National Evaluation of the Housing Opportunities for Persons with AIDS Program (HOPWA)

Prepared for:

The Office of Policy Development and Research
Department of Housing and Urban Development

December, 2000

PREFACE

About 300,000 American men, women and children are currently diagnosed with AIDS and another half million live with HIV infection. Since the beginning of the epidemic in the early 1980s, 430,000 persons have died from the disease. There is no cure for AIDS, nor is there an HIV vaccine, but there are encouraging new drug treatments. Even so, many persons cannot afford these new drugs let alone safe and decent housing.

Housing is an issue that matters on a daily basis to thousands living with HIV/AIDS. Safe, decent and affordable housing can reduce the risk of homelessness that is too often associated with HIV/AIDS. HUD's Housing Opportunities for Persons with AIDS (HOPWA) grant program provides housing assistance and related supportive services for low-income persons living with HIV/AIDS and their families. This program allows communities to design long-term, comprehensive strategies that are specific to the needs of their community.

Enacted in 1992, HOPWA is the first housing program for persons and families with HIV/AIDS. It uses a formula, based on need, to allocated funds to over 100 formula grantees, comprising 67 metropolitan areas and 34 states. Each year, ten percent of HOPWA funds are set aside for a competition. Most of the competitive funds are awarded to Special Projects of National Significance. These projects serve as models due to their innovative nature or potential for replication. Grantees are encouraged to develop community-wide, comprehensive strategies and to form partnerships with area nonprofit organizations to create a spectrum of assistance for this vulnerable population.

HOPWA has helped thousands of Americans who face server challenges in meeting personal, medical and housing costs during their illness. Since the creation of the program in 1992, the Federal Government has appropriated over $1.5 billion for HOPWA. Using the Fiscal Year 1999 appropriation of $225 million, HOPWA grantees provided housing assistance to 51,875 persons, including family members who reside with the person living with HIV/AIDS.

This is the first national evaluation of the HOPWA program. It demonstrates the great need for HOPWA, especially among extremely low-income persons living with HIV/AIDS. This report describes the importance of HOPWA's flexibility in meeting a community's specific housing needs. It reports that HOPWA clients are very satisfied with the housing they are receiving. The report also shows that HOPWA is working in a coordinated effort with other Federal and local programs that can benefit persons and their families living with HIV/AIDS, including Ryan White and the Continuum of Care.

HOPWA has accomplished much success. Together, even more can be done to ensure that the national response to HIV/AIDS is ever vigilant and the housing needs of persons living with HIV/AIDS are appropriately addressed. HUD is pleased to make this evaluation report available to all who care about ensuring safe, decent, and affordable housing to persons living with HIV/AIDS and their families.

ACKNOWLEDGEMENTS

This evaluation was conducted primarily by Dave Pollack, Deborah Volk, Gregory Watson, Heather Gazan, Kristy Greenwalt, Jennifer Rindt and Dena Patterson. They were assisted by Ashley Lare, Liz Drapa, Amanda Warton and Katharine Gale. Overall project guidance was provided by Kate Boland. Artem Gonopolskiy and Odiere Etete assisted with statistical tabulations and design of graphic presentation. Cynthia Whitfield helped with production and editing of the report. We thank HumRRO for their work in disseminating and collecting the survey instruments and compiling the data. At HUD, we especially thank Marge Martin, the Government's Technical Representative, who helped shape this evaluation and guide us along the way to its completion. We also recognize the contributions of David Vos and David Harre from the Office of HIV/AIDS Housing. Their program expertise was critical to completing this report. Betsy Lieberman and Donald Chamberlain of AIDS Housing of Washington were excellent resources who shared their extensive knowledge of AIDS housing. In addition, we had an outstanding advisory board who provided critical insight and a link to the real world. Our appreciation goes to Reginna Quattrochi, Glenda Low, Donald Chamberlain and Leslie Leitch for their thoughtful comments and suggestions. We extend our gratitude to the staff at organizations we visited on the site visits of competitive grantees. They welcomed us and provided us with first hand experience into their daily operations. Finally, we recognize and thank all of the grantees, providers, and anonymous clients who took time out of their busy schedules to respond to the survey.

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I. EXECUTIVE SUMMARY

OVERVIEW OF THE HOPWA PROGRAM

The Housing Opportunities for Persons with AIDS (HOPWA) program provides housing assistance[1] and supportive services for low-income persons living with HIV/AIDS and their families. HOPWA housing assistance is designed to help these eligible persons retain, or gain access to, appropriate housing where they can maintain complex medication regimens and address HIV/AIDS related problems.

While providing housing assistance to many persons, the HOPWA program does not address the affordable housing needs of all persons living with HIV/AIDS. HUD estimated in 1999 that the HOPWA program was providing housing assistance to approximately 49,000 low-income persons living with HIV or AIDS[2]. This is approximately one-sixth of the estimated 311,701 persons living with AIDS in the United States as of June, 2000, as reported by the Centers for Disease Control and Prevention (CDC). The CDC also reported that as of the end of 1998, the estimated number of persons living with HIV or AIDS in the United States was between 800,000 and 900,000 persons.[3]

HOPWA grants provide assistance through: (1) formula allocations to eligible States and metropolitan areas; and (2) competitive selection of projects proposed by State and local governments, and nonprofit organizations. Ninety percent of HOPWA funds are allocated by formula, and 10 percent are awarded by competition. Most of the competitive funds are awarded to Special Projects of National Significance—projects that due to their innovative nature or potential for replication have the potential to serve as effective models in addressing the needs of eligible persons.

The grantee for an Eligible Metropolitan Statistical Area (EMSA) is the most populous city in that area. To be an EMSA, a metropolitan statistical area must have a population of at least 500,000 and more than 1,500 cumulative AIDS cases. To be an eligible State, a State must have more than 1,500 cumulative AIDS cases in those areas of the State outside of the EMSAs.

In Fiscal Year 2001, formula allocations were made to 105 formula grantees, including 71 EMSAs and 34 States. These grantees are encouraged by HUD to develop community-wide comprehensive strategies and to form partnerships with area nonprofit organizations to create a spectrum of assistance for this vulnerable population.

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[1] Throughout this report the term "housing assistance" is used in its broadest sense to include all forms of assistance that subsidize clients' housing expenses, including housing development/production projects that serve to indirectly subsidize housing expenses, and direct housing subsidy programs, such as tenant-based rental assistance.

[2] HUD, Office of HIV/AIDS Housing, *Performance Information on the Housing Opportunities for Persons with AIDS Program*, June 1999.

[3] U.S. Department of Health and Human Resources, CDC, *Morbidity and Mortality Weekly Report,* December 1, 2000.

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Since the program was first funded in 1992, the Federal Government has appropriated over $1.8 billion for HOPWA to support community efforts to create and operate HIV/AIDS housing initiatives. The appropriation for Fiscal Year 2001 is $258 million.

FOCUS OF THIS EVALUATION

To better understand the HOPWA program and its impacts, HUD contracted with ICF Consulting to conduct a national evaluation primarily to answer these major questions:

- How are the housing needs of persons living with HIV/AIDS being met through the HOPWA program, and what barriers might exist in addressing those needs?
- Is the HOPWA program well coordinated with other programs, including health care and supportive services within a community strategy for assisting persons living with HIV/AIDS, and how has coordination occurred?
- To what degree have Special Projects of National Significance accomplished their goals and used innovative ideas or techniques, and how applicable are those innovations to other programs?

To conduct the evaluation, ICF reviewed existing data sources, interviewed local program personnel and clients, and conducted three surveys. Two of the survey instruments—the Formula Grantee Questionnaire and the Housing Assistance Provider Questionnaire—were distributed to the universe of funding recipients. The third survey instrument, the Client Questionnaire, was used in anonymous phone interviews with 36 HOPWA clients.

SUMMARY OF MAJOR FINDINGS AND POLICY IMPLICATIONS

The information collected was analyzed, and the following findings resulted:

- The HOPWA program predominantly serves extremely low-income and very low-income persons living with HIV/AIDS, including many people with additional burdens.
- The HOPWA program's flexibility helps meet clients' housing needs and preferences.
- The HOPWA program appears to enhance clients' housing stability.
- Clients report a high level of satisfaction with the housing they are receiving.
- Most grantees and housing assistance providers report some degree of coordination with Ryan White CARE Act and Continuum of Care systems.
- Most HOPWA housing assistance providers develop local partnerships to make available a broad range of supportive services.
- On average, each dollar used for HOPWA housing assistance is being combined with a dollar for housing assistance from other government and private sources.

- ❐ Collaboration is a key component to successful project implementation.
- ❐ Special Projects of National Significance are providing effective models for replication.

These findings, as well as policy implications arising from them, are discussed below. The order in which the findings appear is not intended to imply a ranking of importance.

Finding: The HOPWA program predominantly serves extremely low-income and very low-income persons living with HIV/AIDS, including many people with additional burdens.

By statute, the HOPWA program is intended to serve low-income persons living with HIV/AIDS and their families whose household incomes are no greater than 80 percent of the area median income. HOPWA grantees and housing assistance providers can choose to serve persons whose incomes are in the upper range of income eligibility. However, they are overwhelmingly serving persons whose incomes are much lower. Fifty-four percent of the persons receiving assistance from the program have extremely low incomes (less than 30 percent of area median income) and another 27 percent have very low incomes (30-50 percent of area median income). Moreover, about a third of HOPWA grantees are targeting their programs to serve sub-populations within the overall population of low-income persons living with HIV/AIDS, including persons with mental illness, persons with chronic substance abuse problems, and homeless persons.

Policy Implications

The persons being served by the HOPWA program are among the poorest of the poor and can be expected to have the most acute housing needs. There are no indications that further targeting of the program is necessary.

The National Low Income Housing Coalition reports that in more than three quarters (76 percent) of U.S. counties, households earning 50 percent of median income could not afford the fair market rent for a two-bedroom unit.[4] The overwhelming majority of HOPWA-assisted households do not have incomes that reach even this income level.

The incomes of the population being served by the HOPWA program have implications for the costs of housing subsidies. Virtually all HOPWA clients need housing subsidies and, given the very minimal incomes of this population, these subsidies are often large. With housing markets getting tighter and affordable housing more scarce and expensive in communities with large numbers of persons living with HIV/AIDS, the number of households that can receive housing assistance with the same amount of funding is decreasing.

Reducing the level of housing subsidies to continue to serve the same number of households could adversely affect the ability of the HOPWA program to meet the needs of the eligible client population. Serving households with incomes in the higher ranges of eligibility would ignore the housing needs of the most needy. Concentrating HOPWA housing assistance only in neighborhoods with the lowest housing costs would ignore important factors beyond cost, such as the availability of health care and other

[4] National Low Income Housing Coalition, *"Out of Reach,"* September 1999. Available: www.nlihc.org.

supportive services, or the appropriateness of the neighborhood. It would be counterproductive, for example, to locate housing for a recovering substance abuser in an inexpensive neighborhood known for its heavy drug traffic.

As housing costs increase, the Executive Branch and Congress should consider further increases in the HOPWA appropriation to help ensure that the program can continue to appropriately serve at least the same absolute number of persons currently served. Additional funding should also be provided to assist the increasing number of persons who are living with HIV/AIDS and are eligible for HOPWA assistance.

Finding: The HOPWA program's flexibility helps meet clients' housing needs and preferences.

The HOPWA program provides for a broad variety of eligible housing and service activities. The flexibility that this breadth of eligible activities provides grantees allows them to decide the extent that HOPWA funds will be used for housing. During their most recently completed operating years, grantees spent an average of 68 percent of their HOPWA funds to provide housing assistance, including direct housing subsidies, housing development costs, and housing operating expenses. (They also spent an average of 22 percent for supportive services, seven percent for administration and three percent for other expenses.)

The program's flexibility also allows grantees to determine what types of housing assistance to offer to meet the clients' housing needs and preferences. HOPWA housing assistance is being provided primarily in the form of tenant-based rental assistance and short-term payments for rent, mortgage, and/or utilities. Forty-two percent of households receiving HOPWA housing assistance received tenant-based rental assistance and an additional 24 percent received short-term payments. Most of the remaining households received some form of facility-based housing.

Because the range of eligible activities is so broad, HOPWA activities, in many cases, complement activities of other programs developed locally and funded through other sources. This combination of resources is described in detail in Chapter V.

Policy Implications

The HOPWA program's diverse array of housing options allows State and local HOPWA programs to tailor housing assistance to meet the varied circumstances of persons living with HIV/AIDS. For example, both short-term payments for rent, mortgages or utilities, and tenant-based rental assistance can help persons living with HIV/AIDS remain in their current housing if their incomes decrease. Tenant-based rental assistance can also help persons living with HIV/AIDS who must move, or are homeless, afford the rental costs of their new housing units. A room in a community residence is often the most appropriate housing for clients needing the most intensive services, such as help managing daily life, nutritional services, and personal assistance/attendant care.

The high use of tenant-based rental assistance and short-term payments for rent, mortgage, and/or utilities probably reflects client preference, the relative simplicity of administering these types of assistance as compared with housing development, and the speed with which these types of assistance can be provided. The inherent flexibility within tenant-based rental assistance is another feature that makes it attractive. However, there may be other explanations as well for the high use of tenant-based rental assistance and short-term payments for rent, mortgage and/or utilities. Many HOPWA housing assistance providers are

agencies that identify their primary activities as case management and supportive services, and may have limited experience with housing alternatives. Some of these housing assistance providers may be reluctant or unprepared to undertake activities that would involve them in the complex and lengthy housing production process. Additional factors that may deter HOPWA providers from engaging in significant production efforts include prohibitively high construction or rehabilitation costs, difficulty in identifying suitable sites, and local regulatory barriers, such as exclusionary zoning policies.

HUD should conduct further research to assess the factors that contribute to the program's current emphasis on tenant-based rental assistance and short-term payments. In addition, HUD should examine the desirability of encouraging an expansion of production efforts (including significant rehabilitation activities) through HOPWA, while retaining the program's critical emphasis on local flexibility and the need to meet client needs and preferences.

Finding: The HOPWA program appears to enhance clients' housing stability.

Stable housing is critical to increasing the ability of clients to focus on maintaining good health and adhering to medication regimens. In examining housing stability, this study focused primarily on what happens to clients' housing situations when they leave the program.

Based on clients' housing situations when they leave the program, as reported by providers that responded to the Housing Assistance Provider Questionnaire, housing stability appears to have been enhanced by HOPWA assistance. Where information was available, it was clear that persons who had been receiving HOPWA assistance almost always remained housed after the assistance ended.

According to the survey responses, less than three percent of the persons who had been receiving HOPWA-funded *permanent* housing assistance, but then ceased receiving it, became homeless. Of those who ceased receiving this HOPWA assistance, approximately 23 percent were able to stay in the same housing either without a housing subsidy or with another non-HOPWA funded housing subsidy, and approximately 21 percent moved to other housing again either with a non-HOPWA funded subsidy or without a housing subsidy. About 6 percent moved to group facility, and almost 20 percent are reported to have died. Information was not reported on what happened to 18 percent of persons leaving permanent housing assistance.

For persons who had been receiving *temporary/transitional* housing assistance, survey responses showed that less than four percent became homeless upon leaving the program. The largest impact noted was that approximately 60 percent were able to move to other housing or to a group facility, as may be expected from the design of this type of housing as transitional support. Information was not available on the housing situations of 32 percent of the persons leaving temporary/transitional housing upon leaving the HOPWA program.

Another situation involving clients leaving the HOPWA program is associated with the statutory limitation on HOPWA-funded short-term payments for rent, mortgage, or utilities. Under the statute, such payments may not extend for more than 21 weeks in any 52-week period.[5] For clients who used their full 21 weeks of eligibility for short-term payments for rent, mortgage, or utilities, 44 percent were known to have

[5] 42 U.S.C. 12907

remained in their current housing using other public or private funds, and 18 percent were known to have had a household income increase that was enough to remain in their current housing. However, 13 percent could not remain in their current housing, and information was not available on the remaining clients (25 percent) who had used their full 21 weeks of eligibility for short-term payments.

Policy Implications

While HOPWA appears to enhance clients' housing stability, data weaknesses in the survey (i.e., the high rates of "Don't Know" responses) make it difficult to reach statistically valid conclusions on a program-wide basis. These data weaknesses might reflect the lack of resources to track persons who leave the program, or tracking difficulties arising from concerns about client confidentiality. Some clients will not volunteer information about their future plans when exiting the program. Weakness in outcome data is not a problem that is unique to the HOPWA program. Efforts are underway across the Federal Government to improve outcome measurement, including efforts at HUD and within the HOPWA program, but funding to track persons who cease receiving program assistance is not readily available. Moreover, funding alone will not address all data collection difficulties.

The success of these efforts will depend, at least in part, upon improved data collection systems and training at the provider level. As an incentive to improve these systems, the Executive Branch and Congress should consider alternative sources of funding specifically earmarked for improving data collection efforts in the program. Such alternative funding sources could include a modest increase in the statutory limit on administrative costs, possibly indicating that the increase is solely for improvements in data collection, with emphasis placed on measuring program benefits to clients.

HUD should conduct further research to (1) gather additional data on client housing stability, both while clients are being served by the program and when they leave the program; and (2) to determine the relative effects on housing stability of the various types of assistance provided by HOPWA.

Finding: Clients report a high level of satisfaction with the housing they are receiving.

The 36 clients interviewed by telephone report a high level of satisfaction with their HOPWA-assisted housing. This satisfaction was measured in terms of overall satisfaction, as well as in terms of housing stability, housing suitability, and quality of life as affected by the client's housing.

Clients report very high overall satisfaction with housing assistance they are receiving under the HOPWA program. Sixty percent of those surveyed responded that they were very satisfied and another 30 percent responded that they were satisfied.

When asked about housing stability, 80 percent of those clients who reported living in their own home or apartment, a group home, or an SRO said that their housing was "more stable" or "significantly more stable" now that they were receiving HOPWA assistance. Of those clients surveyed who reported living in a shelter, hotel/motel, or in a transitional housing program, 60 percent reported that their opportunities to obtain permanent, stable housing after they leave has significantly improved since receiving assistance.

When asked if their residences were adequate in terms of their physical needs, 91 percent of the clients interviewed responded affirmatively. Only nine percent found their units inadequate. Of the majority of the

clients interviewed who live with other people, two-thirds believe their residence has an adequate amount of room for their household needs. When asked, "Aside from the cost of your housing, what other factor is the most important to you about where you live or would like to live", almost half responded with "location/neighborhood." This response was the most frequent response by a factor of more than two to one.

Clients were also asked if their "quality of life" was better or worse on a range of issues, now that they were receiving HOPWA housing assistance. Included were such issues as "access to medical care" and "access to supportive services." The clients' responses indicate that they believe their quality of life has clearly improved under the HOPWA program.

Policy Implications

While this telephone survey provides some insight into clients' views of the program, this very small sample is not statistically valid. In addition, there are selection problems in that the clients are theoretically continuing to participate in the program because there is some advantage for them. Therefore, it would be inappropriate to draw policy implications from these responses.

Obtaining a statistically valid, representative sample of clients' views is difficult to achieve because of major concerns about client privacy. Understandably, housing assistance providers will not release the names, telephone numbers, or addresses of their clients. This telephone survey was possible because a sample of housing assistance providers agreed to provide a notice to their clients requesting that they call a toll-free number to be anonymously interviewed about the HOPWA program.

Similar research in the future should also include interviews with potential clients who decided not to participate in the HOPWA program to learn their reasons for declining. It should also include interviews of clients who left the program to determine what proportion of their departures, if any, were due to dissatisfaction with the assistance they received through the HOPWA program. People participating in a voluntary program are by definition a self-selected group, and that should be considered when weighing client, or potential client, perceptions of the program.

Finding: Most grantees and housing assistance providers report some degree of coordination with Ryan White CARE Act and Continuum of Care systems.

Grantees and providers coordinate with Ryan White CARE Act and Continuum of Care systems on two different levels. One type of coordination happens at the grantee level, where it is possible to coordinate funding priorities and high-level community-wide decisions. At the project level, housing assistance providers have the opportunity to coordinate service provisions and make sure clients are not slipping through cracks in the system.

At the project level, there is evidence of coordination. For example, 92 percent of providers reported that they worked to link clients to assistance provided under Ryan White CARE Act programs. In addition, nearly 70 percent of all housing assistance providers surveyed participate in Ryan White CARE Act planning councils or consortia. Coordination generally occurs through case management and client needs assessments, with 76 percent and 68 percent, respectively, coordinating these activities with Ryan White CARE Act providers.

At the grantee level it is less clear if any real integration is occurring with regard to joint program planning and joint fund allocation decisions. There is evidence of meetings and data sharing, for example, but this evidence is insufficient to conclude that these activities are having an appreciable impact. Data sharing appears to be the most common activity, with over 90 percent of grantees surveyed indicating that they share data with Ryan White CARE Act planning councils and consortia and nearly 75 percent indicating that they share data with Continuum of Care agencies.

Policy Implications

Real integration of programs occurs when the benefits of coordination clearly outweigh the obstacles, including limited time and the difficulty of overcoming inconsistent program requirements. Coordination occurs at the project level because it is most directly beneficial to program clients. At the grantee level, where coordination occurs in a more complex and formal process, it is a greater challenge. Participating in meetings and planning processes where groups share information and data is helpful only in that it educates the community. However, unless beneficial outcomes for clients result, these sessions are of little consequence. Helping communities create plans and agreements that are workable and provide direct benefits to clients calls for sharing best practices and offering technical assistance.

Finding: Most HOPWA housing assistance providers develop local partnerships to make available a broad range of supportive services.

Most providers develop local partnerships and use several sources of funding to provide a wide array of supportive services. This range of services helps clients continue to lead as independent a life as possible. Nearly 90 percent of providers report providing case management services, while approximately three-quarters provide mental health, alcohol and drug abuse, and/or nutritional services. Just over one-half of providers are making available employment assistance to clients.

To connect clients with needed services, more than 90 percent of HOPWA providers provide referrals to other supportive service providers, over 60 percent have formal memorandums of understanding or linkage agreements with other providers, and more than 55 percent attend community planning meetings.

The range of services accessed by clients appears to be related to the type of housing assistance being provided. Generally, the more dependent the living situation, the higher the level of services. For example, residents of group homes generally use the most supportive services, while clients receiving short-term payments for rent, mortgage or utilities generally use the least. This may imply that the prevalence of short-term payments as a type of HOPWA housing assistance is related to its low cost in terms of both housing expense and the relatively low level of associated supportive services.

Policy Implications

Caution must be exercised in stating that HOPWA funds should be maximized for housing, as this diminishes one of the program's most appreciated characteristics—its flexibility. The allocation of funding to particular activities should remain a local decision based on a community's analysis of gaps in housing and services. However, as rising housing costs continue to outpace HOPWA funding allocations, it is becoming increasingly important that providers maximize the use of HOPWA funds for housing assistance and link clients to supportive services funded by other resources whenever possible.

Employment assistance provides an example of reliance on other funding sources for supportive services. As highly active anti-retroviral therapy (HAART) is allowing many persons living with HIV/AIDS to regain their strength and remain healthier longer, many are finding that they wish to return to work, and employment assistance is becoming more important. The impact of this trend is noticeably evident as 50 percent of providers responding to the survey indicated that they offer employment assistance to clients. However, only a small proportion of these providers are using HOPWA funds to provide employment assistance. Even that level of reliance on HOPWA funds might be higher than necessary. There may be sufficient other resources available within a community (Department of Labor Workforce Investment Act funds, for example) so that no HOPWA dollars need be earmarked for this purpose.

Finding: On average, each dollar used for HOPWA housing assistance is being combined with a dollar for housing assistance from other government and private sources.

Most housing assistance supported with HOPWA funding is also being supported by other government and private sources. Funding sources other than HOPWA, on average, covered 52 percent of expenditures for housing assistance by providers responding to the Housing Assistance Provider Questionnaire. HOPWA housing assistance providers most often combine HOPWA with other funding for housing development projects and housing operating expenses, with the other funding providing, on average, 70 percent of housing development costs and approximately 58 percent of housing operating expenses.

Although providers are using many different sources of funds in combination with HOPWA for housing development efforts, most are using a very small percentage from each source. For example, HOME, a block grant program that allows State and local governments discretion to implement housing strategies, including assisting persons with special needs, is used by only 32 percent of providers and typically contributes only 11 percent of total development funding. As another example, Community Development Block Grant (CDBG) funds are only being used by 17 percent of providers and typically contribute only two percent of project total funding.

Policy Implications

Projects combining HOPWA and HOME or HOPWA and CDBG funds, for example, can help provide long-term affordable housing for persons living with HIV/AIDS. This is especially true for developing housing units, as these funding sources are large and are typically used for housing development projects. The fact that this linkage is only happening on a small scale and only by relatively few providers may suggest the need for more training and technical assistance on how HOME and CDBG can be used in AIDS housing development projects. Within most communities, however, HOME and CDBG have long-standing histories and established funding patterns, making it difficult to fit people living with HIV/AIDS into the equation. As a result, HUD should place more emphasis on ensuring that local Consolidated Plan processes are knowledgeable of, and take into account, the needs of persons living with HIV/AIDS and their families.

Finding: Collaboration is a key component to successful project implementation.

As indicated by site visits made to six communities awarded competitive HOPWA funds for Special Projects of National Significance (SPNS), regular collaboration and communication with partners and other local service providers is a key component to successful project implementation. Coordination not only

promotes a more efficient use of resources within a given community and prevents duplication of services, but it also allows clients to spend more time focusing on their health as opposed to patching together needed services from agencies located throughout the city. While coordination proved to be crucial in four of the applicants' success in achieving their program goals, a significant factor in the limited success of two other SPNS recipients in fully achieving their goals proved to be an insufficient level of agreement between the partnering agencies as they implemented their activities.

Staff of the agencies that were visited identified various challenges to successful collaboration. Collaborating can be particularly difficult when agencies have similar missions and compete for both clients and resources. Collaboration can also be difficult when case managers from different agencies serve the same client. The size of the community may have a large impact on a grantee's ability to deliver services effectively and efficiently. Where grantees were able to form well-functioning collaboratives, many have been in smaller communities with fewer service providers and a higher degree of specialization among those providers.

