

Minnesota HIV Housing Coalition

HIV Housing Plan

August 2017

INTRODUCTION

Everyday sayings like “*there is no place like home*” express the importance of having a home – a place where people can feel safe and build a secure, healthy life. For many low-income individuals living with or at risk of HIV, it is almost impossible to find affordable and stable housing. The HIV Housing Plan identifies a range of housing and supportive service strategies for people living with HIV to be safely, permanently housed so they can access medical care and prevention services on a regular basis. Housing must be part of a comprehensive HIV care continuum that includes immediate access to a range of safe, affordable housing options throughout Minnesota that are adaptable to an individual’s changing health and age needs. The meaning of affordability varies by an individual’s circumstances, but everyone needs to be able to meet their basic needs such as food, medications, and transportation while maintaining their housing.

This plan lays out the following:

- Vision and Value statements that are the foundations of the plan
- A Statement of Need that provides a snapshot of the housing situation in Minnesota for people living with HIV (PLWH)
- Goals, Strategies, and Desired Outcomes that will ultimately describe the what and how of the plan to move toward the vision
- Milestones that identify the measurable events for each of the next three years
- Appendices that provide a summary of the data collected, ideas generated at the planning meeting, the planning process used, and a communication schedule.

This plan should be seen as the beginning point for continuing our work to build a comprehensive continuum of housing for people living with HIV by 2025. The goals and strategies speak to meeting the housing and service needs of all people living with HIV, with a priority of reaching traditionally underserved and low-income individuals and families living with HIV in Minnesota. Some strategies also address the housing needs of people at high risk of contracting HIV.

VISION

By 2025, all people living with HIV have access to permanent affordable housing that respects the life they want to live.

The vision for the HIV Housing Plan is built on evidence-based research that demonstrates housing stability is key to engaging and retaining persons with HIV in the care they need to stay healthy and prevent further transmission. The ability to meet the basic living needs such as safe, affordable, quality housing, food and transportation—is essential for any person with HIV to access and benefit from antiretroviral treatment. Research findings continually demonstrate strong links between housing status and the full range of HIV health outcomes including access to care and viral load suppression.

VALUES

- **Housing is Healthcare:** People living with HIV (PLWH) who have access to stable, affordable housing, are more likely to engage in their health care and to maintain adherence to medical treatment and to have undetectable viral loads.
- **Housing Options are Valuable:** PLWH should have an array of innovative housing and support service choices meeting the needs from youth to seniors so that they can live how they want and age in place.
- **Collaboration is Critical:** Public and private sector collaboration is necessary to provide for more flexibility in terms of regulations and funding to meet the individual housing and service needs of people living with HIV.
- **Housing and Services need to be Flexible and Fluid:** A person-centered approach provides for supportive services and housing which are available when and where they are needed.
- **Data is Vital:** Coordinated, accessible, and available cohesive, statewide data is necessary to inform funder and service provider decision-making and to demonstrate outcomes and impact.

STATEMENT OF NEED

The statement of need considers the HIV population in Minnesota and the need for and the supply of housing. An analysis of this data indicates that there is insufficient affordable housing to meet the needs of people living with HIV in Minnesota. *(See appendix C for additional details).*

HIV in Minnesota

In 2016 there were 8,554 persons living with HIV/AIDS in Minnesota. Disproportionately affected communities include the following:

- Men who have sex with men (MSM) continues to be the main risk factor for males of all ages.
- Three out of every five newly reported cases were among communities of color.
- Among transgender individuals, there was a slight decrease in new infections bringing the total of transgender individuals living with HIV to 69.
- The number of new cases (26) among injection drug users (IDU) indicates a trend of continued HIV infection among IDU in the state over the past two years. 22 of the IDU cases were among MSM/IDU.
- Regionally, there was a 41% increase in new HIV infections in Greater Minnesota, with 52 new cases in 2016.

The Need for Housing

Homelessness and unstable housing undermines HIV treatment, care and prevention. And for people living with HIV (PLWH) not having stable housing can be the difference between life and death – and is strongly linked to inadequate HIV health care, high viral loads and overall poor health. Achieving viral suppression requires collaboration across all levels of HIV care and treatment, and stable housing serves as the foundation for increasing access to and retention in HIV

treatment and quality care. By providing housing and wrap-around supportive services, we can help people living with HIV in Minnesota maintain their housing, access and remain in care, and adhere to complex treatment regimes, which results in reduced use of emergency care and hospital services and new infections.

Housing Status Data

Historically, Minnesota has not tracked housing status for people living with HIV. As a result, housing status data available to us at the time of this report is limited, most likely does not reflect an accurate estimate of the current need for affordable housing and does not provide sufficient data to determine the housing needs for people living with HIV.

While homeless status and history is collected in the Homeless Management Information System used for federal and state homeless funding and programs, reporting HIV status is optional, and people may also opt out of sharing that data. Sensitivity to stigma, as well as HIPPA requirements, also impact decisions to share or collect data.

With that said, we have summarized several data points to help develop the scale of current need and profile of individuals in an unstable or temporary housing situation.

In 2016, of the 8,554 people living with HIV in Minnesota, 1,096 people were in need of safe, stable, affordable quality housing.

It is important to note, that the compiled HIV-specific housing data collected in 2016 only identifies Ryan White service recipients and does not include those who do not receive Ryan White services nor those who are positive but don't know their status.

The existing data demonstrates that those with the lowest income in our communities are most likely to be in a non-permanent housing situation. MSM represent the largest at risk group of individuals needing housing, and those who identify as Black experience higher rates of non-permanent housing than all other race groups.

Affordable Housing in Minnesota

In 2016, there was and continues to be a significant shortage of affordable housing in Minnesota, very low vacancy rates and increasing rents in many parts of the state. Over 50% of homeless adults are on a waiting list for subsidized housing, with an average wait time of around one year.

The Minnesota HIV Housing Coalition (MHHC) annually tracks available HIV-specific housing inventory. At the end of 2016, there were 341 units of HIV-specific housing, all of which were fully utilized. Several HIV housing providers maintain waiting lists with over 400 people waiting for permanent housing.

Overall, the Minnesota HIV Housing Coalition estimates that up to 1,500 people living with HIV are currently in need of permanent affordable housing in Minnesota.

STATEWIDE HIV HOUSING PLAN GOALS, STRATEGIES AND OUTCOMES

GOALS	STRATEGIES	2020 DESIRED OUTCOMES	MILESTONES TO ACHIEVE BY 2019
GOAL 1			
Increase the supply of safe and affordable quality housing units for all people living with HIV throughout Minnesota	1.1 Increase partnerships with housing providers across the state to set aside affordable, quality units for PLWH	5 new housing providers set aside up to 50 units of housing for PLWH with at least 1 provider in Greater MN	1.1.1 By 2018, develop an outreach plan and materials to educate building owners/landlords on HIV housing need and resources 1.1.2 By 2019, identify at least 5 new housing partners that are willing to set aside units specifically for PLWH
	1.2 Partner with policy makers to increase units for PLWH and people most at risk of HIV that allow for flexibility and ready access	State, county, and city programs and/or housing policies incent developers/building owners to increase affordable housing units across the state for PLWH and those most at risk for HIV	1.2.1 By 2018, establish partnerships with other public and private affordable housing agencies and/or advocacy organizations to create a policy agenda that increases the availability of quality HIV housing throughout MN 1.2.2 By 2019, launch 1 - 2 pilot programs/policies that create incentives for housing providers to set aside affordable units for PLWH (i.e tax incentives, mitigation funds, etc)
	1.3. Pilot and test new innovative housing models for PLWH	2-3 new innovative housing models have been identified and/or are operational in Minnesota	1.3.1 By 2018, identify at least 2 new, innovative HIV housing models for piloting in Minnesota 1.3.2 By 2019, identify partners and plan to implement at least one new housing model pilot
GOAL 2			
Ensure people living with HIV have access to the necessary support services to achieve long term stability in their preferred housing option	2.1 Create an HIV Housing Continuum so people living with HIV can access a range of support services to stay in their desired housing and maintain their health in both metro and rural areas	PLWH are able to access the services needed to age in place and remain in their desired living situation	2.1.1 By 2018, complete the design of an HIV Housing Continuum that demonstrates the long-term housing and support needs of PLWH as they age
	2.2 Ensure a range of support services including mental health and substance abuse services are available so people living with HIV can remain in their housing	PLWH have access to identified effective resources to address any barriers to maintaining their housing	2.2.1 By 2018, identify and increase the number of providers that can provide a range of home-based services meeting the complex health issues faced by PLWH, helping to maintain their housing and health 2.2.2 By 2018, identify and increase the number of mental health and substance use service providers to support PLWH who are housed but facing eviction or loss of housing because of mental health or substance use issues
	2.3 Partner with community providers who offer a range of services that provide access to resources and information/education which address barriers to maintaining preferred housing for PLWH	PLWH have access to the information and effective free or low cost services needed to maintain their preferred housing	2.3.1 By 2018, identify major barriers facing PLWH to maintaining preferred housing 2.3.2 By 2019, create educational programs and/or advocacy services that offer solutions and support to reducing the barriers PLWH face in securing and maintaining their housing

