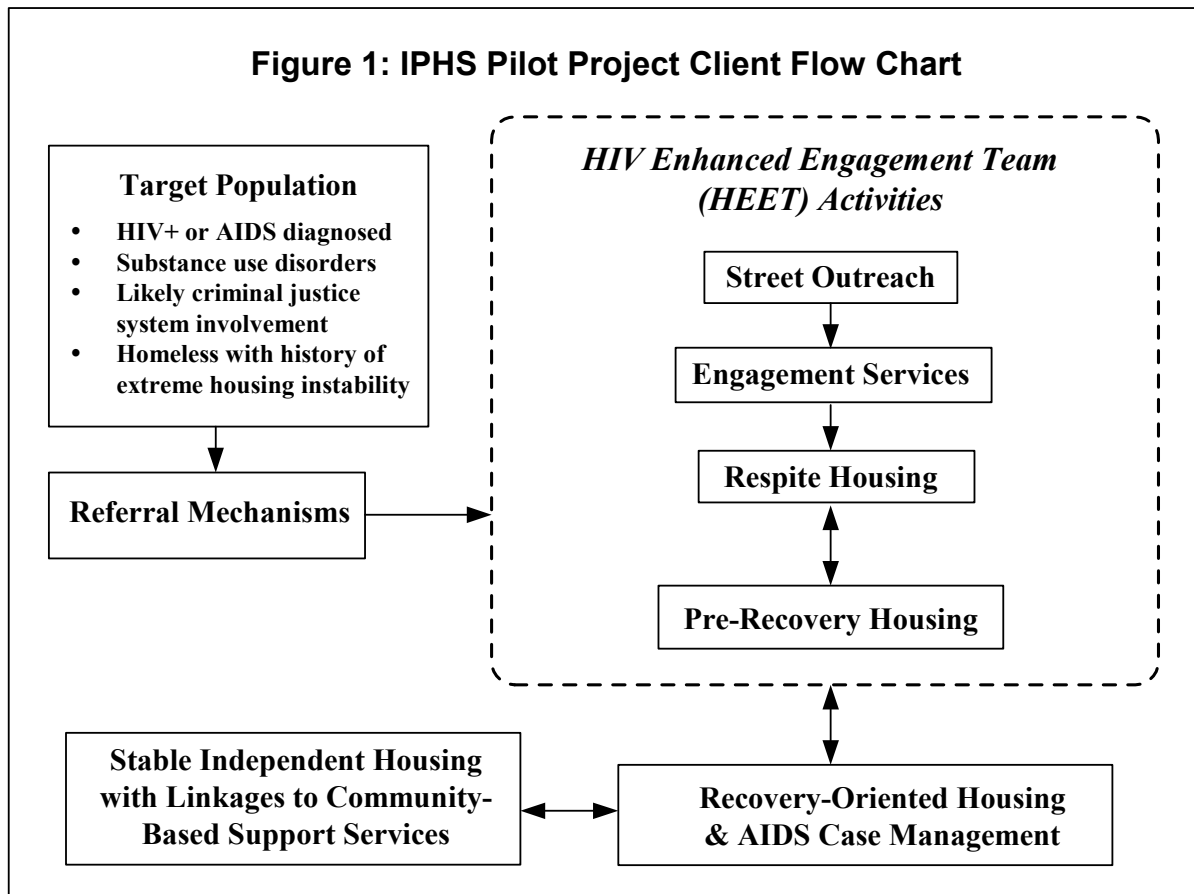
Using the AHSSI Advisory Council's (AC) combined expertise, data on local need, and lessons learned from model programs throughout the United States, the AIDS Housing of Washington (AHW) staff/consultant team developed a model for an innovative pilot project for post-incarcerated individuals who are currently/chronically homeless, have a substance use disorder, are HIV-infected, and are likely to have ongoing involvement with the criminal justice system. The proposed model is being called Integrated Permanent Housing and Services (IPHS) and has been awarded a \$1.3 million grant through the Housing Opportunities for Persons with AIDS (HOPWA) Special Projects of National Significance (SPNS) grant program.

IPHS will have two primary goals: (1) developing 10 units of service-enriched permanent housing dedicated to stabilizing members of this target population; and (2) initiating a new "HIV Enhanced Engagement Team" (HEET) that will provide both direct client services and a boundary-spanning role to coordinate services from multiple mainstream systems in order to enhance the delivery of appropriate care. The pilot project will also provide six new dedicated, contiguous, and staff-supported respite beds on a nightly basis for pilot project clients who are not acutely ill and require a low-demand setting. The new housing units will be woven into a flexible continuum with existing shelter and housing options that include medical respite beds, pre-recovery housing, recovery-oriented housing, clean-and-sober living, and independent apartments in the community, all accessible by IPHS clients depending on their clinical need and housing readiness. The HEET team will help to identify and engage previously underserved consumers and then work with them to define and follow a critical pathway from the instabilities of chronic homelessness and cycling through the jail and the streets to structured supports and long-term housing.

Critical to the success of the IPHS project is system-wide flexibility to allow individuals to move “forward” and “backward” along the continuum of engagement, housing, and support services described above. Maintaining this flexibility across numerous systems and programs will be essential to the ultimate success of IPHS clients. Not all clients will progress all the way through the continuum; individuals should be able to pause or even end their progression at points that are congruent with their illness and stage of recovery. Some clients will experience drug relapse and need to return to a more service-intensive or lower barrier setting.

This increased flexibility, as well as the boundary spanning provided by the HEET staff members, will have positive repercussions for the housing and services continuum as a whole and will affect members of the target population who are not directly enrolled in the pilot project.

A graphic representation of the IPHS model is included below as Figure 1. The two-way arrows between boxes indicate that backward movement to a previous level of the housing continuum and progress to the next level of the continuum are both possible.



Intensive outreach and engagement services

The specialized HEET case managers proposed as a core component of the IPHS pilot project will work to overcome existing gaps and barriers to housing and services for the target population by building alliances with each consumer at her or his own pace. HEET staff will provide outreach/pre-contemplation phase services to individuals who are not yet ready or willing to accept ongoing care, as well as intensive engagement and case management services for up to 40 individuals (20 clients per worker) who are willing to engage with the team. HEET services will therefore be available to a number of consumers who are not living in IPHS housing units.

HEET staff will have the primary responsibility for providing case management and developing service linkages until clients are ready for recovery-oriented housing. At that point, clients will transition to regular, community-based HIV/AIDS case management. HEET staff will have expedited access to the jail and will work closely with staff from other systems that have contact with the target population. Access to IPHS housing will serve as a key engagement tool for some clients.

Low-barrier, pre-recovery housing options

Many of the individuals in the AHSSI target population are currently living in large homeless shelters. Others are on the streets because they are fearful of other shelter residents or of exposure to illness. These consumers can be vulnerable in many more ways than typical homeless shelter residents, yet they may not be ready for the rules and requirements of transitional or permanent housing. HEET staff will help clients who are experiencing acute medical conditions to access existing medical respite beds in the community. For those who require a low-demand setting outside of a medical model, the pilot will provide six dedicated, staff-supported respite beds within a larger shelter or housing site. Pilot clients may access the IPHS (non-medical) respite beds as long as needed.

Some members of the AHSSI target population are managing to stay out of shelters and off the street by staying with friends or family or in other temporary living situations, but their ongoing substance abuse has made it impossible for them to qualify for, or sustain tenure, in other housing. These consumers may be appropriate candidates for the IPHS project's 10 new units of service-enriched, pre-recovery, permanent housing. Other consumers will first spend time in the respite beds and participate in Bailey-Boushay House's Adult Day Health program. HEET staff will work with them to prepare for movement to the permanent IPHS units, if appropriate.

Although there will be no restrictions on length of stay in these units of housing, some clients will attain so much stability in the IPHS units that they will be capable of moving to other permanent housing that may be more appropriate as they progress in their recovery or behavior management.

Varying pathways of transition to permanent housing

While the new units created for the pilot project will fill the most pressing gap in the HIV/AIDS housing continuum in Seattle/King County for the AHSSI target population, consumers accessing the IPHS program won't be restricted to accessing only these units. For those clients who stabilize in IPHS housing, the feasibility of graduating to other service-enriched housing that is specifically

oriented towards ongoing treatment and recovery will be evaluated on a case-by-case basis. The move to recovery-oriented housing will represent a major step towards increased independence for many IPHS clients. Successful graduation of a percentage of residents to other housing options will be essential to maintaining flow through the system and creating new openings in the IPHS units for referrals from respite bed and shelter programs and other HEET referral points.

For those individuals who gain significantly more stability in recovery-oriented housing, moving to permanent, independent housing is the reward. Through formal working agreements with a variety of AIDS and low-income housing programs, units will be made available in the community. Individuals transitioning to these permanent housing resources will continue to receive ongoing AIDS case management services as needed, and be linked to chemical dependency treatment, mental health services, and other recovery-oriented services (such as 12-step programs and self-help groups) that can continue to support their recovery-related goals.

This final component of the housing continuum reflects the goal of providing a maximum amount of independence to individuals who are able to successfully manage their lives and illnesses. Movement towards independent housing also ensures ongoing capacity in recovery-oriented housing for new clients who have been identified by HEET staff members.

Model fluidity that incorporates relapse and multi-directional movement

Clients within the AHSSI target population are struggling with multiple illnesses and issues simultaneously. Alcohol or drug relapse is a recognized dimension of substance use disorders; relapse can often be triggered or exacerbated by other conditions, including medical problems associated with HIV/AIDS, mental health problems such as depression, or social and economic problems such as loss of employment, housing, and/or support services. Best practice principles suggest that repeated episodes of treatment and housing stability increase the likelihood of recovery over time.

Cross-system flexibility, including the ability to move to and from different housing alternatives, is an essential component of the IPHS project, and an AHSSI goal for the target population as a whole. Housing and service providers must increase their capacity to allow vulnerable clients to go in either direction along the continuum of engagement, housing, and support services. This will require a change in how we view the classifications of housing—emergency, transitional, permanent—and acceptance of the fact that some clients may never be able to function in higher demand housing. It also requires that there is a flow through the housing system so that those who do progress have somewhere to live.

Furthermore, some individuals who move “forward” in the continuum will, from time to time, experience relapses or associated difficulties (e.g., jail incarceration) that warrant other treatment interventions (e.g., residential treatment), a return to earlier components of the continuum, or both. These individuals must, as clinically necessary, be able to move in any direction along the continuum without any penalties that might trigger a return to homelessness.

Culturally competent services

In the AHSSI target population, the number of people of color (particularly African Americans, and to a lesser extent Native Americans) is disproportionately high relative to the number in the local population as a whole, as well as to the subset of the local population living with HIV/AIDS. Because there is such a large number of African-American individuals in the target population for whom existing housing and services are not working, and because African-American consumers have reported cultural issues as a barrier, cultural competence in general, and meeting the needs of African American clients in particular, became a major focus for the AC.

The AC engaged in significant discussion of the importance of cultural competence and created a working group to address cultural competence as it impacts services to people living with HIV/AIDS. The AC and the working group grappled with several key issues, including the relative importance of hiring staff who are the same race/ethnicity as the clients when balanced with the difficulty of finding African-American staff in the Seattle area (and the difficulty of hiring qualified staff of any race/ethnicity). Other key issues included the range of meanings of the term “cultural competence” and the challenge of measuring whether services are culturally competent.

The working group developed a specific definition for cultural competence and for measuring success in delivery of culturally competent services in the context of the IPHS pilot project (see Appendix V for definition and success measures).

How Did We Get There? Identifying the Target Population, the Problem, and Promising Practice Models

The AHSSI problem statement

The AIDS Housing and Service Systems Integration (AHSSI) Advisory Council (AC) spent the first several meetings developing a “problem statement” that summarized key areas of difficulty related to housing people with HIV/AIDS and other disabilities in King County. First, the AIDS Housing of Washington (AHW) staff/consultant team interviewed many AC members individually to get their perspectives on gaps, barriers, and solutions, and used this input as the starting point for the problem statement. Then AHSSI staff collected and reviewed relevant data from local, regional, and national sources. The availability of staff expertise from Public Health – Seattle & King County was essential to these data collection efforts. Public Health provided extensive summaries of local client-related information and needs assessments that were critical to accurately identifying the AHSSI target population and their specific housing and support service needs. The AHSSI problem statement laid the groundwork for finding solutions to the identified problem areas. (The problem statement is included as Appendix III.)

Definition of AHSSI target population

In the early meetings of the AC, it became increasingly clear that there was a need to focus particular attention within King County not only on those individuals with HIV/AIDS who were facing homelessness and other diagnoses, but also on those whose behaviors or histories made them the most challenging to house of this group—“pushing the envelope” of who can be successfully housed. Interviews with community-based AIDS case managers determined that most of these individuals are active substance abusers who have drug-related criminal histories. The AC made these individuals the focal point of AHSSI’s efforts, although individuals dealing with mental illness, physical disabilities, or other challenges are still part of AHSSI’s purview, since they too may find it very hard to get or maintain permanent housing.

Information on the target population was culled initially from existing local data sources. Data from the *2001 Seattle-King County HIV/AIDS Care Services Comprehensive Needs Assessment* (conducted by Public Health – Seattle & King County’s HIV/AIDS Program and the HIV/AIDS Planning Council for the Seattle Eligible Metropolitan Area [EMA]) indicates that of 538 people living with HIV/AIDS surveyed, 45% had at least one of the following characteristics:

- Ever diagnosed with a mental illness (30%)
- Used street drugs (not by needle) in the past year (15%)
- Homeless in the past year (11%)
- Used needles to inject drugs in the past year (8%)
- In jail or prison in the past year (incarcerations occurring prior to the past year were not asked about) (7%)

Additional unpublished data from the same data set indicates that of the respondents who had been in jail or prison in the past year, 74% reported a history of illegal substance use.

Public Health – Seattle & King County’s 2001 HIV/AIDS Epidemiology Profile for Community Planning reports that King County jail staff estimate about 2% of inmates on any given day are HIV-positive (60 out of a total population of 3,000 inmates). Between 1986 and 2000, a total of 13,185 inmates in King County correctional and detention facilities participated in voluntary HIV testing; 293 (2.2%) of those tested were HIV-positive.

In response to the data detailed above, the AHW staff/consultant team and the AC decided to examine a subset of this target population by conducting interviews with 18 AIDS case managers at Ryan White-funded agencies. These interviews confirmed that the clients who were least successful in the AIDS housing continuum tended to have histories of both substance abuse and cyclical incarceration; when asked about their most difficult-to-house HIV-positive clients, case managers provided anonymous profiles of 44 unduplicated clients, 36 (82%) of whom were both homeless (or in jail) and had substance abuse histories. Almost all of the 36 had drug-related criminal histories and ongoing substance abuse. African Americans and Native Americans were overrepresented in this client group.

These 36 clients all faced multiple challenges, but in the assessment of the case managers interviewed, current substance abuse was the most significant barrier to housing for 33% of the clients, mental illness or unpredictable behavior was the most significant barrier for 22%, and criminal history was the most significant barrier for 19%. Despite the fact that these clients had so many characteristics that made them challenging for their housing and service providers (not to mention potential neighbors) to deal with, their case managers felt that in many cases, a better integrated system could help them succeed.

The AC also agreed that it wanted to make sure to include options for those individuals who were HIV-positive but not AIDS-disabled, since these individuals do not currently qualify for permanent AIDS housing in King County.

Identification of promising practice models

The AC explored practice models, both nationally and locally, that offered examples of successes with systems integration for difficult-to-house populations or this population in particular. Advisory Council meetings featured presentations about the San Francisco Bay Area’s Health, Housing and Integrated Services Network (HHISN),¹ the New York/New York study,² and Seattle’s own Lyon Building project.³ (See Appendix VI for more information on these best practice models.) The consultant and project coordinator staffing the AHSSI project interviewed staff of other local programs, including Bailey-Boushay House’s Adult Day Health program (a day center for those with HIV/AIDS including a range of on-site programs and services) and the REACH program (intensive street-based outreach and case management for chronic public inebriates). Key aspects of successful programs for this population include co-location or close proximity of a variety of services; talented, dedicated, and flexible staff who have experience with both substance abuse and

¹ HHISN comprises a multi-agency collaborative partnership of “homeless” and “mainstream” housing and service providers and funders. Integrated Services Teams deliver comprehensive services on-site in affordable housing to address health care, mental health, substance abuse, employment, and social service needs.

² A joint city/state program to develop supportive housing for homeless mentally ill individuals and study their service use before and after placement into housing. Data from service providers (including shelters, hospitals, and jails) over a five-year period found that reductions in service use offset 94% of the costs of the supportive housing.

³ A 64-unit building that provides permanent supportive housing to homeless individuals with multiple disabilities, including HIV/AIDS, mental illness, and chemical dependency.

mental health issues; some form of harm reduction; and linkages to other services and agencies. In addition to these key aspects, culturally competent services are particularly important in view of the disproportionate representation of people of color in the target population.

Development of Working Agreements and Stimulation of Cross-System Dialogue

Purpose of working agreements

Working agreements create formal relationships within, between, and across systems and provider agencies in order to promote integration of policies and practices at both client and systems levels. Working agreements can do the following:

- Bring together systems and stakeholders with limited histories of collaborative involvement to identify shared issues, problem areas, and client populations
- Identify the problems of system fragmentation that cause systems to fail in serving their most challenging clients
- Stimulate environments in which the configuration and delivery of services are adjusted in order to make them maximally beneficial to people with a variety of problems
- Institutionalize procedures for ensuring the involvement of different agencies and/or systems that, by working together, can increase service efficiency and effectiveness

The content of working agreements can promote opportunities for case planning and treatment collaboration across multiple agencies, cross-training of staff in multiple disciplines, negotiation of policies and procedures that are complementary across systems, and blending or braiding of resources from different systems. Working agreements have been recognized as a particularly useful tool in promoting effective collaborative relationships among the systems and service providers that most frequently encounter people struggling with homelessness, mental illness, substance use disorders, and criminal justice system involvement.⁴

The implementation of working agreements can be appropriate at several stages during the evolution of cross-system relationships and integrated services:

- Working agreements can serve as “ice breakers,” stimulating cross-system dialogue among systems in which there has been no history of collaborative relationships. Some systems are reluctant to enter into collaborative relationships with other entities until the communication has been officially sanctioned at the policy level. For more cautious policy makers and providers, working agreements can give “permission” for collaborations to occur.
- Working agreements can formalize or institutionalize informal working relationships that have demonstrated their effectiveness over time without being recognized at the systems level. Informal working relationships are inherently fragile; the reconfiguration of services or the departure of staff who have been critical to making these relationships work can be highly disruptive to the working relationship. Working agreements help to ensure systemic continuity of collaborative efforts at the service level.

⁴ See Wertheimer, D. “The Change Agent’s Tool Box,” a series of publications issued in 2001 by the National Association of State Mental Health Program Directors, National Technical Assistance Center. Available at: www.nasmhpd.org/ntac/toolbox/index.html

- Working agreements can stimulate additional collaborative activity among agencies that have already demonstrated the capacity to promote integration. Agencies and systems with strong track records of collaboration can be stimulated to take next steps towards integration, moving towards more complex integration tasks such as the co-location of services and the blending of resources that can produce synergistic results.

AHSSI working agreements

The AIDS Housing of Washington (AHW) staff/consultant team and the AIDS Housing and Service Systems Integration (AHSSI) Advisory Council (AC) dedicated significant effort towards identifying the areas and agencies in which working agreements might enhance the effectiveness of the various players in King County that are actively engaged in the planning, funding, and delivery of services to the AHSSI target population of people with HIV/AIDS and substance use disorders who may have been or are involved with the criminal justice system. In order to stimulate interagency collaboration and the development of new working agreements, the AHW staff/consultant team convened joint meetings of key staff from the identified agencies to discuss the potential value and feasibility of new working agreements. In some of these gatherings, staff from different systems met and discussed collaborative opportunities for the first time. In other gatherings, staff who were already familiar with the work of the other participating agencies met to formalize existing relationships and/or discuss new areas for collaboration.

The AHW staff/consultant team developed a template to assist in identifying the potential uses and value of working agreements. (See Appendix VII.) This template proved to be an extremely useful tool in stimulating and focusing dialogue about the potential structure and content of possible working agreements. Some agencies moved forward from the initial meetings convened by AHSSI to develop working agreements on their own, based on the information gathered during the first meeting. Other agencies requested additional assistance from AHSSI and AHW to help them continue developing agreements.

The AHSSI-initiated working agreements currently in the process of being implemented to enhance the work and reach of the AIDS service system in King County include:

- Creation of a formal working relationship between *Division of Correctional Health and Rehabilitation Services* (Public Health – Seattle & King County’s nationally accredited jail health clinics), *Harborview Medical Center’s Madison Clinic* (a major provider of health care and case management services for people living with HIV/AIDS), and *Lifelong AIDS Alliance* (the county’s primary provider of social and support services to people living with HIV/AIDS) to promote more effective linkage of people leaving the county jail with housing, case management, and support services that can meet their needs.
- Expansion of linkages between *Lifelong AIDS Alliance*, the *Madison Clinic*, and *Pioneer Human Services* (a private nonprofit provider of housing and employment services to people in substance abuse recovery who have been involved in the criminal justice system).
- Construction of a mechanism between *Lifelong AIDS Alliance*, *YWCA of Seattle/King County/Snohomish County* (a primary provider of emergency shelter and housing for homeless women and families in King and Snohomish Counties) and *Northwest Family Center* (a primary provider of case management services to women and families living with HIV/AIDS) to expedite the referral of homeless families with significant treatment needs into appropriate transitional and permanent housing.

Where there was no existing working agreement between providers, there was a likelihood that services were being underutilized (because, for example, staff at the other organization were not aware of what was available for their clients) and care was not being effectively coordinated. In the case of the first working agreement listed, for example, the existing lack of formal linkage (or even consistent communication) between the county jail and housing, health care, and case management providers results in HIV-positive inmates often being released from jail without being engaged in housing or services, leaving them homeless, vulnerable, and at high risk of re-offending. All parties who participated in the discussion of a potential working agreement were enthusiastic about instituting more frequent communication, cross-training and expedited referrals, and coordinated discharge planning, all of which could significantly improve the chances that HIV-positive people leaving jail will succeed in gaining stability in housing.

Stimulation of cross-system dialogue

By convening an advisory council comprising individuals with a diverse range of roles and affiliations, AHW stimulated dialogue and creative thinking across multiple service systems. The AC had 35 members (representing 25 different agencies/affiliations), with each meeting drawing about 20-30 attendees. Some members attended regularly, others sporadically, but there was a high degree of interest among all participants in learning from each other. Connections created around the AC table helped to facilitate ongoing communication and collaboration among AC members outside of the AHSSI setting. The activities of the AC and its membership resulted in both the enhancement of existing multi-system partnerships and the stimulation of new cross-system relationships.

AHW staff collected written evaluations at the conclusion of each AC meeting. The tabulated results of these evaluations suggest that members of the AC found the information provided and the resulting discussions worthwhile, and they valued the investment of time and effort towards improving housing and support services for multiple-problem clients living with HIV/AIDS.

At the end of the AHSSI process, AC members stated that they felt they had become better educated about the other participating organizations and systems and more aware of the complexity of the issues clients struggle with. They also understood more about the importance of tailoring housing and integrated services to the population, as well as the need for integrated funding. AHSSI Advisory Council members acknowledged the ongoing value of the relationships that were created or strengthened over 18 months of cross-system dialogue with other individuals and agencies actively involved in the provision of housing and support to the target population. Many AC members stated their intention to continue cultivating these cross-system relationships through both informal collaborations and formal cross system working agreements, even after the conclusion of the AHSSI planning process.

Identification of Housing Sites and Expanded Housing Stock

The need for additional permanent affordable housing was identified early in the AIDS Housing and Service Systems Integration (AHSSI) initiative as a baseline need. AIDS Housing of Washington (AHW) staff set a goal of creating 25 additional units of permanent affordable housing dedicated to people living with AIDS and their families. This goal was exceeded, and 14 of the planned units were on-line before the end of the 18-month grant period. These completed units include Shirley Bridge Bungalows, a six-unit development in West Seattle for very low-income individuals and families living with HIV/AIDS, and Casa Luis, an eight-unit SRO in South Seattle that serves monolingual Spanish-speaking people with AIDS. Still in development are up to 15 units in two different projects serving individuals and families with AIDS and other disabilities. In addition, up to seven units within low-income housing developments that are in construction are planned to be set aside for people with AIDS.

Unresolved Issues and Problem Areas

Throughout the AIDS Housing and Service Systems Integration (AHSSI) planning and development process, a range of systems-level issues and problem areas related to accessing existing housing or developing new housing for the AHSSI target population have emerged. Some of these problem areas have been resolved through the conceptualization and implementation of the strategies and activities that have been identified and described in earlier sections of this report. Other problem areas involve gaps and barriers between and among systems that have proven beyond the capacity of the AHSSI initiative to solve. The key problem areas identified in the AHSSI initiative are below.

Systems disconnection and fragmentation

The continued fragmentation of the health care and human services systems hinders the development of a holistic housing, treatment, and support service array for people living with HIV/AIDS. The existence of a variety of systems, each of which is charged with the development, delivery, and management of a narrow range of housing, treatment, or program activities, perpetuates a “silo” mentality that serves the self-interest of each system far better than it does the needs of the multiple-problem client. Each system zealously guards the limited resources under its control, particularly in times of large-scale economic difficulty when housing and human services funding is put most at risk in federal, state, and local budget reduction processes. To successfully meet the needs of difficult-to-serve clients, staff in each system struggle to cobble together services that engage and include different agencies and players in order to promote client stability and recovery. Case managers, counselors, and advocates often spend more time attempting to bridge systemic gaps than they do providing direct care to the individual clients in their caseload.

For the AHSSI target population, the systems fragmentation that most adversely affects client stability and recovery involves a number of arenas, including:

- HIV/AIDS case managers and housing advocates
- Chemical dependency counselors and treatment providers
- Mental health case managers
- Primary health care providers
- Public housing authorities and other low-income housing providers
- Corrections officers and jail-release staff

The core issues that separate systems and cause significant gaps in and barriers to care include:

- Different definitions of eligibility that exist in different systems
- Different definitions of priority populations that promote or prevent access to care for people in different service systems
- Exclusionary criteria that block access to housing, treatment, or support services
- Stigma associated with substance use disorders and criminal justice system involvement that push stigmatized populations to the margins of society

Through skillful and creative care management and housing advocacy, the effects of systems fragmentation and the access problems faced by individuals in the AHSSI target population can be somewhat mitigated on a case-by-case basis. Unfortunately, staff who are constantly being forced to tackle systems fragmentation and barriers to access experience intense frustration, which contributes to staff burnout and high rates of staff turnover. True systems change that can overcome the problem of systems fragmentation will require careful organizational realignment at the structural level of multiple systems, if not more radical systems reconfiguration.

System capacity and housing availability

Most of the service systems that provide care to individuals in the AHSSI target population never receive sufficient resources to provide adequate assistance to all of the individuals within the purview of their service mandates. This is not a new problem. The issue is complicated by the reality that HIV/AIDS, substance abuse, criminal justice system involvement and homelessness are all conditions that can promote personal economic stress. This stress makes individuals increasingly reliant on publicly funded sources of care as insurance benefits (if available in the first place) are exhausted or terminated. In short, illness and disability tend to move fragile populations in the direction of poverty and disenfranchisement. Many individuals in the AHSSI target population have not chosen to be poor; rather, they were, as one client has stated it, “disabled into poverty.”

The lack of access to safe, decent, and affordable housing further complicates the problems faced by an individual who has been disabled into poverty. When housing is secured, it tends to be located in less desirable neighborhoods where the proximity of criminal and drug-related activities only creates additional risks to client stability and recovery. Even as housing and support service providers, and the clients with whom they are working, struggle to retain the housing that may be available, poverty, racism, and class issues are seldom far away, further exacerbating the instability that jeopardizes hard-won gains.

Dwindling resources in a difficult economic climate

Housing and treatment system capacities become even more problematic for marginalized populations in periods of economic recession. Stigmatized populations are adversely impacted during times of economic downturn when resources for human services become particularly scarce and prioritization processes particularly cruel. Single adults—women and men whose social support networks have disintegrated beyond the point of being dysfunctional—are often among the first to lose access to essential housing opportunities and treatment support.

This cycle is especially vicious for those individuals whose illnesses (e.g., substance use disorders, mental illness) put them at increased risk of contact with the criminal justice system. As treatment services are reduced or eliminated and support systems deteriorate, behaviors that can be classified as criminal in nature are more likely to occur. Instead of receiving treatment for their diagnosed illnesses, individuals end up incarcerated in settings where treatment is usually unavailable. The resulting jail overcrowding places a further strain on criminal justice system resources; jail budgets will be increased as elected officials and the public perceive that public safety is jeopardized, making it even more difficult to restore cuts to treatment systems that could have interrupted the cycle of relapse and re-incarceration.

Information sharing and confidentiality

The reluctance and inability of providers to share information across multiple systems in the interests of promoting client stability and recovery remains one of the greatest barriers to promoting collaboration among the fragmented range of organizations and providers that have regular contact with the AHSSI target population. Providers cite a variety of different statutes and/or policies that prevent them from coming to the service and systems integration table, including RCWs (Revised Code of Washington—permanent state laws) that establish state-level requirements for confidentiality in specific systems (such as RCW 71.05) and federal statutes (such as 42 CFR Part 2), that govern the sharing of information related to the provision of substance abuse treatment services. The emerging privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA) are also increasingly cited as justification for refusing to share information across multiple systems.

As real as some of the limitations created by these statutes may be, these laws and the rigid interpretations of them have become more of a wall behind which systems hide than legitimate barriers to systems integration activities. All too frequently, organizational risk managers and/or legal departments are mandating what treatment providers can and cannot say to one another based on risk-averse interpretations of statutes and minimal understanding of the clinical impact of their edicts. The inability to share information with a colleague engaged in treating the same client at a different agency or in a different system becomes an excuse to not collaborate, even when collaboration is clearly in the best interests of client care.

Many service providers remain reluctant to share information with each other, despite the reality that lawsuits related to breaches of confidentiality are extremely rare and that most clients are ready and willing to sign releases of information once they understand that the purpose of information sharing is to enhance the quality of care. Candid discussion of confidentiality issues across agencies and systems can help to begin to address this reluctance. Interagency working agreements can address information sharing processes in a fashion that increases provider comfort levels with information exchange and makes cross-system dialogue more acceptable. Client services can benefit from cross-agency discussion and decision-making that increase acceptable levels of risk related to information sharing and data management.

What Needs to Happen Next

Addressing the issues and problem areas identified above will require a variety of interventions and actions at the federal, state, and local levels. Some of the activities required to promote greater degrees of systems integration can be undertaken by involved or affected systems without significant changes to existing structures or the addition of new resources. Other activities will require structural changes to current system configurations, reallocation of existing resources, development of new funding streams, or some combination of the three.

The AIDS Housing of Washington (AHW) staff/consultant team and the AIDS Housing and Service Systems Integration (AHSSI) Advisory Council (AC) initiated a range of activities designed to promote systems integration for the designated target population. Some of these activities, such as the IPHS pilot project, will require new resources to support activities that can fill existing gaps in the continuum of housing and support services. Other activities, such as the development of cross-system working agreements, do not depend on additional resources but instead require the development of new relationships among key system stakeholders and the re-alignment of existing resources or programs.

A range of systems integration activities identified and discussed during the AHSSI initiative remains to be further developed and implemented. This section of the report identifies some of the additional system-level integration activities that could increase stable housing opportunities that are accessible to people living with HIV/AIDS and other significant problems, including substance use disorders and involvement with the criminal justice system.

Provide top-down support for integration

Government and private funding sources need to further prioritize integration activities and establish outcomes and measures of their own effectiveness that are predicated on successful cross-system collaboration. The development of policies and procedures that reduce fragmentation is a critical step that requires commitment from the leadership of each stakeholder system. In all of their work, system leaders must model conduct and make decisions that reflect cross-system cooperation, collaboration, and integration. If collaborative, integrated activities are expected from housing and service providers in the field, they must first be manifested at senior levels of each system and established as standard practice. Attitudes, activities, and behaviors that promote integration cannot, however, be manifested only at the senior system levels. In addition to promoting integration in this arena, similar attitudes, practices, and relationships must be developed at the levels of agency directors, program managers or supervisors, and direct service providers. The following figure (Figure 2), based on work developed by Carol Wilkins at the Corporation for Supportive Housing, depicts these four levels of activities that are essential for systems integration to succeed:

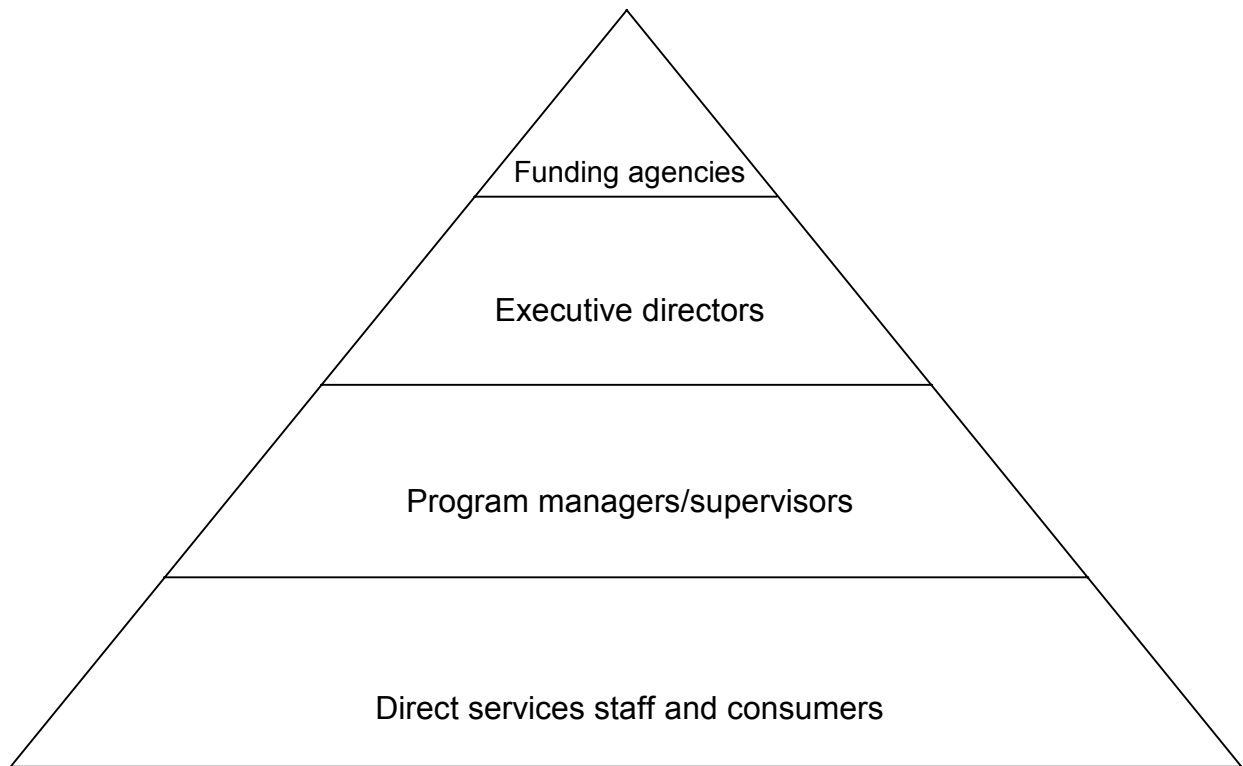


Figure 2: Four Levels of Integration

a. Funding agencies are responsible for ensuring that the principles and goals of integration are embedded in all contracts for housing and support services, and that evaluation of contract agency activities includes the measurement and assessment of integration activities.

b. Executive directors are responsible for insuring that the vision of systems integration is communicated from the funding agency to housing/provider agency level, and that it is embedded in agency-specific policies and procedures.

c. Program managers/supervisors represent a stable element in the agency work force that communicate the nuts and bolts of systems integration to the line staff responsible for the delivery of services to clients/consumers.

d. Direct services staff and consumers are the two groups whose efforts and success are most directly linked to the results of systems integration. Line staff must understand what the provision of integrated services “looks like” and means, and consumers must help to make sure that their various problems and issues are addressed in a holistic, integrated fashion.