Policy Implications

Given the changes in the HIV/AIDS population (e.g., more women with children, more persons with substance issues, and more persons with mental health issues), a wide array of housing options and supportive services is required. Moreover, addressing the problems of HIV/AIDS clients often requires specialized expertise. Thus, it is increasingly critical that communities coordinate service delivery and bundle services to provide clients access to a broad range of services. However, interagency coordination can be extremely difficult particularly for service providers in large metropolitan areas that compete for both clients and resources. One option for circumventing territorial issues among service providers may be appointing an "umbrella" organization to provide ongoing technical assistance and support to the agencies implementing the program.

Finding: Special Projects of National Significance are providing effective models for replication.

Of the six grants reviewed on site, four were able to meet their stated program goals. These four appear to be replicable and should serve as effective models for other HOPWA providers. The two other programs had less success in carrying out their original project designs, largely because of administrative obstacles and difficulty collaborating with partners. Nonetheless, these programs provide lessons learned that should be shared with other HOPWA providers.

Policy Implications

While HUD provides examples of SPNS projects on its web site, these are presented as general project descriptions. When asked in the Housing Assistance Provider Questionnaire and during site visits to provide recommendations for strengthening the national HOPWA program, a number of providers stated that more technical assistance is needed, including, among other suggestions, the development of case studies with detailed descriptions of program design and implementation issues. HUD should consider augmenting its current, general project descriptions with that type of detailed case study, and/or other information that focuses on specific program design and implementation issues. In addition, HUD should pursue other innovative approaches to facilitate the replication of successful program models at the local level.

II. INTRODUCTION

THE AIDS EPIDEMIC

From 1984 through 1994 the number of deaths in the United States reported among persons with AIDS increased steadily. In 1994, approximately 50,000 persons with AIDS died. AIDS deaths fell significantly for the first time in 1996, decreasing to approximately 37,000, primarily due to advances in medical therapies. AIDS deaths have continued to decline since then, decreasing to approximately 16,000 in 1999. As of June 2000, a total of 438,795 persons with AIDS in the United States had died and 311,701 persons were living with AIDS.[1]

In addition to persons living with AIDS, there are many more people living with HIV. The Centers for Disease Control and Prevention (CDC) reported that as of the end of 1998, the total of the number of persons living with HIV plus the number of persons living with AIDS ranged from 800,000 to 900,000.[2] Among these persons, according to the report, approximately one third do not know they are infected with HIV. The report also indicates that CDC anticipates that 40,000 new cases of HIV infection will be reported each year.

Changes are occurring in the demographics of the HIV/AIDS population. The Commentary section of CDC's HIV/AIDS Surveillance Report of December 30, 1999, contains this description of changes in the epidemic:

> "During the 1990s the epidemic shifted steadily toward a growing proportion of AIDS cases in blacks and Hispanics and in women and toward a decreasing proportion in men who have sex with men, although this group remains the largest single exposure group. Black and Hispanics, among whom AIDS rates have been markedly higher than among whites, have been disproportionately affected since the early years of the epidemic. In absolute numbers, blacks have outnumbered whites in new AIDS diagnoses and deaths since 1996 and in the number of persons living with AIDS since 1998. The proportion of women with AIDS increased steadily, reaching 23 percent [of the AIDS population] in 1999, and the proportion infected heterosexually also increased, surpassing (in 1994) the proportion infected through injection drug use. Midway through the 1990s, effective therapies became available and their effects on decreases in AIDS incidence and in deaths were detected at the population level through surveillance as early as 1996. As deaths have decreased, AIDS prevalence has steadily increased year to year, a trend that will continue as long as the number of person with new AIDS diagnosis exceeds the number of person dying each year."

With this steady increase in the number of persons living with HIV/AIDS, and the lengthening of many of their lives as the result of highly active anti-retroviral therapy (HAART), the need for housing assistance and

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[1] U.S. Department of Health and Human Resources, CDC, *Morbidity and Mortality Weekly Report,* December 1, 2000.

[2] Ibid.

supportive service assistance has been increasing. Households are expending their financial resources on medical care and prescription drugs in order to maintain their health, but still need to be able to afford housing and other necessities.

CREATION OF HOPWA AS A RESPONSE

In the 1980's, the HIV/AIDS epidemic was devastating the gay male population in the United States. Tens of thousands of people with compromised immune systems were becoming disabled and dying. As their health deteriorated and their financial resources dwindled, the need for appropriate and affordable housing increased. As described in Financing AIDS Housing, the first response to this growing housing crisis was by persons who made minor modifications to existing houses or buildings to accommodate the needs of the people they were serving.[3] These housing projects often provided care to residents through the end of their lives and focused more on the psychological needs of those individuals and their families than on sophisticated medical interventions. If a program did not have the capacity or services to provide 24-hour care, typically the only alternative was to send people to a hospital.

During those years, communities did not have strategies for meeting the needs of persons living with HIV/AIDS, nor did they have a range of housing options to meet varying needs. Many of these small, grassroots projects lacked secure and sustained funding, and many of their founders were not particularly sophisticated as either housing developers or service providers for persons with HIV/AIDS. In general, they lacked sufficient capacity to address the worsening housing crisis among persons living with HIV/AIDS and their families.

In response to this situation, the U.S. Congress created the Housing Opportunities for Persons with AIDS (HOPWA) program as part of the National Affordable Housing Act of 1990. To ensure a source of reliable and sustainable funding, the program was designed to distribute 90 percent of each annual HOPWA appropriation to eligible States and localities as formula grants.[4] To provide flexibility to States and localities in meeting the varying needs of persons living with HIV/AIDS, the program allows a broad range of eligible activities. Eligible activities include many types of housing assistance, as well as housing information services, housing pre-development costs, and a full range of supportive services.

To help ensure the development of long-term strategies, eligible States and localities apply for their formula allocations as part of a Consolidated Plan submission to the U.S. Department of Housing and Urban Development (HUD). The Consolidated Plan serves as a single planning, strategy, application, and performance assessment document for four HUD formula grant programs (Community Development Block Grants, HOME Investment Partnership Program, Emergency Shelter Grants, and HOPWA).

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[3] AIDS Housing of Washington. *Financing AIDS Housing*. 1997.

[4] The remaining 10 percent is awarded through national competitions, primarily for Special Projects of National Significance—projects which, due to their innovative nature or potential for replication, have the potential to serve as effective models in addressing the needs of eligible persons.

IMPACT OF HOPWA ASSISTANCE

Based on a 1999 HUD report, HOPWA funds are providing some form of housing assistance to an estimated 49,000 persons per year.[5] But what has been the impact of the HOPWA program on the lives of persons living with HIV/AIDS and their families?

One way to determine the impact of the HOPWA program on the lives of the people being assisted is to ask them. The following vignettes briefly summarize how HOPWA has helped two program clients who volunteered to talk about their lives during site visits conducted as part of this evaluation.

- "Sarah" has AIDS and was experiencing repeated opportunistic infections. She was frequently hospitalized and became deeply depressed about her situation. She had a low-paying job, but due to her deteriorating health she had to stop working and was facing homelessness. Fortunately, she was referred to a group home, which receives part of its funding from the HOPWA program. The group home stabilized her housing situation, and her case manager helped her access mental health treatment and other supportive services. Over the course of a year, her health improved as she followed a regimen of medications supervised at the home. Eventually, she no longer needed the intense services available there and she wanted to live "like other people." Because her local program includes a rental assistance component as well as the group home, she was able to move to her own apartment, with the rent subsidized with HOPWA funds. She also has been able to return to work and pay a portion of her rent herself.

- At the time "Jim's" wife "Barbara" was diagnosed with AIDS, they were living a normal life with their three children. Barbara was able to care for the children almost until her death, and Jim continued working to support the family. Shortly after Barbara died, Jim was diagnosed with AIDS. Because of the time needed to care for his children, and because of the side effects of the medication regimen he began, Jim had to stop working. Jim and his three children were living in substandard housing in an unsafe neighborhood. With no income, they were facing homelessness. With HOPWA tenant-based rental assistance, Jim was able to move his family into decent housing in a better neighborhood. Day care for his two youngest daughters is being paid with HOPWA funds. Jim is hoping to be able to return to work on a part-time basis, although this may be difficult because of the continuing side effects of his medications.

As these vignettes show, HOPWA can provide an important part of the safety net for low-income people confronting the physical, emotional, and financial impacts of the HIV/AIDS epidemic.

WHY HUD WANTED THIS EVALUATION

Although anecdotal evidence about the program can be useful, HUD wanted a systematic and comprehensive evaluation. In a broad sense, HUD's interest in this evaluation was motivated by a desire to answer the following questions:

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[5] HUD, Office of HIV/AIDS Housing, *Performance Information on the Housing Opportunities for Persons with AIDS Program,* June 1999.

- How are the housing needs of persons living with HIV/AIDS being met through the HOPWA program, and what barriers might exist in addressing those needs?
- Is the HOPWA program well coordinated with other programs, including health care and supportive services within a community strategy for assisting persons with HIV/AIDS, and how has coordination occurred?
- To what degree have Special Projects of National Significance accomplished their goals and used innovative ideas or techniques, and how applicable are those innovations to other programs?

More specifically, HUD wanted better information on client outcomes, especially how HOPWA is affecting clients' ability to retain or obtain stable housing. HUD also wanted more complete information on the types of programs funded and how they are operating, the characteristics of grantees, project sponsors, and clients, and the extent to which HOPWA is integrated with other programs in the context of local planning and implementation.

DESCRIPTION OF THE HOPWA PROGRAM

The Housing Opportunities for Persons with AIDS (HOPWA) program is the Federal Government's primary targeted response to the pressing housing needs of persons living with HIV/AIDS and their families. The program, which is administered by the U.S. Department of Housing and Urban Development's Office of HIV/AIDS Housing, is authorized by statute "to provide States and localities with the resources and incentive to devise long-term, comprehensive strategies for meeting the housing needs of persons with acquired immunodeficiency syndrome and families of such persons."[6] In general, HOPWA funds are used to help maintain persons in their own homes, to help individuals who are homeless find and access affordable housing, and to offer those with additional needs access to higher levels of support or care.

Ninety percent of HOPWA funds are allocated by formula to eligible communities, while the remaining 10 percent is awarded by competition to State and local governments and nonprofit organizations. The Federal Government has appropriated nearly $1.8 billion to support community efforts to create and operate HIV/AIDS housing initiatives since the program's inception in 1992. The appropriation for Fiscal Year 2000 was $232 million and in Fiscal Year 2001 it is $258 million.

In allocating 90 percent of the annual HOPWA appropriation by formula to eligible communities, HUD uses statistics from the CDC. Seventy-five percent of the funds allocated under the formula are distributed to qualifying cities and eligible States, based on each Metropolitan Statistical Area's (MSA's) or State's proportionate share of the total number of AIDS cases in all eligible metropolitan statistical areas (EMSAs)

[6] HOPWA is authorized by the AIDS Housing Opportunity Act (42 U.S.C. 12901) as amended by the Housing and Community Development Act of 1992 (Pub. L. 102-550, approved October 28, 1992). The program is governed by the HOPWA Final Rule, 24 CFR Part 574, as amended, and the Consolidated Submissions for Community Planning and Development Programs, Final Rule, 24 CFR Part 91.

and States.[7] The remaining 25 percent is allocated among qualifying metropolitan areas that have a per capita incidence of AIDS that is higher than the average for all MSAs with populations exceeding 500,000.[8]

The recipient for the EMSA is the most populous city in that area, which is typically the first jurisdiction in the EMSA title. In Fiscal Year 2001, formula allocations were made to 105 formula grantees, including 71 EMSAs and 34 States.[9] The remaining 10 percent of funds are awarded on a competitive basis. Two types of projects may be funded by competitive awards:

- ❒ Special Projects of National Significance (SPNS), which, due to their innovative nature or potential for replication, are likely to serve as effective models in addressing the needs of eligible persons; and

- ❒ Long-term comprehensive strategies submitted by State and localities that do not qualify for formula grants.

While all States, units of government, and nonprofit organizations may apply for a SPNS grant, only those States and units of local government that do not qualify for formula allocations are eligible to apply for a competitive grant to fund other projects. Grants are awarded based on an application submitted in response to a Notice of Funding Availability (NOFA) published by HUD. The Department of Housing and Urban Development awarded a total of 173 competitive grants from 1992 through 2000, including 22 grants for the Multiple Diagnoses Initiative (MDI) in fiscal years 1996 and 1997.[10]

HOPWA funds, regardless of whether they are formula or competitive, may be used for a wide array of housing development, rental assistance, supportive service, and operating costs. Eligible activities include, but are not limited to, the following:

- ❒ Housing information services, including counseling and referral services to help eligible individuals locate, acquire, finance, and maintain housing;

- ❒ Acquisition, rehabilitation, conversion, lease, and repair of facilities;

- ❒ New construction of community residences and single room occupancy (SRO) units;

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[7] Eligible Metropolitan Statistical Areas (EMSAs) have a population of 500,000 and more than 1,500 cumulative AIDS cases. Eligible States have more than 1,500 cumulative AIDS cases in those areas of the State outside of the EMSAs.

[8] Each qualifying city's allocation reflects its EMSA's proportionate share of the high incidence factor among EMSA's with higher than average per capita incidence of AIDS. The high incidence factor is computed by multiplying the population of the metropolitan statistical area by the difference between its twelve-month-per-capita-incidence rate and the average rate for all metropolitan statistical areas with a population exceeding 500,000. The EMSA's proportionate share is determined by dividing its high incidence factor by the sum of the high incidence factors for all EMSA's with higher than average per capital incidence of AIDS. [24 CFR § 574.130(b)(2)]

[9] When this HOPWA evaluation was conducted in FY 2000, there were 101 formula grantees, including 67 EMSAs and 34 States.

[10] In 1996 and 1997, HUD and the U.S. Department of Health and Human Services (HHS) collaborated on the design and implementation of the HIV Multiple Diagnosis Initiative (MDI). This was a specialized outreach effort to persons living with HIV/AIDS who are also homeless, and who have chronic alcohol and/or other drug abuse issues and/or serious mental illness.

- Project- or tenant-based rental assistance, including assistance for shared housing arrangements;
- Short-term rent, mortgage, and utility payments to prevent the homelessness of the tenant or owner of a dwelling;
- Operating costs for housing, including maintenance, security, operation, insurance, utilities, furnishings, supplies, and other incidentals; and
- Supportive services (e.g., health care, mental health treatment, substance abuse treatment and counseling, nutritional services, and case management).

While grantees may impose stricter selection criteria, the only eligibility requirements for the program are that an individual has HIV/AIDS and has a low-income.[11] Family members of persons meeting these requirements are also eligible.[12]

GENERAL APPROACH TO THE EVALUATION

In June 1999, HUD contracted with ICF Consulting to conduct a national evaluation of the HOPWA program. A comprehensive list of research questions is located in Appendix 1.

To conduct the evaluation, ICF reviewed existing data sources, administered three questionnaires, conducted in-person interviews, and considered the opinions of HOPWA experts to help focus the data collection and to evaluate findings.

These multiple data sources were used to establish an understanding of the HOPWA program from different perspectives in an attempt to obtain the most accurate possible picture of the program. A discussion of the degree to which the perspectives overlap can be found in Appendix 2, Methodology.

Existing Data Sources

Annual Progress Reports (APRs) submitted by all HOPWA grantees to HUD are the primary source of existing data on the HOPWA program. These reports contain information on the following areas:

- Contact information for the grantee;

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[11] According to the AIDS Housing Opportunity Act (42 U.S.C. 12902), the term *low-income individual* means any individual or family whose income does not exceed 80 percent of the median income for the area, as determined by the Secretary of Housing and Urban Development, with adjustments for smaller and larger families, except that the Secretary may establish income ceilings higher or lower than 80 percent of the median income for the area if the Secretary finds that such variations are necessary because of prevailing levels of construction costs or unusually high or low family incomes.

[12] According to the Housing Opportunity for Persons with AIDS regulations (24 CFR § 574), *family* is defined as a household composed of two or more related persons. The term family also includes one or more eligible persons living with another person or persons who are determined to be important to their care or well being, and the surviving member or members of any family described in this definition who were living in a unit assisted under the HOPWA program with the person with AIDS at the time of his or her death.

- ❒ Overview of the past year's accomplishments;
- ❒ Demographic information on the clients who were assisted;
- ❒ Budget information; and
- ❒ Types of housing assistance and supportive services provided.

For this evaluation, ICF reviewed APR data from 1993 through 1999 collected by HUD's Office of HIV/AIDS Housing. In some cases, totals or averages from 1995 through 1999 are reported. In other cases a snapshot of 1999 is reported.

Questionnaires

ICF created three data collection instruments for this evaluation. They are the Formula Grantee Questionnaire, the Housing Assistance Provider Questionnaire, and the Client Questionnaire. A copy of each questionnaire is included in Appendix 3.

Formula Grantee Questionnaire. This questionnaire was sent to cities, counties, and States that received HOPWA formula grants in 1998 and 1999. Questionnaires were returned from 43 HOPWA formula grantees, representing approximately 43 percent of the formula grantees. Although there were not enough responses to establish a high statistical confidence level, the formula grantee sample is believed to be representative of the universe of formula grantees. Appendix 2, Methodology, includes some comparisons of characteristics of the sample with those of the universe. For example, approximately 66 percent of the universe of formula grantees are cities located in MSAs, and 65 percent of the grantees surveyed are cities located in MSAs.

Housing Assistance Provider Questionnaire. This questionnaire was sent to all organizations believed to provide HOPWA-funded housing assistance to HOPWA clients. Best efforts were made to identify as many potential housing assistance providers as possible. There are an estimated 700 housing assistance providers. Questionnaire results were received from 146 providers for this report, representing approximately 20 percent of the estimated universe. This is a confidence level of approximately 80 percent +/- 5 percent. A confidence level of 80 percent +/- 5 percent means that with 80 percent certainty the sample is within 5 percent of the universe of HOPWA housing assistance providers.

Client Questionnaire. This questionnaire was used in anonymous phone interviews with a very small sample of HOPWA clients to obtain their views on the assistance that they receive. HUD estimates that annually 49,000 persons living with HIV/AIDS receive some form of HOPWA housing assistance. ICF attempted to interview 50 HOPWA clients for this report, but received only 36 responses.

In-Person Interviews

To better understand the HOPWA program, ICF also conducted six site visits to locations that received Special Projects of National Significance (SPNS) grants in 1994 or 1995. These site visits were three days in length, and included in-person interviews with grantees, housing assistance providers, partnering service providers, and clients. The methodology that was used to select sites is included as Appendix 4.

Advisory Board

An Advisory Board, comprising seven individuals knowledgeable in HIV/AIDS housing and the HOPWA Program from across the country, provided critical assistance at several stages of the evaluation. Their major roles were providing advice on development of the three questionnaires and commenting on the draft report. More information about the Advisory Board is included in Appendix 2.

Data Limitations

As with any research project, a clear understanding of the potential limitations of the data sources is necessary. These limitations affect the types of analysis that can be performed, the degree of confidence that can be reported for the results, and the possible implications of the analysis. This section describes in general terms some of the issues to remember when examining the data used in this report.

As a general rule, "data is good, more data is better." The advantage of having as much data as possible is that there is close to complete coverage of all affected parties, so that adding another respondent may not make a difference. Ideally, with large amounts of data, the possible problems will be mitigated by the sheer amount of "good" data.

However, even with more data in hand, the data may still present some problems. Common data problems in this study include:

- Incomplete data because questionnaire respondents did not fully answer all questions or submitted incomplete information;
- Out-of-date data because some questionnaire respondents did not provide current data;
- Errors in reported data due to respondents having incorrectly answered questions;
- Small sample sizes due to small universes of potential respondents, and
- Errors in processing (although major efforts were undertaken to minimize errors).

By identifying these potential limitations in advance, the analysis can be conducted with these considerations in mind and can be used to potentially explain why different conclusions can be drawn from different data sources. It must be noted, however, that the low response rate for all Questionnaires administered for this evaluation – the Formula Grantee Questionnaire, the Housing Assistance Provider Questionnaire, and the Client Questionnaire – will have a significant impact on the results of the data analysis and the implications drawn from these results. Effort has been taken throughout this analysis to include references to the limitations in the data. The results and implications identified have been compared to results reported in the APR, read in the context of HUD's *Performance Information on the Housing Opportunities for Persons with AIDS Program, 1999;* and reviewed by the Advisory Board and HUD representatives who have the best understanding of the current workings of the program. The results reported in this evaluation should be used to provide information about the general workings of the program, possible trends in client satisfaction, and potential implications for future programming.

Improving the accuracy of the data for future reports requires a better understanding of the universe of both providers and clients and achieving higher questionnaire response rates. This would allow a better representation of the participants in the HOPWA program.

ORGANIZATION OF THE REPORT

The remainder of this report is organized into four chapters that present the research findings. There are also eight appendices. The four chapters and appendices include:

Chapter III. HOPWA Implementation. This chapter describes the characteristics of formula grantees, sub-grantees, housing assistance providers and the roles they play in implementing HOPWA programs. It also describes the extent to which HOPWA funds are used for housing, supportive services, and administrative expenses.

Chapter IV. Clients and Client Outcomes. Using data gathered in the Client and Housing Assistance Provider Questionnaires, this chapter provides an understanding of who HOPWA clients are, what types of assistance they are receiving, and what difference HOPWA makes in their lives. This chapter also presents client views on the performance of the program and its impact.

Chapter V. Integration of HOPWA with Other Programs. This chapter explores the extent to which HOPWA is integrated with other service and housing programs in a community. Funding coordination as well as service coordination are presented. Specific relationships with Ryan White CARE Act programs and Continuum of Care homeless assistance planning are discussed.

Chapter VI. Special Projects of National Significance. This chapter highlights six Special Projects of National Significance. Using information gathered during on-site visits, the programs' successes, lessons learned, and potential for replication are described.

Appendices

- Appendix 1: Comprehensive List of Research Questions
- Appendix 2: Methodology
- Appendix 3: Questionnaires
- Appendix 4: Site Visit Selection Process
- Appendix 5: Site Visit locations (Chart)
- Appendix 6: Site Visit Protocol and Discussion Guide
- Appendix 7: Grantee and Provider Views and Recommendations
- Appendix 8: Glossary of Terms

III. HOPWA IMPLEMENTATION

CHAPTER OVERVIEW

What Does this Chapter Present?

- ❒ The extent to which grantees use HOPWA dollars for housing, supportive services and administrative costs, and how they set priorities.
- ❒ The processes used by formula grantees to distribute funds, including direct fund allocation and sub-grantee fund allocation.
- ❒ The characteristics of formula grantees and sub-grantees.
- ❒ The criteria used to select individual projects for funding.
- ❒ The characteristics and activities of housing assistance providers.

Why is this Information Important?

- ❒ It places the discussions and findings in subsequent chapters within the context of how the HOPWA program operates at the local level.

INTRODUCTION

While all HOPWA grantees and housing assistance providers share a common goal of assisting individuals and families affected by HIV/AIDS, the manner in which this goal is accomplished varies from one community to the next. The HOPWA program acknowledges the unique and changing needs and circumstances of communities across the country and, as a result, provides grantees and providers with a significant amount of flexibility in the accomplishment of this goal. Understanding who the grantees, subgrantees, and providers are and how they make decisions about project funding is critical to understanding how the HOPWA program helps communities assist those individuals and families affected by HIV/AIDS.

This chapter describes the characteristics of formula grantees, subgrantees and housing assistance providers, and the roles they play in implementing local HOPWA programs. It also describes the processes used to allocate HOPWA funds and select activities for funding. Information presented in this chapter will help to place the discussions and findings in subsequent chapters within the larger context of HOPWA program operations at the local level.

Most HOPWA funds are allocated through a formula entitlement process to the most populous city in an eligible metropolitan statistical area (EMSA) and to eligible States. These "formula grantees" have the responsibility for determining the process and direction of funding for housing and services to help meet the needs of persons living with HIV/AIDS in the EMSA or State.

The formula grantee is the unit of local government or the State government. However, that government designates one of its agencies to be responsible for administering and overseeing the distribution of their annual HOPWA allocation. Based on the survey of formula grantees, approximately half (46.5 percent) of

formula grantee respondents identified themselves as housing, community development, or economic development agencies. In addition, 23.3 percent of agencies identified themselves as health service agencies. Another 11.6 percent indicated they were human services or welfare agencies. The remaining 18.5 percent included grantees identifying themselves as an executive branch of government, grantees identifying themselves as a local government, and grantees who did not give an indication of their organization type.[1]

Grantees have several methods available for structuring the administration of HOPWA funds. They can:

- Administer housing and service programs themselves;
- Allocate all or a portion of the HOPWA money to private nonprofits, which are referred to as housing assistance providers in this report, to carry out a variety of programs;
- Allocate funds to sub-grantees, which are entities charged with administering HOPWA funding allocations to housing assistance providers on behalf of the grantee; or
- Employ a combination of these methods.

Ultimately, grantees are responsible for monitoring their sub-grantees and housing assistance providers and their own use of the HOPWA funds. However, these options allow grantees to use their discretion to disburse the HOPWA allocation within regulatory requirements.

HUD also provides the formula grantees with broad flexibility in determining what programs to fund and the amount of support to provide. Grantees are allowed to set their own rules and develop their own plans for meeting their community's specific needs. Grantees, providers and clients recognize this flexibility as an important strength of the program. Most grantees surveyed believe that HOPWA's regulatory structure allows for maximum local control and encourages community participation in decision making. For example, a central city grantee typically chooses to allocate funds to other governments in their EMSA because those governments are more knowledgeable about the needs of their citizens and are in closer contact with them.

Grantees, sub-grantees, and providers are encouraged to develop comprehensive housing strategies and form partnerships with other government agencies and nonprofit organizations to coordinate the provision of housing assistance and other services. This helps to ensure that there are sufficient services available to meet clients' needs. The range of services, in addition to the depth of the services provided, is a community-wide issue. Chapter V discusses coordination and presents findings on the benefits and challenges grantees and providers face as they work to meet the needs of persons living with HIV/AIDS in their communities.

[1] As defined in the Formula Grantee Questionnaire, "executive branch of government" included the government's office of management, chief executive officer, or chief elected official.

THE FUNDING PROCESS

The Formula

Formula grantees enter into their roles once their Metropolitan Statistical Area (MSA) or State is determined to be an eligible area. Eligibility is based on having at least 1,500 cumulative cases of AIDS as reported by the Centers for Disease Control and Prevention (CDC), a population of at least 500,000, and a HUD-approved Consolidated Plan. Once eligibility has been established, the formula grantee will receive an annual allocation based on the number of AIDS cases as reported to the CDC.

Fiscal Year 2001 HOPWA Funding Overview

For FY 2001, 105 formula grantees were allocated a total of $229.9 million. Seventy-one of these grantees were eligible metropolitan statistical areas while the remaining 34 grantees were States. Of the remaining HOPWA appropriation for FY 2001, $25.5 million is for projects awarded competitively (either new projects or renewal of existing projects) and $2.6 million may be used by HUD for training, oversight, and technical assistance activities. Funds are awarded competitively primarily for Special Projects of National Significance (SPNS), which, due to their innovative nature or potential for replication, are likely to serve as effective models in addressing the needs of eligible persons. Funds may also be awarded competitively for other projects submitted by State and localities that do not qualify for formula grants.

Priority Setting

As described above, grantees have flexibility in determining how funds are spent, including which issues or populations to target for assistance. The major restriction placed on the grantees by HUD is that HOPWA beneficiaries must qualify as "low income" (family income below 80 percent of the area median) and be HIV positive or have AIDS. Family members of persons living with HIV or AIDS are also eligible. Grantees can then add priorities or target assistance to sub-populations of eligible persons. Slightly more than a third of formula grantee surveyed report that they target sub-populations, usually clients with health concerns, including mental illness and substance abuse problems. Other target populations reported include homeless persons and persons released from correctional institutions. By targeting assistance, grantees can give priority to individuals or groups with the most pressing needs or with substantial unmet needs.

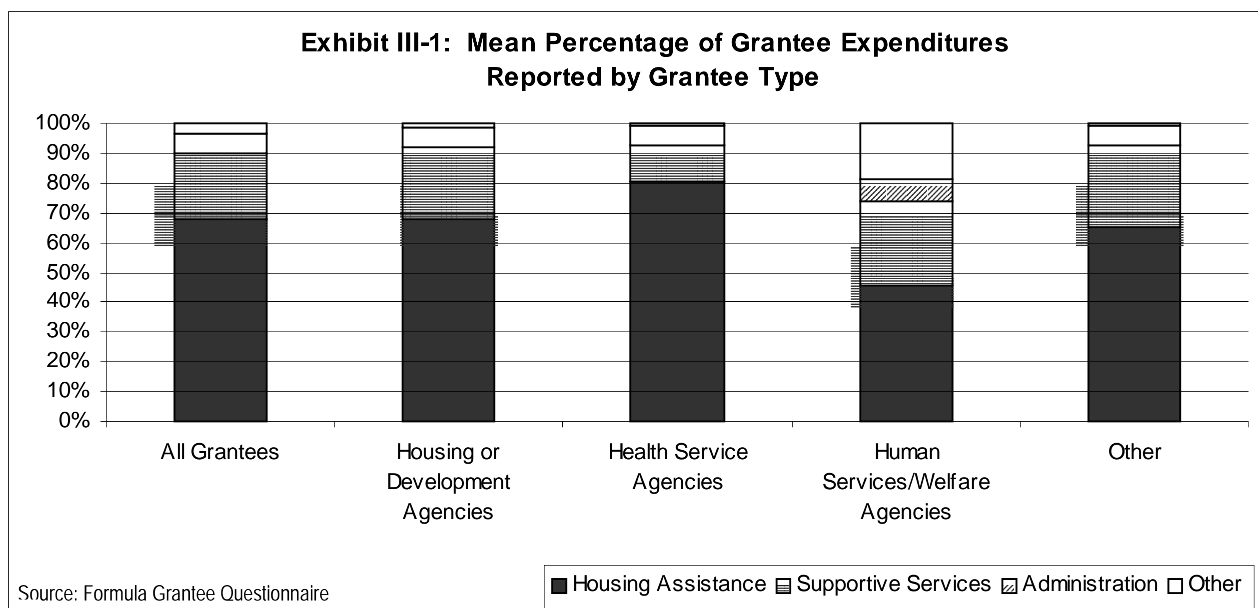
About half of grantee respondents indicated that they use some type of advisory group to help determine priorities for the allocation of their HOPWA funds. These groups included planning councils, AIDS service organizations, clients/persons living with HIV/AIDS, and groups related to housing, including housing commissions and homeless assistance task forces.

Forty-nine percent of grantees indicated that program priorities had changed since they first began receiving HOPWA formula funding. Changes varied by jurisdiction, although several indicated they have devoted more funds to rent subsidies and some have added substance abuse services. Changes in priorities should be expected, as the needs of the assisted population change or more immediate crises develop. This flexibility in the HOPWA program allows the grantees to make these appropriate adjustments in their priorities without needing approval from HUD.

Expenditures by Grantee Type

Overall, HOPWA grantees reported spending a far greater proportion of HOPWA funds on housing assistance than on the provision of supportive services. Exhibit III-1 shows that, on average, grantees spent 67.7 percent of their HOPWA allocations for housing assistance in their most recently completed fiscal year. Slightly less than one-quarter (22.2 percent) of HOPWA funds, on average, went towards providing supportive services, such as case management, health care or mental health services, drug or alcohol abuse treatment and counseling, and nutritional services. Administrative and "other" costs comprised smaller portions of grantees' HOPWA expenditures (7.0 and 3.0 percent, respectively). As mentioned previously, HOPWA's flexibility allows grantees to adjust this distribution if priorities or needs change. Because housing continues to represent the largest financial burden for low-income households, it is expected that grantees will continue to earmark the largest proportion of their HOPWA funds for this type of assistance.

Exhibit III-1: Mean Percentage of Grantee Expenditures Reported by Grantee Type



Source: Formula Grantee Questionnaire

Note: The first column in the graph above shows the mean percentage of expenditures for all grantees reporting expenditure data. The last four columns show the mean percentage of expenditures for each set of grantees – by type of grantee – reporting expenditure data. This analysis includes 20 housing or development grantees, 10 health services grantees, five human services/welfare agencies, and seven "other" agencies. In total, this graph reports data for 42 grantees. One grantee was not included in this analysis because they reported no expenditure data for the previously completed fiscal year.

As Exhibit III-1 shows, on average, the highest percentage of HOPWA funds was spent on housing assistance regardless of grantee type. Health service agencies reported spending the largest percentage of HOPWA funds on housing assistance (80.8 percent), while human services/welfare agencies reported spending the smallest proportion (45.4 percent). There is a consistent pattern across all types of grantees that the greatest proportion of their HOPWA allocation is spent on housing assistance, followed by supportive services. The human services/welfare agencies, though still spending a high percentage of their HOPWA funds on housing assistance, also reported spending a portion of their allocation on "other" activities. The Formula Grantee Questionnaire did not ask for a description of these other activities, but it is likely that they include housing resource identification and housing information services because these eligible activities are reported in the HOPWA Annual Progress Report separately from housing assistance or supportive services.

DIRECT FUND ALLOCATION

Overview

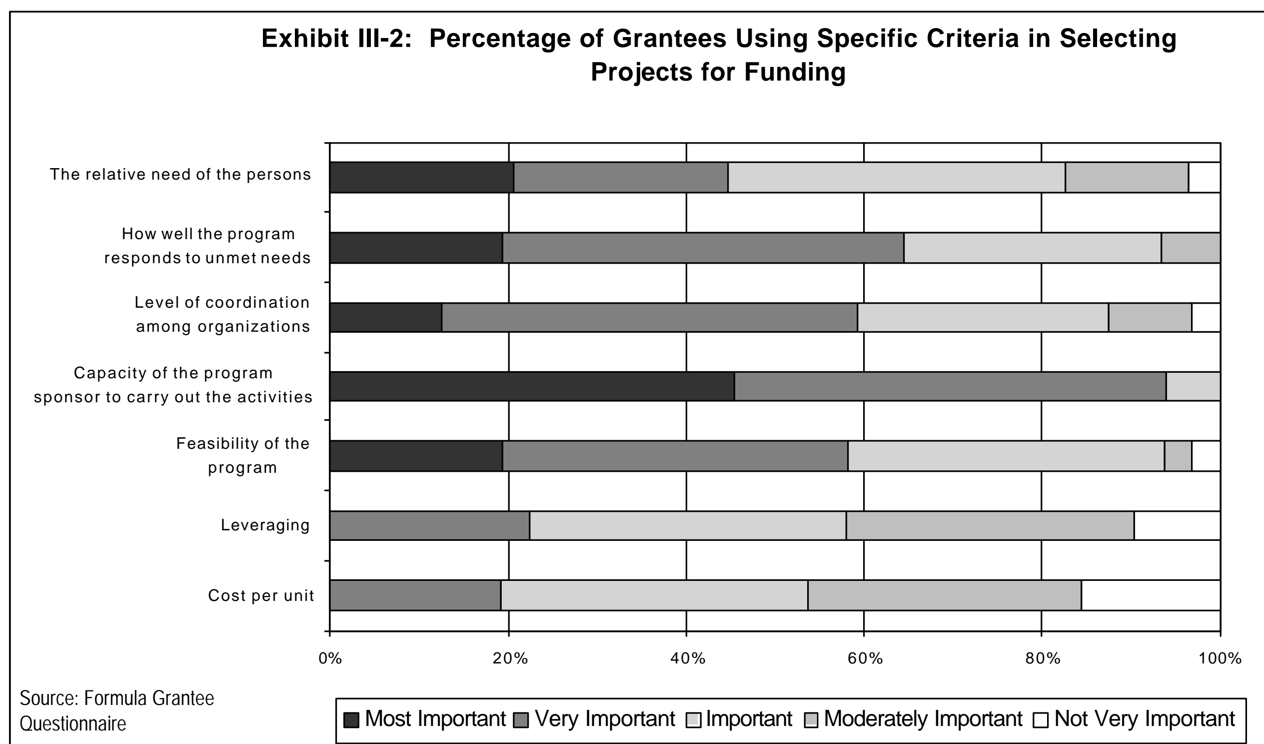
HOPWA grantees can provide funds directly to housing assistance providers to help meet the needs of persons living with HIV/AIDS and their families. Approximately 80 percent of grantees reported using direct fund allocation in their most recent program year. Nearly all (95 percent) of these grantees directed 80 percent or more of their HOPWA formula allocations to directly fund providers. Direct funding from the grantees to the providers eliminates possible layers of administration in the provision of funds. However, use of subgrantees or other local processes may allow for better targeting of assistance inside of diverse geographic and demographic areas. For example, a county within an EMSA may be more familiar than the grantee with the needs of persons living with HIV/AIDS within the county.

Grantees used a variety of processes to select providers for funding, often using more than one method. The most prevalent method—a noncompetitive renewal of previously funded HOPWA projects—was used by 41 percent of grantees that allocated to providers. Use of noncompetitive renewals is a way for grantees to ensure that clients receiving assistance from a provider are able to continue receiving assistance from that provider without interruption in assistance.

Approximately one-third of grantees that allocate funds directly to providers used a competitive process that was open to all types of activities, and about 30 percent used a competitive process that was limited to specific types of activities. One in five (20 percent) used a noncompetitive set-aside for certain specified activities, such as tenant-based rental assistance administered by the local housing authority because of its experience in administering that type of assistance. Finally, approximately one-fourth of these grantees reported using some other process to select projects for funding.

Selection Criteria Under Direct Fund Allocation

Grantees use a variety of selection criteria when choosing which providers to fund. HOPWA provides grantees with the flexibility to tailor the criteria to best meet the needs and preferences of the consumers in their community. Exhibit III-2 shows that grantees reported giving the most weight to the experience and capacity of the program sponsor to carry out the proposed activities. In fact, more than 90 percent of grantees that fund providers reported this factor to be either most important or very important. Grantees may be focusing on the capacity of the provider organizations in order to minimize the risk that there will be failures in the implementation of the program, and that consumers who are intended to receive assistance fail to do so. There are high "costs" associated with interruptions of service or failures of service, often to the very people that the program is designed to assist.



Other important factors included how well the proposed program responds to unmet needs described in an HIV/AIDS assistance strategy, feasibility of the program, and the level of coordination among organizations that will be providing housing and services to clients. The relative need of the persons the program proposes to serve is also important. In contrast, costs per unit and leveraging of funds do not appear to significantly affect the choice of most programs that are funded. A possible explanation for the relatively lesser importance of costs per unit and leveraging of funds may be local circumstances. When there are a number of providers to choose from who are each capable of delivering the same level of service, there may be the potential for competition and for cost and leveraging to be major competitive factors. However, when this situation does not exist, grantees focus on what will best ensure the provision of needed assistance to clients.

SUB-GRANTEE FUND ALLOCATION

Overview

While some grantees allocate HOPWA funds to local housing assistance providers, others use sub-grantees to allocate all or a portion of their funds. Half of the grantee respondents reported allocating some of their HOPWA formula funds to sub-grantees—State or local government agencies, or nonprofit organizations that distribute and manage the funds on the grantee's behalf. Sub-grantees in turn provide funding to providers, in effect, acting the same way as a grantee might but in a more limited area. The formula grant is awarded to the most populous city in the Metropolitan Statistical Area (MSA), or in the case of a State, the State government. An MSA can cross county and State lines, which may result in a grantee being located in one jurisdiction and disbursing HOPWA funds to other jurisdictions in the MSA. These other jurisdictions can then act as sub-grantees and determine the appropriate use of the HOPWA funds in their part of the MSA. As a result, there can be multiple sub-grantees in an area. Grantees can also

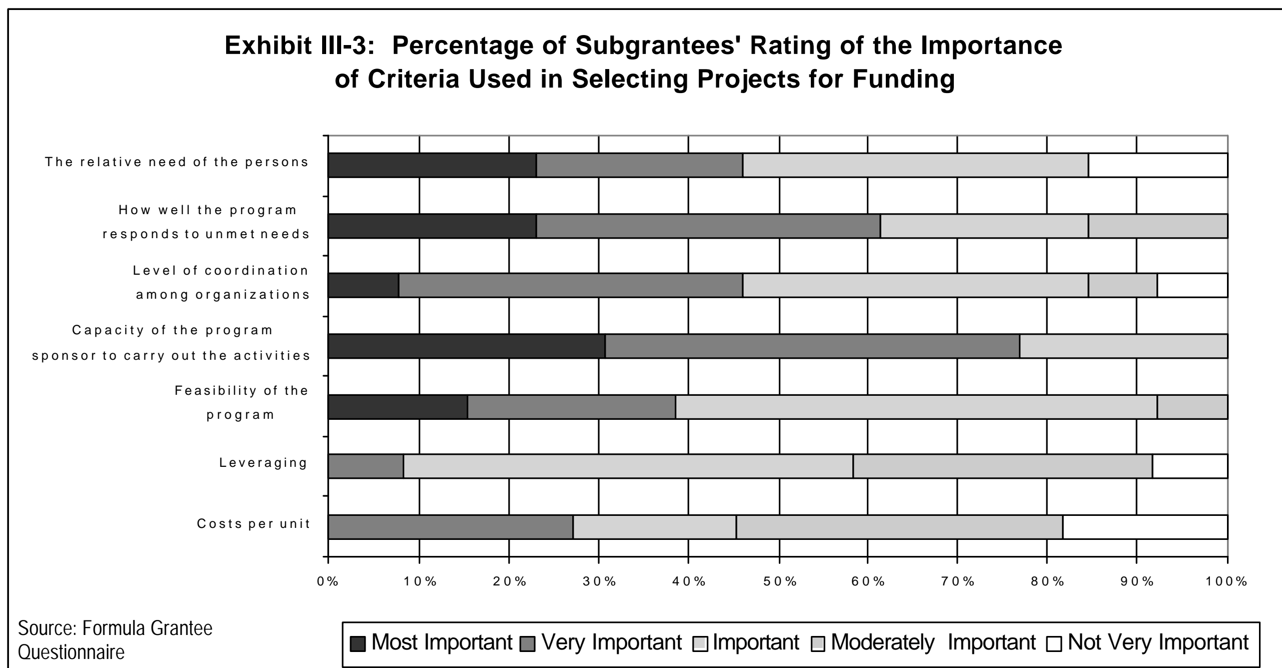
delegate all or part of the responsibility for the administration of the HOPWA grant to a single sub-grantee. Of the grantees that reported allocating funds to sub-grantees in the past year, all but two allocated to less than 10 sub-grantees. In fact, half had only one sub-grantee. Two organizations had more than 20 sub-grantees.

Most grantees that allocated funds to sub-grantees allocated a significant portion of their funds. In fact, nearly three-fourths of these grantees reported allocating from 80 to 100 percent their HOPWA formula funds to sub-grantees. Approximately 20 percent allocated from 1 to 19 percent, while about 10 percent allocated from 40 to 59 percent.

Selection Criteria Under Sub-Grantee Fund Allocation

The processes used by subgrantees—as reported by their grantees—to select individual projects for HOPWA funding varied. Examples of processes included competitive processes and re-funding of previous projects. Some sub-grantees used a competitive process when they first awarded funds, but have since primarily re-funded the original award winners.

Nearly three-quarters of grantees using sub-grantees reported familiarity with the criteria used by their sub-grantees for selecting individual projects for funding. Exhibit III-3 shows that sub-grantee priorities are quite similar to those of grantees. As with grantees, sub-grantees seem most concerned with housing assistance providers' experience and capacity to carry out the proposed activities. The program's aim to respond to unmet needs described in an HIV/AIDS assistance strategy, the relative need of the persons the program proposes to serve, and the level of coordination among organizations are important as well. As with grantees, costs per unit and leveraging of funds did not appear to be priorities for sub-grantees when selecting projects for funding.



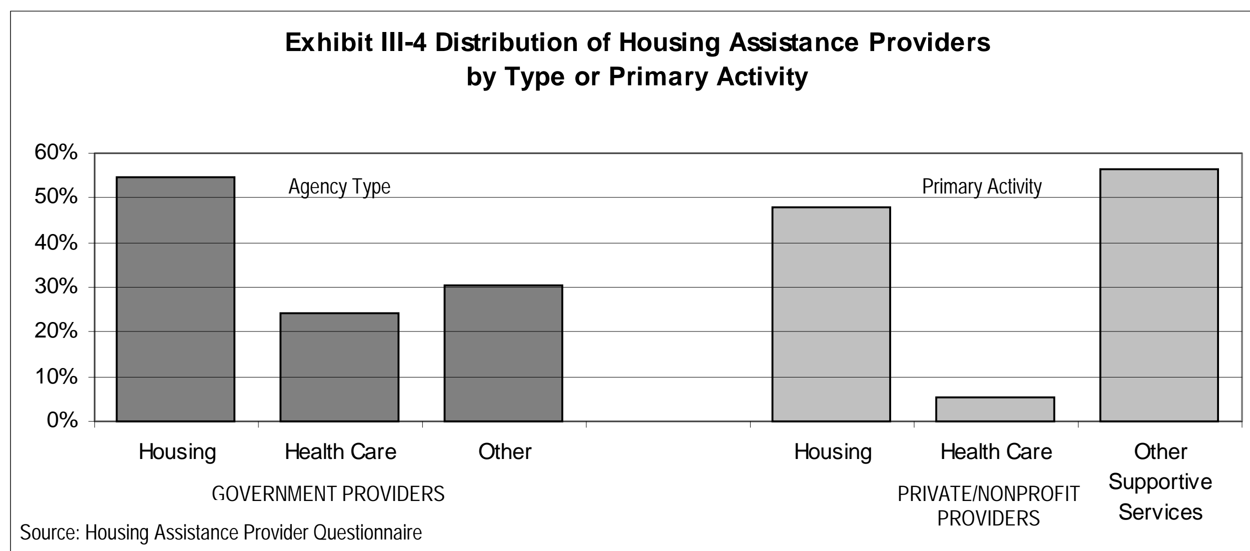
HOUSING ASSISTANCE PROVIDERS

Overview

Housing assistance providers are those organizations that directly make housing and services available to persons living with HIV/AIDS. These organizations are on the "front lines" of service provision. They may assist HOPWA clients exclusively, or as a portion of a larger population being assisted. Housing assistance can range from short-term financial support enabling a client to stay in a unit, to tenant-based rental assistance for an extended period, to the provision of a unit in a group home or other facility-based project. Providers can be funded directly from a grantee or from a sub-grantee. Either a government agency or a private, nonprofit entity, providers range in size and capacity and in the type of services they provide.

Types and Activities of Providers

Approximately three-quarters of the HOPWA housing assistance providers surveyed were private, nonprofit entities. Government agencies comprised the remaining quarter. The following graph shows the distribution of provider agencies by their agency type (in the case of government providers) and by their primary activity (in the case of the private/nonprofit providers).



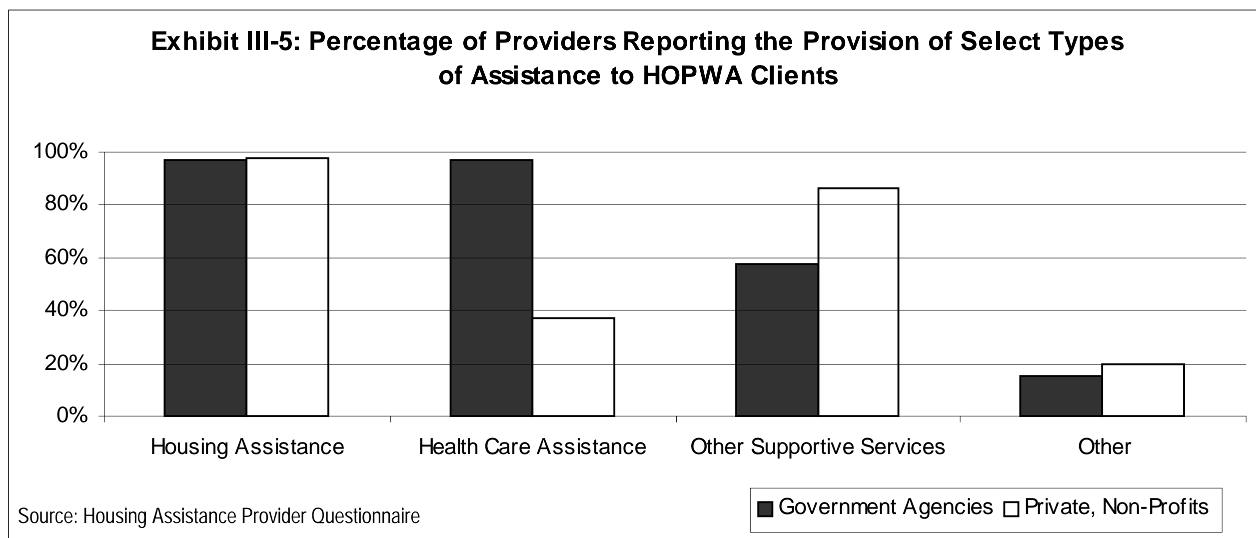
The percents of agency types among government providers totals 109 percent because some providers chose more than one type for their agency. The percents of primary activities among private/nonprofit providers totals 110 percent because some providers chose more than one primary activity.

Of the housing assistance providers who identified themselves as government agencies, approximately 55 percent were government housing agencies while approximately 30 percent were "other" government agencies—primarily social or human service organizations. Twenty-five percent of government

organizations identified themselves as healthcare agencies.[2] Among private nonprofits, about 56 percent reported that their primary activities were related to case management and supportive services, including substance abuse treatment, education, mental health, transportation, employment, meal services, and child care/welfare. Approximately one-third of the private nonprofit providers reported similar types of services for their secondary activities. In contrast, nearly 48 percent reported housing activities as their primary activity, and another 17 percent reported housing as a secondary activity. Approximately 5 percent of private nonprofit providers reported health care services as their primary activity.[3]

The primary activities generally differed between government and private nonprofit organizations.[4] Government agencies tended to report housing, public health, or "other" activities as primary activities, while the primary activities most frequently reported by private nonprofits were case management and supportive services.

Although primary activities generally differed between government and nonprofit providers, Exhibit III-5 shows that for the most part, government and nonprofit providers offer similar types of assistance to clients using both HOPWA and non-HOPWA funds. Because the questionnaire was sent to organizations that were identified as likely to be housing assistance providers, housing assistance is reported at a very high level among providers.[5] Approximately 37 percent of both government and nonprofit providers offer some type of health care services. The biggest difference between the types of providers is that nonprofits are more likely to offer other supportive services.



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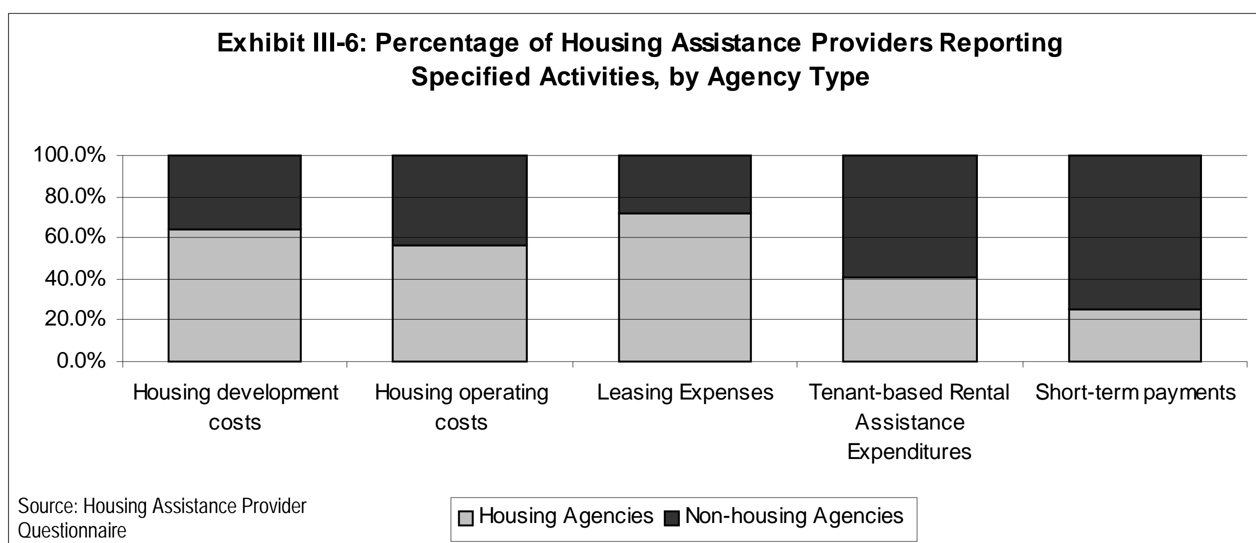
[2] Three government housing assistance providers indicated that their organizations were best described using two different categories. These responses are reflected in the results.

[3] Eleven private nonprofit housing assistance providers indicated more than one primary activity.

[4] It is assumed that government agencies identified their organization type based on their primary activity.

[5] The percentages for organizations providing housing assistance should have been 100%, because the very first question on the questionnaire reads: "Do you provide housing assistance using funds from the U.S. Department of Housing and Urban

Based on data from the housing assistance provider questionnaire, provider organizations that identify their primary activity as housing appear to be more likely to carry out housing development projects. Approximately 64 percent of the housing development projects that are funded at least in part with HOPWA funds are being carried out by these organizations. The remaining 36 percent are being carried out by non-housing organizations (i.e., those that do not identify their primary activity as housing). In contrast, these non-housing organizations are carrying out more programs providing tenant-based rental assistance or short-term payments for rent, mortgage and/or utilities than are the self-identified housing agencies. Seventy-five percent of programs providing short-term assistance for rent, mortgage and/or utilities and 59 percent of tenant-based rental assistance programs are being carried out by service organizations. This is not surprising because housing development projects are complex and often lengthy and expensive undertakings which require a greater depth of housing knowledge and experience than is normally found in non-housing agencies.



Note: each bar in the graph above captures only those housing assistance providers reporting the use of HOPWA funds for that specific activity. Thirty-nine providers reported using HOPWA for housing development activities, 46 providers for operating expenses, seven providers for leasing programs, 64 for TBRA programs, and 56 for short-term payment assistance. It is important to note that the same providers can report the use of HOPWA funds for multiple activities.

Experience of Providers

Current HOPWA housing assistance providers surveyed have been helping persons living with HIV/AIDS for an average of 10 years. Exhibit III-7 shows that there is little difference between the length of time government agencies and private nonprofits have been serving this population, although the mean and median number of years serving clients with HIV/AIDS reported by nonprofits is slightly greater. Organizations with extensive experience can be assumed to have set into place policies and procedures to effectively and efficiently provide services. In addition, more experienced organizations would have had more opportunity to develop partnerships and to coordinate with other organizations. Note that the average experience of the agencies is greater than the life of the HOPWA program. This indicates that organizations often have other, broader, focuses beyond HOPWA and have been functioning well before the HOPWA program was created.

Development's (HUD's) Housing Opportunities for Persons with AIDS (HOPWA) program? ____ Yes ____ No. If yes, please continue, if no, please stop here and return the questionnaire."

Exhibit III-7: Average Length of Time Providers Have Assisted Persons living with HIV/AIDS			
	All Providers	Government Agencies	Private Nonprofits
Mean number of years	10	9	10
Median number of years	10	7	10

Source: Housing Assistance Provider Questionnaire

Overall, approximately 45 percent of HOPWA housing assistance providers reported that they serve only persons living with HIV/AIDS. Here, there seems to be a large difference between government and private nonprofit providers. Private nonprofits were much more likely to serve only persons living with HIV/AIDS. Only 10 percent of government providers reported that they serve only persons living with HIV/AIDS, 55 percent of private nonprofits report serving only this population. It may be that private nonprofits are focused on the needs of persons living with HIV/AIDS, while government agencies have much wider responsibilities for overall housing or health issues for a broader population. It is important to note that organizations only providing support to persons living with HIV/AIDS are not limited to receiving only HOPWA funding. These organizations may be focused solely on serving persons with HIV/AIDS but receive funding from a variety of sources, including both private and public sources.

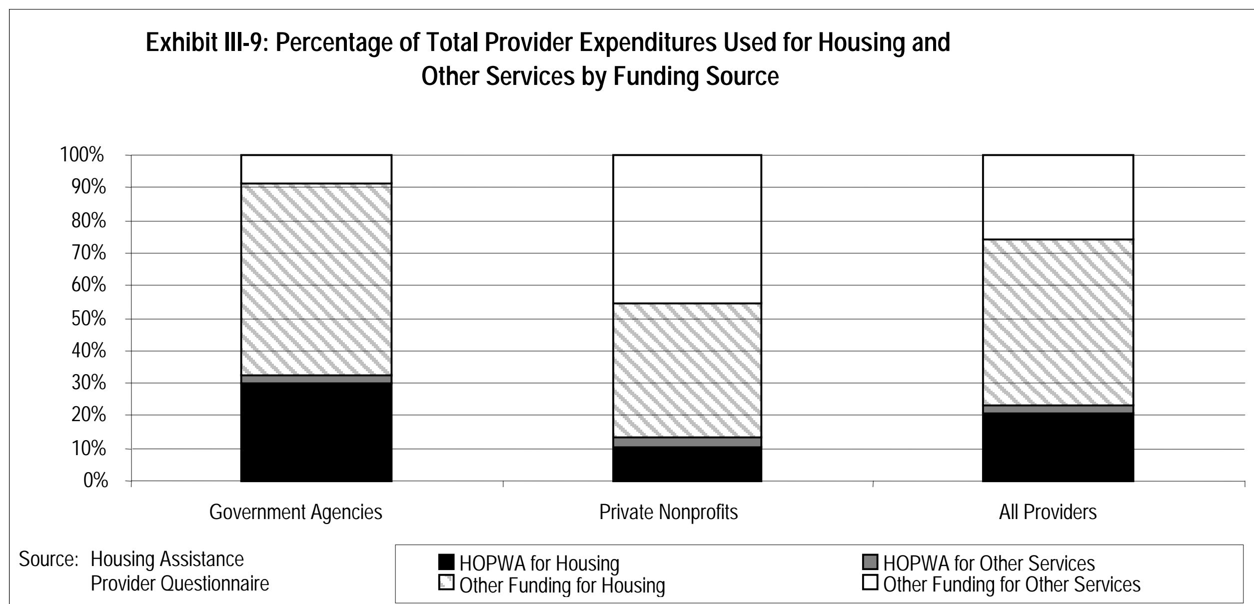
Budgets of Providers

As seen in Exhibit III-8, providers report spending an average of 18.4 percent of their budgets for persons living with HIV/AIDS. Half of all providers, though, spend more than 40 percent of their overall budgets, from HOPWA and all sources, to help persons living with HIV/AIDS.

Exhibit III-8: HOPWA Housing Assistance Provider Budgets			
	Total Budget	Annual Funds Spent on PWAs	Funds Spent on PWAs as a Percentage of Total Budget
Mean	$3,500,000	$664,000	18.7%
Median	$717,000	$314,000	43.8%

Source: Housing Assistance Provider Questionnaire

HOPWA funding comprises approximately one-fourth of the total budget of all providers surveyed that report receiving HOPWA funds. As Exhibit III-9 shows, HOPWA funds comprise a larger average percentage of the total budgets for providers that are government agencies (32.6 percent) than those that are nonprofit organizations (13.4 percent). A similar variation in spending exists between provider types: government agencies report that an average of 30 percent of their budgets is HOPWA funds spent on housing while nonprofits report an average of 10 percent of their budgets is HOPWA funding spent on housing.



SUMMARY

Communities across the country are striving to meet the needs—both housing and supportive services—of persons living with HIV/AIDS and their families. The HOPWA program is an important funding source, which allows grantees to address local needs in ways that are most appropriate for their communities. Over two-thirds of HOPWA funding is used for housing assistance.

Grantees can choose to administer programs in-house, allocate funds directly to providers in the community, and/or use one or more intermediaries (sub-grantees) to act on their behalf in allocating funds. This flexibility in method of administration is particularly important because each formula grantee is responsible for serving multiple jurisdictions, either in its EMSA or throughout a State. The option to decentralize decision-making regarding the activities to fund allows these decisions to be made by persons who are likely to be in closer contact with persons living with HIV/AIDS in their communities and more knowledgeable about their needs.

Eighty percent of the grantees surveyed reported that they use direct fund allocation, with the most important project selection criterion being the capacity of the providers to carry out their proposed activities. Half of all grantees surveyed use one or more sub-grantees to administer a portion of their funds and again the most important project selection is provider capacity.

Given this emphasis on provider capacity, it is not surprising that the housing assistance providers surveyed report having an average of 10 years experience serving persons living with HIV/AIDS. Overall, the level of these providers' experience serving persons living with HIV/AIDS appears deep, with approximately 45 percent of HOPWA housing assistance providers surveyed reporting that they serve only persons living with HIV/AIDS. Another indication of experience is the percentage of providers' budgets spent serving persons living with HIV/AIDS. Half of all providers surveyed report spending more than 40 percent of their overall budgets, from HOPWA and all sources, to help persons living with HIV/AIDS.

IV. CLIENTS AND CLIENT OUTCOMES

CHAPTER OVERVIEW

What Does this Chapter Present?

- ❒ Clients' income ranges and other client characteristics.
- ❒ Types of housing and supportive services assistance provided.
- ❒ Client perceptions of the housing assistance and services they have received and the impact of the HOPWA program on their overall quality of life.
- ❒ Where clients go upon departure from HOPWA programs.

Why is this Information Important?

- ❒ Provides an understanding of the impact that the HOPWA program has had on clients' housing stability and other measures of client outcomes.
- ❒ Provides a measurement of the satisfaction of HOPWA clients with housing assistance and supportive services received.

What are the Major Findings?

- ❒ HOPWA predominantly serves extremely low-income and very low-income persons living with HIV/AIDS, including many people with additional burdens.
- ❒ HOPWA's flexibility helps meet clients' housing needs and preferences.
- ❒ HOPWA appears to enhance clients' housing stability.
- ❒ Clients report a high level of satisfaction with the housing assistance they received.

INTRODUCTION

The HOPWA program is designed to help people who–due to a combination of low-income and potential and actual health issues–are experiencing difficulties in obtaining or remaining in appropriate, decent, safe, and sanitary housing. This chapter begins by providing an overview of the clients being served by the program—their income ranges, demographic characteristics, and living situations just prior to entering the program. Next, it describes the types of housing assistance clients receive, the impact of this assistance on their ability to remain in stable housing situations, and client perceptions of their housing assistance. Then, this chapter describes the types of supportive services clients receive and client perceptions of the impact of these supportive services on their lives. The chapter ends with a summary of findings and policy implications.

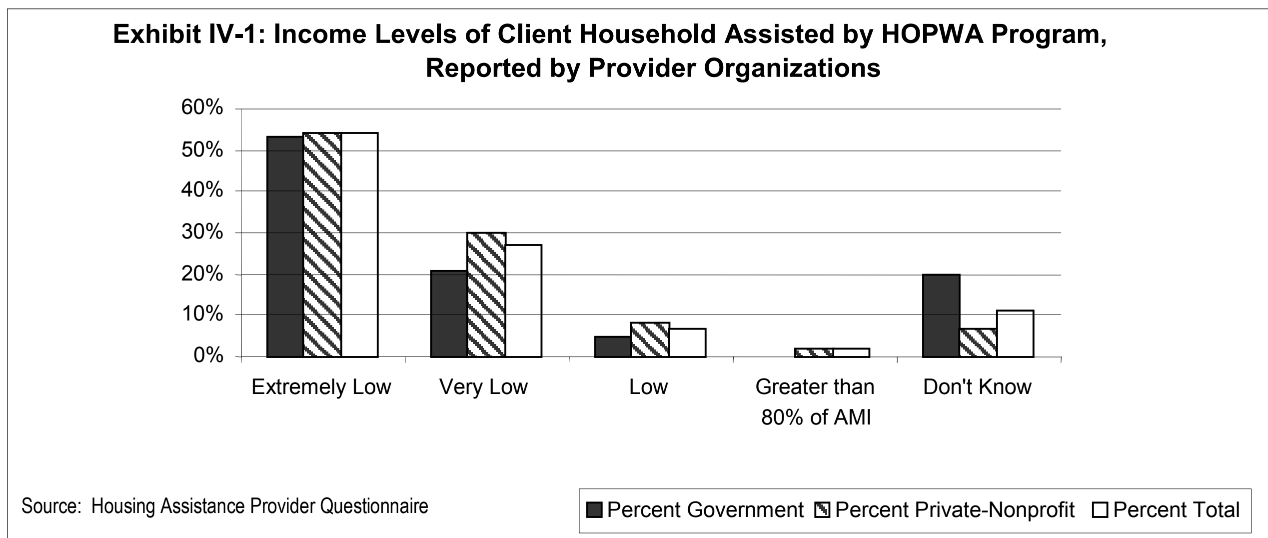
AN OVERVIEW OF THE CLIENTS

HIV/AIDS is usually only one of many problems faced by HOPWA clients. In addition to dealing with the health problems associated with HIV/AIDS, many HOPWA clients live in extreme poverty, suffer from discrimination, lack job skills sufficient to earn a living wage, have problems with alcohol and/or drugs, and

suffer from mental illness. Some HOPWA clients also experience domestic violence and have unmet child care needs. These challenges affect the mix of supportive services and housing options appropriate to meeting the needs of HOPWA clients.

Client Income

By statute, the HOPWA program is intended to serve low-income persons living with HIV/AIDS and their families whose household income is not greater than 80 percent of the area median income (AMI). HOPWA grantees and housing assistance providers could choose to serve persons whose incomes are in the upper range of income eligibility. However, according to housing assistance providers surveyed, four-fifths of all persons served by this program have either extremely low incomes (less than 30 percent of AMI) or very low incomes (30-50 percent of AMI). Specifically, 54 percent of the households being served have extremely low incomes and 27 percent have very low incomes. Exhibit IV-1 shows the distribution of clients being served by income range, according to the type of provider from whom they receive services. The questionnaire did not ask respondents to explain “Don’t Know” responses. This category might include responses from people completing the questionnaire who personally did not have information on client incomes, or it might reflect a mistaken belief that recipients of housing information services, which are not income-limited, were to be included.



Client Subpopulations

Approximately one-third of HOPWA formula grantees surveyed report that their programs are targeting assistance to subpopulations within the overall population of low-income persons living with HIV/AIDS. These subpopulations include persons with mental illness, persons with chronic substance abuse problems, and homeless persons. An analysis conducted by AIDS Housing of Washington of housing consumer survey responses obtained from 1994 through 1998 showed that 38 percent of respondents self-identified as disabled by mental illness, 27 percent indicated they were receiving drug and/or alcohol

treatment, and 41 percent reported they had been homeless at some point in their lives, and seven percent reported they were homeless at the time of the survey. [1]

Race, Gender, Ethnicity and Age

According to the 1999 Annual Progress Report (APR) data, 68 percent of all clients receiving HOPWA assistance are male and 50 percent are white. Forty-four percent of all clients are Black/African American, six percent are American Indians and Alaskan Natives, and one percent are Asians and Pacific Islanders. About 12 percent are of Hispanic origin. Almost 64 percent of all clients are between the age of 31 and 50.

This profile of HOPWA clients is not directly comparable with CDC demographic statistics on the general population of persons living with AIDS. CDC data provides a cumulative reporting of all persons with AIDS, including those currently living with AIDS as well as those who have died. Additionally, the CDC reports all persons with AIDS regardless of income, not separately for persons with low incomes. HOPWA clients must have low incomes to participate in the program.

However, as a general point of reference, the CDC data as of the end of 1999 showed that 82 percent of reported AIDS cases were men, 18 percent were women, 43 percent were whites, 37 percent were blacks, 18 percent were Hispanics, less than one percent were Asians and Pacific Islanders, and less than one percent were American Indians and Alaskan Natives.[2]

Recent Living Situations

According to 1999 APR data, about half of all clients come from rental housing situations immediately prior to the receipt of assistance through the HOPWA program. About 16 percent are homeless or in transitional housing. Comparing APR data reported between 1993 and 1999, these trends have remained constant since the inception of the HOPWA program. Exhibit IV-2 shows in greater detail the recent living conditions of clients as reported by grantees in 1999.

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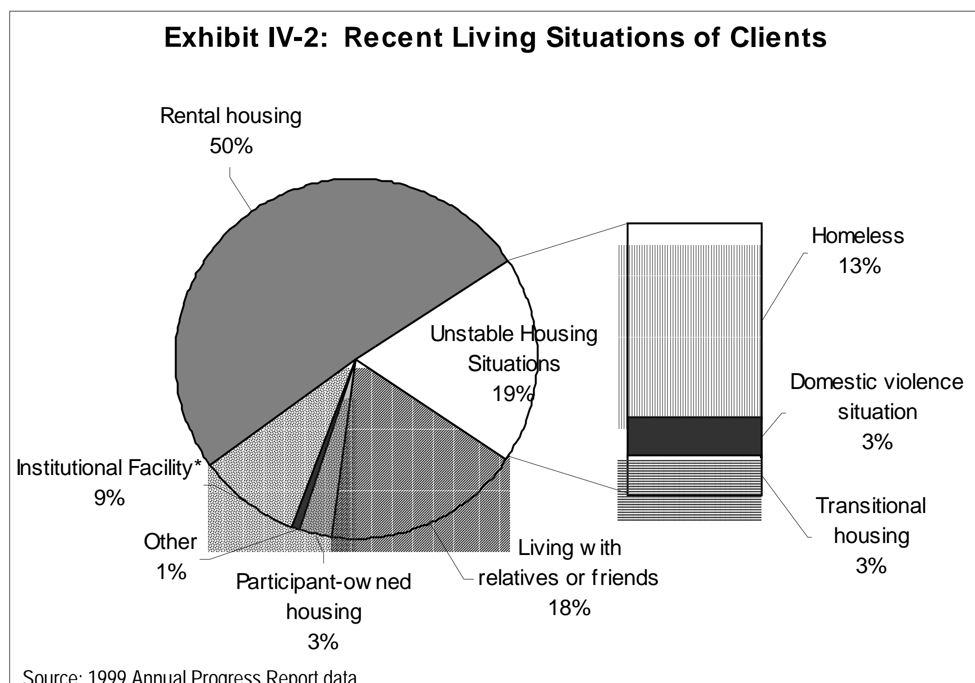
[1] AIDS Housing of Washington, *Third National HIV/AIDS Housing Conference: New Strategies for a Changing Environment,* 1999.

[2] U.S. Department of Health and Human Resources, CDC, *HIV/AIDS Surveillance Report (Volume 11, Number 2)*, December 30, 1999.



Clients represented in this exhibit may represent both new clients entering the program in 1999 and clients who entered the program in a previous year, left the program, and re-entered the program in 1999.

*Institutional Facility includes psychiatric facility, substance abuse treatment facility, hospital or other medical facility, and jail/prison.

HOUSING ASSISTANCE

The HOPWA program provides support for the provision of housing assistance and supportive services. This holistic approach is designed to provide a coordinated effort toward meeting client housing and service needs and preferences. HOPWA housing assistance funds are used to help persons remain in their own homes, to help homeless persons find affordable housing, and to provide those with other housing needs access to appropriate housing. Supportive service assistance provides additional resources to clients to help meet needs such as case management, nutritional services, and alcohol and drug abuse treatment.

Based on data collected through the Formula Grantee Questionnaire, grantees spent an average of 68 percent of their HOPWA funds to provide housing assistance and 22 percent on supportive services during their most recently completed fiscal year. They also spent seven percent for administration and three percent for other expenses. This section focuses on the types of housing assistance provided to clients, the impact of that assistance on clients' housing stability, and client perceptions of the housing assistance they received. A similar analysis of the supportive services offered is discussed later in the chapter.

Types of Housing Assistance

Housing assistance is the primary focus of the HOPWA program. The types of housing assistance available to clients and their families include the following:

- Emergency assistance, including hotel or motel vouchers;

- Short-term payments for rent, mortgage, and/or utilities;
- Tenant-based rental assistance (TBRA); and
- Facility-based housing, such as a room in a group home or a unit in a single-room occupancy (SRO) building.

Based on responses to the Housing Assistance Provider Questionnaire, it appears that the number of households receiving housing assistance is evenly distributed between temporary/transitional and permanent housing.[3] Nonprofit providers report providing a slightly higher percentage of temporary and transitional housing while government agencies serving as providers offer almost three-quarters of all permanent housing assistance.

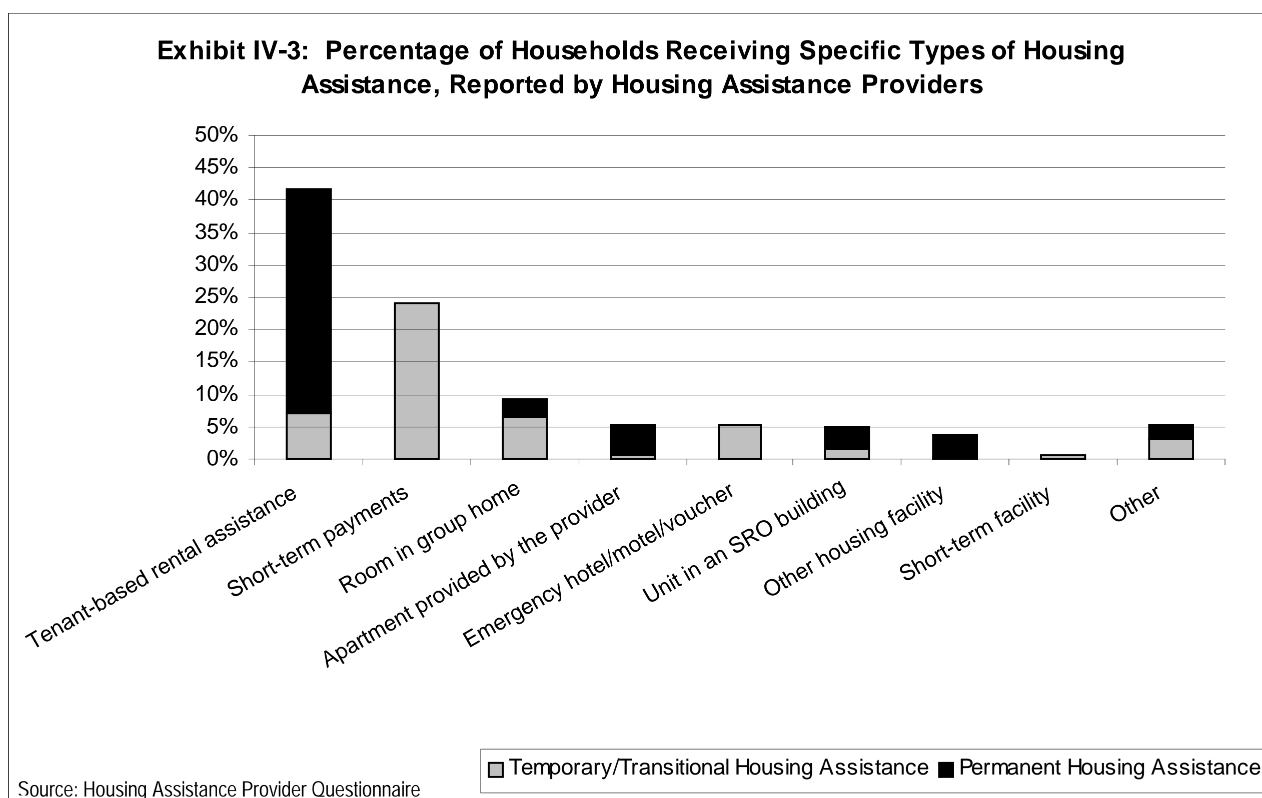


Exhibit IV-3 shows the proportion of clients receiving various types of housing assistance as reported by providers. Housing assistance providers surveyed indicated that the most common form of housing assistance is TBRA, with about 42 percent of the households receiving this type of assistance. Most of the TBRA helps clients access permanent housing, with the remainder providing time-limited transitional

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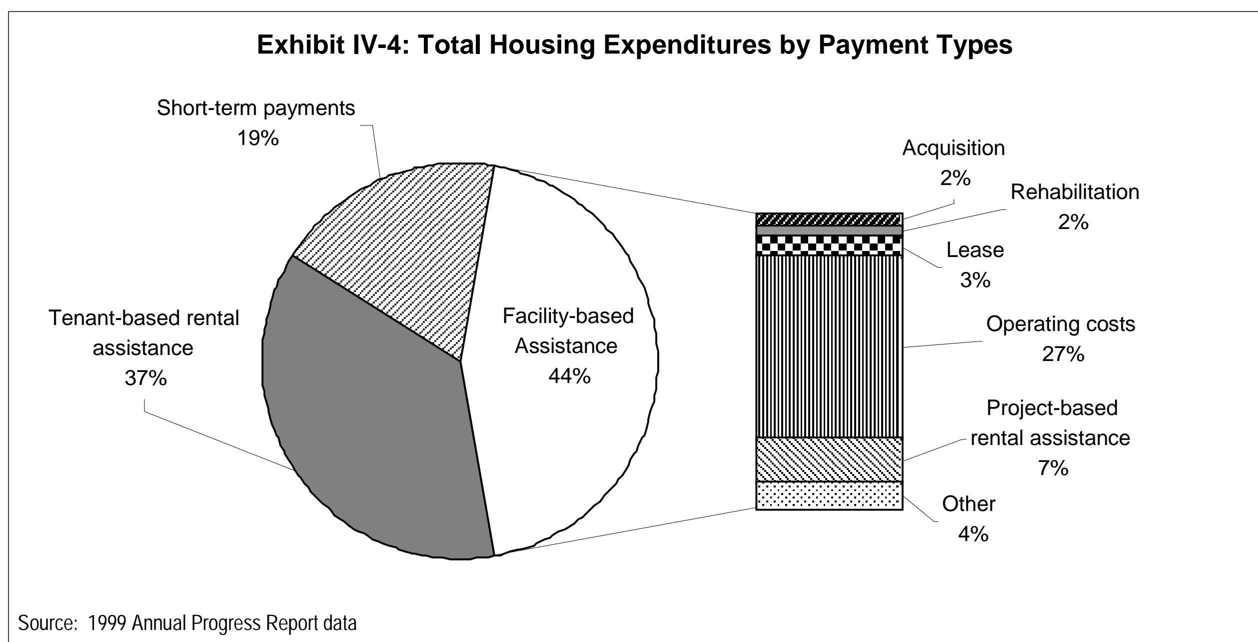
[3] "Temporary/transitional housing assistance" is time-limited assistance for emergency housing (e.g., hotel or motel vouchers) and for transitional housing (i.e., housing with appropriate services to facilitate movement of persons to permanent housing). It also includes short-term payments for rent, mortgage, and/or utilities to enable households to remain in their current housing. "Permanent housing assistance" is assistance for housing that does not place a limit on the length of time a household is able to live there.

housing. Short-term payments for rent, mortgage and/or utilities also represent a large share of housing assistance with providers reporting that 24 percent of households assisted are receiving this form of housing assistance. Most of the remaining households receive some form of facility-based housing.

HUD's APR expenditure data for 1999 shows that about 37 percent of housing expenditures in that year used for TBRA and about 19 percent used for short-term payments for rent, mortgage and/or utilities. The remaining 44 percent of housing expenditures were for facility-based housing (i.e., housing where the HOPWA assistance is tied to a specific structure), with most of those funds spent on operating that housing. Exhibit IV-4 displays expenditure data from the 1999 APR showing the percentage of funds spent for each type of housing assistance.

Exhibit IV-4: Total Housing Expenditures by Payment Types



Source: 1999 Annual Progress Report data

Housing Stability

One of the goals of the HOPWA program is to help clients maintain a high level of housing stability. Housing stability refers to the length of time that clients remain in housing where they can focus on issues such as maintaining good health and adhering to medication regimens. Maintaining a complex regimen of medications and staying connected with supportive services is difficult when a person is homeless or moving from place to place.

In this section the impact of the HOPWA program on clients' housing stability is viewed in several different ways:

- How quickly did the HOPWA program respond to clients' housing needs, helping them either obtain housing or remain in their current housing?
- To what extent were clients required to move in order to receive HOPWA housing assistance?
- What happens to clients' housing situations when they leave the program?

There are other questions related to housing stability that were beyond the scope of this study, such as how long people remain in HOPWA-assisted housing.

Response Time

Of those clients interviewed, more than 61 percent indicated that they waited less than one month to receive assistance. Seventeen percent waited one to two months, 11 percent waited three months to five months, and 6 percent waited 5 months to 1 year. It is important to note that potential clients that are placed on providers' waiting lists may choose to drop off the waiting list or receive assistance through other means if the wait is too long. As a result, the clients responding to this survey may be those who received assistance more immediately and did not have the opportunity to drop off the waiting list. The response times reported by these clients may not be a true representation of the real response times that clients experience simply because the sample may be biased to include clients receiving assistance most quickly.

Location Change

To start receiving assistance, however, clients were not always able to stay in their same housing units. According to those clients surveyed, 61 percent reported changing location to receive assistance. This rate of change in housing location, however, may not necessarily be a negative aspect of the program. Not staying in the same unit may, in fact, be a very positive outcome of the program, moving clients from inappropriate or unsafe housing to more stable residences. Furthermore, clients' health care needs may have changed requiring more intensive services only available through the HOPWA program at specific locations. It is, therefore, difficult to draw any implications from these results.

As shown previously in Exhibit IV-2, approximately 40 percent of clients were homeless, living with relatives or friends, or living in treatment facilities before receiving HOPWA housing assistance. According to those clients who said it was necessary for them to move in order to receive HOPWA assistance, more than one-quarter came from rental housing where they were living alone or with roommates. Twenty-three percent reported living with friends or relatives but paying no rent and 18 percent reported moving from transitional housing, a hospital, or other medical facility.

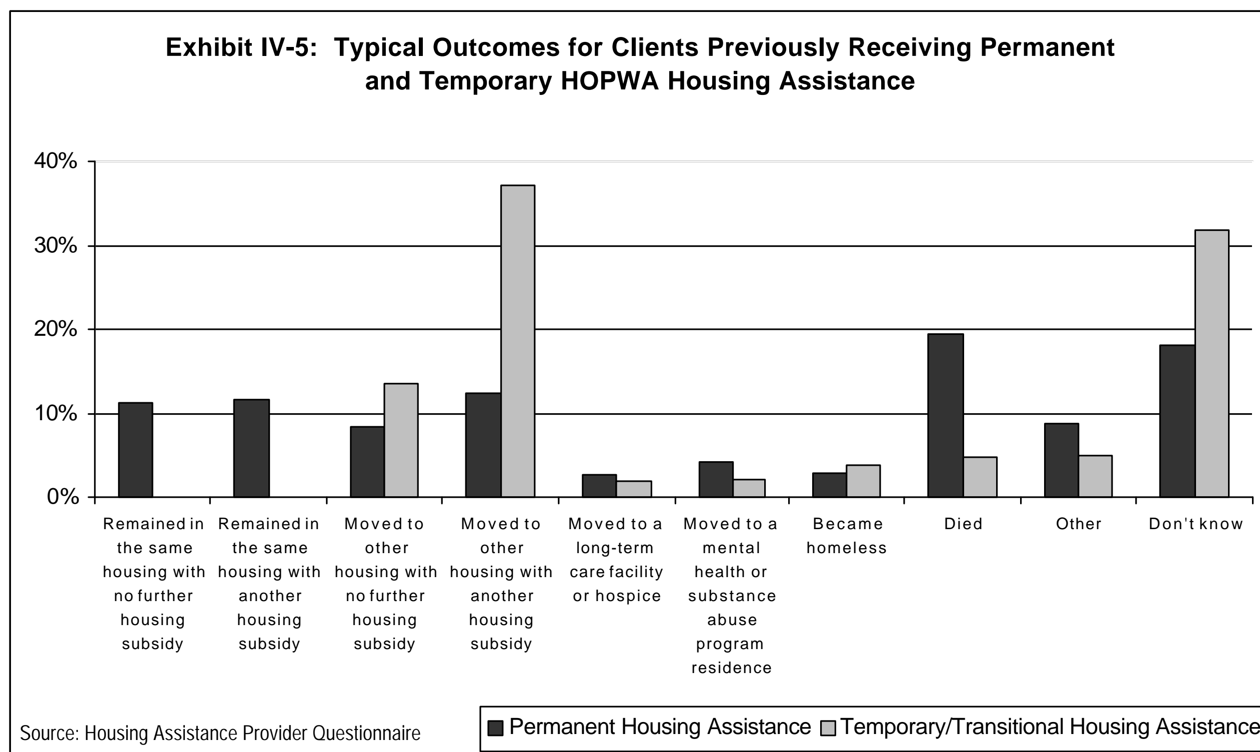
Housing Situations After Clients Leave the Program

Data from the Housing Assistance Provider Questionnaire provides some insight about what happens to clients' housing situations when they leave the program. The following exhibit shows outcomes for clients who previously received either permanent or temporary/transitional HOPWA housing assistance from the providers that responded to the questionnaire.

For persons who had been receiving *permanent* housing assistance, less than three percent were reported as becoming homeless upon leaving the program. Approximately 23 percent were able to stay in the same housing either without a housing subsidy or with another housing subsidy, while approximately 21 percent moved to other housing either with or without a housing subsidy. About six percent moved to group facility, and almost 20 percent are reported to have died. Information was not reported on what happened to 18 percent of persons leaving permanent housing assistance. For persons who had been receiving temporary/transitional housing assistance, less than four percent were reported as becoming homeless upon leaving the program, while approximately 60 percent were able to move to other housing or to a group

facility. Information was not available on the housing situations of 32 percent of the persons leaving temporary/transitional housing upon leaving the HOPWA program.

Exhibit IV-5: Typical Outcomes for Clients Previously Receiving Permanent and Temporary HOPWA Housing Assistance



Source: Housing Assistance Provider Questionnaire

This exhibit represents the distribution of where clients go after HOPWA assistance, as reported by the providers that responded to the questionnaire.

The high rates of "don't know" may reflect the difficulty and cost of tracking clients once they stop receiving HOPWA assistance, particularly when some will not volunteer information or may not have left contact information when ending assistance. The higher "don't know" rate for clients who had been receiving temporary/transitional assistance is probably a result of the higher turnover rate associated with temporary/ transitional assistance as compared with permanent assistance, and the transitory nature of that housing.

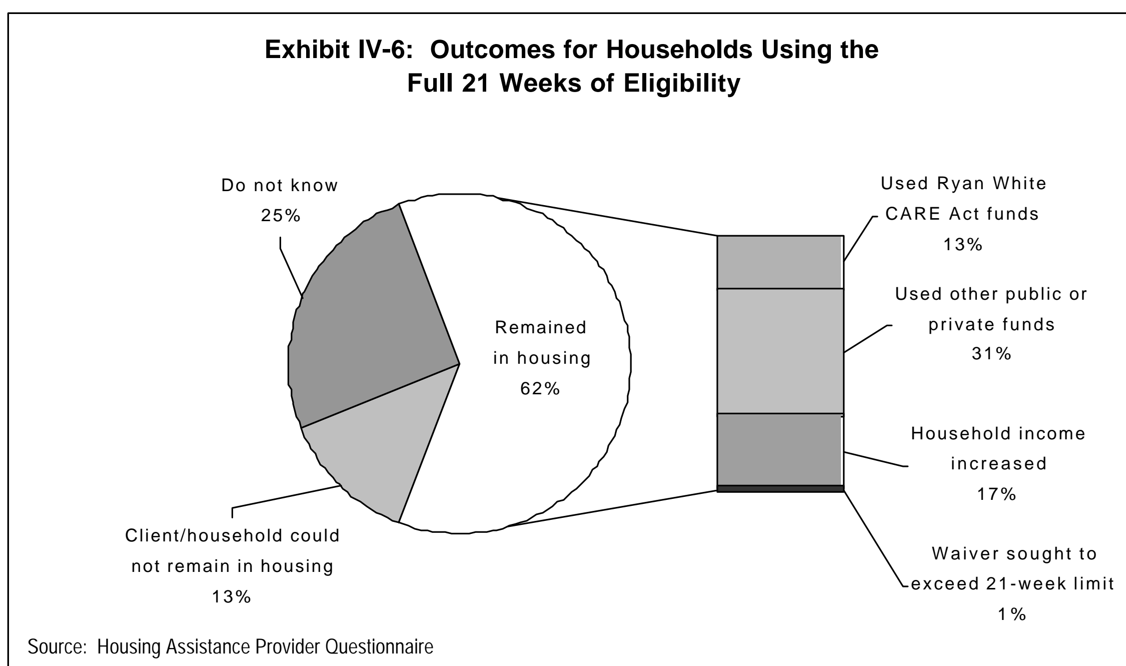
Contribution of Short-Term Payments to Housing Stability

Long-term assistance is not always the most appropriate type of housing assistance for the clients. At times, all a client may need is a small amount of assistance to cover them through a rough patch and enable them to maintain their current living arrangements. The flexibility of the HOPWA program allows providers to be extremely responsive in addressing the needs and preferences of clients and their individual circumstances. The HOPWA statute provides that clients may receive short-term payments for rent, mortgage and/or utilities for not more than 21 weeks in any 52-week period. To avoid homelessness or an unstable housing situation, by the end of the 21 weeks they either must be able to afford the housing without additional assistance, or they must transfer to another form of housing assistance.

Clients can receive the short-term payments for 21 weeks in a row, or they can participate intermittently for shorter periods until the 21-week limit is reached. At the end of the 52-week period, clients are eligible to receive additional short-term assistance. Providers reported that 50 percent of clients who received short-term payments did not use their full 21 weeks of eligibility, 39 percent used their full 21 weeks of eligibility, and the utilization by 11 percent of clients was not known. About 40 percent of providers reported that at least 60 percent of the clients receiving short-term assistance for the maximum allowable time received additional short-term assistance when they again became eligible 31 weeks later.

Exhibit IV-6 shows the distribution of outcomes for clients who did use their full 21 weeks of eligibility. Forty-four percent went on after this assistance to use other public or private funds to continue housing payments and 17 percent reported that their household income increased enough to remain in their current housing. Another 13 percent could not remain in their current housing. Providers reported that they did not know the outcomes for one-quarter of the clients who used their full 21 weeks of eligibility.

Exhibit IV-6: Outcomes for Households Using the Full 21 Weeks of Eligibility



Source: Housing Assistance Provider Questionnaire

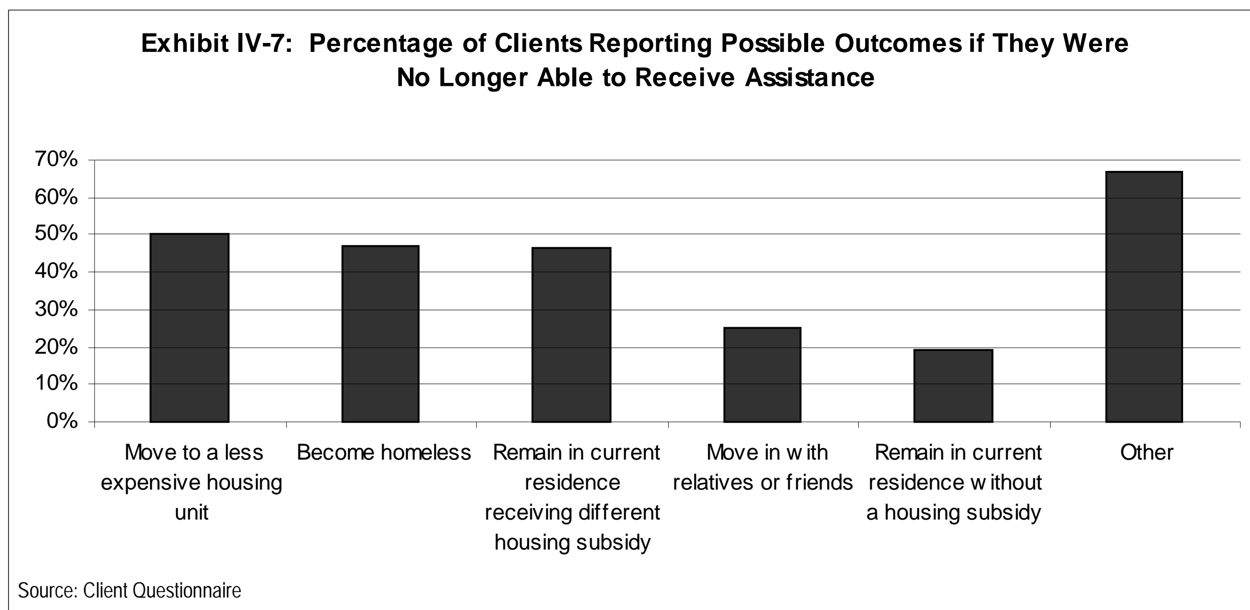
Client Perceptions of their Housing Assistance

The perceptions of clients assisted by the HOPWA program regarding their satisfaction with the program are a key element in an evaluation of the program. Clients generally reported a high level of satisfaction with the housing assistance they received. Of the client comments received regarding their satisfaction or lack of satisfaction with the HOPWA program, an overwhelming majority were positive. Many of the positive comments focused on the "well run" program and the friendly and helpful staff. Many also appreciated the independent living situations and services that are available to them. One person commented, "Now I can concentrate on health and take time to take care of [my]self. I have a big improvement in health and attitude." Negative comments focused on a lack of security and inadequate food. The following section looks more closely at clients' perceptions about their housing stability and housing suitability.

Housing Stability

The HOPWA program promotes housing stability so that clients can focus on other issues such as maintaining good health, adhering to medication regimens, and accessing job training and employment. According to those clients who reported living in their own home or apartment, a group home, or an SRO, over 85 percent reported that their housing was "more stable" or "significantly more stable" now that they receive assistance through the HOPWA program. Of those clients surveyed who reported living in a shelter, hotel/motel, or in a transitional housing program, 60 percent reported that their opportunities to obtain permanent, stable housing after they leave has significantly improved since receiving assistance.

Exhibit IV-7 shows the distribution of possible client outcomes if HOPWA housing assistance were terminated. For each of the possible outcomes, clients were asked if that outcome was possible for them. Of those clients receiving permanent HOPWA housing assistance, almost half reported that it was possible that they would become homeless if their assistance ended. One client reported that if he no longer received HOPWA assistance he would be homeless and "forced into crime in order to survive." About 46 percent reported that it was likely that they would move to a less expensive housing unit and about one-fifth said that they might remain in their current residence with a different subsidy. The most highly reported category of possible outcomes by clients was "other." While this category was undefined by most respondents, one said that this "other" outcome referred to prison, and another said "other" referred to a shelter.



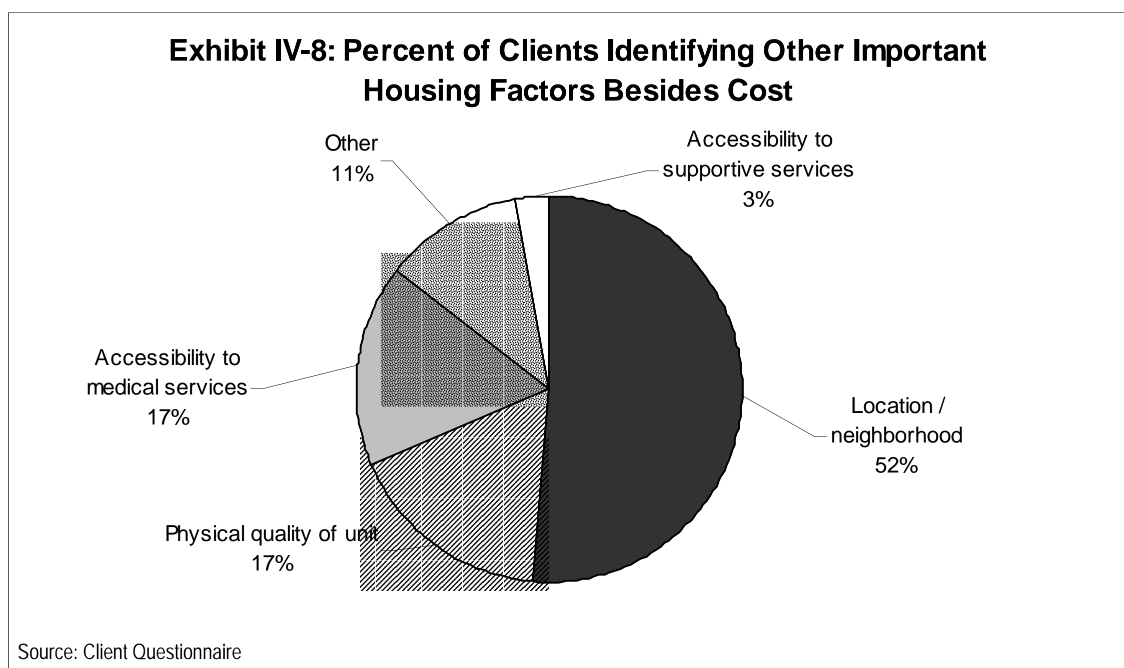
Housing Suitability

In addition to promoting housing stability, HOPWA also promotes housing suitability: a concept referring to the appropriateness of a specific housing unit to a client's needs. For example, a client may have had his or her health decline and is now in need of a unit that provides wheelchair accessibility or a unit in an assisted living community. Suitability implicitly includes a variety of factors, including accessibility, size and design of unit, location, and access to services. Based on those clients surveyed, an overwhelming

majority (92 percent) thought that their current housing units met their personal needs. Eight percent believed that their units were inadequate. The most common complaint among those clients unhappy with their units was that the unit did not meet their physical needs.

Over 65 percent of the clients interviewed reported living with other people. Of those individuals, nearly two-thirds (62.5%) reported that their residences have an adequate amount of space. The remaining third said that their residences are too small for their household's needs. Note that "adequate amount of space" is the client's determination and is not related to any size standards used by HUD in its programs.

Exhibit IV-8 shows the distribution of clients reporting the housing factors most important to them besides cost. Over 51 percent reported that the "location/neighborhood," was most important after cost. The physical quality of the unit rated as the second most important factor for clients–after cost–about their housing. Those reporting other factors most important referred to the friendly staff, opportunity to make choices, and safety.



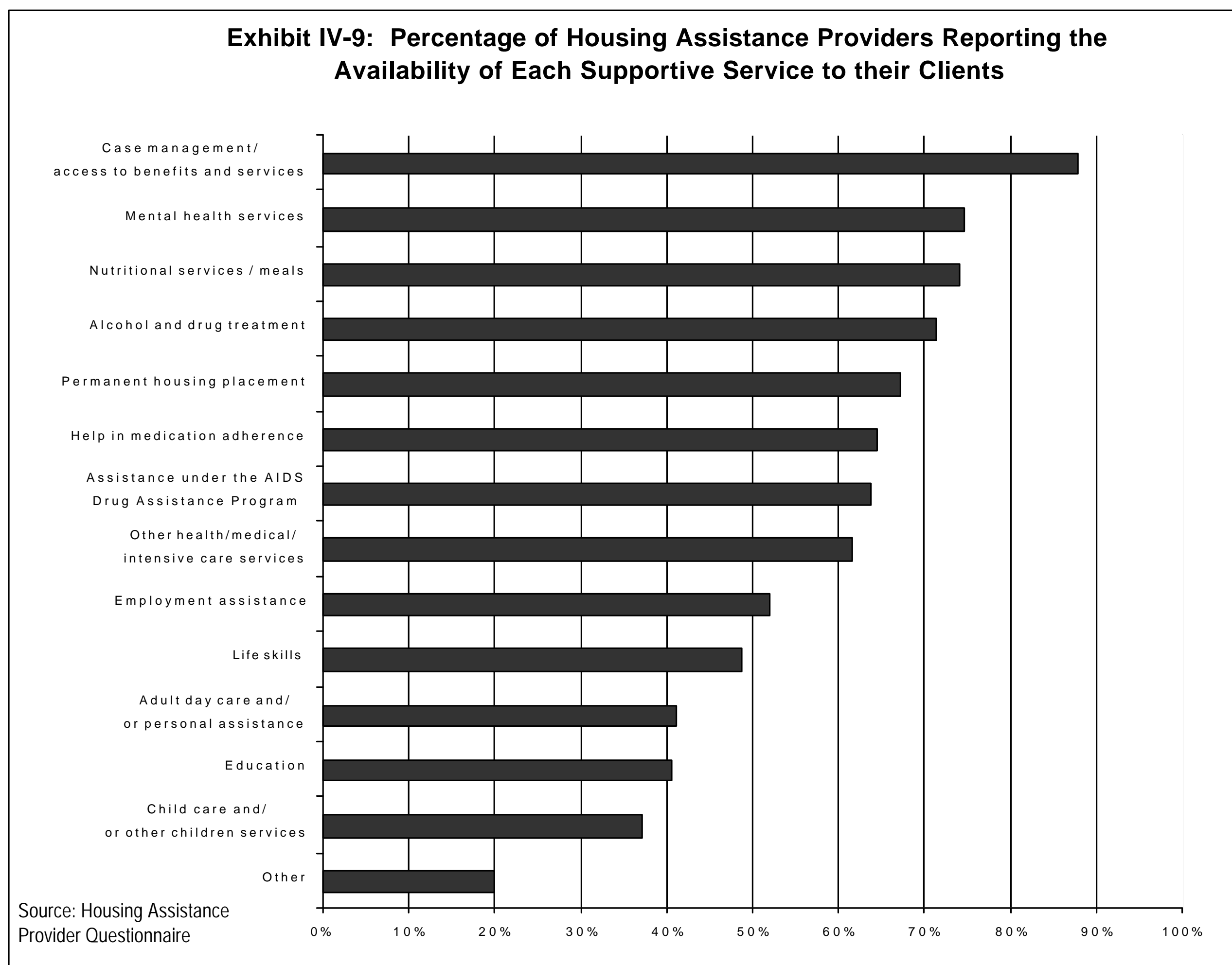
SUPPORTIVE SERVICES

This section describes the types of supportive services clients receive, the relationship between the type of housing assistance and the types of services provided to clients, and client perceptions of the impact on their lives of the supportive services they receive. A discussion of how different assistance providers coordinate the provision of services in their localities can be found in Chapter V.

Types of Supportive Services

In addition to receiving housing assistance, HOPWA clients may access a broad array of supportive services both on-site and off-site through linkages to other providers. These services can be quite varied, ranging from case management to substance abuse counseling to childcare and/or other children services. Providers, on average, reported that clients had approximately eight different services available to them. Exhibit IV-9 shows the percentage of housing assistance providers that report the availability of various types of services using any combination of HOPWA funds and/or other sources. As seen in Exhibit IV-9, case management is the service most widely available with almost 90 percent of providers reporting the availability of this service to their clients.

Exhibit IV-9: Percentage of Housing Assistance Providers Reporting the Availability of Each Supportive Service to their Clients



Source: Housing Assistance Provider Questionnaire

Housing providers use HOPWA funds to wholly or partially fund 28 percent of all services made available to clients. The remaining 72 percent of services are provided through the support of other, non-HOPWA programs. Other sources of funds for these services include other government sources such as Ryan White CARE Act funding and money raised by the housing provider organization from private sources. As will be discussed in Chapter V, the services that are most likely to be supported by HOPWA funds include

permanent housing placement, case management, and other services. The most frequently cited "other services" were transportation services, medical services, and support groups and buddy programs.

Employment Assistance

Because new treatments and therapies are helping persons with HIV/AIDS stay healthier longer, many clients report anecdotally that they would like to return to work in order to feel more productive and active. Recognizing this need, an increasing number of agencies are making "return to work" and other employment assistance programs available to their clients. About 42 percent of the small sample of clients interviewed report working regularly, including persons working on a volunteer basis as well as those working for pay[4]. For those clients who report working, the average number of hours worked per week is 21.7 hours, ranging from 5 to 40 hours per week.

HOPWA clients, however, face many obstacles in obtaining regular, full-time employment. These obstacles include both those related to their medical conditions and those related to general issues affecting very low-income persons. One of the major client concerns is that "negative income" results from the withdrawal of benefits once a client has a regular source of income that is greater than eligibility requirements for particular programs. The income earned is rarely enough to offset the benefits they would otherwise receive. For example, several clients reported that they would work only if they could be paid "off the books," so that they would not be at risk of losing their Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI) benefits, and health insurance that is critical to paying for medications.

Other obstacles to working that were reported by clients interviewed include a lack of good health, including side effects of medications, substance abuse problems, mental health issues, discrimination, and inadequate job skills. One respondent said, "I get really physically ill after working a couple of months to a year, and then lose my job." Another client explained that she did not work because she lived in a rural area that "discriminates against sexual orientation." Others said that a lack of day care for their children and regular transportation were barriers to employment.

Client Perceptions of Supportive Services Received

Clients report a high level of satisfaction with the supportive services that they receive. About 65 percent of clients surveyed reported that it has been "easier" or "much easier" to get the supportive services that they needed since starting to receive HOPWA assistance. About six percent reported that the process of obtaining services was more difficult. About 50 percent of clients reported that their access to care has improved or significantly improved. The remaining half reported that there was no change in their health care access. The following exhibit summarizes client responses to more detailed questions about the services which they receive.

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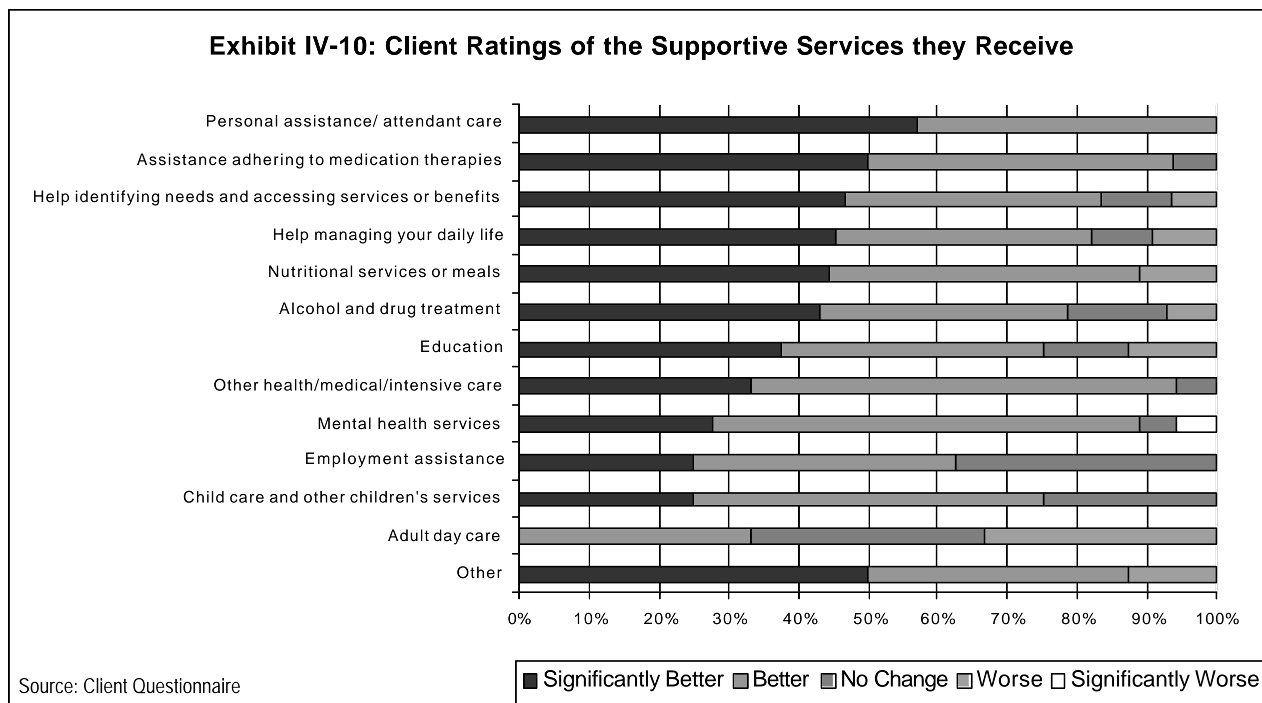
[4] This percentage seems high but is likely due to the nature of the sample. Clients who have their lives relatively stabilized are more likely to call and be interviewed.



Examination of those supportive services that were provided to about half or more of clients surveyed showed that these five key services are improving or significantly improving the lives of clients.

- **Case management**. Case managers help clients assess their needs, apply for benefits, obtain services from service providers in the community, and track their progress toward achievement of personal goals. In Exhibit IV-10, case management is called, "Help identifying needs and accessing services or benefits." Just slightly less than half of clients interviewed said that this supportive service made their life "significantly better" than before. Another third reported that this supportive service made their life "better" than before.

- **Help in medication adherence.** Highly Active Anti-Retroviral Therapy (HAART) involves complex medication regimens, usually including a combination of three or more drugs, and more than one class of drug. Careful adherence to the medication regimen, close monitoring, and medication adjustments, as necessary, are all part of successful therapy. Successful therapy is also dependent upon the client living in a stable housing situation. Almost half (45.7 percent) of respondents report receiving help in medication adherence.

- **Nutritional services or meals**. Assistance with nutritional services or meals can range from nutritional counseling to a home-delivered meals program. The overwhelming majority of respondents, 89 percent, said that nutritional services or meals improved their lives, with the answers split evenly between better and significantly better than before receiving the service.

- **Mental health services**. Mental health services can range from less intensive facilitation of support group meetings to the more intense provision of individualized therapy. Of those respondents that reportedly received mental health supportive services, nearly a quarter reported

that their lives were significantly better as a result, and well over half reported that their lives were better as a result.

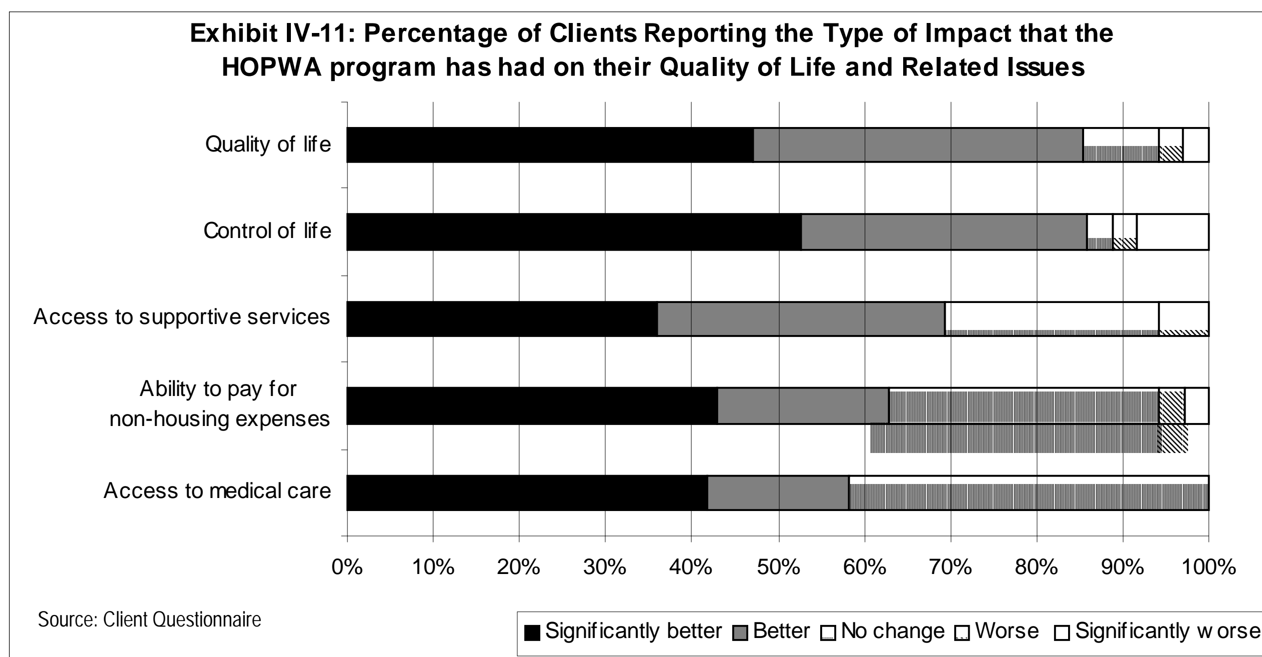
- **Other health/medical/intensive care**. Prompt or more available medical and medical support services may allow clients to have a significantly more stable life with fewer bouts of illness or other situations that may negatively impact them. A third of respondents reported that their lives were significantly better as a result of access to other health/medical/intensive care as a supportive service, while another 61 percent of respondents reported that their lives were better.

Even for those services utilized by fewer than half of clients surveyed, participants still agreed that the supportive services made their lives better as a result.

Client Perceptions of their Quality of Life

One way to understand the overall impact that HOPWA is having on low-income persons affected by HIV/AIDS is to measure clients' quality of life–including aspects such as living environment, health care, and finances. Exhibit IV-11 shows that more than 80 percent of clients surveyed indicated that their quality of life has improved or significantly improved since HOWPA housing assistance began. Clients also reported that they felt more in control of their lives–more than 80 percent indicating that they are more in control or significantly more in control of their lives since HOPWA assistance began. Almost 60 percent of clients interviewed indicated that their ability to pay for things other than housing or shelter has increased or significantly increased.

Exhibit IV-11: Percentage of Clients Reporting the Type of Impact that the HOPWA program has had on their Quality of Life and Related Issues



Source: Client Questionnaire

SUMMARY OF FINDINGS AND POLICY IMPLICATIONS

Finding: The HOPWA program predominantly serves extremely low-income and very low-income persons living with HIV/AIDS, including many people with additional burdens.

By statute, the HOPWA program is intended to serve low-income persons living with HIV/AIDS and their families whose household incomes are no greater than 80 percent of the area median income. HOPWA grantees and housing assistance providers can choose to serve persons whose incomes are in the upper range of income eligibility. However, they are overwhelmingly serving persons whose incomes are much lower. Fifty-four percent of the persons receiving assistance from the program have extremely low incomes (less than 30 percent of area median income) and another 27 percent have very low incomes (30-50 percent of area median income). Moreover, about a third of HOPWA grantees are targeting their programs to serve sub-populations within the overall population of low-income persons living with HIV/AIDS, including persons with mental illness, persons with chronic substance abuse problems, and homeless persons.

Policy Implications

The persons being served by the HOPWA program are among the poorest of the poor and can be expected to have the most acute housing needs. There are no indications that further targeting of the program is necessary.

The National Low Income Housing Coalition reports that in more than three quarters (76 percent) of U.S. counties, households earning 50 percent of median income could not afford the air market rent for a two-bedroom unit.[5] The overwhelming majority of HOPWA-assisted households do not have incomes that reach even this income level.

The incomes of the population being served by the HOPWA program have implications for the costs of housing subsidies. Virtually all HOPWA clients need housing subsidies and, given the very minimal incomes of this population, these subsidies are often large. With housing markets getting tighter and affordable housing more scarce and expensive in communities with large numbers of persons living with HIV/AIDS, the number of households that can receive housing assistance with the same amount of funding is decreasing.

Reducing the level of housing subsidies to continue to serve the same number of households could adversely affect the ability of the HOPWA program to meet the needs of the eligible client population. Serving households with incomes in the higher ranges of eligibility would ignore the housing needs of the most needy. Concentrating HOPWA housing assistance only in neighborhoods with the lowest housing costs would ignore important factors beyond cost, such as the availability of health care and other supportive services, or the appropriateness of the neighborhood. It would be counterproductive, for example, to locate housing for a recovering substance abuser in an inexpensive neighborhood known for its heavy drug traffic.

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[5] National Low Income Housing Coalition, "Out of Reach," September 1999. Available: www.nlihc.org.

As housing costs increase, the Executive Branch and Congress should consider further increases in the HOPWA appropriation to help ensure that the program can continue to appropriately serve at least the same absolute number of persons currently served. Additional funding should also be provided to assist the increasing number of persons who are living with HIV/AIDS and are eligible for HOPWA assistance.

Finding: The HOPWA program's flexibility helps meet clients' housing needs and preferences.

The HOPWA program provides for a broad variety of eligible housing and service activities. The flexibility that this breadth of eligible activities provides grantees allows them to decide the extent that HOPWA funds will be used for housing. During their most recently completed operating years, grantees spent an average of 68 percent of their HOPWA funds to provide housing assistance, including direct housing subsidies, housing development costs, and housing operating expenses. (They also spent an average of 22 percent for supportive services, seven percent for administration and three percent for other expenses.)

The program's flexibility also allows grantees to determine what types of housing assistance to offer to meet the clients' housing needs and preferences. HOPWA housing assistance is being provided primarily in the form of tenant-based rental assistance and short-term payments for rent, mortgage, and/or utilities. Forty-two percent of households receiving HOPWA housing assistance received tenant-based rental assistance and an additional 24 percent received short-term payments. Most of the remaining households received some form of facility-based housing.

Because the range of eligible activities is so broad, HOPWA activities, in many cases, complement activities of other programs developed locally and funded through other sources. This combination of resources is described in detail in Chapter V.

Policy Implications

The HOPWA program's diverse array of housing options allows State and local HOPWA programs to tailor housing assistance to meet the varied circumstances of persons living with HIV/AIDS. For example, both short-term payments for rent, mortgages or utilities, and tenant-based rental assistance can help persons living with HIV/AIDS remain in their current housing if their incomes decrease. Tenant-based rental assistance can also help persons living with HIV/AIDS who must move, or are homeless, afford the rental costs of their new housing units. A room in a community residence is often the most appropriate housing for clients needing the most intensive services, such as help managing daily life, nutritional services, and personal assistance/attendant care.

The high use of tenant-based rental assistance and short-term payments for rent, mortgage, and/or utilities probably reflects client preference, the relative simplicity of administering these types of assistance as compared with housing development, and the speed with which these types of assistance can be provided. The inherent flexibility within tenant-based rental assistance is another feature that makes it attractive. However, there may be other explanations as well for the high use of tenant-based rental assistance and short-term payments for rent, mortgage and/or utilities. Many HOPWA housing assistance providers are agencies that identify their primary activities as case management and supportive services, and may have limited experience with housing alternatives. Some of these housing assistance providers may be reluctant or unprepared to undertake activities that would involve them in the complex and lengthy housing production process. Additional factors that may deter HOPWA providers from engaging in significant

production efforts include prohibitively high construction or rehabilitation costs, difficulty in identifying suitable sites, and local regulatory barriers, such as exclusionary zoning policies.

HUD should conduct further research to assess the factors that contribute to the program's current emphasis on tenant-based rental assistance and short-term payments. In addition, HUD should examine the desirability of encouraging an expansion of production efforts (including significant rehabilitation activities) through HOPWA, while retaining the program's critical emphasis on local flexibility and the need to meet client needs and preferences.

Finding: The HOPWA program appears to enhance clients' housing stability.

Stable housing is critical to increasing the ability of clients to focus on maintaining good health and adhering to medication regimens. In examining housing stability, this study focused primarily on what happens to clients' housing situations when they leave the program.

Based on clients' housing situations when they leave the program, as reported by providers that responded to the Housing Assistance Provider Questionnaire, housing stability appears to have been enhanced by HOPWA assistance. Where information was available, it was clear that persons who had been receiving HOPWA assistance almost always remained housed after the assistance ended.

According to the survey responses, less than three percent of the persons who had been receiving HOPWA-funded *permanent* housing assistance, but then ceased receiving it, became homeless. Of those who ceased receiving this HOPWA assistance, approximately 23 percent were able to stay in the same housing either without a housing subsidy or with another non-HOPWA funded housing subsidy, and approximately 21 percent moved to other housing again either with a non-HOPWA funded subsidy or without a housing subsidy. About 6 percent moved to group facility, and almost 20 percent are reported to have died. Information was not reported on what happened to 18 percent of persons leaving permanent housing assistance.

For persons who had been receiving *temporary/transitional* housing assistance, survey responses showed that less than four percent became homeless upon leaving the program. The largest impact noted was that approximately 60 percent were able to move to other housing or to a group facility, as may be expected from the design of this type of housing as transitional support. Information was not available on the housing situations of 32 percent of the persons leaving temporary/transitional housing upon leaving the HOPWA program.

Another situation involving clients leaving the HOPWA program is associated with the statutory limitation on HOPWA-funded short-term payments for rent, mortgage, or utilities. Under the statute, such payments may not extend for more than 21 weeks in any 52-week period.[6] For clients who used their full 21 weeks of eligibility for short-term payments for rent, mortgage, or utilities, 44 percent were known to have remained in their current housing using other public or private funds, and 18 percent were known to have had a household income increase that was enough to remain in their current housing. However, 13 percent could not remain in their current housing, and information was not available on the remaining clients (25 percent) who had used their full 21 weeks of eligibility for short-term payments.

[6] 42 U.S.C. 12907

Policy Implications

While HOPWA appears to enhance clients' housing stability, data weaknesses in the survey (i.e., the high rates of "Don't Know" responses) make it difficult to reach statistically valid conclusions on a program-wide basis. These data weaknesses might reflect the lack of resources to track persons who leave the program, or tracking difficulties arising from concerns about client confidentiality. Some clients will not volunteer information about their future plans when exiting the program. Weakness in outcome data is not a problem that is unique to the HOPWA program. Efforts are underway across the Federal Government to improve outcome measurement, including efforts at HUD and within the HOPWA program, but funding to track persons who cease receiving program assistance is not readily available. Moreover, funding alone will not address all data collection difficulties.

The success of these efforts will depend, at least in part, upon improved data collection systems and training at the provider level. As an incentive to improve these systems, the Executive Branch and Congress should consider alternative sources of funding specifically earmarked for improving data collection efforts in the program. Such alternative funding sources could include a modest increase in the statutory limit on administrative costs, possibly indicating that the increase is solely for improvements in data collection, with emphasis placed on measuring program benefits to clients.

HUD should conduct further research to (1) gather additional data on client housing stability, both while clients are being served by the program and when they leave the program; and (2) to determine the relative effects on housing stability of the various types of assistance provided by HOPWA.

Finding: Clients report a high level of satisfaction with the housing they are receiving.

The 36 clients interviewed by telephone report a high level of satisfaction with their HOPWA-assisted housing. This satisfaction was measured in terms of overall satisfaction, as well as in terms of housing stability, housing suitability, and quality of life as affected by the client's housing.

Clients report very high overall satisfaction with housing assistance they are receiving under the HOPWA program. Sixty percent of those surveyed responded that they were very satisfied and another 30 percent responded that they were satisfied.

When asked about housing stability, 80 percent of those clients who reported living in their own home or apartment, a group home, or an SRO said that their housing was "more stable" or "significantly more stable" now that they were receiving HOPWA assistance. Of those clients surveyed who reported living in a shelter, hotel/motel, or in a transitional housing program, 60 percent reported that their opportunities to obtain permanent, stable housing after they leave has significantly improved since receiving assistance.

When asked if their residences were adequate in terms of their physical needs, 91 percent of the clients interviewed responded affirmatively. Only nine percent found their units inadequate. Of the majority of the clients interviewed who live with other people, two-thirds believe their residence has an adequate amount of room for their household needs. When asked, "Aside from the cost of your housing, what other factor is the most important to you about where you live or would like to live", almost half responded with "location/neighborhood." This response was the most frequent response by a factor of more than two to one.

Clients were also asked if their “quality of life” was better or worse on a range of issues, now that they were receiving HOPWA housing assistance. Included were such issues as “access to medical care” and “access to supportive services.” The clients' responses indicate that they believe their quality of life has clearly improved under the HOPWA program.

Policy Implications

While this telephone survey provides some insight into clients' views of the program, this very small sample is not statistically valid. In addition, there are selection problems in that the clients are theoretically continuing to participate in the program because there is some advantage for them. Therefore, it would be inappropriate to draw policy implications from these responses.

Obtaining a statistically valid, representative sample of clients' views is difficult to achieve because of major concerns about client privacy. Understandably, housing assistance providers will not release the names, telephone numbers, or addresses of their clients. This telephone survey was possible because a sample of housing assistance providers agreed to provide a notice to their clients requesting that they call a toll-free number to be anonymously interviewed about the HOPWA program.

Similar research in the future should also include interviews with potential clients who decided not to participate in the HOPWA program to learn their reasons for declining. It should also include interviews of clients who left the program to determine what proportion of their departures, if any, were due to dissatisfaction with the assistance they received through the HOPWA program. People participating in a voluntary program are by definition a self-selected group, and that should be considered when weighing client, or potential client, perceptions of the program.

V. INTEGRATION OF HOPWA WITH OTHER PROGRAMS

CHAPTER OVERVIEW

What Does this Chapter Present?

- The extent to which HOPWA providers coordinate with Ryan White CARE Act, Continuum of Care, Consolidated Plan and other local planning processes.
- The extent to which HOPWA providers coordinate with other organizations to provide a wide array of supportive services.
- The extent to which HOPWA housing assistance providers combine HOPWA funds with other financial resources for housing expenses.

Why is this Information Important?

- Coordination of services and resources increase the capacity of a program to serve the target population.
- Coordination can help a community deliver comprehensive assistance without duplication, increasing efficiency and facilitating resource development and sharing.

What are the Major Findings?

- Most grantees and providers report some degree of coordination with Ryan White CARE Act and Continuum of Care systems.
- Most HOPWA housing assistance providers develop local partnerships to make available a broad range of supportive services.
- On average, each dollar used for HOPWA housing assistance is being combined with a dollar for housing assistance from other government and private sources.

INTRODUCTION

At a time when government housing and human service budgets are stretched thin to meet a wide variety of needs, Federal programs are placing a greater emphasis on building partnerships and effectively coordinating resources than ever before. Similar to many other grant programs, the HOPWA program strongly encourages grantees and providers to coordinate with other local agencies to provide comprehensive service systems to meet the growing needs of persons living with HIV/AIDS and their families. By integrating the provision of services, HOPWA assistance helps to provide a comprehensive social safety net of support for those low-income households affected by HIV/AIDS.

The purpose of this chapter is to examine how well the HOPWA program is integrated with other programs, including health care and supportive services, within a community strategy for assisting persons living with HIV/AIDS. This chapter also offers insight into how this integration has occurred.

The chapter begins by examining interagency coordination at the grantee level, with emphasis on HOPWA coordination with Ryan White CARE Act programs and with Continuum of Care homeless assistance planning. Then, it reviews interagency coordination of services at the housing assistance provider level. Next, it examines the extent to which HOPWA funds are combined with other funding sources to help meet the housing needs and preferences of clients. Finally, a summary of findings and policy implications is presented.

INTERAGENCY COORDINATION

The HOPWA regulations indicate that grantees and providers have a "special responsibility" to cooperate and coordinate with the agencies of relevant State and local governments and other public and private organizations providing services to persons living with HIV/AIDS and their families.[1] However, with regard to the formula grants portion of the HOPWA program, through which 90 percent of HOPWA funds are allocated, there is no incentive or enforcement tied to this "responsibility." In contrast, the application rating process in the competitive portion of the program, through which the remaining 10 percent of funds are awarded, provides a specific incentive for interagency coordination.

Ten percent of the points under the Fiscal Year 2000 competition were awarded to applicants based on evidence of the program's "comprehensiveness and coordination." According to the Notice of Funding Availability (NOFA), "[t]his factor addresses the extent to which [the applicant] coordinated the specific proposal with other known organizations, consulted prospective clients or persons living with HIV/AIDS in designing the proposal, participates or promotes participation in the jurisdiction's Consolidated Planning process, and in a community's Continuum of Care Homeless Assistance planning (if homeless persons are to be served by proposed activities), and is working toward addressing a need in a holistic and comprehensive manner through linkages with other activities in the community."

Even without specific incentives and enforcement connected to HOPWA formula grants, interagency coordination is occurring. With two primary sources of Federal funding dedicated to meeting the housing and service needs of people living HIV/AIDS—the HOPWA program and The Department of Health and Human Service's Ryan White CARE Act program—many communities are linking HOPWA and Ryan White CARE Act funding to provide a range of housing, health care, and support services to individuals and families living with HIV/AIDS. As was evident from the site visits conducted for this study, the ability to coordinate with Ryan White CARE Act providers and other local HIV/AIDS service organizations appears to be one of the biggest determinants of a program's success. In effect, the coordination allows communities to establish community-wide funding priorities, efficiently allocate and/or shuffle resources based on both need and program regulations, and prevent the duplication of services, while at the same time making available a comprehensive network of services and preventing individual clients from "falling through the cracks."

In addition to coordination resulting from planning and implementation, some of the coordination may be occurring as a result of grantees and/or subgrantees areas of program focus. As discussed in Chapter III, housing assistance providers often have program priorities in addition to providing housing assistance

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[1] 24 CFR §574.420

through the HOPWA program. In support of these other priorities, the organizations may be receiving money from other, potentially complementary, sources. When the organization is then assisting individuals, they are able to present a full range of services and support to them. This is a form of "internal" coordination—internal to the assistance provider, as opposed to "external" coordination where the assistance provider is partnering to some degree with other organizations.

In Marin County, California, for example, delivery of HIV/AIDS services is a highly coordinated effort. The County, which was the site of one of the six SPNS projects visited for this report, has had a collaborative of public and nonprofit service providers working together since the mid-1980s. This collaborative evolved into the Marin AIDS Commission, which is composed of a standing Housing Committee (the HOPWA Working Group), a standing Education and Prevention Committee, and varying task forces. The HOPWA Working Group is staffed by representatives of the Marin County Community Development Agency (the HOPWA grantee), the Marin County Housing Authority (the housing assistance provider), the Marin County Department of Health and Human Services (the primary Ryan White CARE Act grantee), and a number of partnering nonprofit service organizations. The Ryan White CARE Act funding provides a myriad of supportive services for people living with HIV/AIDS, such as case management, mental health counseling, early treatment intervention services, transportation, food, and dental care. Because of this coordination, Marin County is able to earmark the majority of its HOPWA funds for direct housing subsidies.

Consequently, Marin County has used housing as a way to enhance existing resources, thus giving persons living with HIV/AIDS access to an excellent continuum of care. Unfortunately, not all grantees are able to achieve this level of collaboration due to a variety of limitations or barriers.

Grantee Coordination with Ryan White CARE Act Programs

Formula Grantee Questionnaire results indicate that there is significant coordination between HOPWA grantees and organizations administering Ryan White CARE Act funds. As Exhibit V-1 indicates, data sharing is the most common coordination activity with nearly 90 percent of grantees indicating that they share data with Ryan White CARE Act planning councils and consortia. Unfortunately, from the data that were collected it is impossible to know the nature of the data sharing activities that are occurring, and therefore, to understand the benefits of these activities.

DESCRIPTION OF THE RYAN WHITE CARE ACT PROGRAM

The Health Resources and Services Administration (HRSA) has lead responsibility for the Ryan White CARE Act. The programs of the Act are managed by the HIV/AIDS Bureau (HAB). Since 1991, close to $6.4 billion in Federal funds have been appropriated under the Ryan White CARE Act, providing services to hundreds of thousands of people living with HIV/AIDS. The Ryan White CARE Act provides the following assistance:

- **Title I:** Provides emergency relief grants to cities for health and support services for low-income and under- or uninsured persons living with HIV/AIDS and their families.
- **Title II:** Provides formula grants to all 50 states, the District of Columbia, Puerto Rico, and U.S. territories to improve the quality, accessibility, and organization of health care and support for those with HIV/AIDS.
- **Title III:** Provides grants for comprehensive primary health care services for people living with AIDS and at-risk populations, including women, the homeless, and substance abusers to slow transmission of the disease and provide early intervention. To qualify for funds, organizations must be public or nonprofit private entities.
- **Title IV:** Provides grants for coordinated HIV services and access to research for children, youth, women, and families. Applicants must demonstrate the ability to provide access to clinical trials or to establish links with providers offering clinical trials or other research.
- **The SPNS Program:** Supports the development of innovative HIV/AIDS service delivery models that have potential for replication in other areas, locally and nationally.
- **The AETC Program:** Supports training for health care providers to counsel, diagnose, treat, and manage individuals with HIV infection and to help prevent high risk behaviors that cause infection.
- **The HIV/AIDS Dental Reimbursement Program:** Provides support to dental schools and post-doctoral dental education programs for uncompensated care for persons with HIV disease.

Titles I, II, and IV of the Ryan White CARE Act allow housing-related assistance as eligible expenditures. In FY 1999, an estimated $40 million was proposed for housing services by Ryan White grantees. Funds received under the Ryan White CARE Act may be used for the following housing expenditures:[2]

- Housing referral services defined as assessment, search, placement, and advocacy services must be provided by case managers or other professionals who possess a comprehensive knowledge of local, State, and Federal housing programs and how they can be accessed; or
- Short-term or emergency housing defined as necessary to gain or maintain access to medical care and must be related to either:
  - housing services that include some type of medical or supportive service; including, but not limited to, residential substance abuse or mental health services (not including facilities classified as an Institute of Mental Diseases under Medicaid), residential foster care, and assisted living residential services; or
  - housing services that do not provide direct medical or supportive services but are essential for an individual or family to gain or maintain access and compliance with HIV-related medical care and treatment.

Short-term or emergency assistance is understood as transitional in nature and for purposes of moving or maintaining an individual or family in a long-term, stable living situation. Thus, such assistance cannot be permanent and must be accompanied by a strategy to identify, relocate, and/or ensure the individual or family is moved to, or capable of maintaining, a long-term, stable living situation.

Housing funds cannot be in the form of direct cash payments to recipients for services and cannot be used for mortgage payments.

The Ryan White CARE Act must be the payer of last resort. In addition, funds received under the Ryan White CARE Act must be used to supplement but not supplant funds currently being used from local, state, and federal agency programs.

[2] The Ryan White CARE Act was being reauthorized at the time this HOPWA evaluation report was being completed. The impact of the reauthorization on housing assistance provided under that Act is not as yet known.

RYAN WHITE CARE ACT PLANNING COUNCIL AND CONSORTIA

The Planning Council

The Ryan White CARE Act provides Federal government funding for medical and supportive services for persons living with HIV/AIDS and their families. A planning council must be appointed before an Eligible Metropolitan Area (EMA) can receive Title I monies.

The planning council sets priorities according to what services are most needed in the EMA, allocates resources for each of these services, and develops a comprehensive plan to provide these services. All decisions must be based on needs assessment of persons living with AIDS in the community. The planning council must also evaluate how efficiently providers are selected and paid.

The Ryan White CARE Act requires planning councils to have members from various groups and organizations. At least one-fourth (25 percent) of the planning council members must be people living with HIV. Specific categories of people in the community must be represented and are outlined by the Ryan White CARE Act. The planning council membership must also reflect the population with HIV in the EMA, meaning that the planning council membership must have similar characteristics (such as race or ethnicity, exposure categories, age, etc.) as the people living with HIV disease in the EMA.

Source: Ryan White CARE Act Planning Council Primer, http://hab.hrsa.gov/test/PCP/PCPrimer.htm

HIV Care Consortia

Most States provide some services directly and others through subcontracts with Title II HIV care consortia. A consortium is an association of public and nonprofit health care and support service providers and community-based organizations that plans, develops, and delivers services for people living with HIV disease.

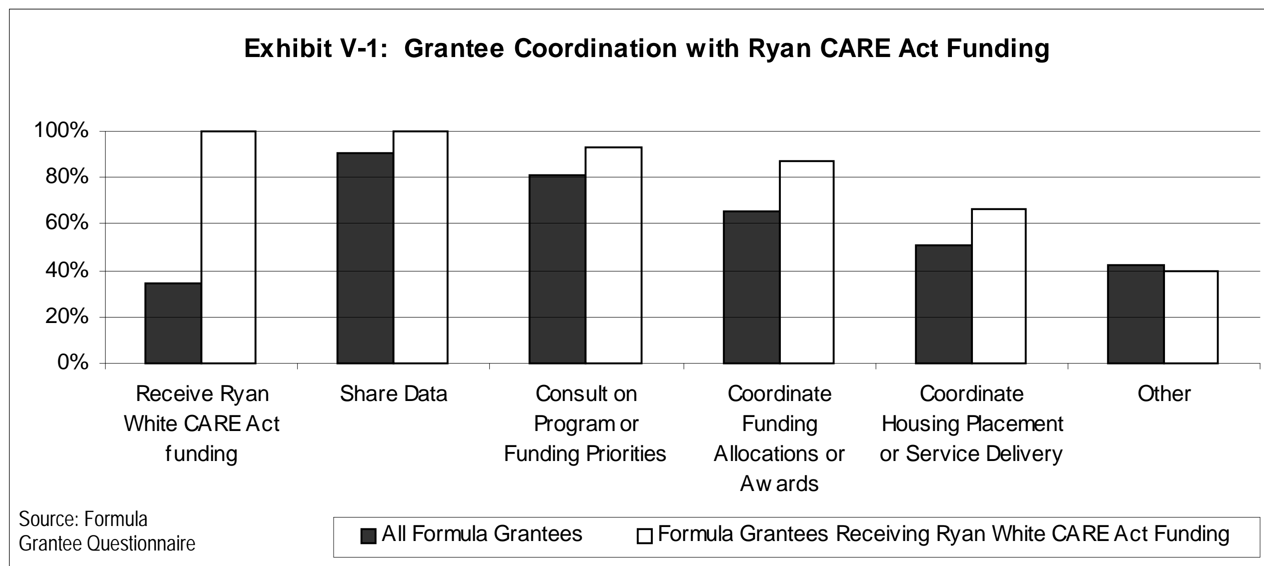
A consortium must submit an application to the State assuring that it has:

- ❑ Conducted a needs assessment;
- ❑ Developed a plan and set service priorities to meet identified needs;
- ❑ Promoted coordination and integration of community resources, addressing the needs of all affected populations;
- ❑ Assured the provision of comprehensive outpatient health and support services; and
- ❑ Arranged to evaluate the success and cost-effectiveness of the consortium in responding to service needs.

Source: Fact Sheet: Title II Ryan White Care Act, http://hab.hrsa.gov/care.html

Over 80 percent of formula grantees surveyed reported consulting on program and/or funding priorities, but only 65 percent attempt to coordinate funding allocations and over half report coordinating service delivery. As Exhibit V-1 shows, the proportion of grantees reporting coordinating activities increases among those grantees also receiving Ryan White CARE Act funding.

While Exhibit V-1 indicates significant coordination, anecdotal evidence suggests that there is considerable room for improvement in coordination at the grantee level. In describing weaknesses of the HOPWA program, several grantees and housing providers reported that the program lacks structured coordination with other grants that serve the same population, mutual understanding between Ryan White CARE Act and HOPWA administrators, and the ability to broaden the type of organizations willing to participate in the HOPWA program. Some grantees indicated that the program could be improved by implementing better communication among all interested and affected government agencies, while others requested further guidance on how to coordinate HOPWA and Ryan White CARE Act funding streams. Currently, the HOPWA and Ryan White CARE Act programs are independent programs with their own rules, policies, application procedures, and funding streams. The lack of coordination of these programs at the Federal level hinders efforts at the local level to use them in tandem.



Nonetheless, where coordination is taking place, grantees generally state that the cooperative approach has been beneficial for their clients and their organizations. Where the feedback was positive, grantees indicated the coordination "maximized the housing and services provided to people living with HIV/AIDS," "led to better decisions about [the] distribution of funding," and "allowed coordination of service system with housing." One staff member commented that their collaborative "provides a lot of services to clients that would not otherwise be provided if we worked separately." By speaking to each other regularly, the collaboration ensures that each client receives a seamless web of services."

Grantee Coordination with Continuum of Care Homeless Assistance Planning

Since 1994, HUD has been encouraging communities to address the problems of housing and homelessness in a coordinated, comprehensive, and strategic fashion. The Continuum of Care planning process was introduced to support communities in this effort. This process encourages communities to plan, organize, and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximum self-sufficiency. It also includes action steps to end and prevent homelessness.

A comprehensive Continuum of Care plan considers the needs of all homeless people, specifically addressing the multiple needs among homeless sub-populations, including, for example, those in need of substance abuse recovery services and those living with HIV/AIDS.

While formula grantees and their housing assistance providers also report working to coordinate with local Continuum of Care processes, they are not reporting as much coordination here as with the Ryan White CARE Act programs. While over 60 percent of grantees indicate coordinating funding allocations with Ryan White CARE Act councils/consortia, only 32 percent of

The Fundamental Components of a Continuum of Care System

- Outreach and assessment to identify an individual's or family's needs and connect them to facilities and services.
- Immediate (emergency) shelter as a safe, decent alternative to the streets.
- Transitional housing with appropriate supportive services, such as job training/placement, child care, substance abuse treatment, mental health services, and instruction in independent living skills.
- Permanent housing or permanent supportive housing arrangements.

grantees report this type of coordination with the Continuum of Care process, as shown in Exhibit V-2. Similarly, while approximately one-half of grantees coordinate housing placement and service delivery with Ryan White CARE Act planning councils and consortia, less than 40 percent do so in the Continuum of Care process.

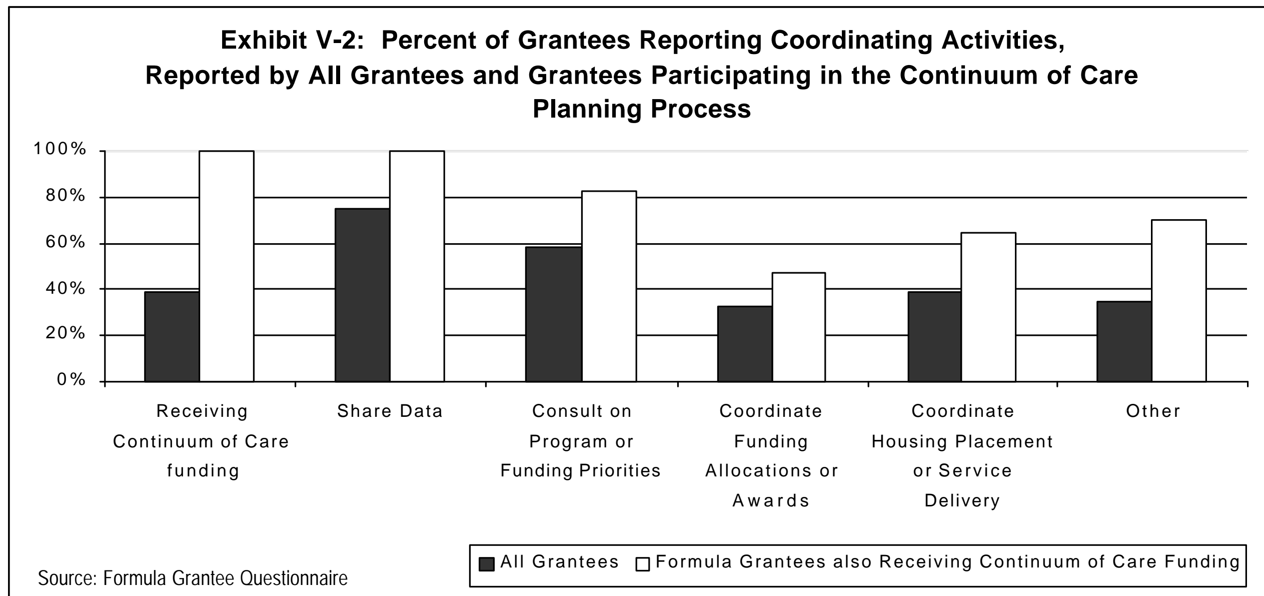


Exhibit V-2: Percent of Grantees Reporting Coordinating Activities, Reported by All Grantees and Grantees Participating in the Continuum of Care Planning Process

Source: Formula Grantee Questionnaire

This lower level of coordination is not surprising for a number of reasons. HOPWA EMSAs usually contain more than one Continuum of Care planning area, making coordination more complex. In addition, while the HOPWA program and the Ryan White CARE Act program share a common population eligible for assistance, the Continuum of Care focuses only on homeless individuals—a subset of whom are living with HIV/AIDS. Also, most Continuum of Care funding is competitive, so that funding is unpredictable, whereas most HOPWA and Ryan White CARE Act funding is by annual formula distribution. Moreover, much of Continuum of Care funding is now being used to renew funding for previously approved projects, so there is less opportunity for coordinating HOPWA and Continuum of Care funding. As with those grantees receiving both HOPWA and Ryan White CARE Act funds, HOPWA grantees actually receiving Continuum of Care funding report more coordination of activities.

Still, over three-quarters of those formula grantees surveyed reported some coordination with, or participation in, the Continuum of Care planning process. Also shown in Exhibit V-2, data sharing is again the most frequently cited coordination activity, followed by consultation on program or funding priorities. Most grantees report favorable benefits from this coordination, including prevention of service duplication, a more holistic approach to the delivery of services, and the provision of higher quality healthcare services. Nonetheless, several grantees and housing assistance providers also cited barriers to more effective collaboration, including difficulty getting HIV/AIDS housing issues included in gap analyses[3], lack of adequate funding, and the difficulty of project development when funding is not reliable.

[3] Gap analysis is the process of comparing needs with available resources to identify unmet needs.

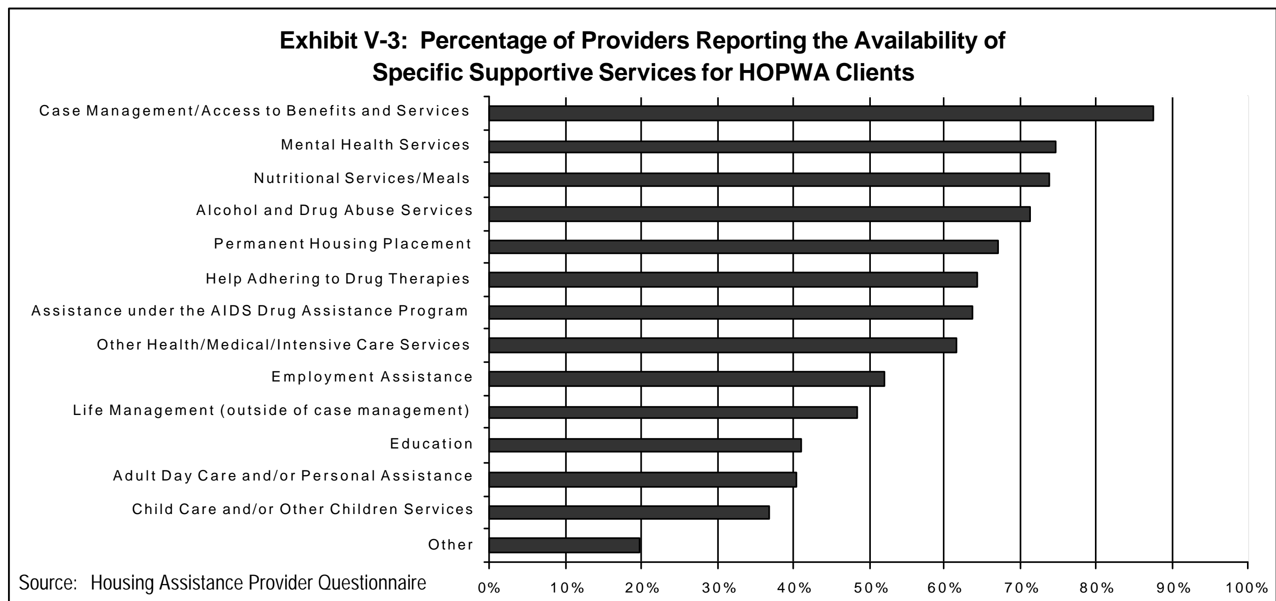
Providers Coordinate to Offer a Broad Range of Support Services

Several housing assistance providers indicated that one of HOPWA's strengths is its recognition of the relationship between housing assistance and supportive services. More specifically, respondents reported that this double emphasis allows for more continuity for clients, facilitates greater adherence to treatment, and encourages the maintenance of healthy behaviors among the clients.

Data from HUD's one-year profile of formula grantees operating in 1998 indicate that approximately 25 percent of HOPWA funds were spent on supportive services during that year. These services include case management, life management, nutritional services, adult day care, child care, education, employment assistance, substance abuse services, mental health services, as well as other health or mental care services, as defined by the HOPWA regulations. Similarly, respondents to the housing assistance provider questionnaire allocated, on average, slightly less than one quarter (22.2 percent) of their HOPWA funds to provide supportive services during their most recent program year.

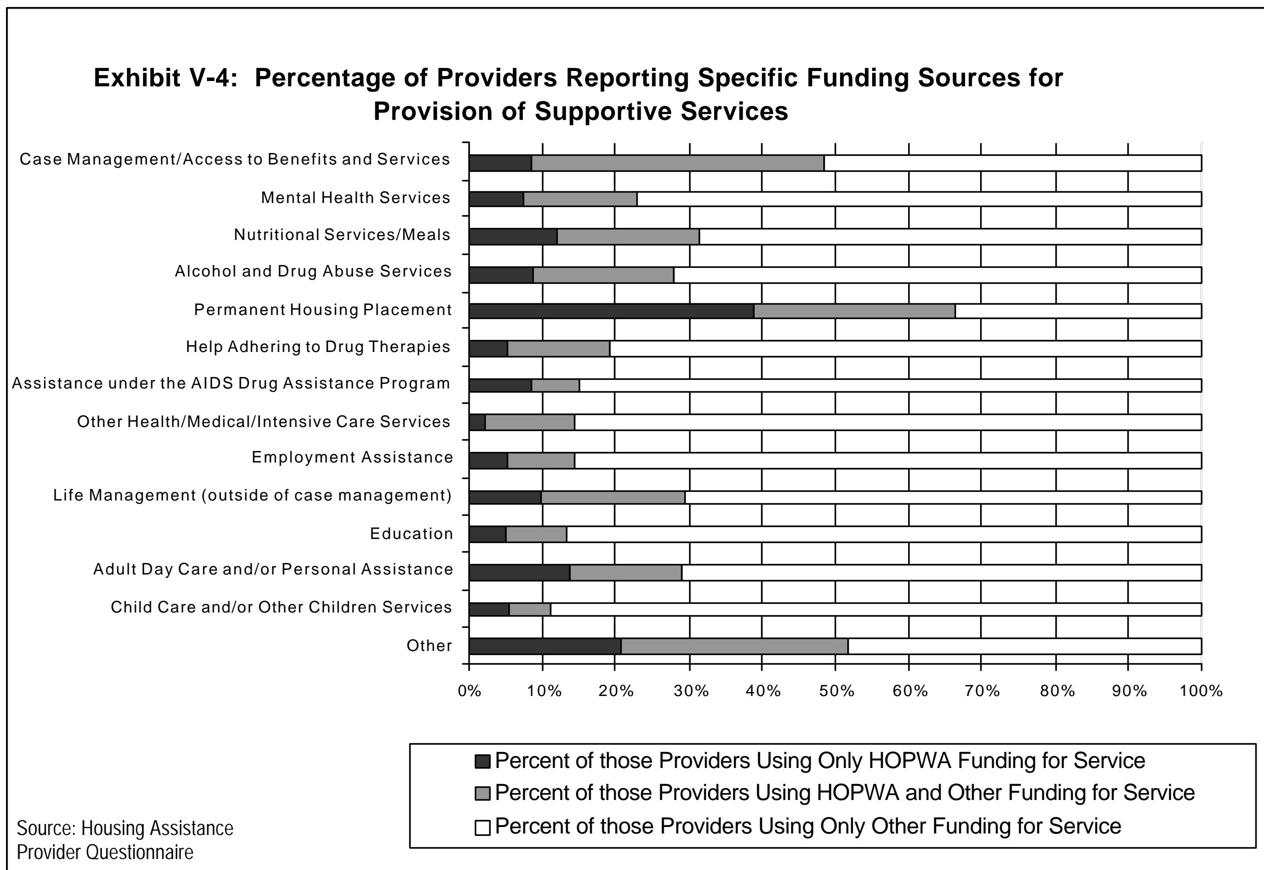
Exhibit V-3 above shows the percentage of providers that reported the availability of specific supportive services for their clients. As the exhibit indicates, nearly 90 percent of providers report that case management services are available to their clients, while approximately three-quarters link clients to mental health, alcohol and drug abuse, and/or nutritional services. Approximately one-half of providers link clients with employment assistance.

Exhibit V-3: Percentage of Providers Reporting the Availability of Specific Supportive Services for HOPWA Clients

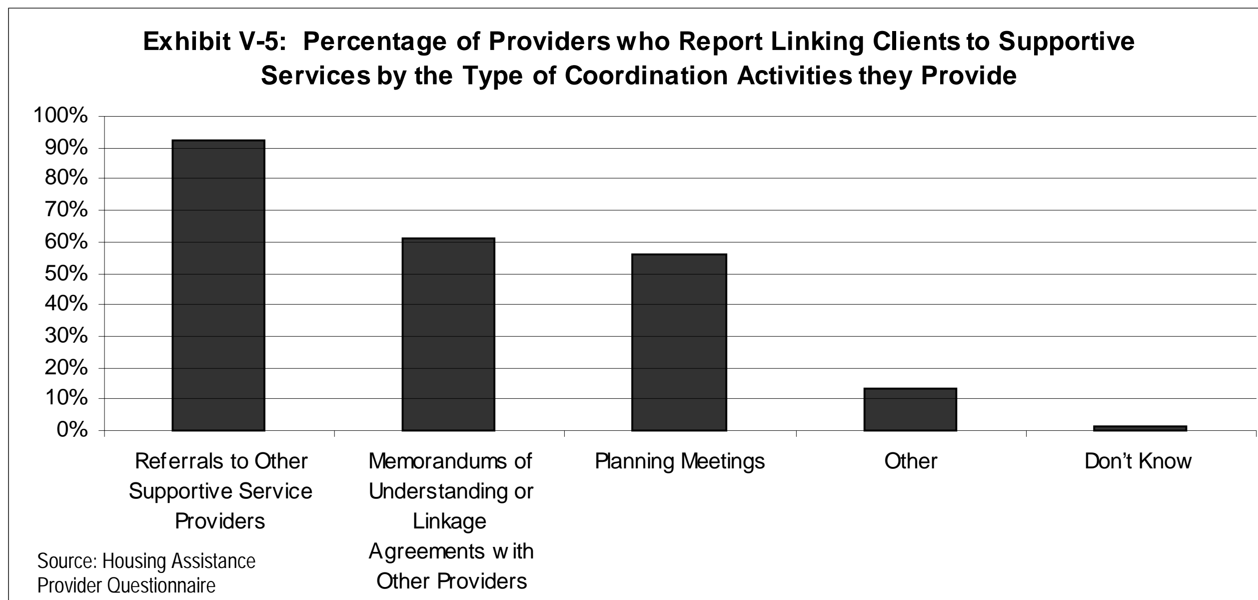


Source: Housing Assistance Provider Questionnaire

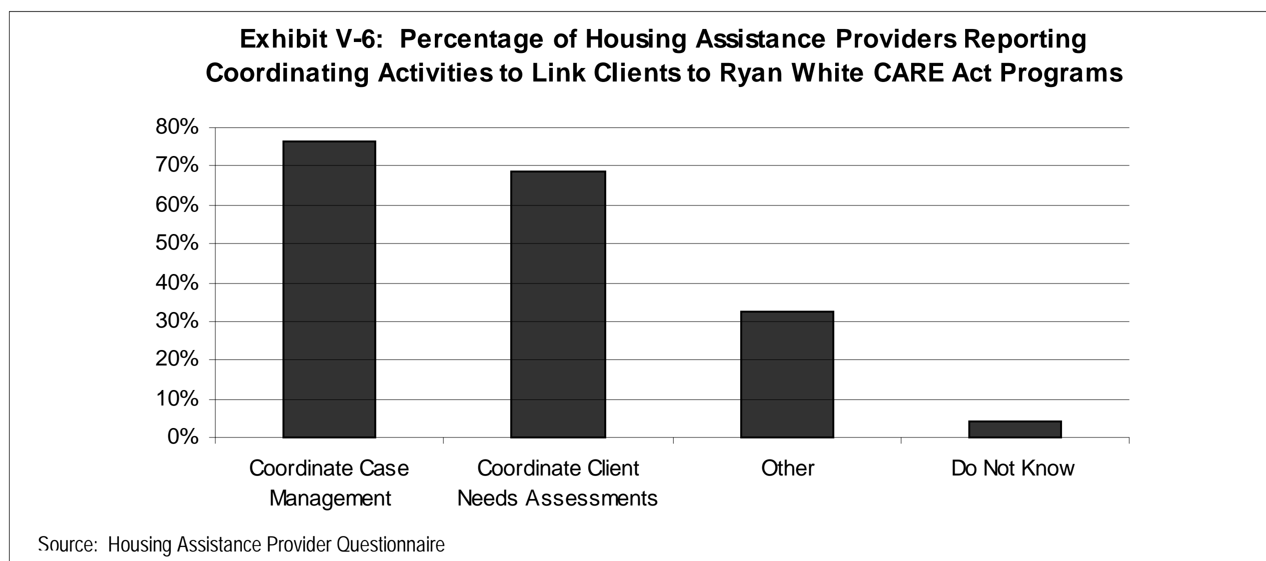
While there seems to be a significant number of services available to HOPWA clients, it seems that other, non-HOPWA funds are generally utilized for these services. Exhibit V-4 shows that most providers report making these available to their clients through a combination of HOPWA and other funding or with only non-HOPWA funds. Of those housing providers surveyed who reported providing at least one service to clients, 65 percent reported using HOPWA and at least one other funding source to provide the service. In fact, almost three-quarters of the providers surveyed indicated that they use seven or more sources of funding for supportive services.



In addition to providing services on their own, providers frequently develop partnerships with other local housing and service organizations, allowing them to make available a greater array of services, efficiently allocate resources, and prevent the duplication of services. As Exhibit V-5 indicates, almost all HOPWA housing assistance providers surveyed (91.8 percent) report that they provide clients with links to social service providers throughout their community. These linkages can greatly strengthen programs serving low-income persons, especially low-income persons living with HIV/AIDS where the provision of a continuum of care encompassing housing, healthcare, and support services is especially crucial. Exhibit V-5 also reveals the rates at which providers are engaging in coordination activities. About 92 percent of all providers surveyed reported some type of linking activity. Of those providers, about 93 percent reported that they use informal networks to provide clients with referrals, while over 60 percent have signed Memorandums of Understanding with other providers. In addition, over half take part in community planning meetings.

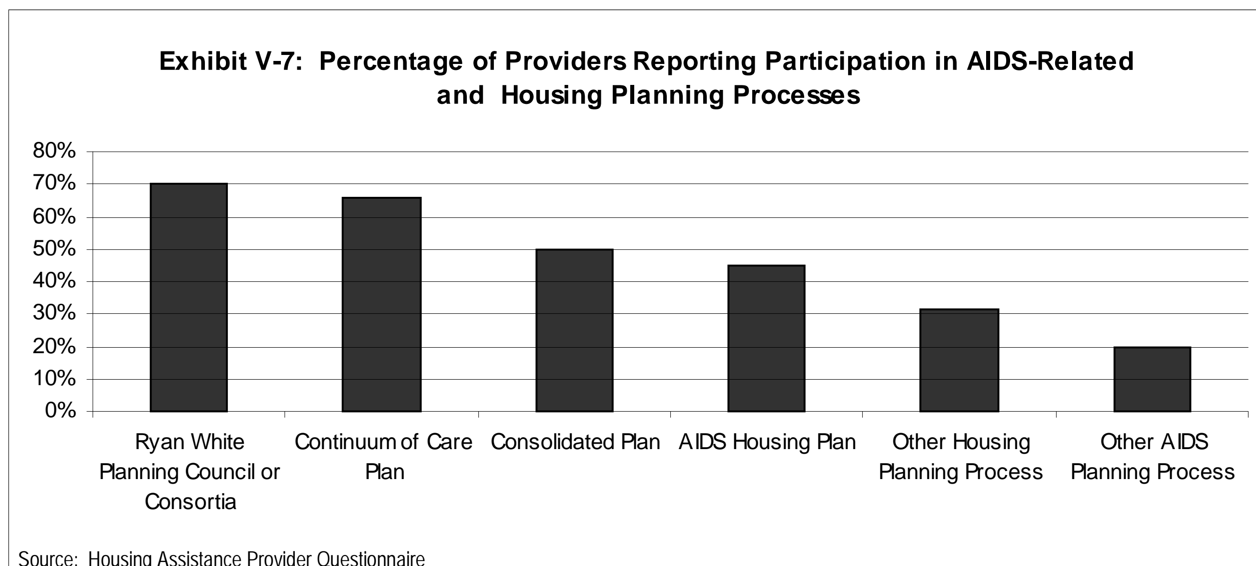


Similar to the coordination activities among grantees described above, HOPWA housing assistance providers also report some level of coordination with the local Ryan White CARE Act programs. Of the providers surveyed, 87 percent reported that they worked to link clients to assistance provided under Ryan White CARE Act programs. As Exhibit V-6 indicates, coordination occurs most commonly through case management and client needs assessments.



In addition to coordinating service delivery, HOPWA housing assistance providers, like grantees, also participated in coordinated planning processes. As Exhibit V-7 indicates, nearly 70 percent of providers participate in Ryan White CARE Act planning councils or consortia. Although, as discussed earlier, there appears to be considerable room for improvement in coordinating HOPWA and Ryan White CARE Act at the grantee level, significant coordination is occurring at the provider level. As with grantees, providers

were slightly less likely to participate in the Continuum of Care planning process, with 65.8 percent reporting participation in this process.



In contrast, only half of providers reported participating in the Consolidated Plan process. This relatively low percentage is interesting considering that all HOPWA formula funds are available as part of an area's Consolidated Plan, which also includes the Community Development Block Grant (CDBG), HOME Investment Partnership program, and Emergency Shelter Grants. Plans are developed through a public process with the goal of assessing area needs and creating a multiple-year strategy for the use of Federal funds and other community resources in a coordinated and comprehensive manner. In addition, there must be an acceptable Consolidated Plan as a condition of eligibility for a formula allocation under HOPWA.

The activities that are carried out with HOPWA funds are required to be consistent with an area's plan, but anecdotal evidence suggests that both grantees and providers do not find the Consolidated Plan process particularly beneficial for their particular circumstances. One major complication is that an EMSA may contain several Consolidated Plans and several CDBG and HOME grantees, making coordination complex. One grantee stated that "HUD's imposition of the Consolidated Planning process…has pulled us away from our mission." Another provider reiterated this by pointing out that in many communities, HOME and CDBG have established constituencies and funding patterns, and that working HOPWA into the equation can sometimes prove difficult. Thus, where coordination with the Consolidated Planning process is lacking, it may not be the case that HOPWA providers are not trying, but rather that the process is not working for them.

While there is always room for improvement in coordinating programs, it appears that local HOPWA programs have been at least moderately successful in building partnerships with other agencies and service providers to establish community-wide priorities, coordinate funding allocations, and ultimately, to offer a broad range of housing and support services to HOPWA clients.

COMBINATION OF HOPWA AND OTHER FUNDING

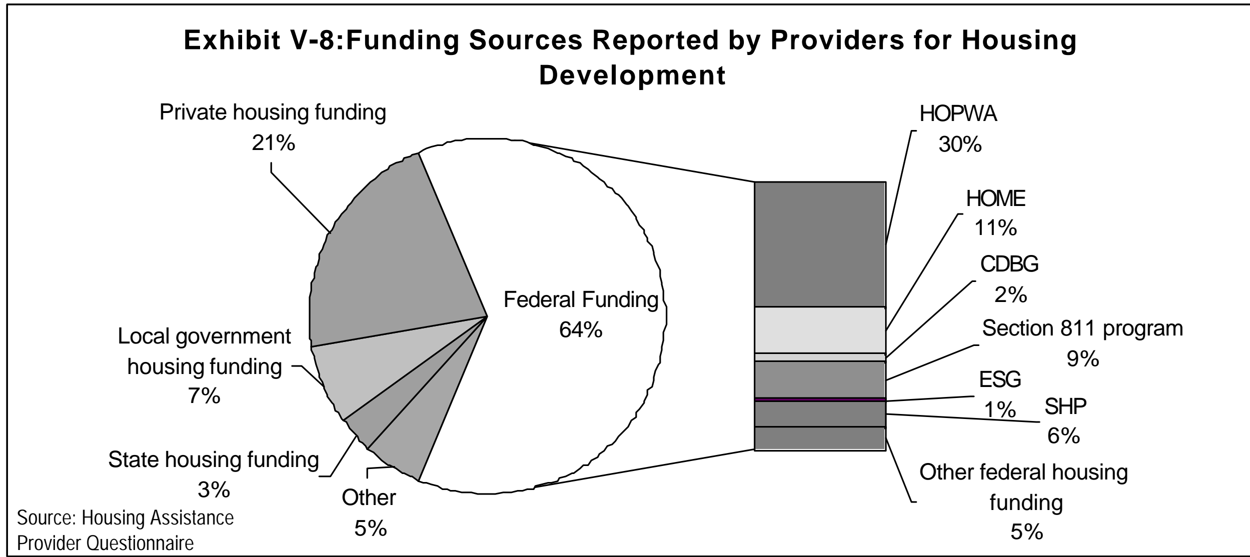
As described in the introduction to this chapter, another way to view the integration of HOPWA with other programs is by examining the extent to which HOPWA funds are combined with other funding sources to help meet the housing needs and preferences of clients. As the following sections will show, housing assistance providers have generally carried out HOPWA activities with a significant amount of other assistance.

Combining HOPWA with Other Funding Sources for Housing Development and Operating Expenses

HOPWA housing assistance providers report that the highest degree of resource combination occurs in housing development projects.[4] This probably reflects the high costs associated with housing project development that generally includes expenses for property acquisition, construction, and/or rehabilitation. The lengthy development process, including pre-development and construction periods, also introduce added costs to housing production. However, after the development is completed, it is usually owned by the assistance provider who can then help ensure that it remains affordable for the future.

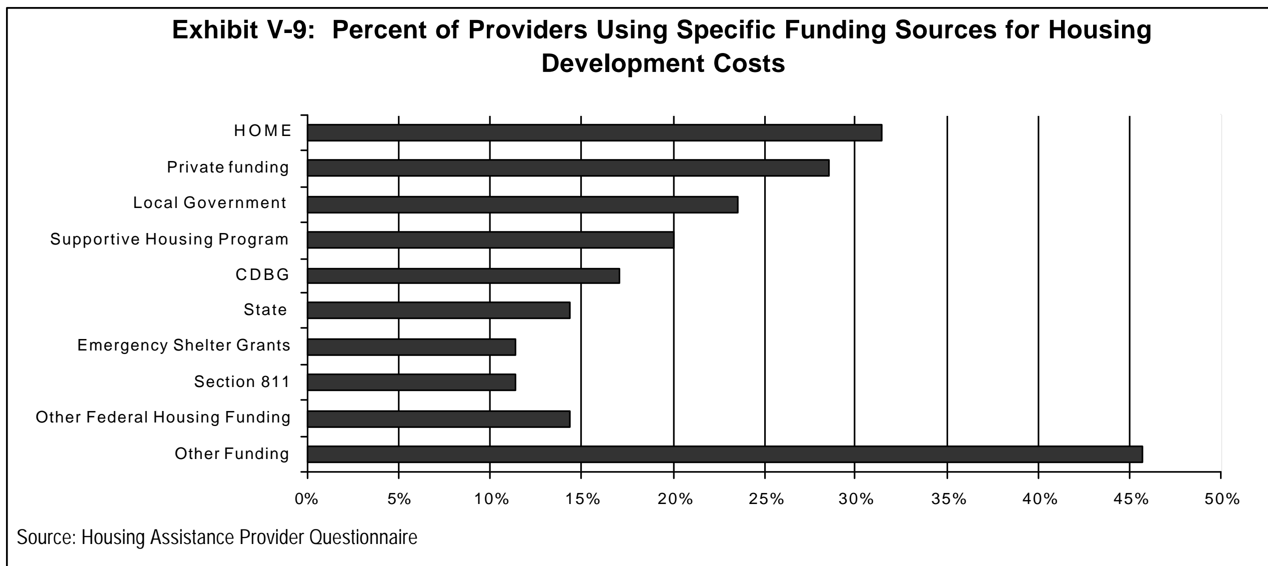
Approximately 25 percent of the providers responding to the Housing Assistance Provider Questionnaire reported using HOPWA funding for housing development projects. On average, they reported spending $1.24 million on housing development, ranging from $8,404 to $6.8 million in size. Of the amounts dedicated to housing development, 70 percent were from sources other than HOPWA. Exhibit V-8 shows the percentage contributed from each source for all housing development costs reported by these providers. However, each funding source represents a relatively small percentage of the total. Aside from HOPWA and private funding (which comprise 30 percent and 21 percent, respectively), no single source represents more than 11 percent of the total. Given that each program has different rules and requirements, combining multiple funding sources to carry out development activities is a complex process and may serve as an impediment to housing development projects. This may be particularly true for agencies with little housing background, as is the case with many AIDS service organizations.

[4] Housing development costs, which were referred to as project development costs in the Housing Assistance Provider Survey, are defined as the costs associated with the development/production of housing. These include both "hard costs" – consisting of payments made for the acquisition of land or existing structures, site work, and construction or rehabilitation – and "soft costs" – including costs for items such as architectural and engineering fees and financing expenses.



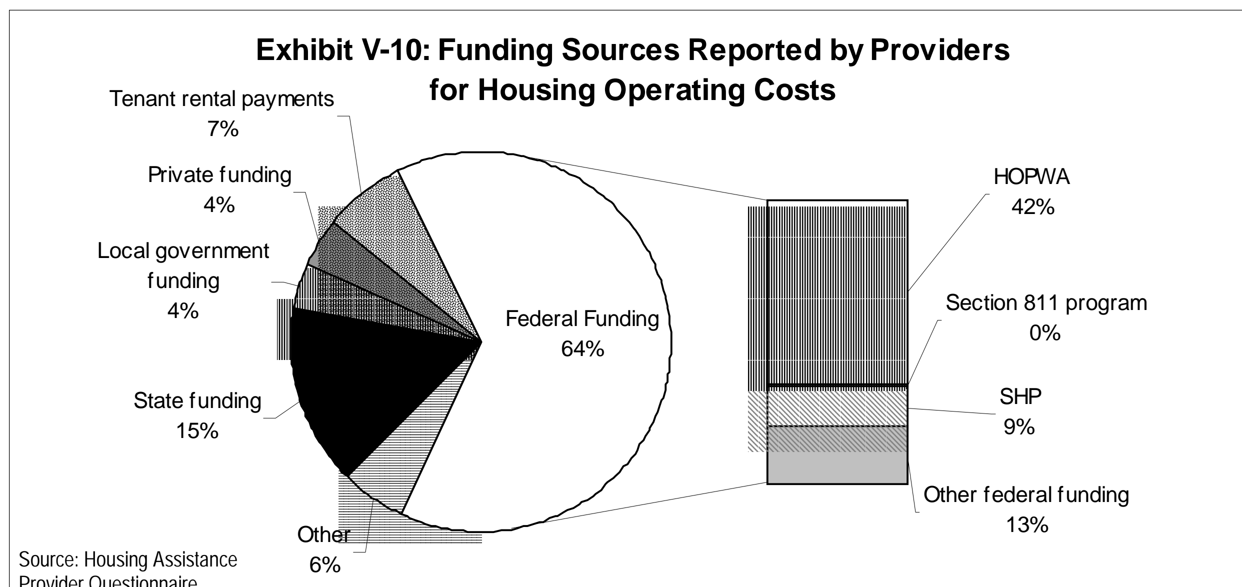
Other Federal funding includes Federal Home Loan Bank funding, owner equity, support from foundations, bank loans, individual donors, community banking consortium, limited partners, general partners, and tenant rental contributions.

Exhibit V-9 examines the combination of resources from a different perspective. It shows the percentage of providers using specific funding sources, in addition to HOPWA, for housing development costs. For example, this exhibit shows that over 30 percent of providers reported using HOME funding together with HOPWA for housing development expenses. Just below 30 percent of these providers also used private funding. Similarly, approximately one-quarter of the providers reported using local government funding, and one-fifth used Supportive Housing Program funds. Note that the funding sources are not mutually exclusive: providers reported using three different funding sources, on average, for housing development.



Other federal funding includes Federal Home Loan Bank funding, owner equity, support from foundations, bank loans, individual donors, community banking consortium, limited partners, general partners, and tenant rental contributions.

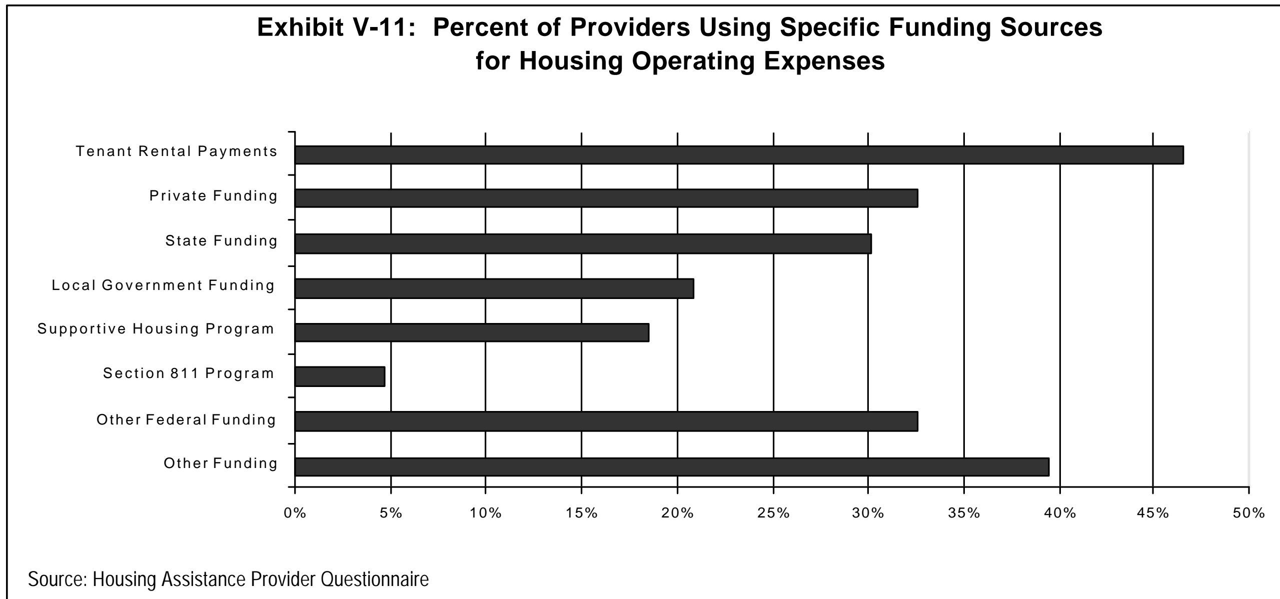
Similar to housing development costs, a relatively high percentage of housing operating costs are funded from sources other than HOPWA.[5] Among those providers surveyed who reported using HOPWA funds for operating expenses, nearly 60 percent of the funds were from other sources. However, as shown in Exhibit V-10, these costs again constitute relatively small proportions of the total budget, with State funding comprising the highest percentage of total funding (aside from HOPWA) at 15 percent. Operating budgets among providers varied widely, ranging from $2,572 to $2.1 million annually.



Other funding includes foundation support and charitable giving.

As with the other types of activities, providers typically combined a variety of sources to cover housing operating expenses. As Exhibit V-11 shows, of those providers who reported using HOPWA for housing operations, approximately one-third also reported using other Federal funding, State funding, and/or private funding, while almost one-half indicated using tenant rental payments for operating expenses.

[5] Housing operating expenses, which were referred to in the Housing Assistance Provider Questionnaire as project operating expenses, are the costs associated with the day-to-day operation of housing, including such costs as housing management, maintenance, insurance, repairs, security, utilities, furnishings, and equipment. Housing operating expenses do not include expenses for supportive services or health care for residents.



Other funding includes foundation support and charitable giving.

Reliance on HOPWA for Short-Term Payments and Tenant-Based Rental Assistance

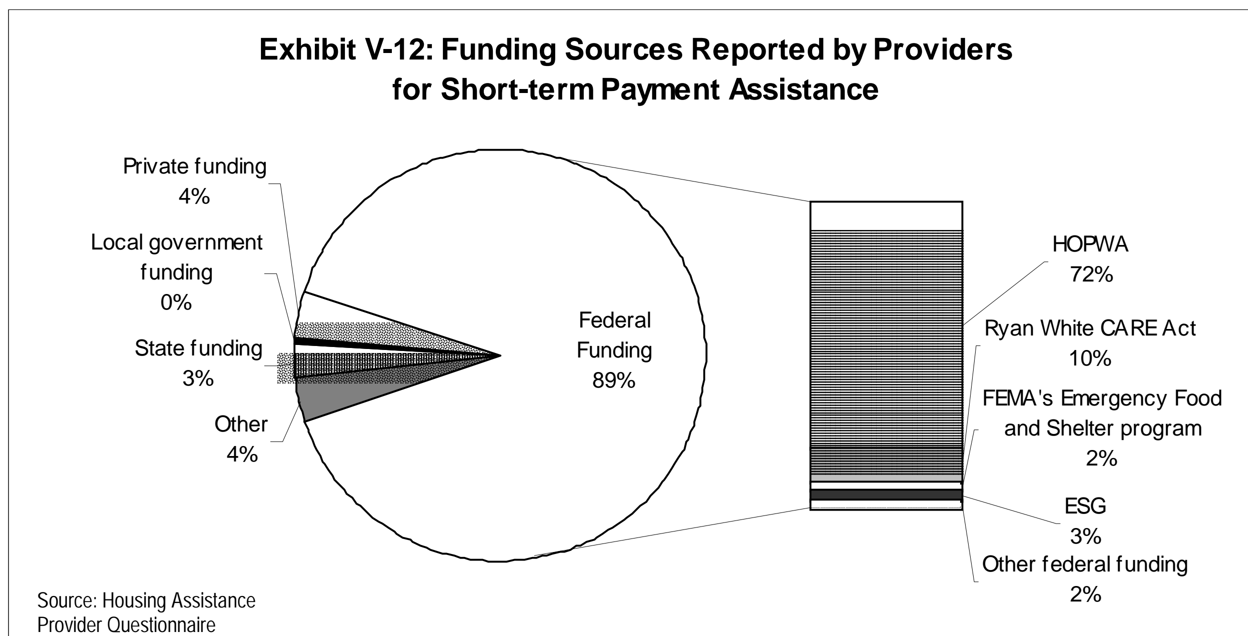
In contrast to housing development and operating costs, combining HOPWA funds and other financial resources for short-term payments for rent, mortgage and/or utilities[6] and tenant-based rental assistance (TBRA),[7] is much less common, according to the data collected from housing assistance providers.

Short-term payments and TBRA probably involve less combining of resources than housing development and housing operating expenses because the number of clients assisted with short-term payments or TBRA can easily be adjusted to fit the amount of HOPWA funds available. In contrast, the costs of a housing development project and the costs of operating such a project are much less flexible and frequently are much higher. Also, guidelines vary among TBRA programs funded from different sources making a combination of resources difficult.

Of those providers that reported using HOPWA funds to provide short-term payments for rent, mortgage and/or utilities, sources of funding other than HOPWA constituted only slightly more than one-quarter of the total budget for these costs. HOPWA funding for short-term payments for rent, mortgage and/or utilities ranged from annual expenditures of $1,925 in one program to annual expenditures of $763,111 in another. Exhibit V-12 shows the percentage of short-term payments provided by each source of funding. Ryan White CARE Act funds contributed ten percent to funding for short-term payments.

[6] Short-term refers to payments for not more than 21 weeks in any 52-week period. These payments can range in size, but their duration is limited.

[7] Tenant-based rental assistance, as defined in the glossary, includes on-going rental assistance for eligible persons, although program design varies by housing provider.

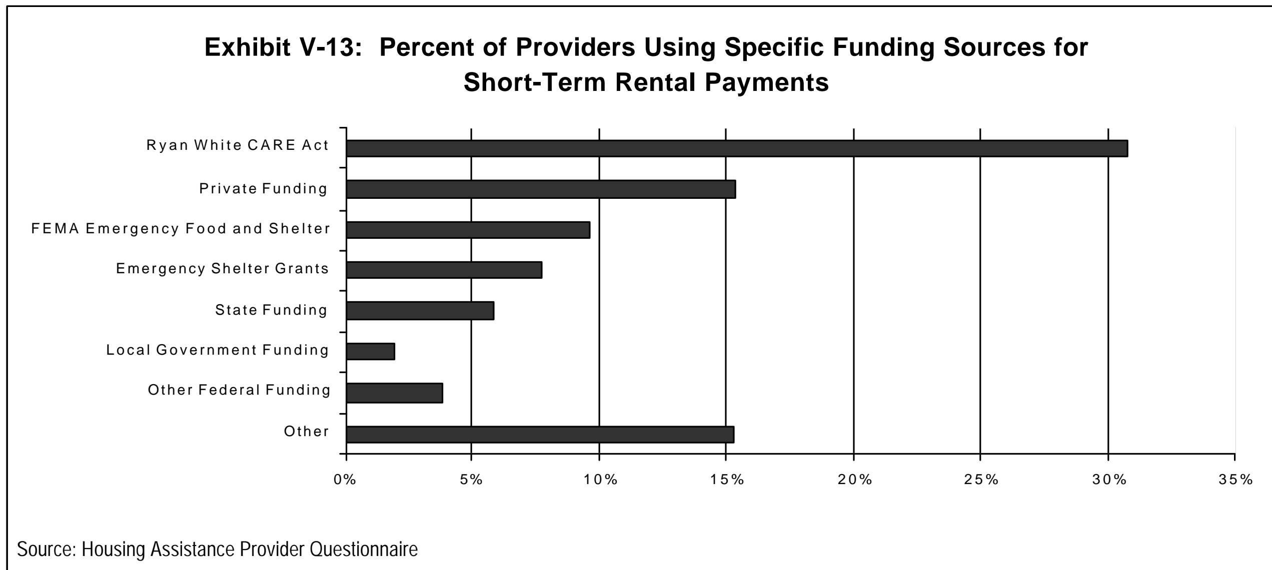


Other funding includes agency-generated unencumbered funds, low-income home energy assistance program, tenant rental payments, and donations.

While approximately 15 percent of providers using HOPWA funds for short-term payments combined more than five sources–including HOPWA–for these payments, over 80 percent reported using only HOPWA or HOPWA and one other funding source. As Exhibit V-10 shows, nearly one-third of providers using HOPWA funds for these expenses also reported using Ryan White CARE Act funds.

While HOPWA accounts for almost three-quarters of the funding for short-term payments, it accounts for an even greater proportion (85 percent) of TBRA. Approximately 41 percent of the providers surveyed provide TBRA to their clients using HOPWA funds. Of those 41 percent, about 25 percent combine HOPWA with other funding sources to provide the assistance. These other funding sources, however, provide a relatively negligible amount of money, accounting for only 15 percent of total funding for TBRA projects.[8]

[8] Other funding sources for TBRA projects include Ryan White CARE Act funds, private funding, general revenue (including tenant rental payments), local government funding, and HUD sources, including Section 8, HOME, