NATIONAL AIDS HOUSING COALITION

HOUSING IS HIV PREVENTION AND HEALTH CARE POLICY TOOL KIT

TALKING POINTS ON FREQUENTLY ASKED QUESTIONS

CONTENTS:

2007

WHY HIV-SPECIFIC HOUSING RESOURCES?

- The need for HIV-specific housing resources has been questioned as an example of "AIDS exceptionalism."

- But HIV/AIDS remains unique in that it:
  - Combines an infectious agent; potentially fatal consequences; rapid spread in vulnerable populations; and the potential for the development of drug-resistant strains,
  - While being highly treatable with antiretroviral therapy that substantially reduces mortality & morbidity.

- Attacking HIV housing resources obscures the real problem - reforming housing and health care financing so that everyone with a serious, chronic illness has access to necessary care and services.

- Successful HIV/AIDS housing supports and programs serve as a model for a modern approach to health care improvement.

The need for categorical HIV housing resources has been questioned as an example of "AIDS exceptionalism," a term used to describe policies that differ from a traditional infectious disease control or chronic care approach (Schilts, 1987; Wachter, 1991). As stated in a recent Institutes of Medicine (IOM) report on health care delivery, HIV disease remains unique in that it combines an infectious agent, potentially fatal consequences, rapid spread in vulnerable populations, and the potential for development of drug-resistant strains, while being highly treatable with anti-retroviral therapy that substantially reduces mortality and morbidity (IOM, 2004). Moreover, to the extent that HIV/AIDS presents lifelong care management issues, attacking HIV specific resources obscures the real problem – reforming housing and health care financing so that everyone with a serious, chronic illness has access to decent medical care, housing, and services.

The success of HIV/AIDS housing interventions should serve as a model for other disabilities groups, and may be especially relevant in the case of other behavioral-based diseases such as diabetes, where access to housing may have a direct impact on health risks and outcomes. Government agencies, working in collaboration with non-profit providers of housing and services, have invested in housing for persons with HIV/AIDS. By necessity, many HIV/AIDS housing programs have pioneered innovative approaches for addressing the co-occurring medical, substance use and mental health needs of the PLWHA they serve. Research findings demonstrate overall stability and connection to care among users of these HIV-specific housing resources, providing important empirical evidence that homeless and unstably housed persons with lifelong chronic care needs, including those who are mentally ill and/or chemically dependent, can live in independent settings if provided with necessary supports, that they will voluntarily access supportive services that they perceive to be relevant and respectful, and that they will, once stably housed, become active participants in their own medical and psychosocial care (NAHC, 2005; NAHC, 2006).

AREN'T HOMELESS/UNSTABLY HOUSED PLWHA JUST RISKY PEOPLE?

- Research shows that the receipt of housing assistance is linked to reduction of HIV risk behaviors and positive change in medical outcomes.
- The data show a strong relationship between housing status and HIV risk and health outcomes, controlling for other client characteristics, health status, and service use variables.
- These findings suggest that the condition of homelessness, and not simply traits of homeless individuals, influences risk behaviors and health service utilization.
- Housing affects an individual's ability to avoid exposure to HIV; an HIV-positive individual's ability to avoid exposing others to HIV; and the ability to access & adhere to care.
- To end the AIDS crisis, we need to move beyond a "risky person" paradigm to a consideration of risky contexts such as housing instability and other structural factors that impact HIV risk and health outcomes.

Research has shown that housing status itself independently predicts HIV risk and health outcomes, and that positive change in housing predicts less risk and better health, regardless of individual client characteristics, health status or service use variables (Aidala, et al., 2005; Kidder, et al., 2007). This suggests that the condition of homelessness, and not simply traits of homeless individuals, influences risk behaviors and service utilization, making housing a strategic target for intervention.

The HIV epidemic in the United States is increasingly concentrated among persons marginalized by race, gender, abandonment (youth), criminal justice involvement, mental illness, substance use, violence and abuse. Until recently, HIV research and practice have emphasized individual-focused factors in seeking to understand and address disparities in risk and health outcomes, yet interventions based on these assumptions alone have had limited success. Published reports reveal little or no progress towards the articulated national goals of substantially reducing new HIV infections, and reducing racial/ethnic disparities in HIV incidence (Holtgrave & Curran, 2006). There is increasing awareness that effectively addressing disparities in HIV risk and health outcomes will require attention to structural explanations that acknowledge the role of housing and other social/contextual factors that determine health (Holtgrave & Curran, 2006). Contextual or structural factors such as housing status directly or indirectly affect an individual's ability to avoid exposure to HIV, as well as HIV-positive individuals' ability to avoid exposing others to infection, and to access and adhere to HIV care (Aidala et al., 2005).

ISN'T HOUSING TOO EXPENSIVE?

- Studies show that supportive housing for homeless persons with HIV/AIDS and other disabilities sharply reduces their use of costly emergency & inpatient services.
- Savings in other publicly funded services have been found to offset up to 95% of the cost of the supportive housing.
- These cost-offset analyses support the provision of housing even before taking into account the costs of heightened HIV risk & treatment failure among homeless PLWHA.
- Each prevented HIV infection saves over $300,000 in life-time medical costs
- Findings from an ongoing HUD/CDC study indicate that housing is a cost-saving and cost-effective HIV prevention and treatment intervention.

Important new cost analyses indicate that the provision of housing is a wise use of limited public resources. Cost-offset analyses have repeatedly demonstrated that supportive housing for persons with chronic health care needs substantially reduces utilization of costly emergency and inpatient health care services (Bendixen, 2006; Wilkins, 2006; Culhane, et al., 2002; Culhane, 2006). These cost-offset analyses support the provision of supportive housing for persons with special needs even without taking into account the substantial costs associated with heightened risk of HIV infection among homeless persons, or the costs of delayed or inconsistent care among unstably housed PLWHA. The economic costs of ongoing HIV transmissions and HIV treatment failure within this population are enormous, with discounted lifetime medical costs associated with each new HIV infection estimated to be $303,000 (Schackman et al., 2006). Cost analyses of behavioral prevention approaches have repeatedly demonstrated that intervention costs are more than offset by the savings associated with the prevented HIV infections (Holtgrave, et al,, 2002). Now evidence is available to answer HIV-specific housing "affordability" policy questions.

The ongoing HUD/CDC Housing and Health Study includes determination of "cost thresholds" – measures that show how many new HIV transmissions have to be prevented in order for housing services to be cost-savings (service costs divided by life-time medical cost savings when a transmission is prevented) and cost-effective (service costs divided by medical cost saved plus a value for each quality-adjusted life year saved when an infection is averted). The analyses indicate that in order for housing services to be cost-saving an average of just one transmission per 19 clients served must be averted; in order for housing services to be cost-effective only one transmission per 69 clients must be prevented (Holtgrave et al., 2007). If, as seems likely, the study findings show that stable housing results in positive mental and physical outcomes at costs in line with other well-accepted interventions such as kidney dialysis and screening tests, it will provide policy makers with new evidence to support public investments in housing.

ISN'T HEALTH CARE MORE IMPORTANT THAN HOUSING FOR PLWHA?

- Research shows that housing plays a critical role in effective systems of HIV/AIDS prevention and health care.
- Housing and health care should not be viewed as competing priorities.
- What's needed is a more progressive and comprehensive definition of health care.

Research has demonstrated the critical role of housing assistance to effective HIV prevention and health care. Housing status is one of the strongest predictors of HIV treatment success; lack of housing is a barrier to entry into care and receipt of anti-retroviral therapy, and receipt of housing assistance is associated over time with improved health care access and outcomes. (Aidala, et al., 2007; Kidder, et al., in press). Yet, housing assistance is viewed as a public welfare function, not a health measure, and separate public payors for housing and health care impede the development of comprehensive, cost-effective systems of care. At worst, housing is viewed as a competing need, fueling attempts to redirect existing housing resources to cover the costs of medications or health care delivery.

To move policy forward we must provide key decision makers across systems of care the data they need to understand that housing assistance supports HIV prevention interventions and systems of care, that homelessness is both a cause and an effect of the continued spread of the HIV epidemic, and that HIV treatments will not be effective if housing is not included in their delivery. This approach will require a much more progressive and comprehensive definition of health care. The current paradigm pits medical care and pharmaceuticals against housing and support services in the distribution of resources. It is a fundamental error to think of these services as opposing priorities. The effective use of anti-retroviral therapies mandates an effective housing policy.

CAN'T PLWHA USE EXISTING LOW-INCOME HOUSING RESOURCES?

- In 2006, 17 million American households - 1 in 7 - were severely rent-burdened (paid more than 50% of income towards rent).
- In not one county in the U.S. can a full-time minimum wage worker afford a 2-bedroom apartment at HUD's Fair Market Rent.
- Yet, housing assistance is available to only 1 in 4 low-income households in need.
- National average rents for efficiency units are more than the entire monthly income of elderly and disabled persons who rely on SSI ($603 in most states).
- Meanwhile, funding for core federal housing programs is declining.

The unmet housing needs of low-income people living with HIV/AIDS are part of the larger and rapidly worsening national affordable housing crisis. In 2006, 17 million American households – one in seven – were severely rent burdened (spent more than half of their income for housing), an increase of 3.2 million households since 2001 (Harvard University Joint Center for Housing Studies, 2007). In not one county in the United States can a full-time minimum wage worker – even at the proposed new federal minimum wage of $7.25 – afford a one-bedroom apartment at the HUD determined Fair Market Rent (Pelletiere, et al., 2006). National average rents for both one-bedroom and efficiency units are more than the entire monthly income ($603 in most states) of elderly and disabled persons who rely solely on Supplemental Security Income (SSI) income (O'Hara, et al. , 2007). Yet, housing assistance is available to only one in four families in need (Rice & Sard, 2007). An estimated 750,000 persons are homeless in the United States each night, sleeping in shelters or on the streets, and a quarter of these persons can be considered chronically homeless, which, according to HUD's definition, means they are homeless for long periods or repeatedly, and have a disability such as HIV/AIDS (National Alliance to End Homelessness, 2007).

Compounding the national housing affordability problem is the lack of public funding for housing. In 2006, funding for HUD's affordable housing and community development programs was $3.3 billion (8%) below the 2004 level, adjusted for inflation (Rice & Sard, 2007). These cuts threaten the continuation and viability of the full range of core federal housing programs that serve low-income and disabled Americans (National Low Income Housing Coalition, 2007). For example, more than 150,000 Section 8 Housing Choice Vouchers have been lost over the past two years alone (Rice & Sard, 2007). HOPWA funding has remained essentially level even as more jurisdictions reach the thresholds of HIV/AIDS incidence to qualify for program formula grants. For fiscal year 2007 the program is funded at $286 million, which is $9 million less than HOPWA's highest appropriation in 2004, and far short of the estimated $3.6 billion needed to meet actual need in the 124 jurisdictions that will be eligible for funding in fiscal year 2008 (National AIDS Housing Coalition, 2007).

CAN PLWHA WITH CHRONIC SUBSTANCE USE PROBLEMS BE HOUSED?

- "Housing first" or "low-demand" housing models place persons with substance use and/or mental health issues directly into permanent housing without requiring sobriety.
- Growing evidence shows that these programs achieve housing and service use outcomes comparable to traditional abstinence-only supportive housing.
- Low-demand housing programs that enrolled "more challenging" consumers did not see worse housing outcomes, demonstrating that "housing readiness" is not a good predictor of outcomes.

In order to meet the housing needs of persons with HIV/AIDS, it is critical to employ housing models that are accessible to all homeless/unstably persons, including those who are actively using substances. Continued drug use is often a barrier to housing placement, and among former users relapse is often grounds for eviction. However, a growing body of evidence demonstrates that use-tolerant housing approaches achieve stability and service use outcomes comparable to more traditional abstinence-only housing models (Bendixen, 2006; Wilkins, 2006; Martinez & Burt, 2006). These approaches include: "housing first" models (placing persons directly from the streets into permanent housing without requiring them to demonstrate they are "housing-ready"); low-demand housing (making participation in services optional rather than a condition of housing); and use of a harm reduction approach (practical strategies designed to reduce the negative consequences of drug use by promoting first safer use, then managed use, and finally abstinence if people can do it) (Burt, 2004).

Even in the absence of sobriety requirements, supportive housing has been found to provide substantial housing stability and connection to care for clients with a diagnosis of substance use disorder (Rosenheck, et al., 2003; Shubert, 2006), with research showing in some cases that residents in low-demand housing models compared to those with sobriety and treatment requirements have better treatment outcomes without worsening symptoms of substance use or psychiatric disorder (Tsemberis, et al., 2004; Rosenheck, et al., 2003).

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