Designate funds for collaborative activities

Funding agencies can designate specific resources for collaborative efforts across currently fragmented systems. It surprises no one that dollars drive and define the creation and configuration of housing and service supports. As funding entities prioritize integration activities by attaching specific requirements for cross-system collaborations to requests for proposals and executed

contracts, collaboration and integration will follow. These efforts should include the identification and designation of resources that can be used flexibly to maximize access to holistic, cross-system services without limitation or restriction.

Create additional system-level working agreements

The negotiation of formal, cross-system working agreements is an activity that should not be limited to agencies and organizations that come into direct contact with clients and provide housing or support services. System-level working agreements at intergovernmental levels can both create and promote a climate in which collaboration and integration can flourish. Efforts at the federal level must include organizations such as the U.S. Department of Housing and Urban Development (HUD) and the U.S. Department of Health and Human Services (HHS). In addition, efforts within HUD and HHS are equally fertile ground for working agreements, if they promote greater integration of programs such as HUD's Office of HIV/AIDS Housing or promote increased collaboration among programs within HHS, such as the Center for Mental Health Services and the Center for Substance Abuse Treatment. At the state level, working agreements could be highly effective in promoting increased opportunities within the Washington State Department of Social and Health Services (DSHS), such as between the Division of Alcohol and Substance Abuse and the Mental Health Division as well as across system lines, such as between DSHS and the Washington State Department of Community, Trade and Economic Development.

Tackle community acceptance issues

Elected and appointed officials at the federal, state, and local levels can make more effective use of their access to the public by promoting community education and awareness that increases public understanding of the importance of, and public interest in supporting, critical housing and services. Such education efforts reduce the levels of community opposition to projects related to the AHSSI target population. In particular, public officials can work to minimize the impact of stigma on the placement of housing and support services and reduce the risk that organized community resistance to fragile and challenging populations will prevent the development of critically needed resources, such as housing for people not yet ready for recovery.

Educate for and about the value of integrating housing and support service resources

Although appointed government staff and nonprofit provider agencies must be cautious about the extent to which they actively lobby for specific legislative initiatives or the reinstatement of funds for housing and support services reduced in or eliminated from the state budget, it is within acceptable parameters to provide information and education to elected officials about both the positive and negative consequences of their decisions. The goals of systems integration are highly compatible with government initiatives related to maximizing efficiency and effectiveness of housing and support service programs; providing anecdotal information and outcome data related to collaboration and integration efforts can assist key decision makers at the state and federal levels to increase system capacity and expand the reach of available resources.

The AIDS Housing and Service Systems Integration (AHSSI) Model

Background and Problem Statement

Why we needed AHSSI

Over the past twenty years, King County, Washington has established a significant continuum of housing and support service opportunities for people living with HIV/AIDS. This continuum grew out of partnerships between government and community-based agencies. Local housing resources include a skilled nursing facility, supportive permanent housing for multiply diagnosed people with HIV/AIDS, and other AIDS-specific transitional and permanent housing. A broad range of support services, with case management as the main point of access, is available to help individuals and families living with HIV/AIDS to sustain housing tenure.

Despite the presence of these resources, however, there is a documented need for more housing units, more intensive services, and successful integration of multiple housing and service systems to promote more effective utilization of existing resources. In particular, there remains a significant number of individuals for whom the current array of housing and support services fails to provide solutions to ongoing cycles of homelessness, substance abuse relapse, mental health decompensation, and episodes of jail incarceration. Although local research suggests that this population of difficult-to-house individuals comprises a limited subset of the individuals living with HIV/AIDS in King County, the time, energy, and resources that are expended across multiple systems on these individuals are highly disproportionate to their numbers. They cannot be adequately served by current models.

The emergence of the AHSSI initiative

In 1997, The Lyon Building, which provides supportive housing for homeless people living with HIV/AIDS, mental illness, and chemical dependency, opened in downtown Seattle. AIDS Housing of Washington (AHW) and Downtown Emergency Service Center partnered to develop the 64-unit Lyon Building in response to the need for housing for those who were multiply diagnosed and had difficulty maintaining tenancy in standard housing situations without appropriate support services. The Lyon Building has been a great success for many tenants; the average resident stay in the first four years was 22 months.

While tenant turnover was decreasing in the Lyon Building, the number of multiply diagnosed people with HIV/AIDS kept increasing. The development of HAART (Highly Active Anti-Retroviral Therapy) medication regimens has resulted in improved health status and increased life expectancies for many people with HIV/AIDS, meaning greater demand for housing in general but diminishing need for medically supported housing (such as hospices). Even when housing is available, members of this multiply diagnosed population face numerous barriers to getting into and retaining housing. As community-based AIDS case managers reported a growing number of clients who were not eligible for any existing housing due to their histories and behavior, or who were accepted into housing but needed more intense services to have any hope of maintaining their

tenancy, AHW board and staff became concerned about the issue, and began to look for creative solutions to the problem.

More AIDS housing stock was clearly needed, but it was also clear that it was crucial to address the fragmentation of the existing housing and service systems, which was particularly detrimental for people with multiple systems involvements and diagnoses. When one-time Housing Opportunities for Persons with AIDS (HOPWA) money became available through the City of Seattle Human Services Department, AHW quickly mobilized to submit a grant proposal addressing the need for systems integration as well as the need for more housing units. This funding enabled AHW to launch the AIDS Housing and Service Systems Integration (AHSSI) initiative in mid-2001.

Description of the AHSSI Model

Goals

AIDS Housing and Service Systems Integration (AHSSI) is focused specifically on individuals and families with HIV/AIDS who are homeless or at risk of homelessness, and who have histories of mental illness, chemical addiction, and/or other chronic health problems, and criminal histories. The 18-month AHSSI initiative had two core objectives:

- 1. Increase permanent, affordable housing resources for individuals and families living with HIV/AIDS in Seattle-King County**
- 2. Improve access to, and promote the integration of, supportive service options for diverse and chronically underserved groups with HIV/AIDS**

The AHSSI structure

The AIDS Housing of Washington (AHW) staff and consultants involved in the AHSSI initiative developed a structure and format for implementation of AHSSI activities. A schematic diagram of this structure is provided in Figure 3, below. It includes the following components:

Funder

The resources supporting the AHSSI initiative were provided under the auspices of the U.S. Department of Housing and Urban Development's (HUD) Housing Opportunities for Persons with AIDS (HOPWA) program as administered locally by the City of Seattle Human Services Department. Staff from Human Services received quarterly reports detailing the progress of the AHSSI initiative and were actively involved with the AHSSI project through membership on the Advisory Council (see below) and conferring regularly with AHW staff and consultants.

AHW staff

Betsy Lieberman, AHW's Executive Director, provided oversight to the AHSSI initiative and supervision of the initiative's in-house and consultant staff. Amanda Klein provided ongoing management of the AHSSI initiative as the project's System Integration Coordinator. Sara Nelson, AHW's Director of Community Development, provided oversight to development of the new AIDS-dedicated housing units as well as to fundraising. Donald Chamberlain, AHW's Director of Technical Assistance, was a regular member of the AHSSI Advisory Council (AC) and met frequently with AHW staff and consultants to help advance AHSSI's progress. Other AHW staff and board members were consulted on an as-needed basis to assist with specific questions related to their areas of expertise. The Program and Planning Committee of the AHW Board of Directors served as the core executive team for the AC to guide key decisions in the planning process.

AHSSI consultants

David Wertheimer provided services to AHSSI as the project's primary external consultant. A nationally recognized expert in the integration of human service systems, Mr. Wertheimer combined his experience of systems integration with a knowledge of the local health and human services environment to provide guidance and technical support to the AHSSI initiative. Carol

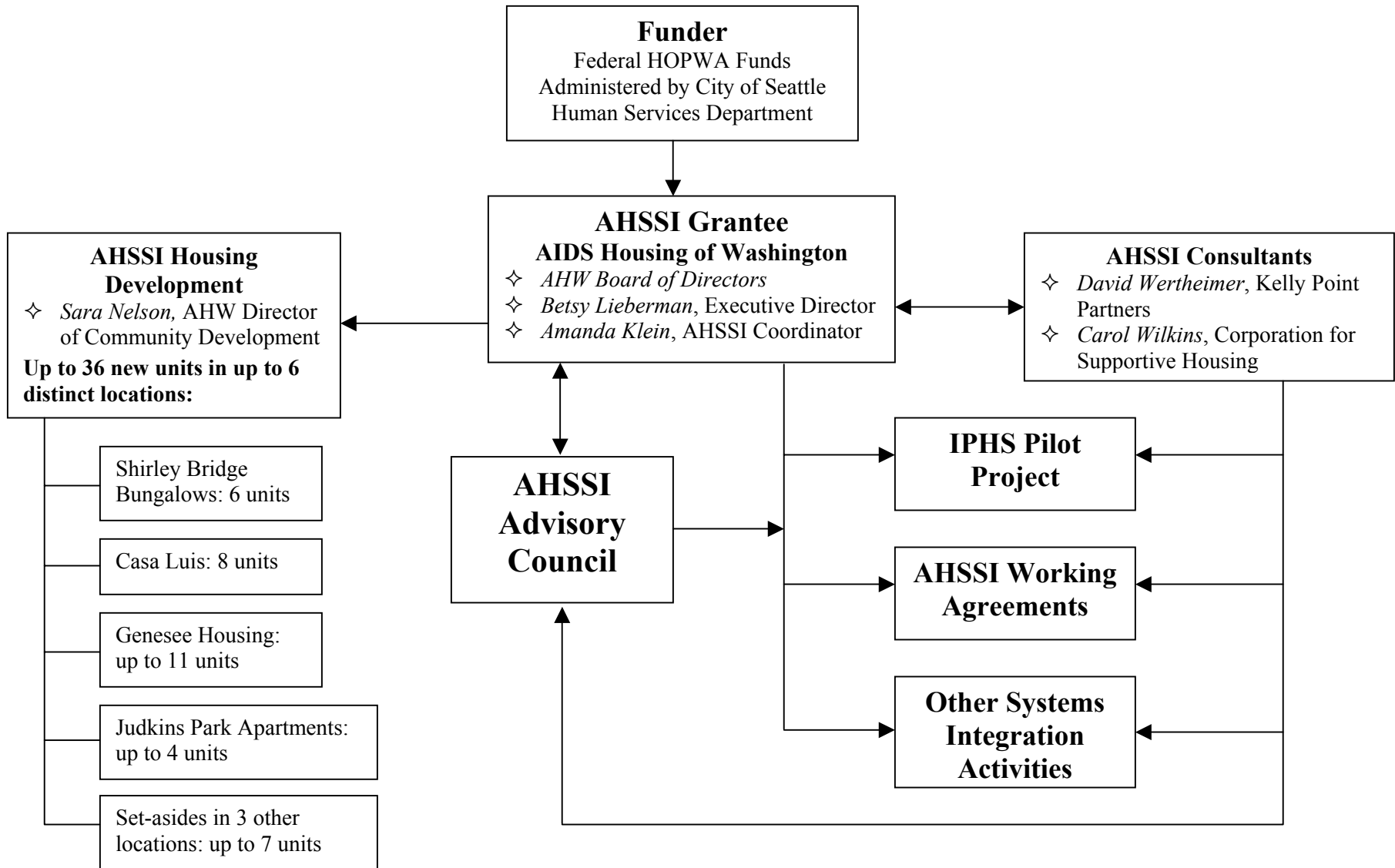
Wilkins, Director of Intergovernmental Affairs for the Corporation for Supportive Housing (a national housing intermediary), was a special consultant to the project. With a broad range of relevant experiences in supportive housing development, systems integration, fiscal management, and program design and evaluation, Ms. Wilkins offered periodic review of AHSSI activities and occasional visits to inform and facilitate the work of the AC.

AHSSI Advisory Council

AHW convened a notably vigorous group of key system stakeholders to assist AHSSI to investigate cross-system linkages that would reduce client barriers to services in multiple systems and to propose new mechanisms for funding the development and operation of HIV/AIDS housing. AC membership included consumers, advocates, and specialists in the fields of HIV/AIDS services, homelessness, primary care/public health, mental health, substance abuse/chemical dependency, housing and housing development, and financial supports/entitlements. In order to stimulate meaningful dialogue, membership in the AC included professionals with expertise in direct service delivery, policy formulation, and planning. The consumer representatives were very involved through the entire planning process, and were diverse in gender, race, physical ability/disability, and range of life experiences and challenges.

The AC studied various relevant practice models currently being implemented around the nation and reviewed local data in order to develop a strategic plan for increasing partnerships among multiple systems and integrating the needed, but uncoordinated, systems that provide supportive services for people living with HIV/AIDS in King County. The AC developed and adopted a formal “problem statement” and identified a specific AHSSI target population. The AC played a central role in articulating the vision and design for the IPHS pilot project and suggested areas in which working agreements and other types of systems integration activities might be undertaken. (See appendices for copies of related documents.) Specific issues such as the configuration of the IPHS pilot project, confidentiality issues, and cultural competence were addressed by ad hoc working groups. The AHW staff/consultant team provided meeting facilitation and staff support for the AC. The full group met 14 times over an 18-month period to define the problem and propose solutions to the second AHSSI objective.

Figure 3: AIDS Housing and Service Systems Integration (AHSSI) Structure & Activities



What AHSSI Accomplished

Major outcomes of the AHSSI initiative

Also included in Figure 3 (above) are the major outcomes of the AIDS Housing and Service Systems Integration (AHSSI) initiative. Those outcomes are:

Housing development

In fulfilling the housing resources objective, AIDS Housing of Washington (AHW) staff identified housing development partners and sites in the community that could incorporate more than 25 new AIDS-dedicated housing units. Of these, 14 were occupied (or ready for occupancy) by individuals and families living with AIDS before the end of the 18-month grant period.

IPHS pilot project

The AHSSI Advisory Council (AC) and the AHW staff/consultant team proposed the creation of the Integrated Permanent Housing and Services (IPHS) project, a model targeting post-incarcerated individuals who are homeless (or chronically homeless), HIV-positive, and active substance abusers. (The IPHS model is a flexible continuum of housing and services combining new and existing resources designed to better meet the needs of this chronically underserved population and is described more fully above, beginning on page 1.)

As the model began to take shape, Downtown Emergency Service Center (DESC), a participant in the AC and Seattle's largest provider of services to people who are homeless, proposed setting aside units in a planned project for homeless individuals if additional needed capital funds could be located. At just that time, an apt funding opportunity arose through the Housing Opportunities for Persons with AIDS (HOPWA) Special Projects of National Significance (SPNS) grant program. When the need for expertise in street-based outreach was identified, Evergreen Treatment Services (a major provider of outpatient addiction treatment services and home of the REACH program) was recruited as another partner for the pilot. AIDS Housing of Washington agreed to play a small ongoing coordinating role in IPHS and assisted DESC in submitting the HOPWA SPNS grant proposal. In December 2002, DESC received notification of \$1.3 million in funding for the IPHS pilot, which will cover capital costs for part of its new building and fund the project for three years.

AHSSI working agreements

In addition to developing the IPHS model, the AC and the AHW staff/consultant team recognized the value of cross-system working agreements targeting existing gaps and barriers in the housing and human service systems that pose significant difficulties for people in the AHSSI target population who are seeking housing, treatment, and support. The AHSSI initiative proposed, and actively pursued, working agreements related to the needs of both homeless single adults and homeless families affected by HIV/AIDS. The proposed working agreements are listed above on page 10.

Other systems integration activities

The AHSSI initiative has pursued other types of cross-system discussions and changes that would promote collaboration, integration, and the enhancement of service and housing options available to the target population. These activities have included:

- Interfacing with the Seattle and King County Housing Authorities to promote increased attention to the housing needs of people with HIV/AIDS (especially those who are multiply diagnosed) and greater flexibility in the use of Section 8 vouchers
- Exploring strategies to create increased flexibility for tenant movement within HUD's permanent homeless housing programs and allow at-risk tenants who have transitioned from these programs to mainstream housing to re-enter homeless housing if clinically necessary to prevent a return to homelessness
- Strategic discussions with the Northwest Family Center about opportunities to enhance existing case management services for homeless families living with HIV/AIDS
- Meetings with the providers of HIV/AIDS case management services to identify and address the specialized needs of the AHSSI target population
- Creation of a plan to ensure the delivery of culturally competent services to people in the target population
- Discussion with representatives of the publicly funded mental health and substance abuse treatment systems about the specialized service needs of people living with HIV/AIDS
- Identification of issues related to the needs of the target population that require additional educational efforts with policy makers, elected officials, and the agencies that fund housing and human services
- Cross-system discussions among the various funders of housing and service supports for people living with HIV/AIDS about the feasibility and desirability of creating a "funding collaborative" that would coordinate and integrate resource development and allocation procedures related to the target population of people with multiple problems who are living with HIV/AIDS.

In addition to these activities, the AHW staff/consultant team has participated in other efforts taking place in King County to identify resources that can further the integration of housing and services and are likely to benefit the AHSSI target population, including the following:

- Efforts to ensure that the renewal of the Seattle Housing Levy would include an allocation of resources for very low-income single adults and families with special needs.
- Participation in the Housing Development Consortium's work to involve private philanthropy in funding supportive housing
- Work with the Seattle Foundation to establish a housing affinity group to increase private philanthropy for AIDS housing
- Involvement in the Sound Families initiative's proposal to use public Temporary Assistance to Needy Families (TANF) funds to provide services linked to supportive housing projects for families
- Negotiations with King County Housing Authority to explore the possibility that they will provide set-aside beds for people with AIDS if they take over the closed Cedar Hills Addiction Treatment Facility

How to Make Best Use of This Report

Replicating the AHSSI initiative in Other Jurisdictions

The work undertaken through the AIDS Housing and Service Systems Integration (AHSSI) initiative resulted from an intensive period of data review, key informant interviews, and system stakeholder discussions. As a result of these different types of preparation, AHSSI interventions were specifically tailored to the unique demographic profile and housing and service needs of King County.

Despite the local specificity of AHSSI's activities, the AHSSI model itself was developed to identify a strategic approach to systems integration activities related to housing and service opportunities for people living with HIV/AIDS that could be replicated in other jurisdictions across the United States. In this section of the AHSSI report, a strategic model for systems integration planning activities that can be applied in other jurisdictions is delineated. The essential steps in the strategic planning process that was developed by AHSSI are identified and described in order to facilitate their replication in other geographic areas and with other key stakeholder systems.

Conduct local research and data analysis

In each part of the nation, the specific demographic characteristics of the AIDS pandemic may vary significantly. It is essential that systems integration activities related to housing and services for people living with HIV/AIDS be rooted in a thorough understanding of these characteristics, as reflected in historical data as well as health service projections of future patterns of infection and illness. Issues to consider in this regard include:

- Historical patterns of infection and illness among those populations at highest risk for HIV/AIDS, including men who engage in unsafe sexual activities with other men, intravenous drug users and their sexual partners, children of individuals who engage in high-risk behaviors, sex industry workers, etc.
- Local patterns of drug use that define the frequency of needle sharing and other high-risk behaviors
- The presence and demonstrated effectiveness over time of needle exchange programs
- The presence and demonstrated effectiveness over time of other prevention efforts, including safer sex education targeting populations that may engage in high-risk behaviors

Analysis of data from various sources will help to inform discussions of local demographic characteristics of at-risk populations. Data collected as part of local Ryan White planning processes may be extremely valuable, as well as data from local health departments on seroprevalence, mortality, and morbidity. Highly informative and relevant data from local correctional health settings, homeless shelters, and other public health and human service programming may also be available for review.

In addition to examining “hard” data available from multiple sources, strategic planning related to AHSSI-type initiatives will also benefit from structured interviews and discussions with key informants from a number of different systems. Although these interviews may result in more

anecdotal data and an impressionistic sense of the problem areas, the information is invaluable in identifying and describing the nature of the local environment in which HIV/AIDS services are provided. The extent and tenor of local cross-system linkages can be clarified, and the success of existing cross-system efforts can be evaluated. Focus groups and interviews with consumers and individuals actually receiving services are an essential component of this key-informant interview process; no one is more familiar with the nature of existing gaps and barriers than the individuals who are seeking (often unsuccessfully) to access the services they need to survive.

Define problem areas

As a result of a thorough data collection and analysis process, the work of defining problem areas and issues specific to the local environment can begin, including identifying the composition and size of sub-populations of people living with HIV/AIDS who face particularly significant gaps or barriers related to accessing housing and service supports. The nature of the problems they face can be described in a formal “problem statement” similar to the King County problem statement (Appendix III).

Utilizing a strategic planning approach to the problem areas and the challenging, multi-problem populations identified can provide an extremely useful framework for determining the precise nature of local problems as well as the form and structure of possible systems integration activities to address identified system deficiencies. For example, once the target population has been identified, a standard strategic planning tool such as a SWOT analysis (Strengths, Weaknesses, Opportunities, Threats) will quickly help to focus problem-solving energies on the most important areas of inquiry and intervention:

- Strengths may include the presence of existing housing providers and support service providers with skills to address the needs of the target population (and may already be meeting some of the needs), a willingness to engage in cross-systems dialogue, resources that can be targeted and/or leveraged, the presence of effective community leadership around target population issues, etc.
- Weaknesses may include the absence of a comprehensive array of housing and support services, a “silo mentality” across service systems that discourages cross-system dialogue and collaboration, a focus on abstinence-based treatment models that ignores the importance of meeting consumers where they are, the absence of resources that could help address target population needs, the lack of community leadership, etc.
- Opportunities can include both “real dollar” resources that could be re-allocated or generated to address target population issues as well as “soft” resources that can be dedicated to problem areas, including everything from available volunteer and staff time, to the education and cultivation of community leaders open to taking on a visible leadership role, to general community interest and good will. Philanthropy may have a role in both kinds of resources.
- Threats can be both real and perceived. These threats comprise social, political, and economic forces that appear beyond the capacity of local stakeholders to control, community opposition to the siting of housing and service programs, etc.

Identify target populations

A comprehensive problem statement will help to identify the specific target populations that could most benefit from enhanced systems integration efforts. Once the problem areas have been described, focal point(s) will emerge to which local energies can be applied.

In King County, the process of creating a problem statement led to specific conclusions about a target population. People living with HIV and/or AIDS and substance use disorders, with likely involvement in the criminal justice system, were identified as the sub-population of people living with HIV/AIDS who face the largest set of system-level gaps and barriers. In addition, this was a relatively small number of individuals and addressing their needs seemed an attainable goal. As a result, the AHSSI initiative focused the bulk of its activities in this area, seeking to promote integration strategies that could address the needs of this target population.

Building a consensus around the need for interventions targeting identified populations with the greatest levels of unmet needs may be challenging; the strength of the case made will depend largely on the thoroughness of the local data collection efforts, the accuracy of the analysis of this information, and the ways in which these findings are communicated and marketed to key stakeholders and other affected communities.

Describe resources

As part of the strategic analysis of the local system, a clear understanding of the scope and range of existing resources available to individuals living with HIV/AIDS must be understood and documented. Once again, local health and human resource planning documents, such as those created by Ryan White Planning Council and Continuum of Care planning processes, may be extremely useful sources of information. However, existing limitations built into many of these resources must be understood and incorporated into the systems integration planning effort. For example, in some localities certain housing resources may be accessible only by individuals and families that are AIDS-disabled (as is the case in King County), and not by those who are HIV-positive but not disabled by AIDS. Other restrictions can further complicate local efforts to understand what resources are available to which populations. Eligibility for services in different systems may be affected by financial limitations, different types and intensities of co-occurring disabilities such as mental illness and substance use disorders, histories of incarceration and involvement with the criminal justice system, etc.

Any matrix developed locally to describe the existing array of services must incorporate an understanding of all of the restrictions and limitations that apply to various populations of individuals who are living with HIV/AIDS. Understanding these limitations is an essential part of crafting an accurate and complete problem statement. What appears to be even the most seamless continuum of housing and support services may begin to show cracks or points of strain when placed under close and informed scrutiny.

Tailoring Integration Activities to Different Local Jurisdictions

Systems integration in a local context is best defined as the sharing of information, planning, clients, resources, and responsibility across the traditional boundaries that exist between multiple housing and social service systems in the interests of promoting improved care for clients with multiple problems. Simply suggesting or mandating that these systems work together cannot achieve the goal of systems integration. Forging effective strategies for integration requires acknowledging that the involved systems represent distinct sub-cultures within the environments of local government and housing and human service providers. Creating an integrated response to an identified target population requires that the many systems involved promote a true multi-system or “multi-cultural” environment that can bring them all together. The many systems of care sustain different histories, beliefs, practices, and institutions that comprise the current status of systems fragmentation. Addressing cross-system/cross-cultural barriers requires managing a broad range of issues, including, for example, how target and priority populations are defined, how information is collected and shared, how standards of care are developed and monitored, and how providers of care are trained and certified.

Systems integration activities must, therefore, be specifically tailored to the local environment and the patterns of interaction, collaboration, distrust, and fears that are present among local housing and social service systems. There are several critical steps to creating a local climate that will support, sustain, and mobilize true systems integration efforts.

Identify the “right” stakeholders and systems

It is essential to determine what systems must be at the table in order to promote cross-system integration activities, as well as which individuals from each system are best equipped to both discuss relevant issues and act to promote the changes necessary to achieve identified goals.

Some systems are obvious choices. Government agencies that are responsible for the funding and oversight of services to people living with HIV/AIDS should play a prominent role in addressing and promoting integration activities. This will include those local government entities that manage federal resources such as HOPWA and Ryan White. Other government agencies, although they may not have direct administrative authority for specialized AIDS funding, should also be represented. This includes state, county, and municipal health, human service, and housing agencies. Local housing authorities also are an essential addition to the stakeholder mix. If addressing issues related to involvement by the target population in the criminal justice system, it is also critical to include stakeholders from local law enforcement authorities, relevant court systems, and jail health.

Private agencies and organizations that are engaged in housing and social services are also a critical constituency. Included in this group should be AIDS housing and service organizations, mental health and substance abuse treatment providers, etc. Local low-income housing developers and providers, as well as organizations providing survival services to people who are homeless or at risk of homelessness, should also not be left out of the mix.

Government and agency stakeholders who need to be involved in the systems change process should represent a mix of direct service and supervisory staff with an intimate knowledge of how systems operate and what the major gaps and barriers are. Senior representatives from policy levels

who have (or have immediate access to) the authority to make policy-level decisions that will promote increased cross-system collaboration should also be included. Without staff familiar with day-to-day operational issues, proposed integration strategies will not be grounded in the realities of existing system fragmentation and provider-level frustration. Without staff who have the authority to actually change existing systems of care, proposed interventions will have little chance of success over the long term.

Consumers, family members, and advocates represent an important and powerful constituency that is all too frequently overlooked when strategic planning and stakeholder working groups are assembled. Consumers of services bring a clear and valuable perspective about what actually works and doesn't work from the perspective of the service recipient. Consumers who have struggled to address multiple problems in a world of fragmented housing and service systems bring a note of reality to any discussion of systems integration goals and objectives. Ultimately, if the goal of systems integration efforts is to create a service system that is logical and accessible from the viewpoint of the person seeking assistance, then the presence of consumer voices will both inform and legitimize the work products created.

Family members and advocates are also of great value to collaborative efforts promoting systems change. Many have struggled to overcome the gaps and barriers of a fragmented service system. Their frustration can be translated into a unique perspective that can inform what needs to change and why. In addition, family members and advocates provide a truly powerful voice when the time comes to overcome the inertia that accompanies the need for bureaucratic reforms or legislative changes to promote a more holistic and integrated service system. Unlike government employees or provider staff from community-based agencies, who may appear to be pursuing agendas of self-interest, family members and advocates speak with an authority not tainted with any hint of personal or organizational gain.

Demonstrate to stakeholders the value of their involvement

Most of the individuals identified as key stakeholders in the systems integration arena are already overburdened in their existing roles and functions. Getting the attention of these individuals and convincing them of the value of coming to yet another meeting may present a formidable challenge. AIDS service and housing providers should be among those who are the easiest to sell on the value of their participation. These systems have the potential to benefit by gaining increased access to services and supports in other systems that can help with the stabilization and management of those who are among their most challenging clients.

For other systems, it is essential to make the case for how they can benefit from participating in a planning process. For social service providers, the potential for increased access to HIV/AIDS services for their clients who are HIV/AIDS-affected may hold some value. For housing providers, the possibility of gaining access to case management and support services for difficult-to-serve clients with HIV/AIDS creates an incentive for participation in cross-system discussions. For representatives of the criminal justice system, strategies that promote diversion of people living with HIV/AIDS from arrest, incarceration, and court procedures offer a valuable rationale for their involvement. Policy makers and other government officials can be convinced to participate based on the potential to realize increased efficiency in the use of existing resources and increased effectiveness at meeting identified, system-specific benchmarks and outcomes.

Providing a modest level of compensation can promote participation by consumers living with HIV/AIDS, especially those with multiple problems that have led to histories of homelessness and involvement with the criminal justice system. Unlike government and agency staff whose job expectations include participation in public meetings and planning processes, consumers are not regularly paid for their advice and insights. Providing payment for their involvement is a way of acknowledging the value of their input.

Assemble key stakeholders in working groups

The successful promotion of systems integration goals requires formal planning and implementation processes. Integration activities that are dictated from the top down are rarely grounded in a realistic understanding of the gaps and barriers that have created fragmentation in the first place. Integration activities that are promoted solely by those working at the direct service level rarely attract the attention at the policy and funding level that is required to create the momentum to promote change.

As a result, planning and implementation processes must meld the “top-down” and “bottom-up” activities that are crucial to creating a problem statement, identifying a target population, formulating solutions, and implementing change. One of the most successful strategies that can lead to real systems change is the creation of stakeholder working groups that become the forum for essential strategic planning and systems change activities.

The AIDS Housing and Service Systems Integration (AHSSI) Advisory Council (AC) is an example of one such working group. Following a period of data collection, research, and key stakeholder interviews completed by the AIDS Housing of Washington (AHW) staff/consultant team, those systems and individuals who were identified as relevant to the systems change process were invited to participate in the AC. Invitations to the first meeting were co-signed by the local city and county government directors of human service and housing systems, thereby adding weight and legitimacy to the planning process. All those systems and stakeholders with the potential to have contact with people living with HIV/AIDS who were having difficulty accessing housing were invited to participate.

The invitee list was long. AHW wanted to avoid the risk of leaving any key system or any important stakeholder out of the loop. Individuals who are not involved in strategic planning processes from the outset are often reluctant to become involved in a process that is already underway, or become suspicious of the product that has been created in their absence. It is more important to over-involve and over-invite, especially to initial meetings that set the agenda for problem definition and target population identification. Some stakeholders may quickly recognize that their input will have limited value and that they will not have an appropriate role to play in cross-system discussions. These individuals and agencies will gradually wander away from the cross-system effort. This is to be expected as a natural part of the planning process. It is important, however, to keep the key systems that do have an important role to play at the table for ongoing discussions, even when they may seek to drift away from the process as they perceive that change efforts will require applying time, attention, and resources to doing business differently from how it has been done in the past. Members of the AHSSI AC found that the planning dialogue itself was a significant process outcome, as were the resulting relationships and increased awareness of each other's systems.

It is also essential to cultivate the participation of individual consumers of services from the very initial stages of the stakeholder planning process. The solitary involvement of one consumer (or even two) is not sufficient; in order to avoid tokenism, consumers should be well represented among stakeholders involved in the planning process and they should be included as full partners in the initiative.

Engage stakeholders in strategic planning

Stakeholder discussions must be specific, focused, and strategic. Advisory councils and other planning processes quickly lose momentum when there is no clearly articulated vision, goal, or work product associated with the effort. Generalized discussion only leads to whining, frustration, and finger pointing; most stakeholders will show limited patience for this type of process.

Stakeholder planning processes will be much more energized and effective if specific and concrete tasks are undertaken and short-, intermediate-, and long-range goals are identified. Early “quick victories” can help to further stimulate the process and generate ongoing interest and support from involved stakeholders. Short-term goals can include:

- Presentation of readily available resources and data
- Development of consensus around potential problem statements
- Agreement on the definition of the target population
- Commitments to work together to enhance cross-systems responses to the target population

Intermediate range goals can include:

- Mobilization of pilot projects addressing problems encountered by the target population
- Development of formal cross-system working agreements that promote integration and increasingly holistic systems of care
- Promotion of collaborative responses to requests for proposals and other potential sources of funding

Long-range goals can include:

- Development of collaborative models for funding that can include the braiding or blending of resources from multiple systems to promote enhanced capacity to address the needs of the target population
- Issuance of requests for proposals that represent joint funding and require collaborative responses from multiple systems
- Reorganization of service delivery and housing systems to promote collaboration and integration, particularly in the housing and treatment of people with multiple problems

Clearly define action steps

Stakeholder working groups will be most effective when a range of possible actions are clearly defined and consensus is built around the desirability of pursuing specific action steps. Activities can be focused simultaneously on short-, intermediate-, and long-range goals and action steps, as long as discussion remains focused on appropriate and reasonable timelines for completion of specific tasks.

Action steps can relate to both client-specific and system-level goals. Client-specific action steps can include such items as the development of a certain number of housing units, and mobilizing service and support models to support identified target populations. System-level action steps can include the development of cross-system working agreements to promote enhanced system responses to individuals in the target population, the co-location of services to promote cross-training and collaboration, and the blending of funding to promote integrated care.

Ad hoc working groups and subcommittees can be created to develop and implement action and management plans related to the areas of consensus that emerge in relation to the identified target population. These working groups should include an array of stakeholders representing all systems affected by the specific activity to be undertaken; leaving out a key player can result in systems change failure, either because critical information and perspectives were not considered, or because of deliberate efforts to undermine an outcome whose development excluded an important individual, agency, or system.

Progress towards each identified outcome should be tracked on a timeline appropriate to the tasks being undertaken. Such timelines provide an end-point stimulus that promotes activity. Timelines should be realistic enough that they promote investment from required systems, but not so restrained that they promote delay and inactivity.

Evaluate outcomes and accomplishments

Evaluation is an essential component of any cross-system collaboration or systems integration effort. Evaluation of both client- and system-related outcomes ensures that you are measuring the effect of concrete activities and the results of multiple-stakeholder efforts.

Outcomes and accomplishments should be linked to agreed-upon activity areas. They should be able to capture and measure a range of variables that are identified as appropriate indicators of success. As with the development of specific collaboration and integration activities, outcome measures should reflect progress on both client-specific and system-level activities. Examples of outcome measures to consider include:

Client-related	System-related
Number of clients housed in newly-developed units	Successful execution of working agreements across providers and systems
Number of individuals with multiple problems who are housed and have access to the necessary array of support services	Amount of specialized cross-training achieved by agency directors, managers, and line staff
Client satisfaction with housing and services provided	Creation of venues for cross-system case consultation about specific clients with multiple problems
Decreased client utilization of crisis services and/or decreased episodes of incarceration	Extent to which braided or blended funding to promote integrated programming has been achieved
Increased access to primary care services related to the treatment of HIV/AIDS	Co-location of staff from different systems or professions to promote integrated client care
Increased access to chemical dependency treatment services, as needed	Hiring and retention of culturally competent staff with skill sets required to effectively address needs of diverse client groups
Increased access to mental health treatment services, as needed	Promoting strategies to increase job satisfaction and increase staff-retention rates
Increased access to educational and vocational opportunities	Continuation of cross-system dialogue at senior agency/system levels
Increased rates of employment and regular wage progression for those employed	Development of formal “report card” that measures systems-related integration and communicates this information to the public

Evaluation of integration efforts should be formative and oriented towards the provision of feedback that can improve and enhance existing and future efforts. Using the principles of continuous quality improvement, evaluation activities cease being punitive and become mechanisms for ensuring the capacity to make mid-course corrections in the mobilization of activities related to housing and serving complex clients with multiple problems.

Resources dedicated to evaluation should be commensurate with the specific work required. This means not skimping on evaluation budgets; if these activities are to be considered essential to the feedback loop that informs program improvement over time, the dollars invested in evaluation become an essential part of the resource allocation mix that yields successful programming and increasingly positive client and system outcomes. Many foundations and funders estimate that effective evaluation budgets need to represent 15-20% of the overall costs dedicated to new initiatives.⁵

⁵ For additional information on evaluation, see *Tools for Outcome-Based Evaluation of HOPWA-Funded Programs*, prepared by Clegg and Associates, Inc. for AIDS Housing of Washington, June 2001.

Potential Problem Areas: What to Watch Out For

Problem areas and pitfalls will invariably be unique to each environment in which systems change activities are being attempted. Problem areas are related to a variety of variables, some situation-specific and some generic. These generic variables include a region's economic condition and changes in economic factors, political priorities and realities, individual personalities involved in the change process, and specific local events that may have an impact on public opinion or funding priorities. How these variables affect systems change efforts will vary with their origin, duration, and intensity.

There are a number of specific variables that are most likely to have a positive or negative impact on local and regional efforts to promote systems change for target populations of people living with HIV/AIDS and other simultaneous problems. These variables are discussed briefly in this section of this report.

Systems inertia

Among the most prevalent barriers to change are the traditions of “the way things are” and “the way we do things.” The inertia created by existing policies and procedures, established statutes and regulations, and the folkways associated with specific systems can create a significant level of drag on systems change efforts. Systems inertia can cause delays in the collection and analysis of critical data, the creation of strategic plans, the mobilization of specific action steps, and the evaluation of change efforts that are implemented. These delays can increase levels of staff and client frustration, resulting in demoralization and even abandonment of critically needed initiatives that have the potential to affect identified problem areas.

System defensiveness or hostility

Just as is the case with individuals, when organizations, agencies, and systems feel threatened by the winds of change, they manifest defense mechanisms that offer both adaptive and maladaptive protections from the anxiety associated with the change process. Some of the most frequently encountered systems-level defense mechanisms include general defensiveness and outright hostility. Involved stakeholders and systems may interpret proposed changes to “the way things are” as suggesting that what they have been doing for years has been “wrong.” Hostility can take the form of aggressive behaviors (e.g., pulling funding or support for a specific initiative, criticizing systems change efforts to other key stakeholders, etc.) as well as passive-aggressive behaviors (e.g., discontinuing participation in systems change efforts, shifting system priorities away from identified target populations and action steps, etc.). It is essential to address these indicators of systems-level defenses when they first begin to emerge, and to work to reassure and sustain the involvement of parties who are threatening to abandon or undermine the change efforts. At times, it may be necessary for stakeholder meetings to focus more on relationship building and common goals than strategic planning and “product.”

Turf issues

In an environment of highly limited resources, issues involving turf will invariably emerge. Most systems perceive that they do not have the resources necessary to accomplish their most basic books of business; asking these systems to adjust or change existing business practices, or to take on new or additional tasks, all too frequently results in efforts to protect the few resources directly under the system's control.

The funding “silos” to which systems may retreat when threatened are not the gentle corn silos that can be found on a country farm or that dot the pages of childhood readers. The silos of the various human service and housing systems are more accurately described as reinforced concrete missile silos: carefully hidden, heavily defended, and virtually impossible to penetrate. Discussing systems integration efforts requires that the missiles be disarmed and the security systems disabled. The exploration of braiding or blending resources can represent a particularly threatening activity, and is best approached only after significant discussion and exploration of the demonstrated benefits of the action steps being contemplated.

Cross-system “cultural” conflicts

As discussed previously, the systems involved in the change process represent distinctly different “cultures”—each has its own history, belief system and philosophy, institutions, language, etc. Each also has its own biases and stereotypes of the other systems with which it must interact to promote true collaboration and integration. These cultural differences and biases may lead to cross-cultural conflicts that can be rooted in both a lack of knowledge or information about other systems (i.e., ignorance) and general distrust of those who come from “different” environments (i.e., fear).

For example, the meanings associated with the concept of “case management” vary across systems, including mental health, HIV/AIDS, and criminal justice. Stakeholders may use this and other terms without a common understanding of what is being discussed. Yet this common ground is essential for meaningful cross-system conversation. In short, effective cross-system dialogue requires the development of multi-cultural competencies. This does not mean the inevitable homogenization of all social service and housing systems; the “melting pot” theory is more myth than reality. Rather, multi-cultural competence requires an awareness of, and respect for, the unique differences of all involved systems. Multi-cultural competence also requires appreciating the added value that results from increased levels of cross-system discussion and collaboration.

Community opposition

Systems-change efforts related to identified target populations are likely to meet community resistance, especially when these target populations represent individuals with multiple problems that have been stigmatized by the larger society (e.g., HIV/AIDS, mental illness, substance abuse, criminal justice system involvement, etc.). Negative community reactions should be anticipated as a standard by-product of public planning efforts and the reactions should be addressed even before they begin to emerge. Pilot projects should be interpreted for the communities in which they will be located, and partnerships forged that will endorse and support new housing and service initiatives rather than greet them with skepticism and hostility. Involving the community in planning processes is a good place to begin. Educating the community about the value of proposed activities is an

essential next step, as is addressing community concern before it becomes organized into potent political opposition.

Resource limitations

Particularly in the current economic climate of recession, the lack of available resources for systems change initiatives is a convenient excuse to disrupt or stymie cross-system collaboration or integration. This rationale should always be questioned, as it may be either irrelevant or contrary to the potential advantages of the action steps identified by key stakeholders. Although resources in any given system may be limited, it is often useful to look across systems for the impact of collaboration and integration efforts. Often, cross-system savings are silver lining of systems integration; systems integration activities can promote greater service efficiency and effectiveness, resulting in significant reductions in expenditures in expensive and repeating venues that often have limited impact on an individual's underlying problem areas. Increasing opportunities for stable housing and support services can decrease the need for lengthy medical and psychiatric hospitalizations or repeated episodes at detoxification centers. Promoting engagement of clients with multiple problems can decrease involvement with the criminal justice system and rates of incarceration and recidivism. Each of these by-products of systems integration has a cost *savings* associated with it. Calculating and marketing the value of these savings across systems can help to address and mitigate the effect of claims that there are no resources available for investment in integration efforts.

Lack of funding opportunities

It may often seem that strategic planning efforts and cross-system stakeholder working groups are capable of generating endless creative programming ideas without identifying a similarly large list of funding streams to support these concepts. Certainly, funding for creative integrated initiatives is limited and competitive. But resources are out there, and the apparent absence of funding opportunities should never be accepted as an excuse to avoid strategic planning activities and the pursuit of the dollars that are available. In fact, it is increasingly the case that both public and private funding streams are giving increased priority to the funding of proposals that represent multi-system, collaborative efforts. This is true of federal dollars available from HHS, HUD, and the Department of Justice as well as private philanthropic resources from organizations such as the Robert Wood Johnson and Bill and Melinda Gates Foundations. When mobilizing RFP responses, the greater the degree of documentation possible of stakeholder involvement and strategic planning that reaches across systems to address the gaps and barriers faced by clients with multiple problems, the more likely it is that funding sources will take note of integration that is happening at local and regional levels. These proposals will receive higher reviewer scores, and are more likely to receive funding.

Loss of momentum

Over time, many systems integration initiatives lose steam. Stakeholders may lose interest as the challenges of the work mount, as financial pressures increase or as public and political priorities change. Systems integration is hard work, and needs to be acknowledged and recognized as such. Sustaining stakeholder working groups, strategic planning initiatives, and innovative program development requires ongoing effort over periods of time that must be measured in years rather than

months. There are, however, steps that can be taken to support and nurture the momentum needed for systems change over time. This requires systems change agents to be strategic about the strategic planning process itself.

As discussed earlier in this report, ensure that opportunities are provided for early “quick victories” that represent successful collaborative efforts. Focusing only on long-range goals and outcomes will frustrate even the most determined stakeholder. Make sure to identify goals and outcomes that can be reasonably achieved on short and intermediate time frames. In addition, acknowledge and celebrate successes and accomplishments as they occur. Positive feedback and reinforcement go a long way to sustain the challenging work of systems change. Pause to recognize milestones and sub-goals achieved along the way to long-term systems realignment. Stakeholder groups should be acknowledged for their efforts with periodic reports about their progress along with concrete rewards such as food at meetings, occasional parties, and recognition events at which certificates of merit and achievement are distributed.

Defining Your Own Next Steps

The precise configuration of the systems change process will of necessity vary from locality to locality, from jurisdiction to jurisdiction. Each community must engage in the process of defining its own next steps based on the determination of local need, the definition of the problems to be addressed, the identity of the target population, and the nature of the interventions to be mobilized. In addition, each community will need to determine the precise nature of the objectives, goals, and outcomes to be pursued and the ways in which success will be measured and evaluated over time.

The work is challenging, but rewarding. Even as local strategic planning efforts become mired in the sometimes frustrating details of locating system and service gaps and barriers, designing innovative responses to identified problems, securing the resources necessary to mobilize new programs, and evaluating the effectiveness of new interventions, involved stakeholders must never lose sight of the reality that the work being undertaken is, at its core, about improving the quality of life of those who are among our most fragile citizens. That the work is at times about actually saving these lives may sound trite, but it is nonetheless accurate.

This work deserves nothing less than our undivided attention. It is well worth the effort.

Appendices

- Appendix I:** Sample Advisory Council Invitation Letter
- Appendix II:** Sample Advisory Council Minutes
- Appendix III:** Final Problem Statement
- Appendix IV:** Pilot Project Needs Assessment Overview & Summary
- Appendix V:** Cultural Competence: Preamble, Definitions, Measures, & Bibliography
- Appendix VI:** Best Practice Models
- Appendix VII:** Blank Working Agreement Template
- Appendix VIII:** Sample Meeting Evaluation Form
- Appendix IX:** Sample Final Meeting Self-Evaluation Form
- Appendix X:** Bibliography & Online Resources
- Appendix XI:** Glossary

September 17, 2001

Dear Friend,

For the past 20 years, Seattle/King County communities have been working with extraordinary dedication to create one of the most comprehensive continuums of housing and services for people living with HIV/AIDS in the United States. As a result of these efforts, many of the region's local programs have become national models of effective AIDS housing and services.

As the changing AIDS epidemic continues to challenge our creativity and stretch our resources, we believe it is time to renew our efforts to work collaboratively and collectively to maximize both the housing and services available to people living with HIV/AIDS in our communities. The AIDS epidemic gives no indication of being over; on the contrary, recent local statistics suggest that HIV is continuing to have a significant impact on men, women and children throughout the Puget Sound area. In addition, with medications that are able to provide more stability to persons living with HIV/AIDS, the housing and supportive service needs of these individuals have become increasingly complex.

AIDS Housing of Washington (AHW) is convening an advisory council of key system stakeholders in order to lay the groundwork for AIDS Housing and Service Systems Integration (AHSSI). We are writing to invite you to become a member of the AHSSI Advisory Council and to contribute your perspective on both barriers and solutions as we work toward our goal of forming an improved continuum of care to meet the supportive service and housing needs of persons living with HIV/AIDS. We believe that the inclusion of many voices is crucial to making the AHSSI Advisory Council an effective coalition that will promote creativity and change.

AHW has received 18 months of funding support through the City of Seattle Human Services Department from the federally-funded Housing Opportunities for Persons with AIDS (HOPWA) program to create the AHSSI initiative, aimed at improving access to and promoting the integration of supportive service options for chronically underserved persons living with HIV/AIDS. As a core component of AHSSI, the Advisory Council will investigate and propose opportunities for cross-system linkages that can increase accessibility of services as well as explore new mechanisms to fund services and operations of HIV/AIDS housing.

Advisory Council members will be asked to attend one meeting per month for 18 months. AHSSI project staff and consultants may also request individual meetings with Council members from time to time to help the initiative further its goals. If you are not able to join the Council, please pass this letter on to an appropriate delegate on your staff.

The inaugural meeting of the Advisory Council will take place on September 25 from 8:15 a.m. to 12:30 p.m. at Planned Parenthood (directions attached). Most of the Advisory Council meetings will not require more than two hours of your time. We have scheduled the September 25th event for a full morning in order to provide you with a more complete briefing on the AHSSI initiative as well as to provide time for a presentation by Carol Wilkins. Carol, who will serve as one of the AHSSI project advisors, is a former Deputy Mayor for the City of San Francisco and is the Director of Intergovernmental Policy for the Corporation for Supportive Housing. In this capacity, she has developed the Bay Area Health, Housing and Integrated Services Network (HHISN), which is seeking to achieve many goals similar to our local AHSSI effort. We think you will find her presentation most informative and engaging.

Please RSVP for the meeting by calling or emailing Amanda Klein, AHSSI Project Coordinator, at (206) 448-5242 or amanda@aidshousing.org. Amanda will also be in touch with as many of you as possible to schedule one-on-one meetings to gather your input and ideas about the AHSSI initiative prior to the September 25th meeting.

We hope that you will respond favorably to this request for participation, and we look forward to your participation in this important and strategic initiative.

Warmly,

Barbara Gletne
Director, Department of Community and Human Services

Venerria Knox
Director, Human Services Department

Cynthia Parker
Director, Office of Housing

Betsy Lieberman
Executive Director, AIDS Housing of Washington

**AIDS Housing and Service Systems Integration (AHSSI)
Advisory Council Meeting, mmmmm d, yyyy
SAMPLE MINUTES**

Attendees

Roger Anderson, VA Medical Center	Michael Lee, community member
Brian Childress, Evans School of Public Affairs	Daniel Malone, DESC
Joan Clement, Harborview Medical Center	Adimika Meadows, AHW Board
Terry Elizabeth Edwards, consumer	Farrel Oglesby, consumer
Theresa Fiaño, HIV/AIDS Program, Public Health – Seattle & King Co.	Alex O'Reilly, City of Bellevue Human Services Division
Michael Hanrahan, HIV/AIDS Program, Public Health – Seattle & King Co.	Rubén Rivera, Jr., Therapeutic Health Services; AHW Board
Jeff Henderson, community member	Bill Rumpf, City of Seattle Office of Housing
Chuck Kuehn, Lifelong AIDS Alliance	Janna Wilson, Health Care for the Homeless

AIDS Housing of Washington (AHW) staff and consultants: Donald Chamberlain, Director of Technical Assistance; Amanda Klein, Systems Integration Coordinator; Betsy Lieberman, Executive Director; Jaline Quinto, Executive Team Coordinator; David Wertheimer, AHSSI consultant.

I. Welcome/Evaluation of Previous Meeting/Announcements

Betsy Lieberman (AHW Executive Director) welcomed the Advisory Council. Amanda Klein presented a slide summarizing evaluations from the February 27th meeting. Ratings were positive: on a scale of 1-5 (5 = highest level of satisfaction), 19 participants gave average ratings ranging from 4.1-4.5 on six items.

As announced by email, there have been two changes to the schedule of Advisory Council meetings for later in the year: the August meeting has been cancelled, and the September meeting will be on September 18th, not September 25th as previously planned.

Betsy Lieberman noted that although the focus of the pilot project is new options for individuals with HIV/AIDS, AHW's housing development efforts taking place as a part of the AHSSI initiative will bring many new units on line to serve families as well. These include six units at Shirley Bridge Bungalows (construction started April 1), 22 units at Rainier Vista for individuals and families with disabilities, and a potential development at 23rd and Judkins. In addition, we will continue to maintain a commitment to addressing the needs of families as we explore systems integration solutions not included under the pilot project.

II. Update on data collection related to target population (Amanda Klein, AHW Systems Integration Coordinator, and Brian Childress, UW graduate student)

Amanda Klein presented an overview of the pilot needs assessment process and noted in particular the goal of establishing that there is a sufficient level of demand for the pilot without making an exhaustive count of everyone in the target population. The key feature of the needs assessment is a set of structured interviews with case managers to obtain descriptions of specific clients who closely fit the target population for the pilot. Brian Childress (a master's candidate at the University of Washington's Evans School of Public Affairs) has been conducting the interviews and has so far spoken with 16 case managers at Ryan White-funded sites, including Madison Clinic, UW Virology Clinic, Northwest Family Center, and Lifelong AIDS Alliance.

From the initial round of interviews, we have identified 33 clients who fit the specific parameters for the pilot: all have a history of substance abuse and are currently homeless (if we include those in jail), and most have drug-related criminal history. The Northwest Family Center case managers provided case descriptions of 7 women with children who fit this target population, but also reported that most of their clients (of 217 families affected by HIV/AIDS) are as difficult to find housing solutions for as these 7.

Of the 26 of these clients who are individuals without children, many have a history of evictions and most are reported to have some kind of mental illness. A key engagement opportunity may lie in the fact that 8 of these clients participate in Bailey-Boushay House's Adult Day Health program. Brian gave a mini-case presentation on a composite client with characteristics typical of the clients on whom we've gathered information. (For additional information, see presentation notes distributed at the meeting.)

_____ raised a concern about the large number of clients with a history of violent behavior (violent behavior in this case referred to both criminal charges and other incidents known to case managers), since assaultive behavior has been proposed as a reason for barring individuals from the pilot. It is likely that violent behavior while a resident of the pilot would be treated far more seriously than a history of violence. A tool for assessing violent behavior or risk of becoming violent could be useful in helping to make appropriate admission decisions.

Advisory Council members requested more details about the clients with mental illness identified in the case manager interviews. "Mental illness" in most instances includes dementia, depression, and personality disorders. Available information will be broken down further in the written report (incorporating data from additional interviews) that will be distributed at the May meeting. Case managers had more specific information in some cases than others, and some clients have not been formally assessed and/or diagnosed with a mental illness or had symptoms fully evaluated. A comprehensive mental health screening could be used as part of the intake/engagement to the pilot project, and it may be helpful to sort clients into broad categories and/or level of functioning related to symptoms of mental illness.

_____ noted that there are people who are in need of services but don't seek case management because they are not in crisis or not aware of what is available. She stressed that there should be outreach to people with HIV/AIDS before they are in a crisis state. _____ added that lack of information about available services can also be a barrier for consumers.

III. Report from Pilot Project Work Group (David Wertheimer, AHW consultant)

The goal of the pilot project is to develop a continuum of housing opportunities that can promote and demonstrate success for a subset of currently homeless/difficult-to-house individuals with HIV or AIDS in King County who have a substance use disorder and are likely to have ongoing involvement with the criminal justice system. David Wertheimer unveiled the current draft of the pilot project configuration, depicted as a flowchart (the “horseshoe”) with the key segments of the continuum. The continuum is designed for flexibility so people can move forward or backward between levels as needed; linear progression is not expected for all residents.

One new piece of the continuum will be a small group of “respite beds” or a small and enriched shelter-type space, which would build on engagement activities occurring in Bailey-Boushay House’s Adult Day Health (BBH ADH) program, with participation in day health services linked to accessing the nighttime beds. The use of respite beds would allow the individual to engage with the service providers, interact with others on a 24-hour basis, and develop relationships upon which they might be able to build enough stability to move to other housing.

The other new piece of the continuum would be pre-recovery housing, which could potentially be 15 units sited at DESC’s new 1811 project. This project is currently being developed primarily for chronic public inebriates, so the program model would have to be adapted to be appropriate for our target population, most of whom abuse substances other than alcohol.

David also shared with the Advisory Group a list he drafted (with input from the Pilot Project Work Group and AHW staff) of clinical and policy/regulatory issues related to the pilot project. The Advisory Council was asked to add to this list of issues to be addressed in the near future, as well as to give feedback on the current model for the pilot project configuration. (The versions of these two documents attached incorporate the feedback that was given at the meeting.)

The medical respite program run by Pioneer Square Clinic through Health Care for the Homeless was suggested as a good model for the pilot respite beds program, as well as perhaps DESC’s Crisis Respite Program (CRP) for people with acute psychiatric symptoms. The MAPS houses (small programs for 4-7 residents such as Ravenna House) were suggested as an appropriate model of recovery-oriented housing for this population. Amanda Klein will follow up on obtaining more information about these programs.

Other comments made at the meeting that will be incorporated into the list of clinical and policy/regulatory issues include:

- ◇ The AIDS service system needs training on the harm reduction model (clinical issue)
- ◇ Given the high number of people of color in the initial list of potential pilot residents, we need to ensure cultural competence in service delivery (clinical and policy issue)
- ◇ Confidentiality between systems (clinical and policy issue)

There was some discussion of how the pilot project might impact existing service systems, and of what additional steps AHSSI plans to take to promote true systems change to enhance housing opportunities for the target population, over and above creating a pilot. Several members of the Advisory Committee noted that this is still an important focus that we must not lose sight of.

IV. Group discussion about mission alignment

David Wertheimer asked the group to comment on issues raised in the previous meeting by Carol Wilkins, who suggested that each Advisory Council member look at ownership of the pilot project and how AHSSI goals in moving forward meshed with the mission and goals of his or her organization.

David asked each member to respond to the question: How does the pilot project fit with what your organization does? Some Advisory Council member comments are summarized below:

- ◇ The need is so great that it's unlikely that any current programs will be diluted. Will it increase complexity if we create another track to serve people? Will people with HIV/AIDS be unable to be served elsewhere if we create this service?
- ◇ The model is good because it increases flexibility. A lot of training will need to happen as a part of this: case managers and service providers need to understand the harm reduction model better.
- ◇ Do we have the deep reach to serve this small segment of the population in need, particularly when there are others in need?
- ◇ From a funding perspective, it may not be a major issue to fund something that is not located on the Eastside as long as it benefits people from the Eastside.
- ◇ The project aligns well with the harm reduction model and has a strong public health/prevention component. This isn't competition to any existing program because providers have worked hard to find housing for these individuals.
- ◇ Bear in mind that Ryan White funding requires that any support services make provisions for health care.
- ◇ This project would address a very small group of people within a vast pool of need; although there will be people referred to this pilot there will be many other individuals who will not be eligible for it.

Next Full Advisory Council Meeting:

Date: mmmmm, dd, yyyy, 8:30-10:30 a.m.

Location: **Safeco Jackson Street Center**, Multipurpose Room, 306 23rd Ave. S., Suite 200,
Seattle, WA 98144

AIDS Housing and Service Systems Integration (AHSSI) Problem Statement Summary December 2001

The AIDS Housing and Service Systems Integration (AHSSI) initiative seeks to increase permanent affordable housing resources and improve access to and integration of support service options for individuals and families living with HIV/AIDS in Seattle-King County.

In approaching these activities, the AHSSI Advisory Council has focused particular attention on individuals with histories of substance use disorders who are particularly difficult to house due to the complexity of their situations, challenging behaviors related to their illnesses and frequent involvement with the criminal justice system. The AHSSI Advisory Council further acknowledges that public and private sector resources dedicated to housing and support services for individuals and families living with HIV/AIDS are insufficient to meet current levels of need. Solutions must address the fragmentation of existing housing and treatment systems serving persons with multiple co-occurring disabling conditions in addition to HIV/AIDS.

AHSSI Pilot Project Summary

In an effort to address the problem areas identified above faced by individuals and families living with HIV/AIDS in Seattle-King County, AHSSI is mobilizing a pilot project to demonstrate the value-added of integrated approaches to the provision of housing and support services. The goal of the pilot project is to utilize existing resources from multiple systems to increase access to and tenure in housing as well as increased individual and family stability for persons living with HIV/AIDS and co-occurring disabling conditions.

AIDS Housing of Washington AIDS Housing and Service Systems Integration (AHSSI) Advisory Council

AHSSI Background Problem Statement, Final Draft of 12/01

Twenty years into the AIDS epidemic, service providers from multiple systems in King County have mobilized an impressive array of treatment and support options for persons with low incomes who are living with HIV/AIDS. Yet, as the epidemic continues to grow and evolve in an era of expanding treatment options and diminishing resources, significant deficits have emerged.

After a review of available data and extensive interviews of key system stakeholders and members of the AIDS Housing and Service Systems Integration (AHSSI) Advisory Council, AIDS Housing of Washington (AHW) has developed the following brief summary of key problem areas related to housing persons in King County living with HIV/AIDS and other disabilities (such as substance use disorders and mental illness) that can complicate effective treatment and support activities. AHW staff believe that the AHSSI initiative must address these key problem areas that reach across multiple systems in order to achieve the identified goal of improving access to, and promoting the integration of, supportive housing and service options for individuals and families with low incomes who are living with HIV/AIDS.

Consumer Characteristics

Individuals with histories of substance use disorders are among the most difficult people living with HIV/AIDS to house in stable, permanent settings. It is important to acknowledge that a small subset of this group may be impossible to house within the existing array of local housing options due to the complexity of their situations, legal issues (such as histories of involvement in the criminal justice system), and illness-related behaviors that can be challenging for housing and service providers, family members, neighbors and landlords. Difficulties encountered by individuals in this group can include:

- Limited availability of subsidized housing that will tolerate active substance use.
- Frequent episodes of relapse can result in destabilization and eviction from housing.
- Difficulty sustaining compliance with the complex medication regimens often taken by people living with HIV/AIDS.
- Multiple, co-occurring medical and/or mental health problems in addition to HIV/AIDS
- Social support systems that have become weak or non-existent over time.
- Histories of involvement with the criminal justice system that can cause difficulty in securing safe, affordable housing.
- Treatment providers and case managers may become frustrated by what are perceived to be “non-compliant” behaviors.

Resources, System Structures and Service Deficits

Government and private sector resources dedicated to housing and support services are insufficient to meet current levels of need. In addition, fragmentation of housing and service systems (HIV/AIDS, primary care, mental health, substance abuse, etc.) results in poor

communication across systems, significant gaps in the housing and service continuum and ineffective and inefficient use of existing resources. These realities limit the ability of consumers to secure and sustain stable housing. This is especially true for people living with HIV/AIDS who also experience other co-occurring disabling conditions.

- Existing government resources, including HUD/SHP funds, mental health and chemical dependency resources are being significantly reduced over time and/or are allocated in a categorical fashion with strict eligibility requirements that limit access to housing and/or services for many with significant needs.
- Private sector and individual donor support for HIV/AIDS organizations is diminishing, which forces existing service agencies to reduce staff and/or service arrays.
- Bureaucratic structures promote fragmentation rather than integration. Larger systems fail to communicate effectively (i.e., information sharing) or promote integrated funding that can facilitate more holistic approaches to residential care.
- Regional housing costs price market-rate units out of reach for many people living with HIV/AIDS, even when housing subsidies such as Section 8 resources are available.
- Undocumented persons present a particular set of challenges related to accessing stable, safe, affordable, and culturally appropriate housing because most federal housing programs (including public housing authorities) limit access to people who are citizens or those who have the necessary documentation of their immigration status.
- Housing that is available outside the immediate Seattle area is often considered less desirable by consumers due to the absence of adequate transportation and the distance that must be traveled to health care, support services, and culturally appropriate environments related to such factors as ethnicity, age, sexual orientation, etc.
- The case management supports provided to persons with multiple problems (including HIV/AIDS, substance use disorders, mental illness, physical disabilities, etc.) are often insufficient to ensure their housing stability. Case managers may not have sufficient expertise or time to follow clients across multiple systems and secure needed service-level linkages.

AHSSI Advisory Council Role in Addressing Background Problem Statement

Over the coming months, the AHSSI Advisory Council will examine these key problem areas and identify the treatment and service supports required to promote housing stability and successful community tenure. AHSSI's short-term objective is to develop an agenda for cross-systems initiatives that could have significant impact on the problem areas identified above. These initiatives must address the two core AHSSI goals:

1. *Increase permanent, affordable housing resources for individuals and families living with HIV/AIDS in Seattle-King County*
2. *Improve access to, and promote the integration of, support services for chronically underserved groups with HIV/AIDS*

The Advisory Council will recommend action steps that have the capacity to create solutions that can improve the lives of people living with HIV/AIDS in King County. These action steps will also offer models of intervention that may be replicable in other communities struggling with the provision of housing and service supports to people living with HIV/AIDS.

AIDS Housing and Service Systems Integration (AHSSI) Pilot Project Needs Assessment Overview

In the first four months of 2002, AIDS Housing of Washington undertook a needs assessment of the priority population for the AHSSI pilot: individuals with HIV or AIDS who have a substance use disorder and are likely to have ongoing involvement in the criminal justice system.

Goals:

- ◇ Identify those without current viable housing options
- ◇ Verify level of demand for pilot
- ◇ Verify barriers and solutions
- ◇ Improve ability to project total need

Methods:

- ◇ Conduct structured interviews with case managers (only at Ryan White-funded sites to avoid duplication) to obtain descriptions of specific clients
- ◇ Review wait-list and turn-away data (Lyon Building and other wait lists)
- ◇ Solicit additional information from other service providers

The case manager interviews were the primary focus of the needs assessment, and concentrated on obtaining anonymous but detailed information about consumers in the priority population for whom the existing array of housing and services doesn't work. This group included some families, for whom AHSSI is exploring solutions, but the bulk of the consumers identified are potential residents for a project to house individuals without children.

AIDS Housing and Service Systems Integration (AHSSI) Pilot Project Needs Assessment Summary of Case Manager Interview Results

Between February 7 and April 10, 2002, 18 case managers (out of a total of approximately 40 FTEs) at Ryan White-funded agencies were interviewed. Of these 18, 4 were from Madison Clinic, 4 were from UW Virology Clinic, 4 were from Northwest Family Center, and 6 were from Lifelong AIDS Alliance.

Case managers provided anonymous profiles of 55 clients in response to the question, “Do you have HIV+ clients who are difficult to house and for whom you are having difficulty finding solutions?” In many cases, client details were reported from memory and case managers sometimes gave approximate answers.

There were 43 clients (36 individuals without children and 7 with children) of those 55 who closely fit our specific parameters: all 43 have a history of substance abuse and are currently homeless, and most have drug-related criminal history. Below is a summary of information about these 43 clients, divided into two groups. Some categories of information were collapsed or deleted in cases where it seemed it would otherwise be possible to identify an individual from the information provided.

I. Individuals (clients who do not have children), n=36:

Barriers to Housing

32 Current substance abuse¹

- 13 *primarily* using crack
- 8 *primarily* using alcohol
- 7 *primarily* using methamphetamines
- 4 *primarily* using heroin

33 Criminal history related to drugs

12 History of violent behavior

- 9 have served time for assault or domestic violence
- 3 history not involving incarceration is reported by case manager

¹ Most clients use multiple substances, with the exception of some who use alcohol only. Specific substance listed is the one that the case manager identified as the substance of choice.

Barriers to Housing, continued**25 Known psychiatric disorders**

- 10 have bipolar disorder
- 6 have depression
- 9 other, including personality disorders and organic brain syndromes

4 Suspected psychiatric disorders, including depression**16 History of evictions****Case Manager's Assessment of Most Significant Barrier to Housing****12 Current substance abuse is most significant****8 Mental illness or unpredictable behavior is most significant****7 Criminal history is most significant****4 Housing or credit history is most significant****5 Other/case manager unable to pick just one barrier****Demographics****Race**

- 16 African-American
- 13 Caucasian
- 5 Native American
- 2 Latino/Latina

Sex

- 31 Male
- 5 Female

HIV Status**16 Have an AIDS diagnosis based on opportunistic infection****3 Have an AIDS diagnosis based on CD4****2 Are HIV+ with symptoms****15 Are HIV+ without symptoms**

Current Living Situation

- 15 Temporarily housed with friends or relatives**
- 9 Using emergency motel vouchers**
- 8 Living on the streets**
- 2 In jail**
- 2 In the shelter system**

Housing Waiting Lists²

- 18 Not on any waiting list**
- 9 On one waiting list**
- 9 On two or three waiting lists**
 - 9 spots on Lifelong AIDS Alliance (LAA) list³**
 - 9 spots on Lyon Building or AIDS-specific housing lists (Rosehedge, MAPS Ravenna House, etc.)**
 - 5 spots on low-income housing lists (e.g., Plymouth Housing)**
 - 4 spots on Section 8 list**

Engagement**Case management**

- 19 receive case management at Madison Clinic**
 - 5 receive case management at UW Virology Clinic**
 - 9 receive case management at Lifelong AIDS Alliance**
 - 3 receive case management at Northwest Family Center**
- 9 Participate in Bailey-Boushay Adult Day Health**

² In some cases, case managers were unsure whether a client was on a particular waiting list or not, so totals are approximate.

³ Most of these clients are on the waiting list for transitional housing. In a few cases, case managers were unsure or didn't specify whether the client was on the list for permanent or transitional housing.

II. Families (clients who have children), n=7:**Barriers to Housing**

- 5 Current substance abuse⁴**
- 6 Criminal history related to drugs**
- 2 Known psychiatric disorders**
- 2 Suspected psychiatric disorders**
- 3 History of evictions**

Case Manager's Assessment of Most Significant Barrier to Housing

- 2 Current substance abuse is most significant**
- 2 Mental illness or unpredictable behavior is most significant**

Demographics**Race**

- 3 African-American**
- 2 Caucasian**
- 2 Native American**
- 0 Latino/Latina**

Sex

- 0 Male**
- 7 Female**

HIV Status

- 4 Have an AIDS diagnosis**
- 3 Are HIV+**

Current Living Situation

- 3 Temporarily housed with friends or relatives**
- 4 Using emergency motel vouchers/in the shelter system/living on the streets**
- 0 In jail**

⁴ Clients in this group, for the most part, appear to be using only the substance identified.

Housing Waiting Lists

- 3 Not on any waiting list**
- 4 On one waiting list (not AIDS-specific housing)**

Engagement

Case management

- 7 receive case management at Northwest Family Center

AIDS Housing and Service Systems (AHSSI) Advisory Council

Cultural Competence Work Group

AHSSI Pilot Project: Preamble, Definitions, Proposed Measures, and Bibliography

AHSSI Pilot Project:

1. Preamble: The AHSSI Pilot Project is *not* a solution to racism, classism, sexism, etc. The Pilot Project *is* an effort to provide culturally competent services to a population the current system has failed. Rather than measuring our success in vague or global terms, we will use clearly defined and concrete measures of our efforts to provide culturally competent services.

2. Definitions:

- ◇ culture—A specific set of social, educational, religious and professional behaviors, practices and values that individuals learn and adhere to while participating in or out of groups they usually interact with. It is important to acknowledge that health care and housing are themselves cultural constructs.
- ◇ cultural competence—Cultural competence is a set of respectful behaviors, attitudes and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations and alignment with clients from diverse backgrounds. “Competence” implies having the capacity to function effectively as an individual and an organization within the context of cultural beliefs, behaviors and needs presented by consumers and their communities.

3. Proposed Measures for Evaluation of Pilot Project:

Policies/Procedures:

- ◇ Mission/vision statement stresses the importance of culturally competent services to clients from the full range of diverse communities represented in the AHSSI Pilot Project target population
- ◇ Because of the disproportionate number of African American and Native American individuals identified as members of the AHSSI Pilot Project target population, agency documents efforts to hire culturally competent, African-American and Native American staff. Activities can include:
 - Advertising in appropriate local, regional, national, and specialty publications
 - Recruiting from community colleges, schools of social work, counseling programs, etc.
 - Recruiting from other agencies
 - Recruiting from outside of the immediate area/region
 - Networking with specific individuals and agencies in the community
 - Recruiting from faith-based communities

- Recruiting from organizations with appropriate ethnic/cultural constituencies, such as the National Association of Black Social Workers, specific fraternities and sororities, etc.
- Setting competitive salary levels designed to attract qualified candidates
- ◇ Governing board or advisory committee includes representation from desired client populations
- ◇ Completion of cultural competence training is required of all agency employees
- ◇ Access and transportation is provided to and from culturally competent providers/services, including evenings and weekends
- ◇ Grievance procedures are in place to address cross-cultural ethical and legal conflicts in service delivery; complaints or grievances about unfair, culturally insensitive, or discriminatory treatment; difficulty in accessing services; or denial of services
- ◇ Service sites managed by agency are welcoming of individuals from diverse backgrounds

Staff Training and Development:

- ◇ 100 percent of staff have completed cultural competence training
- ◇ Percentage of staff receiving additional cultural competence training annually
- ◇ Cultural issues are regularly addressed in staff supervision
- ◇ Staff have access to culturally specific consultation services

Intervention and Treatment Model Features:

- ◇ Treatment plans include culturally specific issues and concerns and understanding of illness and conditions from client's cultural perspective

Assessment of Cultural Competence:

- ◇ Consumer satisfaction with cultural appropriateness or competence of services provided, including respectful attitudes, behaviors, and policies
- ◇ Number of clients/consumers from each cultural/ethnic group who maintain appropriate, continued participation in program activities over time
- ◇ Partner/peer agency assessment of cultural competence of services provided
- ◇ Indicators of cultural competence are included in overall program evaluation procedures
- ◇ Provision of culturally competent services is a component of staff evaluation

4. Bibliography and Online Resources

Child Welfare League of America, Inc. (2002). *Cultural Competence Agency Self-Assessment Instrument*. Washington, DC: CWLA Press.

Diversity Rx: A website promoting language and cultural competence to improve the quality of health care for minority, immigrant, and ethnically diverse communities. Available online: www.diversityrx.org

IQ Solutions, Inc. (2001). *National Standards for Culturally and Linguistically Appropriate Services in Health Care*. Washington, DC: Office of Minority Health, U.S. Department of Health and Human Services. Available online: www.omhrc.gov/omh/programs/2pgprograms/finalreport.pdf

The Lewin Group, Inc. (2001). *Health Resources and Services Administration Study on Measuring Cultural Competence in Health Care Delivery Settings: A Review of the Literature*. Health Resources and Services Administration, U.S. Department of Health and Human Services. Available online: www.hrsa.gov/OMH/cultural/cultural.htm

National Leadership Institute “Cultural Relevance and Diversity” National Leadership Institute, Substance Abuse and Mental Health Services Administration. Available online: www.samhsa.gov/nli/news/TATips.htm#cultrev

National Leadership Institute “Underserved Populations” National Leadership Institute, Substance Abuse and Mental Health Services Administration. Available online: www.samhsa.gov/nli/Resources/underserved.HTM

Office of Minority Health “Assuring Cultural Competence in Health Care: Recommendations for National Standards and Outcomes-Focused Research Agenda” (includes “A Practical Guide for Implementing the Recommended National Standards for Culturally and Linguistically Appropriate Services in Health Care”) Office of Minority Health, U.S. Department of Health and Human Services. Available online: www.omhrc.gov/clas/

Washington State Department of Health, Community and Family Health Multicultural Work Group. (2001). *Building Cultural Competence: Guidelines for Action*. Washington State Department of Health. Available online: www.doh.wa.gov/cfh/Pubs/MCWG2001Lo.pdf

Best Practice Models Identified through the AHSSI Process

The Health, Housing and Integrated Services Network (HHISN)

The Health, Housing and Integrated Services Network (HHISN) is a multi-agency collaborative partnership of San Francisco Bay Area “homeless” and “mainstream” housing and service providers and funding systems, convened with the help of the Corporation for Supportive Housing. HHISN targets primarily single adults disabled by mental illness and substance abuse, with multiple barriers to work and housing stability—those most at risk for chronic homelessness and inappropriate utilization of health services. HHISN’s Integrated Services Teams deliver comprehensive services on-site in affordable housing to address health care, mental health, substance abuse, employment, and social service needs, using strategies that do not require sobriety or stabilization of psychiatric symptoms as a pre-condition for participation. In a study of 280 tenants who moved into two HHISN buildings between 1994–1998, 82% remained in housing at least one year, and average annual visits to the emergency room declined 58%.

(For additional information, go online to www.csh.org to access the publications *Supportive Housing and its Impact on the Public Health Crisis of Homelessness* and *The Network: Health, Housing and Integrated Services: Best Practices and Lessons Learned*.)

The New York/New York Agreement and Study

A research team from the Center for Mental Health Policy and Services Research, University of Pennsylvania, conducted a comprehensive study looking at the impact of supportive housing for homeless mentally ill people on the use of publicly funded services in New York City.

The study used as its initial data set the 4,679 individuals who were placed into housing created by the New York/New York Agreement to House Homeless Mentally Ill Individuals between July 1, 1989 and June 30, 1997. Under this agreement (known as the New York/New York Agreement), the state and city governments worked with over 50 nonprofit groups to create 3,615 units of service-enriched housing for homeless mentally ill individuals over a nine-year period.

The study examined service use by formerly homeless people with serious mental illness in the two years before and the two years after being placed into service-enriched housing. The researchers looked at these 4,679 individuals’ use of emergency shelters, psychiatric hospitals, medical services, prisons, and jails, and compared their service use in these two time periods to the service use by control groups of similar homeless individuals who had not been placed in New York/New York housing. The study found that reductions in service use offset 94% of the costs of the supportive housing, with the majority of the service use reductions in health services.

(For additional information, go online to www.csh.org to access the publications *A Description and History of The New York/New York Agreement to House Homeless Mentally Ill Individuals* and *The New York/New York Agreement Cost Study: The Impact of Supportive Housing on Services Use for Homeless Mentally Ill Individuals*. Also see Culhane, D.P., Metraux, S., and Hadley, T. (2002). Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing. *Housing Policy Debate*, 13(1): 107-163.)

The Lyon Building

The Lyon Building, which provides 64 units of permanent housing for homeless adults with multiple disabilities, including HIV/AIDS, mental illness and chemical dependence, offers an example of a best practices model in Seattle. This innovative partnership between AIDS Housing of Washington and Downtown Emergency Service Center (DESC) has been in operation since September 1997, and no program of its kind exists in the area. A key aspect of the project is the collaboration involving AIDS, mental health, substance abuse, and homeless service providers. Lyon Building staff members, including four clinical specialists, provide intensive support and coordination to ensure that residents' service needs are met and housing is successfully maintained. The staff members work to engage residents in a range of services, and support services are meant to encourage a harm reduction approach to unhealthy behaviors. Alcohol (as a legal substance) is allowed in the building; although drug use is not permitted, drug use that occurs in a resident's room and is not causing problems in the common areas is not targeted for specific intervention (even by local police).

Mentally ill and chemically affected people who are not HIV-positive may qualify to live in the building, but those who are AIDS disabled and mentally ill (who may also be chemically affected) are in the highest priority category on the wait list. Every applicant must have a case manager, proof of homelessness, and income below 30% of the median income; the majority of residents were using emergency shelters or transitional housing immediately prior to move-in. An in-depth screening process focuses on whether a potential resident will be successful at the Lyon Building.

In the first four years of the Lyon Building's existence, 130 people lived there, 54 of whom stayed for more than two years.

(For additional information, go online to www.desc.org or contact Daniel Malone, DESC, (206) 587-2460.)

**AIDS Housing of Washington
AIDS Housing and Service Systems Integration (AHSSI)**

***Background Information for Working Agreement
Between
Lifelong AIDS Alliance
And
Pioneer Human Services***

DRAFT of September 30, 2002

Goal of Working Agreement

To increase opportunities to promote success in housing and employment opportunities for persons living with HIV/AIDS who have histories of substance use disorders and involvement in the criminal justice system.

Key Parties to Working Agreement

Lifelong AIDS Alliance (LAA): A primary provider of case management and housing support services to persons living with HIV/AIDS in King County

Pioneer Human Services (PHS): A primary provider of housing and employment services for persons with histories of substance use disorders and involvement in the criminal justice system

What Key Parties Bring To and Seek From a Working Agreement

	Lifelong AIDS Alliance	Pioneer Human Services
What each agency seeks from a working agreement and working relationship with other involved agencies	◇	◇
What each agency brings to a working agreement and working relationship with other involved agencies, (strengths, assets, resources, opportunities, etc.)	◇	◇

	Lifelong AIDS Alliance	Pioneer Human Services
<p>Constraints, problem areas and issues that must be addressed for a working agreement and working relationship to succeed</p>	<p>◇</p>	<p>◇</p>
<p>Specific and measurable desired outcomes from a working agreement and working relationship</p>	<p>◇</p>	<p>◇</p>

	Lifelong AIDS Alliance	Pioneer Human Services
Next steps for each agency in relation to development of a working agreement and working relationship		
Realistic timeframe for development of a working agreement and working relationship		
Other issues that must be addressed to help insure success		

AIDS Housing of Washington
AIDS Housing and Service Systems Integration (AHSSI) Advisory Council

Meeting Evaluation Form

Date: ___/___/___

In order to improve the quality of our meetings and ensure the success of the AHSSI initiative, we need your feedback. Please answer the questions below and return this form at the end of the meeting.

1. Do you feel that the questions and concerns you bring to the AHSSI Advisory Council are being addressed?

1	2	3	4	5
<i>No</i>		<i>Part of the time</i>		<i>Yes</i>

If you answered “no” to #1, please specify the issues that you believe need to be addressed now:

2. Were the materials provided prior to the meeting helpful in preparing you for today’s meeting?

1	2	3	4	5
<i>Not helpful</i>		<i>Helpful</i>		<i>Very helpful</i>

3. Were all of the agenda items fully addressed?

1	2	3	4	5
<i>All items not addressed</i>		<i>Agenda items addressed somewhat</i>		<i>Agenda items fully addressed</i>

Please let us know what was omitted:

4. Did the meeting generally follow the agenda and achieve its stated purpose?

1	2	3	4	5
<i>Did not follow agenda</i>		<i>Followed agenda somewhat</i>		<i>Followed agenda effectively</i>

5. How would you rate the quality of the group’s interaction and member participation during the meeting?

1	2	3	4	5
<i>Having very little value</i>		<i>Fair</i>		<i>Very good; contributed to effectiveness</i>

6. Overall, how did you feel about the investment of your time in this meeting?

1	2	3	4	5
<i>Not at all satisfied</i>		<i>Somewhat satisfied</i>		<i>Very satisfied; a good use of my time</i>

Please feel free to use the back of this form for additional comments. Thank you for your continued support and feedback.

Bibliography: AIDS, Housing, and Systems Integration

Bridgman, R. (2002). Housing Chronically Homeless Women: “Inside” a Safe Haven. *Housing Policy Debate*, 13(1): 51-81. (Journal Article: 31 pages)

Buckley, R., and Bigelow, D.A. (1992). *Brief Report: The Multi-Service Network: Reaching the Unserved Multi-Problem Individual*. *Community Mental Health Journal* 28(1): 43-50. (Journal Article: 8 pages)

Clegg and Associates, Inc. (2001). *Tools for Outcome-Based Evaluation of HOPWA-Funded Programs*. Seattle, WA: AIDS Housing of Washington. (Evaluation Guide: 85 pages)

Cocozza, J.J., Steadman, H.J., and Dennis, D.L. (1998). *Implementing Systems Integration Strategies: Lessons from the ACCESS Program*. In press, Administration and Policy in Mental Health. (Unpublished Paper: 38 pages)

Culhane, D.P., Metraux, S., and Hadley, T. (2002). Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing. *Housing Policy Debate*, 13(1): 107-163. (Journal Article: 57 pages)

Federal Task Force on Homelessness and Severe Mental Illness. (1992). *Outcasts on Main Street: Report of the Federal Task Force on Homelessness and Severe Mental Illness*. Washington, DC: Interagency Council on the Homeless. (Report: 91 pages)

(see also: Center for Mental Health Services. (1996). *Outcasts on Main Street: Implementation Report*. Rockville, MD: Center for Mental Health Services.) (Report: 28 pages)

Goldfinger, S.M., Susser, E., Roche, B.A., and Berkman, A. (1998). *HIV, Homelessness, and Serious Mental Illness: Implications for Policy and Practice*. Rockville, MD: Center for Mental Health Services. (Report: 40 pages)

Konrad, E.L. (1996). A Multidimensional Framework for Conceptualizing Human Services Integration Initiatives. *New Directions for Evaluation*, 69: 5-19. (Journal Article: 15 pages)

Kraybill, K. (2002). *Outreach to People Experiencing Homelessness: A Curriculum for Training Health Care for the Homeless Outreach Workers*. National Health Care for the Homeless Council. (Training Curriculum [three-ring binder]: 380 pages)

Law Offices of Goldfarb & Lipman. (2001). *Between the Lines: A Question and Answer Guide on Legal Issues in Supportive Housing—National Edition*. Corporation for Supportive Housing. (Implementation Guide: 209 pages)

Lenoir, G. (2000). *The Network: Health, Housing and Integrated Services: Best Practices and Lessons Learned*. Corporation for Supportive Housing. (Report: 168 pages)

Proscio, T. (2000). *Supportive Housing and its Impact on the Public Health Crisis of Homelessness*. Corporation for Supportive Housing.

Steadman, H.J. (1992). Boundary Spanners: A Key Component for the Effective Interactions of the Justice and Mental Health Systems. *Law and Human Behavior*, 16(1): 75-87. (Journal Article: 13 pages)

Wilkins, C. (1996). Building a Model Managed Care System for Homeless Adults with Special Needs: the Health, Housing, and Integrated Services Network. *Current Issues in Public Health*, 2: 39-46. (Journal Article: 8 pages)

Zerger, S. (2002). *Substance Abuse Treatment: What Works for Homeless People? A Review of the Literature*. National Health Care for the Homeless Council & HCH Clinicians Network Research Committee. (Report: 62 pages)

Note: Please contact Emily Parker at AIDS Housing of Washington, (206) 322-9444, ext. 26, if you would like to request a copy of any of these publications.

Online Resources: AIDS, Housing, and Systems Integration

□ AIDS Housing of Washington’s online resource library

The AIDS Housing of Washington web site has information on AIDS and special populations, housing development, program operations, homelessness, best practices, systems integration, and more. From the home page, click on “Resources,” then on “Resource Library.” Available at: www.aidshousing.org/

□ Comprehensive Needs Assessment

Natter, J. (2001). *2001 Seattle-King County HIV/AIDS Care Services Comprehensive Needs Assessment*. Public Health – Seattle & King County. Available at: www.metrokc.gov/health/apu/assessment/index.htm

□ HIV/AIDS epidemiology in King County

The HIV/AIDS Epidemiology Program, Public Health – Seattle & King County, offers ten fact sheets in bulleted format. In addition to two general fact sheets, the series covers incarcerated persons, homeless persons, substance users, people of color, women, gay and bisexual men, heterosexuals, and young people. Available at: www.metrokc.gov/health/apu/epi/factshts.htm

The *HIV/AIDS Epidemiology Profile for Community Planning* contains more extensive data for providers and planners of health care and services. Available at: www.metrokc.gov/health/apu/epi/profile.htm

□ Mental health and chemical dependency services integration

Wertheimer, D. (1999). *Promoting Excellence: A Plan for an Integrated Continuum of Mental Health, Chemical Abuse and Dependency Services in King County*. Department of Community and Human Services, Mental Health, Chemical Abuse & Dependency Services Division. Available at: www.metrokc.gov/dchs/mhd/excellence.htm

□ Systems Integration series

“The Change Agent’s Tool Box” is an eight-part series written by David Wertheimer for the National Association of State Mental Health Program Directors, promoting integration across service systems to meet the needs of persons with co-occurring mental illness and substance abuse disorders and consumers with multiple needs. The eight articles are entitled “Making the Case,” “Building Coalitions,” “Involving the Private Sector,” “Getting Started,” “Finding the Money,” “Making Systems Change Happen,” “Evaluating Progress,” and “Core Qualities of the Change Agent.” Available at: www.nasmhpd.org/ntac/toolbox/index.html

Glossary of HIV/AIDS- and Housing-Related Terms

This glossary includes terms used in AHSSI documents and terms related to HIV/AIDS and housing.

AFFORDABLE HOUSING Housing is generally defined by the U.S. Department of Housing and Urban Development as affordable when the occupant is paying no more than 30 percent of their adjusted gross income for housing costs, including utilities. Affordable housing may refer to subsidized or unsubsidized units.

AIDS Acquired Immunodeficiency Syndrome. A person with HIV infection is diagnosed with AIDS when either a) they develop an opportunistic infection defined by the Centers for Disease Control and Prevention as an AIDS indication, or b) on the basis of certain blood tests related to the immune system.

ALCOHOL AND OTHER DRUG ABUSE The problematic use of alcohol, tobacco, and illicit drugs in a fashion that may also harm individual health, family life, public safety and the economy.

ASSISTED HOUSING Owner-occupied or rental housing which is subject to restrictions on rents, rate of return or sales price as a result of one or more governmental subsidies including: grants, loans, or rent subsidies from public funds; housing bonus, transferable development rights programs, or mitigation funds administered by the city; or tenant-based subsidies such as certificates or vouchers.

ASYMPTOMATIC HIV INFECTION Without symptoms. Usually used in the HIV/AIDS literature to describe a person who has a positive reaction to one of several tests for HIV antibodies but who shows no clinical symptoms of the disease.

AT RISK OF BECOMING HOMELESS Being on the brink of becoming homeless due to one or more of the following: having inadequate income or paying too high a percentage of income on rent (typically 50 percent or more), living in housing that does not meet federal housing quality standards, or living in housing that is seriously overcrowded. Also see Homeless Person.

BEDS The unit of measure when describing the overnight sleeping capacity or availability for shelters, skilled nursing facilities, hospices, board and care, adult family living, assisted living, and other such facilities.

CASE MANAGEMENT The central component of HIV/AIDS care is case management. Case managers coordinate all the care a client receives from all providers in the community. Typically, case management services are provided by agencies separate from the housing providers. When a case management client resides in a residence, however, the residential staff members have the most frequent contact with the resident and often are responsible for the care coordination. Case management is also provided through other social service systems.

COMMUNITY DEVELOPMENT BLOCK GRANT PROGRAM (CDBG) A federal grant program, administered by the U.S. Department of Housing and Urban Development, authorized under Title I of the Housing and Community Development Act of 1974 and administered by state and local governments. CDBG funds may be used in various ways to support community development, including acquisition, construction, rehabilitation, and/or operation of public facilities and housing.

CONSOLIDATED PLAN A document written by a state or local government and submitted annually to the U.S. Department of Housing and Urban Development that serves as the planning document of the jurisdiction and an application for funding under any of the community planning development formula grant programs (Community Development Block Grant, Emergency Shelter Grant, HOME Investment Partnerships Program, and Housing Opportunities for Persons with AIDS). The document describes the housing needs of the low- and moderate-income residents of a jurisdiction, outlining strategies to meet the needs and listing all resources available to implement the strategies.

CONTINUUM OF CARE An approach that helps communities plan for and provide a full range of emergency, transitional, and permanent housing and service resources to address the various needs of homeless persons. The approach is based on the understanding that homelessness is not caused merely by a lack of shelter, but involves a variety of underlying, unmet needs—physical, economic, and social. Designed to encourage localities to develop a coordinated and comprehensive long-term approach to homelessness, the Continuum of Care consolidates the planning, application, and reporting documents for the U.S. Department of Housing and Urban Development’s Shelter Plus Care, Section 8 Moderate Rehabilitation Single-Room Occupancy Dwellings (SRO) Program, and Supportive Housing Program.

DISCRIMINATION Treating a person differently because they belong to, or are perceived to belong to, an identifiable group. Often discrimination is due to a person’s being from a different race, country, or religion, or because they’re female, have a family, are older, disabled, or are gay or lesbian.

DUALLY DIAGNOSED See Multiply Diagnosed.

EMA OR EMSA Eligible metropolitan (statistical) area. Geographic area based on population and cumulative AIDS cases, to receive federal funds through the Ryan White CARE Act and Housing Opportunities for Persons with AIDS (HOPWA) Program.

EMERGENCY HOUSING ASSISTANCE Emergency housing assistance is one-time or very short-term assistance provided to address an immediate housing crisis—often for people who are homeless or at imminent risk of becoming homeless. The primary goal of emergency assistance is to solve the immediate housing crisis. The assistance is usually one of the following: emergency rent, mortgage or utility payments to prevent loss of residence, motel vouchers, and/or emergency shelter.

EMERGENCY SHELTER Any facility with overnight sleeping accommodations, the primary purpose of which is to provide temporary shelter for the homeless in general or for specific populations of homeless persons.

EMERGENCY SHELTER GRANTS (ESG) A federal program administered by the U.S. Department of Housing and Urban Development that provides funds to local governments to help provide additional emergency shelters or improve the quality of existing emergency shelters and to help meet operating costs of essential social services to homeless individuals. Funds are provided to grantees through both a formula-based process for eligible metropolitan areas and urban counties and through a national competition for non-formula-eligible counties.

EXTREMELY LOW-INCOME An individual or family whose income is between 0 and 30 percent of the median income for the area, as determined by the U.S. Department of Housing and Urban Development.

FAIR HOUSING ACT The Federal Fair Housing Act prohibits, among other things, the owners of rental housing from discriminating against potential tenants based on race, sex, national origin, disability, or family size.

FAIR MARKET RENT (FMR) Rents set by the U.S. Department of Housing and Urban Development (HUD) for a state, county, or urban area that define maximum allowable rents for HUD-funded subsidy programs. HUD calculates FMR to be at the 40th percentile of recent moves, excluding apartments built within the past two years, meaning that 40 percent of recent movers paid less, and 60 percent paid more.

FAMILY For purposes of the plan and local policy interpretation, and in keeping with HOPWA regulations, the term “family” encompasses nontraditional households, including families made up of unmarried domestic partners. A family is a self-defined group of people who may live together on a regular basis and who have a close, long-term, committed relationship and share responsibility for the common necessities of life. Family members may include adult partners, dependent elders, or children, as well as people related by blood or marriage.

HAART Highly Active Anti-Retroviral Therapy. The preferred term for potent anti-HIV treatment. This means a combination of drugs (usually three or more) to combat HIV. Usually more than one class of drug is included in a HAART regimen. Includes protease inhibitors, and is often referred to as combination therapy or the “cocktail.”

HARM REDUCTION A set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies for safer use, from managed use to abstinence. Harm reduction strategies meet drug users “where they’re at,” addressing conditions of use along with the use itself.

HIV Human Immunodeficiency Virus. The virus that causes AIDS. HIV disease is characterized by a gradual deterioration of immune functions. During the course of infection, crucial immune cells, called CD4+ T cells, are disabled and killed, and their numbers progressively decline. People infected with HIV may or may not feel or look sick.

HOMELESS FAMILY WITH CHILDREN A family that includes at least one homeless parent or guardian and one child under the age of 18; a homeless pregnant woman; or a homeless person in the process of securing legal custody of a person under the age of 18.

HOMELESS PERSON According to the U.S. Department of Housing and Urban Development, a homeless person is an individual or family who 1) lacks a fixed, regular, and adequate night-time residence, or 2) has a primary night-time residence that is a) a publicly supervised or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill); b) an institution that provides a temporary residence for individuals intended to be institutionalized; c) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings. Individuals paying more than 50 percent of their income for housing are also considered at such high risk for homelessness that they are included in the definition of homeless for some federal programs. The term “homeless individual” does not include any individuals imprisoned or otherwise detained under an act of federal or state law.

HOPE VI HOPE VI, or the Urban Revitalization Program, a program administered by the U.S. Department of Housing and Urban Development, funds rehabilitation and/or replacement of distressed public housing units and support services. Through the end of FY 2001 the program has awarded \$4.8 billion to 146 communities in 37 states since 1993.

HOPWA Housing Opportunities for Persons with AIDS. A U.S. Department of Housing and Urban Development program which pays for housing and support services for people living with HIV/AIDS and their families. Created by an Act of Congress in 1990.

HOPWA SPNS Housing Opportunities for Persons with AIDS Special Projects of National Significance. A competitive program (under the U.S. Department of Housing and Urban Development’s HOPWA program) that funds projects which, due to their innovative nature or potential for replication, are likely to serve as effective models for addressing the housing needs of people living with HIV/AIDS and their families.

HOUSING QUALITY STANDARDS (HQS) Standards set by the U.S. Department of Housing and Urban Development (HUD) to ensure that all housing receiving HUD financial assistance meets a certain level of quality. HQS requires that recipients of HUD funding provide safe and sanitary housing that is in compliance with state and local housing codes, licensing requirements, and any other jurisdiction-specific housing requirements.

HRSA Health Resources and Services Administration. HRSA is an agency of the U.S. Department of Health and Human Services that works toward providing health care to low-income, uninsured, isolated, vulnerable, and special needs populations through a number of programs including: Ryan White CARE Act, Rural Health Initiative, and other community-based health initiatives.

HUD U.S. Department of Housing and Urban Development. HUD is a cabinet-level agency designed to advocate for the housing needs of people with low incomes through programs for public housing, special needs housing, and first time homebuyers.

LOW-INCOME FAMILY Family whose income does not exceed 50 percent of the median income for the area, as determined by the U.S. Department of Housing and Urban Development (HUD), with adjustments for smaller and larger families. HUD may establish income ceilings higher or lower than 50 percent of the median for the area on the basis of findings that such variations are necessary because of prevailing levels of construction costs or Fair Market Rents, or unusually high or low family incomes.

MCKINNEY-VENTO ACT The primary federal response targeted to assisting homeless individuals and families. The scope of the Act includes: outreach, emergency food and shelter, transitional and permanent housing, primary health care services, mental health, alcohol and drug abuse treatment, education, job training, and child care. There are nine titles under the McKinney-Vento Act that are administered by several different federal agencies, including the U.S. Department of Housing and Urban Development (HUD). McKinney-Vento Act Programs administered by HUD include: Emergency Shelter Grant Program, Supportive Housing Program, Section 8 Moderate Rehabilitation for Single-Room Occupancy Dwellings, Supplemental Assistance to Facilities to Assist the Homeless, and Single Family Property Disposition Initiative. Also see: Emergency Shelter Grants, Federal Emergency Management Administration, Shelter Plus Care, Section 8 Moderate Rehabilitation for Single-Room Occupancy Dwellings, and Supportive Housing Program.

MEDICAID A program jointly funded by the states and the federal government that provides medical insurance for people who are unable to afford medical care. The program focuses mainly on the needs of the elderly, people with disabilities, and children.

MEDICARE A federal program under the Social Security Administration that provides health insurance to the elderly and disabled.

MENTAL ILLNESS A disorder of the brain that disrupt a person’s thinking, feeling, moods, and ability to relate to others. Just as diabetes is a disorder of the pancreas, mental illnesses are brain disorders that often result in a diminished capacity for coping with the ordinary demands of life.

MULTIPLY DIAGNOSED To be diagnosed with HIV/AIDS and also have histories of other disabilities. This term generally refers to people who are HIV-positive and have chronic alcohol and/or other drug use problems and/or a serious mental illness. The terms “dually diagnosed” and “triplly diagnosed” are also used.

PERMANENT HOUSING Housing which is intended to be the tenant's home for as long as they choose. In the supportive housing model, services are available to the tenant, but accepting services cannot be required of tenants or in any way impact their tenancy. Tenants of permanent housing sign legal lease documents.

PERSON WITH A DISABILITY HUD's Section 8 program defines a "person with a disability" as: a person who is determined to: 1) have a physical, mental, or emotional impairment that is expected to be of continued and indefinite duration, substantially impedes his or her ability to live independently, and is of such a nature that the ability could be improved by more suitable housing conditions; or 2) have a developmental disability, as defined in the Developmental Disabilities Assistance and Bill of Rights Act.

PROJECT-BASED RENTAL ASSISTANCE Rental assistance that is tied to a specific unit of housing, not a specific tenant. Tenants receiving project-based rental assistance give up the right to that assistance upon moving from the unit. Also see Rental Assistance, Shallow Rent Subsidy, and Tenant-based Rental Assistance.

RENTAL ASSISTANCE Cash subsidy for housing costs provided as either project-based rental assistance or tenant-based rental assistance. HOPWA short-term rental assistance is available for up to 21 weeks. HOPWA long-term rental assistance is provided for longer than 21 weeks. Due to HOPWA regulations, rental assistance cannot be guaranteed for longer than three years. Ryan White funds can be used for short-term, transitional, or emergency housing defined as necessary to gain or maintain access to medical care. Also see Project-based Rental Assistance, Tenant-based Rental Assistance, and Shallow Rent Subsidy.

RYAN WHITE CARE ACT Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. A program of the Health Resources and Services Administration (HRSA) providing funds for health care and supportive services for people living with AIDS. Created by an Act of Congress in 1990. Also see HRSA.

SECTION 8/HOUSING CHOICE VOUCHER PROGRAM A federal program operated by local housing authorities providing rental assistance to low-income persons and administered by the U.S. Department of Housing and Urban Development. Under the Section 8 Housing Voucher program, the local housing authority determines a standard amount of rental assistance an individual or family will receive. The tenant would pay the difference between the amount of assistance and the actual rent, which may require the tenant to spend more than 30 percent of their income on rent. The Section 8 voucher program is a tenant-based program, meaning the subsidy is specific to the tenant as opposed to the unit.

SECTION 8 HOUSING OPPORTUNITIES FOR PERSONS WITH DISABILITIES (MAINSTREAM PROGRAM) The Mainstream Program, created in 1997 and administered by the U.S. Department of Housing and Urban Development, utilizes up to 25 percent of the funds originally earmarked for Section 811 to a separate tenant-based rental assistance program for persons with disabilities. Also see Section 811.

SECTION 8 MODERATE REHABILITATION FOR SINGLE-ROOM OCCUPANCY DWELLINGS This program provides Section 8 rental assistance for moderate rehabilitation of buildings with SRO units (single-room occupancy dwellings). The program, administered by the U.S. Department of Housing and Urban Development, is designed for the use of an individual person. Units often do not contain food preparation or sanitary facilities. A public housing authority makes Section 8 rental assistance payments to the landlords for the homeless people who rent the rehabilitated units.

SHELTER PLUS CARE A national grant program administered by the U.S. Department of Housing and Urban Development providing rental assistance, linked with support services, to homeless individuals who have disabilities (primarily serious mental illness, chronic substance abuse, and disabilities resulting from HIV/AIDS) and their families.

SKILLED NURSING FACILITY A nursing home or facility providing 24-hour care from nurses and aides.

SRO Single-Room Occupancy. Refers to studio apartments which provide very limited cooking facilities and typically have shared bathrooms. They are often in rehabilitated hotels, and can be used for emergency, transitional, or permanent housing.

SOCIAL SECURITY DISABILITY INSURANCE (SSDI) A federal government benefit for individuals who are medically disabled and have worked for enough years to be covered under Social Security.

SPECIAL NEEDS HOUSING Housing for people who require specific accommodations and/or support to access and maintain housing. Special needs housing may target the elderly; the disabled, including people living with HIV/AIDS; and those with histories of homelessness, mental illness, and substance use issues.

SUBSIDIZED RENTAL HOUSING Assisted housing (see glossary definition) that receives or has received project-based governmental assistance and is rented to low- or moderate-income households. Subsidized rental housing does not include owner-occupied units, nor does it include Section 8 certificate/voucher holders in market-rate housing.

SUBSTANCE USE DISORDER The abuse of alcohol and other drugs (see glossary definition above) that has reached a level at which clinical diagnosis of a medical condition can be made.

SUBSTANCE USE ISSUES The problems resulting from a pattern of using substances such as alcohol and drugs. Problems can include: a failure to fulfill major responsibilities and/or using substances in spite of physical, legal, social, and interpersonal problems and risks.

SUPPORTIVE HOUSING Housing, including housing units and group quarters, which include on- and off-site support services.

SUPPORTIVE HOUSING PROGRAM (SHP) Provides grants to develop housing and related support services for people moving from homelessness to independent living. Program funds help homeless people live in a stable place, increase their skills or income, and gain more control over the decisions that affect their lives. Funding may be used for capital costs, facility operations, and support services.

SUPPORT SERVICES Services provided to individuals to assist them to achieve and/or maintain stability (including housing stability), health, and improved quality of life. Some examples are case management, medical or psychological counseling and supervision, child care, transportation, and job training.

SYMPTOMATIC HIV INFECTION Any perceptible, subjective change in the body or its functions that indicates disease or phases of disease, as reported by the patient. When referring to a person who is HIV-positive, this indicates a person who is sick and/or shows medical symptoms of the disease, but does not have an AIDS diagnosis.

TANF Temporary Assistance for Needy Families, a program administered by the U.S. Department of Health and Human Services. TANF, which replaced and is sometimes referred to as welfare, provides assistance and work opportunities to families with low incomes by granting states the federal funds and guidelines to administer their own welfare programs.

TENANT-BASED RENTAL ASSISTANCE A form of rental assistance in which the assisted tenant may move to a different housing unit while maintaining their assistance. The assistance is provided for the tenant, not a specific housing unit. Also see Project-based Rental Assistance, Rental Assistance, and Shallow Rent Subsidy.

TRANSITIONAL HOUSING A project that is designed to provide housing and appropriate support services to homeless persons to facilitate movement to independent living within 24 months, or a longer period approved by the U.S. Department of Housing and Urban Development (HUD). For purposes of the HOME program, there is not a HUD-approved time period for moving to independent living.

UNDOCUMENTED PERSON In general, undocumented persons are considered to be those individuals who are not citizens of the United States and who have entered the U.S. illegally or who entered the U.S. under the terms of time- or condition-limited visas that have expired.