STATEWIDE HIV HOUSING PLAN GOALS, STRATEGIES AND OUTCOMES

GOALS	STRATEGIES	2020 DESIRED OUTCOMES	MILESTONES TO ACHIEVE BY 2019
GOAL 3			
Promote the availability of reliable and useful data to inform decision-making, strategy development, and program accountability for PLWH and in particular, for traditionally underserved groups	3.1 Develop common metrics with HIV housing providers and traditionally underserved communities which can be readily compiled and shared (both housing and health outcomes)	Create an HIV housing information system so that there is accurate and appropriate statewide information	3.1.1 By 2019, establish a common HIV housing metrics and begin collecting data to establish need and current housing inventory
	3.2 Develop systems which can share data, including having reliable common sources for housing need	Establish a centralized HIV housing waiting list system	3.2.1 By 2018, develop and implement a common source for HIV housing availability and waiting lists in coordination with Coordinated Entry or other appropriate entities
	3.3 Work with leaders of traditionally underserved communities to collect data that will identify unmet HIV housing needs and gaps	Collect data on the housing needs and gaps of traditionally underserved communities	3.3.1 By 2018, develop a plan with leaders of traditionally underserved communities to collect data that will identify unmet HIV housing needs and gaps
GOAL 4			
Build sustainable resources to create affordable housing units and supportive services for PLWH	4.1 Work in partnership with elected and appointed public officials, government staff, and advocacy organizations to identify and increase funding for the development of HIV-specific housing, rental assistance and support services	Ensure funding for HIV-specific housing and related supportive services	4.1.1 By 2018, establish case statement for HIV-specific housing and support service funding
			4.1.2 By 2018, establish white paper to pilot a new flexible pool of HIV funding that addresses rental assistance and supportive services for very low-income and homeless PLWH
		Pilot a new HIV Housing funding model based on the federal HOPWA program that provides flexible funding to address the housing, rental assistance and support service needs of very low-income and homeless PLWH	4.1.3 By 2018, begin conversations with policy makers and key government agencies to share information and build support for increased HIV Housing funding
			4.1.4 By 2019, introduce legislation for increased HIV Housing funding and/or piloting a new pool of flexible HIV Housing funding to support rental assistance and supportive services

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APPENDIX A

PLANNING PROCESS

The Planning Process was guided by a Planning Team of 3 HIV Housing Coalition members and was comprised of three major components:

- 1) Assessment and data gathering
- 2) Idea generation and plan development
- 3) Plan review and refinement

Planning Team:

Kim Lieberman, Minnesota AIDS Project
Mary McCarthy, Rural AIDS Action Network
Chuck Peterson, Clare Housing

Consulting Support:

Emil Angelica, Community Consulting Group
Linda Hoskins, Community Consulting Group

Assessment and Data Gathering

An initial phase of gathering information from HIV Housing Coalition members and other key informants/stakeholders, as well as from existing materials and reports to clarify the issues facing the organization

- Conducted phone interviews with 7 HIV Housing Coalition Members and 6 Key Informants or Stakeholders
- Conducted 4 focus groups with Ryan White program participants in Greater MN (19 consumers) and 1 in-person focus group with Case Managers in Ryan White funded agencies (6 case managers)
- Reviewed data from existing reports and data summaries

The information and data from all of these sources was compiled, analyzed, and summarized for presentation.

Idea Generation and Plan Development

HIV Housing Coalition members and others participated in a planning session where they reviewed the results of the assessment and data gathering, developed a common vision and drafted goals and strategies for the future of HIV Housing in Minnesota. Three follow-up planning meetings with the Planning Team resulted in a draft of the plan.

- Three meetings of the membership of the HIV Housing Coalition to develop and review the plan
- Two meetings or phone calls of Planning Group members with external experts to clarify data or strategies for the plan

Participants in development of the plan, or interviewed, included the following:

Participants

Alysen Nesse	Jake Maxon	Rachel Greenwald
Amy Moser	Jennifer Walker	Rod Hamilton
Bill Tiedemann	Jessica Hering	Sarah Wilcox
Branden Alkire	Kat Hill	Stephanie Zadora
Breanna Guernsey	Kathy Hermes	Suzanne Nash
Bryan Bick	Kelby Grovender	Tammy Wiger
Chuck Peterson	Ken Oltman	Teri Shuraleff
Cristina Klappa	Kim Lieberman	Val Smith
Ejay Jack	Kristen Hoyles	Vicki Farden
Erika Pieniniemi	Lauri Simons	Mikkel Beckmen
Erin Foss	Mady Ekue-Hettah	Jane Lawrenz
Gail Dorfman	Mary Dooher	Cathy ten Broeke
Gerri Mills	Mary McCarthy	
Gwen Velez	Michele Boyer	

Plan Review and Refinement

Participants reviewed the final plan one last time through a survey where they were asked to respond to each of the sections of the plan. The results of the survey influenced the final revisions of the plan completed by the Planning Team. The final version of the plan was brought to the August, 2017 meeting of the MHHC.

**MHHC
Strategic Planning Process
March 16, 2017 Meeting Summary**

Participants

Alysen Nesse
Amy Moser
Bill Tiedemann
Branden Alkire
Bryan Bick
Chuck Peterson
Cristina Klappa

Ejay Jack
Erika Pieniniemi
Erin Foss
Gerri Mills
Jake Maxon
Jessica Hering
Kim Lieberman

Kristen Hoyles
Mary McCarthy
Michele Boyer
Sarah Wilcox
Tammy Wiger

Welcome

Chuck Peterson welcomed participants to the meeting and gave a brief overview of the purpose and goals for the morning.

Introductions

Emil asked participants to stand in rows for a brief introductory exercise. The following are responses to the questions he asked participants to discuss and debrief:

- a. What do you think are the top 3 issues around housing in MN?**
 - i. More affordable units
 - ii. Safe, well-kept, desirable
 - iii. Access
 - iv. HIV and aging
- b. What are the greatest differences in housing needs between Greater MN and the Metro?**
 - i. More stigma and discrimination in Greater MN (It's hard to develop an HIV specific building because of the stigma)
 - ii. Access and transportation
 - iii. Diverse needs (Marshall is different from Duluth)
- c. What are some strategies you'd like to see the plan speak to?**
 - i. HIV housing subsidy unique to the person, that meets their needs for whatever they need
 - ii. Common metrics across the field and the ability to share data
 - iii. Housing dedicated to the people we serve
 - iv. Space for people to rest during the daytime – other space options
 - v. People who are at high risk of HIV and becoming stabilized around mental health and chemical dependency issues
 - vi. More resources for people in transitional housing
 - vii. Shared housing models – coop, communal living, etc.

Data Collection Summary

Emil presented the *attached* PowerPoint summary of data collected over the past two months from phone interviews, focus groups, and existing reports. The comments reflected the perspectives of people living with HIV in Greater MN, case managers both in

the metro and Greater MN, MHHC members, and key informants in State and National government agencies and nonprofit organizations as experts in housing for people living with HIV. The majority of the findings confirmed what MHHC members knew to be the overall trends, needs, and perspectives in the field of housing for people living with HIV.

Critical Issues

Emil asked participants to gather in small groups to brainstorm a list of critical issues. Each small group was to take their list of critical issues and prioritize them to the top 4. Once all the critical issues were listed, each participant was asked to vote for their top 3 issues. The issues in vote order are listed below:

1. How do we incentivize and educate landlords to have them consider opening access to housing people living with HIV (ex: lowering barriers) How can we encourage landlords to take housing assistance program funds? (Vote: 14)
2. How do we build a case to funders using the data on the cost benefit of housing people living with HIV, in order to increase the stock of affordable housing? (Vote: 9)
3. How can we better share data, waitlists, housing information to better serve people living with HIV with housing needs (collaborative with govt, nonprofits) (Vote: 8)
4. How can we identify and fund innovative housing ideas? What kind of housing solutions can be created to serve the HIV community? (Vote: 7)
5. How can definitions of homelessness and eligibility be broadened so that people don't slip through the cracks? (Vote: 4)
6. How do we keep individuality and flexibility in the funding of services and housing? (Vote: 3)
7. How do we make sure our programs are having an impact/how do we measure success? (Vote: 3)
8. How can we encourage other providers (ex: the Y) to have HIV housing specific carve out programs? (Vote: 3)
9. How do we define the HIV housing continuum? (Vote: 2)
10. How do we open communication between HIV specific housing providers and mainstream housing providers? (share information, openings, resources and contacts, etc.) (Vote: 2)
11. What are the appropriate housing and services for people aging with HIV? (Vote: 1)
12. What kind of services are needed so people leave our programs with fewer legal and housing barriers than they entered with? (Vote: 1)
13. How can housing access be simplified so that it is easier to understand and navigate? (Vote: 0)
14. Within a congregate setting, how do we provide the mental health and substance abuse services to keep people housed and independent? (Vote: 0)

Strategies

How do we incentivize and educate landlords to have them consider opening access to housing people living with HIV?

Why is this an issue now? There is a low vacancy rate; gentrification, and great stigma and stereotyping of those who receive housing supports

What are the desired outcomes?

1. Safe, affordable, accessible housing options (location, physical, access to transportation)
2. Sustainability – keep units long-term, add new units, promote long-term residency
3. Strengthen and improve relationships with landlords (trust is established, they call with openings, etc.)

What are the key strategies?

1. Mitigation fund for landlords and guarantee repairs for damage
2. Offer incentives to take 'high-risk' clients and tax credits for taking subsidies
3. Provide access to housing specialists and medical case managers
4. Educate clients on how to be a good renter and neighbor; budgeting, legal rights, etc.

What implications do the strategies have?

1. Retention of qualified staff
2. Ongoing staff training
3. Establish a dedicated landlord liaison to foster relationships and provide ongoing customer service to both clients and landlords

How can we better share data, waitlists, and housing information to better serve people living with HIV housing needs?

Why is this an issue now? Waiting lists are not accurate (people on more than one list = duplicates count); privacy issues make it difficult to share data, we are moving to a 'big-data' model now

What are the desired outcomes?

1. Data must answer why people are not getting access to housing
2. With better data sharing, we can leverage our resources
3. We don't want to duplicate efforts
4. We want to generate data that is persuasive

How can we identify and fund innovative housing ideas? What kind of housing solutions can be created to serve the HIV community?

Why is this an issue now? We know housing = healthcare = prevention

1. Conventional ways of housing people are maxed out
2. We need to leverage new funding and need flexible dollars for supports
3. Current housing models don't provide a lot of choices
4. The state is moving away from congregate setting models

What are the desired outcomes?

1. Having a continuum of housing options that meet individuals needs in metro and rural
2. Cluster a group of folks in larger settings to maximize services
3. Develop a catalog of innovative options to identify how to best serve people with HIV
4. Collaborate with other communities to provide co-housing or communal living

What are the key strategies?

1. Create a housing continuum
2. Partner with other movements or groups using/developing housing
3. New service models – how can we rethink services to better serve the people living with HIV

What implications do the strategies have?

1. Flexible dollars and agencies
2. New partnerships

Vision

Participants brainstormed and prioritized statements that laid out a vision for the future of housing in MN. Responses included:

- Homelessness will not be a barrier for PLWH to receive care
- Multiple innovative housing options for PLWH
- Funding world has become flexible and fluid to meet the multiple needs of clients
- People living with HIV have access to housing that respects the life they want to lead
- Flexible immediate housing is available for PLWH
- Data driven, coordinated decision making that can quantify social and economic impact
- Long term housing – people don't need to move based on the housing program they are in
- More available housing
- Funding based on individual needs vs what the program says people need
- Those at highest risk of HIV have access to housing for very low-income
- Housing is healthcare and is proven to create the path to end HIV
- Increased life expectancy for PLWHA
- Uninterrupted health care
- Low/no stigma for people with HIV/AIDS
- Low/no homeless PLWH
- Low/no new cases of HIV
- No spend down
- Viral load is suppressed, there are no new infections,
- PLWH stay in one location with stable housing and have more choice of housing options
- Normalization of HIV (educated, no stigma)
- More and more flexible funding
- Better cooperation/collaboration

Final Worksheet

Emil asked participants to complete a worksheet with: **2-3 ideas you heard today that stand out to you as the best strategies/actions that address one or more of the critical issues?**

Responses included:

- **Landlord education/incentives/mitigation fund/liaison**
 - Strategically work with private landlords to incentivize them to take low-income folks with barriers. Arrange a “friendly landlord list”
 - One of the things that stood out was the educating piece and incentivizing landlords to better serve our clients and landlords at the same time
 - Landlord liaison – manage relationships
 - Build a larger base of landlords to create access to subsidized programs
 - Client and landlord education
 - There should be more private landlords willing to accept HIV+ individuals with barriers to traditional housing (criminal history, negative rental history, etc.) and incentives for these landlords to take a risk on housing those individuals
 - Incentives for landlords: risk mitigation fund to cover potential damage by tenants, tax credits for taking subsidies/rental assistance
 - More collaboration with landlords to encourage them to accept rental assistance
 - Landlord engagement to create more options for housing
- **Create a housing continuum**
 - Develop an HIV housing continuum in context with the HIV Care and Prevention Continuum – use it to really ID the different levels of needed intervention, how many PLWHA are in each area of the continuum and then we can target innovative strategies to meet specific quantifiable needs
 - Innovative housing options that follow the continuum of care – housing that meets the client where they are medically
 - Develop continuum of housing options/new models/ co-housing/ set-aside units
 - Keep working on innovation (“catalog of continuum of housing options”) – current ASO’s working together on new collaborations to meet needs.
 - Finding alternative and innovative models of housing or ways to use funding that will better meet the wide variety of needs or barriers
 - There should be an HIV-specific “Section 8 type” housing subsidy
 - Alternative models from what exists now, but not replace what housing options we have now
- **Better data sharing**
 - Creating better data to describe housing supply and need – these data need to be common across all sectors
 - Data sharing – this must be figured out
 - Coordinated data to quantify and address the housing needs for PLWHA
 - Clear reasons/need for housing PLWH (public health, cost benefits, housed!)
 - Using better data to target better identified needs to various audiences
 - Collaborative data collection and sharing is essential in crafting an argument for why we need housing for PLWHA
 - Using existing data for why supportive housing works and is cost-effective
 - How to present data to different audiences

- **Fluid and flexible funding**
 - Funding innovative programs/ideas
 - Cost-benefit of housing PLWHA is known but needs to be presented to the 'right' people to achieve desired changes
 - Flexible funding/agencies
 - Increased flexibility of funding/programs to address the true needs of housing with PLWHA
 - Flexible funding to serve individuals
- **Broader collaboration**
 - Coordinate with other groups looking at housing options; innovative – community groups, aging groups, communities for a life time, or MH/CL housing conversations
 - Collaborate with big agencies that don't often focus on HIV/AIDS and start offering housing for only HIV positive families/individuals
 - Open collaborative across all community based services
 - Collaborate with other housing advocates and their programs to share resources and housing openings and ideas and strategies to obtain affordable housing
- **Other**
 - Day centers to help create sense of community/give people something to do during the day
 - Direct services for non-English speakers instead of having to use interpreter
 - Engage HIV population to ensure that services can be tailored to the specific needs of clients
 - The community needs to have a broader understanding of the HIV and aging population

Next Steps

- a. CCG will create a summary of this MHHC meeting
- b. CCG will draft a MHHC Housing Plan for MN; the MHHC will review and give feedback on the plan at the May meeting and approve the finalized plan in June, 2017.

APPENDIX B

DATA GATHERING

Greater Minnesota

The following is a compilation of the results of 4 Greater MN focus groups held in the Bemidji, Moorhead, Mankato, and St. Cloud areas. A total of 19 people participated in the focus groups.

1. What is your current housing status?

- 0 Homeless
- 3 Live in other people's homes/apts
- 6 Rent a home or apartment
- 9 Own a home
- 1 Other: transitional housing

2. What is your monthly household income/range?

- 2 \$0 to \$500
- 8 \$501 to \$1,000
- 5 \$1,001 to \$2,000
- 4 \$2,001 and above

3. What do you pay monthly for rent/mortgage alone (not including utilities)?

0	220	400	900
0	221	450	939
178	236	450	1295
185	268	500	
200	320	750	

4. Does paying rent/mortgage keep you from paying for (check all that apply):

- 10 Food
- 1 Medications
- 12 Utilities
- 6 Other: a car, transportation, women's items, I have just relocated to a senior residence and they cut all my food stamps to \$16 and no more allowances; it's hard to get by without storage

5. Where is your preferred place to live in Minnesota? (please check one)

- 15 Rural
- 7 Urban
- 3 Suburban

6. What kind of housing situation would you like?

- 19 Independent
- 0 Congregate (facility living)
- 0 HIV Specific (ex: Clare Housing, Hope House)
- 2 Other: would like a house to share; without bed bugs

7. Other ideas you want the MHHC to consider in the MN HIV Housing Plan? (Record here)

- Need drug free, family housing with kids allowed
- Pay a month's rent for me

2016 Ryan White CAREWare data:

(specific to Rural AIDS Action Network)

Total clients served – 324

Gender

Male – 225

Female – 94

Transgender – 5

Race

White – 189

Black – 76

More than 1 race – 10

Unknown – 2

Asian – 3

Hispanic – 29

American Indian/Alaska Native – 15

Age

Under 19 – 4

20 to 29 – 36

30 to 39 – 58

40 to 49 – 86

50 to 59 – 99

Over 60 – 41

Monthly Household Income Range (does not include family size or relevant FPG)

\$0 - \$500 – 65

\$501 to \$1,000 – 80

\$1,001 to \$2,000 – 97

\$2,001 and above – 82

Housing Status (numbers may not tie to those MCM clients as we also include those who are case managed elsewhere who have supportive services only)

Stable/Permanent – 264

Temporary – 25

Unstable – 11

No answer – 5

Case Manager Input

Draft Summary of Themes by Question

Participants: case managers represented Rural AIDS Action Network, Hennepin County Medical Center: Positive Care Clinic, Salvation Army, African American AIDS Task Force, and Minnesota AIDS Project.

1. What is keeping people living with HIV from getting housing? The main barriers?

- a. No income
- b. Not qualifying (ex: not long term homeless)
- c. Availability and location of housing
- d. Stigma
- e. Criminal and rental background
- f. Chemical Dependency or Mental Health challenges
- g. GRH – hard to get clients to commit to the program
- h. Understanding the process and system and literacy – applications, meeting the landlords, everybody has different requirements, asking too many questions
- i. Not being able to reach the client if a space opens
- j. Other priorities (ex: kids have appointments, other important activities)

2. What kind of housing do most people living with HIV want? Described as:

- a. Affordable for low income, vouchers
- b. Well maintained
- c. Safe and secure
- d. Not HIV specific
- e. Convenient in location
- f. Available when needed
- g. Some like supportive services and some don't (often part of the criteria)
- h. Portable
- i. Not institutional and not isolated

3. What might help people living with HIV to get the kind of housing that they want?

- a. * Better sources of income
- b. * Get on waiting list before you're homeless (can't qualify until actually homeless – need to be proactive for housing crisis) (vote: 7)
- c. * Variety in types of housing and how funding is used (Vote: 5)
- d. Allow case manager input when people are applying for housing – vouching for people if possible; case managers know who will keep their housing (vote: 1)
- e. Housing security – ability to know that my rent won't keep going up, I can live successfully under the rules (vote: 0)
- f. Have a consolidated accessible list (like coordinated entry list) would also help new case managers (vote: 1)
- g. Do something about key housing barriers (vote: 1)

* Voted as a priority strategy

4. What kinds of support services would be most helpful to people living with HIV?

- a. Life skills or housing coach, classes or services (financial literacy, how to pay rent on time, how to cook for yourself, how to set up a bank account, build rental history, etc.)
- b. Supportive services feeling supportive – some are so restrictive
- c. Creating a sense of community – being good neighbors and feeling like you belong
- d. Retrain staff to value people they work with
- e. Have access to mental health professional to maintain stable mental health and make informed choices

Key points in Interviews with National informants at the Office of HIV/AIDS Housing at HUD and National AIDS Housing Coalition

Overall

- Generally across the country, there is a crisis of affordable housing and that particularly affects people of low income and those who need access to health care services such as people living with HIV
- We need an array of housing options (permanent all the way to short term rental assistance), make sure we have a continuum.
- HIV is different from other chronic illnesses in that housing is a structural intervention; if people are stably housed, more likely engaged in medical care, less risky behaviors,
- Housing models: it really depends on the community and the individuals; a mixed model is probably better in all situations, not just HIV, but it's hard to say one is better than the other since some individuals find a community within the segregated housing.

What is important to include in this Housing Plan for MN?

- Accessible housing (not just for physical disabilities) must be connected to community resources, employment, and family. Often affordable housing gets pushed into communities where there aren't those resources.
- The strategies in the plan most show integration with housing and other resources
 - What are the strategies to connect the important segments or communities
 - Insurance community - understand that housing is a direct benefit to them through better health outcomes and fewer trips to the ER
 - Medical community for better health care
 - Families; churches, etc.
 - how it is connected to the homeless and what are the avenues that will connect these other systems
- Also note that HOPWA has highlighted employment services in the "Getting to Work" initiative. Many HIV/AIDS housing and service providers are increasingly recognizing that employment is a key component of serving the whole person.
- Housing providers with the ability to track, evaluate, and demonstrate improvement in HIV-related outcomes (including improved viral loads) for assisted households will be in the strongest position to participate in community planning for integrated HIV care systems and to advocate and apply for continued and expanded housing resources.
- Communities cannot rely on HOPWA funds alone to address their HIV housing needs. Local providers are encouraged to work across systems to coordinate service provision and to leverage necessary services to provide ongoing housing stability for PLWHA in their local communities. This includes other HUD programs, as well as exploring partnerships with Ryan White, private or foundation resources, and the medical/insurance community.

Hennepin County HIV Strategy: Positively Hennepin Listening Sessions Summary – July 1, 2015

INTRODUCTION

Community Consulting Group conducted 10 listening sessions involving nearly 100 people living with HIV, 45% were people of color. Listening Session participants brought their experience and that of other people to discussing how to get and keep people with HIV in their community in medical care. The following summary highlights themes or common answers we heard from multiple sessions on housing and related concerns.

Why don't people get tested, stay in medical care, or take their meds?

- Don't want to disclose
- Stigma/shame/embarrassment
- Lack of housing, food, refrigeration
- Drug or alcohol addicted
- Lack of transportation
- Complications with other health conditions
- Financial concerns

What is most helpful to stay in medical care?

- Courteous, caring medical team (ex: doctors, receptionist, phlebotomist)
- Support group or system
- Case manager
- Housing and transportation
- Insurance and financial assistance with co-pays
- Help with depression and stress

What helps people to stay on meds?

- Being in stable housing with easily available food
- Financial assistance

What would be the biggest change to the system in Hennepin County?

- More people living with HIV speaking out and helping others
- More public discussion and accurate information – like ads on TV
- One stop shops – reduce redundancy and ensure medical team and support staff understand HIV issues
- Help communities organize to deal with HIV in their own community and reduce the associated fear and stigma

THEMES IN RESPONSES

Why don't people who are at risk of HIV, get tested for HIV, continue with their meds or doctor's appointments?

Lack of housing, food, refrigeration: *Sometimes you don't feel like cooking or you don't have food. You have to take the pills with food. Some pills require refrigeration.*

Stigma: *People are concerned about how others will respond; they are afraid their spouse or partner might leave them if they're positive; if people are in survival mode, they don't want to be seen taking or carrying meds*

Complications with other health conditions: *People need to get tested for other things too – colon cancer is also deadly*

Lack of transportation: *People can be homeless or the clinic is far away or the name on the nearest one is visible on the building and people might see me going in*

What is most helpful to keep people in medical care?

Courteous, caring medical team: *Courteousness of the workers is important and don't talk about patients with other people and be discriminatory; Docs should be compassionate*

Support group or system: *People need to talk to their friends and have support groups – GLBT, in schools, YMCA's, colleges, friends and relatives*

Case manager: *A good caseworker won't put you down and you can talk to them and they will help you deal with any programs; they know more about the system*

Housing and Transportation: *Clare Housing is a place off the street where I can tell people I'm positive and get support everything I need - there should be more like this*

Insurance and financial assistance with co-pays: *Knowing who will pay for this and will my insurance cover it is important*

Help with depression and stress: *Docs and nurses should be more aware of priorities like food and housing and they should be recommending programs that can help*

Youth – unique challenges

- **Social media:** *is the source of education/information – accurate or not; it's also a source bullying and stigma; it's the way youth communicate with others*
- **Limited life experience:** *some youth have to deal with adult problems such as homelessness and getting a job on top of dealing with HIV while they are young and inexperienced; often youth lack good role models, coaches, supports for how to live a healthy, secure life*
- **Education:** *People need more accurate information on health and sex. Some ways could be: advertising on the bus or at the mall, snapchat composite stories, or community centers/programs*

African Born (including Ethiopian, Somali, and Liberian)

- **Less emphasis on prevention:** *With regard to health care, the emphasis is on dealing with illness when it can no longer be ignored and not on prevention and maintaining health*
- **Confidentiality within the community:** *People are afraid being seen going to an HIV clinic; Translators have been known to tell community members about the results of someone's test*
- **Need for more education on basic health care, HIV, and other diseases:** *One program was very effective – it began by educating leaders in each community (imams, pastors, etc.) and then they educated community members and lead the way in accepting people with HIV*

MINNESOTA HIV HOUSING COALITION

March 16, 2017

Summary of Data Gathered through
Interviews and Focus Groups

Data Collection

Data collection activities included:

- National and local reports and data
- Interviews
 - MHHC Members (8),
 - Key Informants (5),
 - TC and Greater MN stakeholders (8)
- Focus Groups: Greater MN (4), Urban case managers (1)
- Worksheets completed by focus group participants (19)

Research Reports Summary

Affordability of Housing

- Significant shortage of affordable housing in MN
- The number of people are paying more than 30% of their income increased 69% in from 2000 to 2014
- Great lack of subsidized housing – 41% of homeless adults are on a waiting list with wait time of nearly a year

HIV Housing is Health Care

- Housing IS a health intervention: Findings show improved housing is associated with retention in care and viral suppression
- Up to 70% of all PLWHA experience housing instability in their lifetime

Common Themes – Interviews/FG

1. There is a great need for stable, affordable housing and quality housing is in short supply; no increase in the supply is projected for the future for PLWH
2. Good, stable housing enables PLWH to stay in health care
3. In most areas, waiting lists are closed and it is hard to use them as an indicator of need – not very accurate
4. Most people who are homeless are living with others or “couch hopping” vs “on the street”
5. PLWHs’ preference is to live as independently as possible
6. Biggest barriers are: supply, personal history (credit, rental, and criminal), funding, stigma, MH, CD
7. HIV is sometimes not included in the screenings/criteria in a housing search and if the person doesn’t disclose their status, HIV specific housing resources are not considered

Common Themes – Interviews/FG

1. The future for clustered or site-based/segregated housing is limited due to state and national policy, integration, cost/available funding, stigma, and consumer preference and choice
2. HIV housing and support services are very siloed and need to figure out how to put a whole package together working with outside providers
3. For the future, flexibility is the key to having different housing models and choices – both formal and informal arrangements
4. There are times when segregated housing can keep people from changing their behaviors because of negative influences and bad models

Important Comments – Interviews/FG

1. PLWH want to 'age in place' by accessing a portfolio of services when needed – “ebb and flow” support services need to include MH, CD, chronic diseases
2. We need to figure out how people can keep their housing if they go into a hospital or nursing home for longer than 60-90 days
3. A significant barrier is the broad perception that HIV is no different than any other chronic medical condition
4. On the other hand, for some communities stigma is very strong and people do not want to be viewed as living in HIV housing

Different Communities – Interviews

1. Solutions need to come from within the community versus being imposed on them from outside
2. Definitions of homelessness are different, narrow and can create barriers to accessing housing
3. Some people put a priority on living in preferred areas and having a drug free lifestyle, and may view current affordable, stable housing options as degrading
4. Need to have more housing and connected programs for GLBTQ 18-24 yr olds, single women with children, as well as families
5. For some individuals the greatest assistance would be to have legal support to address bad credit, housing and criminal histories, to give them a second chance

Importance of Housing – Listening Grps.

Context:

1. Lack of affordable, stable housing was identified as one of the primary reasons that people do not stay in medical care
2. For youth, any housing models should be mindful of issues around stigma and provide good role models/coaches for healthy lives
3. For African-born PLWH providers need to understand the importance of confidentiality and associated fear and stigma in the communities

Focus groups highlight Greater MN vs Metro Differences

1. Greater isolation – both physical and social
2. Greater need for reliable, low cost transportation
3. Rural respondents preferred living in a rural setting 2:1
4. The majority in rural settings prefer independent over congregate/HIV specific living
5. Some rural areas have more affordable housing or housing that accepts waivers but often have few amenities or supports close by

Case Managers Feedback

- Barriers from Case Manager perspective:
 - Clients need to understand the process and system and be literate
 - Not being able to reach the client if a space opens
- The priority strategies were:
 - Increasing income while maintaining benefits
 - Get on waiting list before you're homeless (can't qualify until homeless)
 - Variety in types of housing and how funding is used
- What supports are most helpful to PLWHA:
 - Life skills or Housing coach, classes or services
 - Supportive services feeling supportive and not so restrictive
 - Creating a sense of community (Retrain staff as well)
 - Access to mental health professionals

Ideas for Changes/Improvements

1. Centralized Outreach Centers (especially in Greater MN) that offer:
 - Housing coordinator
 - Assistance with paperwork/finances
 - Food bank and other dietary supports
2. Support to live independently – e.g. Aging in place, PCA's,
3. Network of welcoming churches
4. Increase the cultural sensitivity of all health care providers (those who don't provide HIV specialty services)

Ideas for Changes/Improvements

Housing and Supports Models

- Co-Housing/Communal living – Denmark & UK increasing life-style choice
- Multi-unit apartments that designate a few units for HIV along with supports
- Temporary mobile housing or stable, safe smaller housing
- HOPWA's "Getting to Work" initiative
- Live Out Loud program for 18-24 yr old young adults
- 'Master Leasing' idea

APPENDIX C

DATA SUMMARY

Statement of Need

HIV/AIDS 2016 Data

Minnesota has seen a total of **11,309** cases of HIV/AIDS since the Minnesota Department of Health (MDH) began tracking HIV/AIDS in 1982. Today, there are **8,554** persons living with HIV/AIDS in the state. Over the last 10 years, Minnesota has averaged approximately 300 new HIV infections each year. In 2016 MDH reported 290 new HIV cases, a 3% decrease from the previous year.

Some highlights of the 2016 surveillance data included:

- Among people living with HIV in Minnesota, communities of color and men who have sex with men continue to be overrepresented and have higher rates of HIV infection due to cultural barriers, socioeconomic conditions, and limited access to culturally specific healthcare.
- Men who have sex with men continues to be the main risk factor for males of all ages making up 63% of male HIV infections. Young males, 20 – 29 years old, accounted for 37% of new male cases in 2016.
- The number of cases among injection drug users (IDU) was similar to the previous year with 27 cases in 2016 compared to 26 cases in 2015, which indicates a troubling trend of continued HIV infection among IDU in the state over the past two years.
- More than half, three out of every five (59%) of newly reported cases were among communities of color.
 - Among females, about one of every two new cases were seen among black, African born women (49%) and one in every five infections were seen among African-American women (20%).
 - Among males, about one in every five new HIV infections were seen among African-American men (21%) and about one in every six were seen among black, African-born men (17%).
 - New infections among black, African-born men increased by 65% from the previous year with 38 cases in 2016, compared to 23 in 2015.
- Among transgender individuals, there was a slight decrease in new infections bringing the total of transgender individuals living with HIV to 69.
 - Among male to female there was a 23% increase in new cases with 44 cases in 2015 and 54 cases in 2016.
 - Among female to male there was an 87% increase in new cases with 8 cases in 2015 and 15 cases in 2016.
- Regionally, there was a 41% increase in new HIV infections in Greater Minnesota, with 52 cases in 2016 compared to 37 cases in 2015.
- There was a 37% decrease in deaths for all causes of people living with HIV/AIDS in Minnesota, with 67 deaths in 2016 compared to 106 deaths in 2015.

Why we need HIV Housing

Housing is crucial. Everyday sayings like “there is no place like home” express the importance of having a home – a place where people can feel safe and build a secure and healthy life.

Homelessness and unstable housing undermine HIV treatment, care and prevention. And for people living with HIV/AIDS (PLWHA) not having stable housing can be the difference between life and death – and is strongly linked to inadequate HIV health care, high viral loads and overall poor health.

We know from national research that PLWHA are more vulnerable to housing instability and risk of becoming homeless. In fact, 50% of PLWHA will have some form of a housing crisis in their lifetime (Aidala, et al. 2012). Findings from the 2011 Center for Disease Control and Prevention’s Medical Monitoring Project, indicated that among interviewed participants engaged in HIV care, 8 percent had been homeless and another 15% had housing challenges.

National research also consistently demonstrates that housing is a critical component of HIV care and prevention. It improves health outcomes of those living with HIV/AIDS and leads toward decreased new HIV infections in our community. For low-income and homeless individuals living with HIV/AIDS, housing assistance is among the strongest predictors of accessing HIV primary care, maintaining continuous care, and entry into HIV care among those outside or marginal to the health system (Aidala, et.al, 2007). And, homeless persons with HIV who received a housing placement were twice as likely to achieve viral suppression to a matched comparison group that remained homeless (Buchanan, et. al, 2009).

Currently in Minnesota, 62% of people living with HIV/AIDS are achieving viral load suppression as shown in Minnesota Departments of Health’s HIV Care Continuum. Achieving viral suppression requires collaboration across all levels of HIV care and treatment and stable housing serves as the foundation for increasing access to and retention in HIV treatment and quality care. By providing housing and wrap-around supportive services, we can help people living with HIV in Minnesota maintain their housing, access and remain in care, and adhere to complex treatment regimes, which results in reduced use of emergency care and hospital services and new infections.

Top Six Evidence-Based Reasons for HIV Housing

1. **Need:** Persons living with HIV/AIDS are significantly more vulnerable to becoming homeless during their lifetime.
2. **HIV Prevention:** Housing stabilization can lead to reduced risk behaviors and transmission.
3. **Improved treatment adherence and health:** Homeless persons living with HIV/AIDS provided HOPWA housing support demonstrated improved medication adherence and health outcomes.
4. **Reduction in HIV transmission:** Stably housed people living with HIV/AIDS demonstrated reduced viral loads resulting in significant reduction in HIV transmission.
5. **Cost savings:** Homeless or unstably housed persons living with HIV/AIDS are more frequent users of high-cost hospital-based emergency or inpatient services, shelters, and criminal justice systems.
6. **Discrimination and stigma:** HIV/AIDS-related stigma and discrimination add to barriers and disparities in access to appropriate housing and care along with adherence to HIV treatment.

Source: HOPWA 20: Housing Innovations in HIV Care

Housing Data

Historically, Minnesota has not tracked HIV housing status. As a result, housing status data available to us at the time of this report is limited and most likely does not reflect an accurate estimate of the current need for affordable housing within the HIV community. With that, we have summarized several data points to help develop the scale of current need and profile of individuals in an unstable or temporary housing situation.

CAREWare

As stated previously, at the end of 2016 there were 8,554 people living with HIV in Minnesota. We also know that of those individuals, 4,288 (50%) received Ryan White (RW) funded services in 2016. Demographic data on this sub-group of individuals is captured annually through CAREWare (CW), an HIV clinical and support service data program that RW funded grant recipients across the county use to report year-end client data and quality of care. CW represents the primary data source for this housing plan.

In reviewing Minnesota's CW data for 2016 we found that 1,096 (32% of RW clients that identified a housing status) indicated their housing situation was temporary or unstable. This represents a decrease from 2015 when 1,314 individuals (34%) indicated a temporary or unstable housing status.

However, when compared to the 2015 national Ryan White data, Minnesota's 2015 numbers were 56% higher than the 15% reported (10% reported a temporary housing status and 5% a unstable housing status).

Housing Status	2014	2015	2016
Stable/Permanent	3588	3292	2805
Temporary	335	607	678
Unstable	735	707	418
Total Clients that indicated a housing status	3874	3814	3475
Total Ryan White Clients Served	4130	4126	4288

Housing Status	2014	2015	2016
Stable/Permanent	93%	86%	81%
Temporary	9%	16%	20%
Unstable	19%	19%	12%
Total Clients Served That Had a Housing Status	3874	3814	3475

The demographics of those who indicated they were unstably housed in 2016 include:

Age

- Within each age group, the highest percentages of temporary or unstable housing were among those aged 40 – 49 (8.66%); 30 – 39 (8.43%); 50 – 59 (7.08%); 20 – 29 (5.15%) and 60+ (1.96%)

Gender

- Among males, 14.4 % (501) indicated a temporary housing status and 8.7% (302) indicated they were unstably housed.
- Among females 4.5% (158) indicated a temporary housing status and 3% (106) indicated they were unstably housed.
- Among transgender individuals, less than 1% (28) indicated they were not stably housed. Of note, of the 28, 27 represent MtF transgender individuals of which 18 indicated a temporary housing status and 9 were unstably housed.

Risk Factor

- Men who have Sex with Men (MSM) represented the largest group of individuals not stably housed – 14% (487). Of that group, 180 indicated they were unstably housed and 307 were in a temporary housing situation.
- MSM who are also Injection Drug Users (IDU) was the smallest group of individuals not stably housed – 1.35% (47), with 27 being temporarily housed and 20 unstably housed.
- 62 (1.78%) individuals who identified as an IDU indicated they were unstably housed, 35 indicated they were temporarily housed and 27 in unstable housing.
- 500 (14.39%) did not indicate a risk factor. Of this group, 309 indicated a temporary housing status and 191 indicated they were unstably housed.

Sexuality

- 534 (15.4%) individuals who identify as a MSM or a bisexual man indicated they were unstably housed; 334 indicated a temporary status and 200 indicated an unstable status.
- 450 (12.9%) individuals who identify as heterosexual men/women or bisexual women indicated they were unstably housed; 279 indicated a temporary housing status and 171 indicated an unstable housing status.

Race

- Among individuals who identify as black, 564 (16.23%) indicated they were in a temporary or unstable housing situation.
- Among individuals who identify as white, 418 (12.03%) indicated they were in a temporary or unstable housing situation.
- Among individuals who identify as Indian/Native American, 49 (1.41%) indicated they were in a temporary or unstable housing status.
- 62 individuals 1.7% identified as Asian, Pacific Islander, two or more races, other or unknown.

Income

- 811 (23.65%) of individuals indicated income below 100% of the Federal Poverty Level of \$11,880; of these individuals 40% (328) reported they had no income. Of these individuals, 488 (60%) indicated a temporary housing status, and 323 (40%) indicated an unstable housing status.
- 227 (6.53%) indicated they had incomes between 100% - 200% of the Federal Poverty Level (\$11,880 - \$16,020). Of that group, 73% indicated a temporary housing status.

Geographic Location

- Of the 1,096 individuals who indicated a housing status of temporary or unstable, 92% (1,014) were located in the Traditional Grant Area (TGA) for Minnesota which includes 13 counties (Anoka, Carver, Chisago, Dakota, Goodhue, Hennepin, Ramsey, Rice, Scott, Sherburne, St. Croix, Washington and Wright).
- Of this group, 67% (731) were located in Hennepin County and 17% (181) were located in Ramsey County.
- The remaining individuals (82) are in rural counties throughout Minnesota. 37 (45%) are located in Olmsted, St. Louis, Mower, Stearns and Rice Counties.

The housing data compiled from CW identifies that those with the lowest income in our communities or most likely to be in a non-permanent housing situation. MSM represent the largest risk group of individuals needing housing, and those who identify as Black experience higher rates of nonpermanent housing than all other race groups.

Current HIV-specific Housing Inventory in Minnesota

The Minnesota HIV Housing Coalition tracks HIV Housing inventory in Minnesota. In 2016, Minnesota had approximately 341 units of HIV-specific housing.

Facility	Address	Housing Type	# Units
Clare Housing Apartment Buildings (Clare Apartments, Clare Midtown, Clare Terrace)	Minneapolis	PSH	113
Clare Housing Adult Foster Care (Grace House, Damiano House, Agape Home, Agape Dos)	Minneapolis	AFC	16
Clare Housing Scattered Site Housing	Various Locations Metro Area	PSH	42
Ford House	Minneapolis	PSH	11
Hope House	Stillwater	AFC	4
Lydia Apartments	Minneapolis	PSH	6
MLK Court (YWCA of St. Paul)	St. Paul	PSH - Families	8
St. Christopher Place (Catholic. Charities)	St. Paul	PSH	5
The Salvation Army	Metro Area	PSH - Families	14+
Metropolitan Council HRA – Housing Assistance Program (THP)	Scattered Site:	PRA	52
Minnesota AIDS Project (MAP) - Transitional Housing Program (THP)	Metro Area	THP	70
Total (Including HAP & THP housing vouchers):			341

Current State of Affordable Housing in Minnesota

Gaps in Affordable Rental Housing

MHFA report: Statewide Analysis of Gaps in Affordable Rental Housing, March 2015

The key findings of Minnesota Housing's statewide gap analysis of affordable rental housing in 2015 are:

- There is a significant shortage of affordable housing in Minnesota. About 236,000 renter households with an income at or below 80% AMI are cost burdened (pay more than 30% of their income for housing costs) and need greater access to affordable housing.
- Households with income at or below 30% of AMI have the greatest need: 76.9% of households with an income at or below 30% of AMI are cost burdened. Households at this income level account for over half of the 236,000 low-income renters.
- There is a substantial shortage of units affordable for households with incomes at or below 30% of AMI. Minnesota has about 160,830 households with an income at or below 30% of AMI, but only 100,080 units that are affordable for them. However, 43.6% of these units are occupied by higher-income households.

Increase in Cost Burdened Households

MHFA report: 2016 Key Trends for Affordable Housing, April 2016

- The number of cost burdened Minnesota households increased 69%, from 350,000 in 2000 to 590,000 in 2014.
- The share of renters increased from 37% in 2000 to 48% in 2014.
- The highest percentages of lower-income households (annual income less than \$50,000) are generally in the metro area and surrounding communities, and the lowest percentages are generally in the western part of the state.

Insufficient Affordable Housing

MHFA Affordable Housing Plan 2017

- **Decrease in incomes:** After adjusting for inflation, median incomes have declined by **5.6 percent** since 2000.
- **Increase in housing costs:** Monthly housing costs have increased by **8.1 percent** since 2000. In just the last year, rents and home prices in the metro area increased by **5.3 percent**. Average monthly rents increased from \$1,018 to \$1,072, and median home prices climbed from \$229,000 to \$242,000.
- **Decrease in supply:** The rental vacancy rate is about **3 percent** around the state (5 percent reflects a balanced market).

Lack of Subsidized Housing

Wilder 2015 Homelessness in Minnesota, November 2016

"The 2015 study shows us that 41 percent of homeless adults are currently on a waiting list for subsidized housing, with an average wait time of nearly a year. An additional 14 percent report they are unable to get on a waiting list because those lists are closed. The private housing market is not well suited to serve those with the least income, especially when vacancy rates are low, as they are now. Consequently, most of the work of creating affordable housing falls to the nonprofit and government sectors. For those who need ongoing supportive services to stay in housing, new supportive housing developed as part of the regional and statewide plans for ending homelessness has been successful. However, the availability of supportive housing, as well as rental units for low-income people, does not meet the need."

Issues Unique to Greater Minnesota

- Seniors in rural areas tend to be more likely to age in place than their counterparts in urban and suburban settings.
- A number of cities around the state are finding their supplies of rental housing are not well-matched to the needs of students and households who have moved there to take jobs. As an example, prospective employees in Duluth report rents to be relatively high and vacancy rates for units in Mankato are less than 1%

Summary of Findings - Reports and Bibliography

GAPS IN AFFORDABLE RENTAL HOUSING

Excerpts from MHFA report: Statewide Analysis of Gaps in Affordable Rental Housing, March 2015, Planning, Research & Evaluation

The key findings of Minnesota Housing's statewide gap analysis of affordable rental housing in 2015 are:

- There is a significant shortage of affordable housing in Minnesota. About 236,000 renter households with an income at or below 80% of area median income (AMI) are cost burdened (pay more than 30% of their income for housing costs) and need greater access to affordable housing.
- Households with income at or below 30% of AMI have the greatest need: 76.9% of households with an income at or below 30% of AMI are cost burdened. Households at this income level account for over half of the 236,000 low-income renters.
- There is a substantial shortage of units affordable for households with incomes at or below 30% of AMI. Minnesota has about 160,830 households with an income at or below 30% of AMI, but only 100,080 units that are affordable for them. However, 43.6% of these units are occupied by higher-income households.

INCREASE IN COST BURDENED HOUSEHOLDS

Excerpts from MHFA report: 2016 Key Trends for Affordable Housing, April 2016

- The number of **cost burdened** Minnesota households **increased 69%**, from 350,000 in 2000 to 590,000 in 2014.
- The share of **renters increased** from 37% in 2000 to **48%** in 2014.
- The highest percentages of lower-income households (annual income less than \$50,000) are generally in the metro area and surrounding communities, and the lowest percentages are generally in the western part of the state.

INSUFFICIENT AFFORDABLE HOUSING

From MHFA report: Affordable Housing Plan 2017: Minnesota Needs More Affordable Housing

- **Decrease in incomes:** After adjusting for inflation, median incomes have declined by **5.6 percent** since 2000.
- **Increase in housing costs:** Monthly housing costs have increased by **8.1 percent** since 2000. In just the last year, rents and home prices in the metro area increased by **5.3 percent**. Average monthly rents increased from \$1,018 to \$1,072, and median home prices climbed from \$229,000 to \$242,000.
- **Decrease in supply:** **The limited supply of housing will continue to drive up housing costs.** The rental vacancy rate is about **3 percent** around the state (5 percent reflects a balanced market). The months' supply of homes for sale is **3.9 months**, well below the desired 5 month supply.

LACK OF SUFFICIENT SUBSIDIZED HOUSING

Excerpts from Wilder 2015 Homelessness in Minnesota November 2016: Finding affordable and accessible housing

The 2015 study shows us that 41 percent of homeless adults are currently on a waiting list for subsidized housing, with an average wait time of nearly a year. An additional 14 percent report they are unable to get on a waiting list because those lists are closed. The private housing market is not well suited to serve those with the least income, especially when vacancy rates are low, as they are now. Consequently, most of the work of creating affordable housing falls to the nonprofit and government sectors. For those who need ongoing supportive services to stay in housing, new supportive housing developed as part of the regional and statewide plans for ending homelessness has been successful. However, the availability of supportive housing, as well as rental units for low-income people, does not meet the need.

EXPERIENCING HOMELESSNESS

Excerpts from Wilder Research 2015 Homeless Study, Single Night Count, 2015. Data tables (<http://mnhomeless.org/minnesota-homeless-study/detailed-data.php>) provide detailed survey results for questions asked in face-to-face interviews with people experiencing homelessness who participated in the triennial Minnesota Homeless Study survey.

From the table “Physical and mental health”:

Question 162: “During the last 12 months, did you have any of the following illnesses, conditions, or problems - HIV or AIDS?”

- 70 people responded yes to HIV or AIDS
- Responses by shelter type: 22 men & 9 women in emergency shelters, 6 women in domestic violence shelters, 14 men & 7 women in transitional housing, 4 women in rapid re-housing, 6 men & 2 women in non-shelter locations.
- Responses by geographic comparison: 7 men & 16 women in Greater MN, 34 men & 12 women in Metro.

The statewide data tables are based on interviews with 1,502 men and 1,428 women in emergency shelters, domestic violence shelters, transitional housing programs, and a few Rapid Rehousing programs that continue to function as transitional housing sites. Another 1,112 interviews were conducted with adults in non-shelter locations. According to the interviews, the sample of adult respondents had a total of 1,837 children with them.

PLWH EXPERIENCING HOMELESSNESS: HMIS DATA 2014 - 2016

While homeless status and history is collected in the Homeless Management Information System (HMIS) used for federal and state homeless funding and programs, reporting HIV status is optional, and people may also opt out of sharing that data. Sensitivity to stigma, as well as HIPPA requirements also impact decisions to share or collect data. A summary of the Minnesota data revealed:

A total of 300 people living with HIV/AIDS were served between 2014 – 2016

- 198 in Permanent Supportive Housing
- 43 in Emergency Shelters
- 15 were reached via Street Outreach
- 14 received Supportive Services only (no housing)
- 12 received Homeless Prevention Services

- 10 in Rapid Re-Housing
- 5 in Transitional Housing

Of these individuals, 63% (188) were male, 34% (103) were female and 3% (8) were MTF Transgender. Of the 300 people served, 83 were served by an HIV-Specific Provider, and all received permanent supportive housing placements.

ISSUES UNIQUE TO GREATER MN

- Seniors in rural areas tend to be more likely to age in place than their counterparts in urban and suburban settings.
- A number of cities around the state are finding their supplies of rental housing are not well-matched to the needs of students and households who have moved there to take jobs. As an example, prospective employees in Duluth report rents to be relatively high and vacancy rates for units in Mankato are less than 1%
- The rental vacancy rate for the 60 Greater Minnesota communities that added more than 100 jobs in the last five years declined steadily from 2004 through 2015.

SYSTEMATIC STUDY OF HOUSING AS A DETERMINANT OF HEALTH FOR PLWH

Points below copied from slides of presentation: Housing and HIV/AIDS, David Holtgrave, PhD, Johns Hopkins Bloomberg School of Public Health (<https://careacttarget.org/sites/default/files/supporting-files/PlenaryWedHoltgrave.pdf>) (Summary of Aidala study) Housing as a Determinant of Health for People with HIV Results from a Systematic Review of Research 1996-2014 Angela A. Aidala, et al. Housing status, medical care, and health outcomes among people living with HIV/AIDS: A systematic review. American Journal of Public Health 2016;106(1):e1-e23

Summary

- Findings show homelessness/ unstable/ inadequate housing is consistently associated with worse engagement with HIV health care - poor retention in care, lack of ART uptake, lack of adherence to treatment
- Homelessness/unstable/inadequate housing associated with poor HIV clinical outcomes - failure to achieve viral suppression
- Homelessness/ unstable housing also associated with increased sex and drug risk behaviors
- Better/ Improved housing associated with retention in care, ART uptake, treatment success

Policy implications

- Housing status is strongly associated with HIV medical care and outcomes
- Homelessness/ unstable/ adequate housing can contribute to continued HIV transmission
- Housing is a promising structural intervention to stop the spread of HIV and improve the health of individuals and communities most affected by the epidemic
- Housing can be a cost savings/ cost effective prevention and treatment intervention

Health Care Outcomes

- 35 papers examined access to HIV medical care and medications, service utilization
- 33 (94%) found worse HIV medical care outcomes among those who were homeless/ unstable/ inadequately housed compared to PLWH 'better' housing
- 29 (83%) reported statistically significant differences comparing homeless/ unstable/ inadequate housed PLW and those with stable, appropriate housing

Adherence

- 30 papers examined housing status and adherence to ARV treatment regimens
- 28 (93%) found worse adherence among those who were homeless or unstably housed
- 24 (80%) reported statistically significant differences in adherence comparing homeless/ unstable PLW and those with stable housing

HIV Clinical Health Outcomes

- 27 papers looked at HIV-related health outcomes CD4 counts, viral load, opportunistic infections, mortality
- 24 (89%) found worse HIV-related health outcomes among those who were homeless or unstably housed
- 20 (74%) reported statistically significant differences comparing homeless/ unstable PLW and those with stable housing
- 5 of 8 mortality studies found housing status associated with HIV mortality risk - studies that assessed lifetime homelessness or poor housing at diagnosis less likely show association with mortality

ER visits / Hospital stays

- 13 papers examined housing status emergency room visits and/or hospital inpatient stays among PLWH
- 13/13 (100%) found higher rates of ER visit or inpatient stays among those who were homeless or unstably housed
- 12/13 (92%) reported statistically significant differences comparing homeless/ unstable PLW and those with stable housing
- ER/ Inpatient service utilization indicator of poor engagement with HIV primary care with implications for health of PLWH and health care cost savings

HIV Risk Behaviors

- 20 papers examined HIV sex and drug risk behaviors – needle using and sharing, unprotected sex, sex exchange etc.
- 100% found higher rates of risk behavior among those who were homeless or unstably housed
- 16 (80%) reported statistically significant differences comparing homeless/ unstably housed PLW and those with stable housing

Housing and the Treatment Cascade PLWH who are homeless or unstably housed:

- More likely to have a delay in entry into care
- Experience discontinuous care – lack of retention
- Not be receiving medical care that meets minimal clinical practice guidelines
- Less likely to be on ARVs or adherent to regimen
- Less likely achieve sustained viral suppression

HOUSING AND HEALTH OUTCOMES

Points below copied from slides of presentation: *Housing & Health: Integration for Improved Health*, Russell Bennett, CEO—Collaborative Solutions, Inc. (<https://careacttarget.org/sites/default/files/supporting-files/6726Pope.pdf>)

HIV and Homelessness

- Up to 70% of all people living with HIV/AIDS (PLWHA) experience homelessness or housing instability in their lifetime
- 3%-14% of all homeless persons are HIV+ (10x the rate in the general population)

Housing and Health

- Studies show that among persons at high risk for HIV infection due to injection drug use or risky sex, those without a stable home are more likely than others to become infected
- PLWHA who are homeless are less likely to
 - Report good or excellent health
 - Take HIV medication
 - Adhere
 - Have CD4 > 200
 - Have undetectable viral load

Housing IS an Intervention

- Housing improves access to care, maintenance of care, and health outcomes along the care continuum
- Stable, affordable housing is a strong predictor of well-being, employment, and education attainment
- National HIV/AIDS Strategy cites housing as a critical structural intervention necessary to HIV prevention and care

HOUSINGS IMPACT ON HEALTH OUTCOMES

Housing Instability:

1. Delayed diagnosis
2. Increased risk of acquiring and transmitting
3. Delayed entry into care
4. Delayed use of ART
5. Less likely to be virally suppressed

Housing Stability:

1. Reduced risky behaviors
2. Increased rates of care visits
3. More likely to return to care
4. More likely to receive ART
5. More likely to be virally suppressed
6. Reduced use of ER and public resource

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<https://careacttarget.org/library/ryan-white-2016-social-determinants-health-and-health-equity>

Addressing HIV Care and Housing Coordination Through Data Integration to Improve Health Outcomes along the HIV Care Continuum <https://blog.aids.gov/2017/01/hrsa-and-hud-launch-data-integration-pilot-to-improve-hiv-care-and-housing-coordination.html>

National Low Income Housing Coalition

The Gap: A Shortage of Affordable Homes <http://nlihc.org/research/gap-report>

HOPWA in Minnesota

Formula Funds: \$1,208,807

Granted Annually

Grantees/Administrators

- City of Minneapolis - \$1,055,095
- Minnesota Housing Finance Agency - \$153,722

Grants Awarded to:

- Minnesota AIDS Project – Transitional Housing (approximately 70 units of rental assistance)
- Metro Housing and Redevelopment Authority (approximately 40 units of permanent housing assistance)
- Short-term rent, mortgage and utility assistance payments to prevent homelessness; serves on average 150 households per year

Competitive Grant Funds: \$1,890,791 (three year grant total)

Funds granted are a three-year grant cycle

Funds awarded to two Minnesota organizations

- Clare Housing – Clare Apartments
 - \$420,906 (every three years)
 - Pays for supportive services and 24/7 front desk staff/security
 - HOPWA funds provide supports to all 32 units of Clare Apartments each year
- Clare Housing – Clare Midtown
 - \$986,114 (every three years)
 - Covers rental assistance for up to 18 units (resident pays 30% of income towards rent; HOPWA pays difference)
 - Pays for supportive services and 24/7 front desk staff/security for all 45 units
- Salvation Army – HOPE Harbor
 - \$483,771 (every three years)
 - Rental assistance for 10 units (resident pays 30% of income towards rent; HOPWA pays difference)
 - On site supportive services for 10 households

Summary

Minnesota receives approximately \$1,839,070 in HOPWA funds annually reaching on average 197 units of housing each year with rental supports, supportive services and case management.

APPENDIX D
Communication Plan
August 2017 – December 2017

AUDIENCE	TIMEFRAME	LEAD CONTACTS/PRESENTERS
Elected and appointed public officials and staff		
• Hennepin County	10.9.17	Chuck Peterson, Allen Henden
• City of Minneapolis	Fall 2017	Chuck Peterson and Alysén Nesse
• Rural Minnesota Legislative briefing(s)	Fall 2017	Mary McCarthy and Matt Toburen
• Twin Cities Legislative Briefing	Fall 2017	Chuck Peterson, Matt Toburen, Nancy Hylden
• Minnesota Housing Mary Tingerthall, MHFA Commissioner	September/October	Chuck Peterson, Kim Lieberman, and Mary McCarthy
• DHS – Home and Community Based Services/Disability Division	10.23.17	Chuck Peterson, Kim Lieberman, and Mary McCarthy
• MDH – STD/HIV/TB Section	10.23.17	Mary McCarthy, Kim Lieberman, and Chuck Peterson
• MN Council for HIV/AIDS Care and Prevention	September/October	Johnathan Hanft

Housing Groups and Networks		
• MN Office to Prevent and End Homelessness – Cathy ten Broeke	Fall 2017	Kim Lieberman, Mary McCarthy and Chuck Peterson
• MN Coalition for Homeless Annual Conference	9.26.17	Kim Lieberman and Michele Boyer
• MN CCD Housing Workgroup	9.14.17	Chuck Peterson
• Heading Home MN Funders Affinity Group	Fall 2017	Chuck Peterson and Jean Sazevich
• Homes for All	10.19.17	Chuck Peterson
Public – press releases, social media, websites etc		
• Press Release(s)	Fall	Chuck Peterson, Ginger Sisco, and Andy Birkey
• Housing Plan Website (post on MAP's housing advocacy page or create new page for the plan)	Fall	Kim Lieberman and Andy Birkey
• Draft an announcement/press release that MHHC members could distribute and/or post on their own websites	Fall	All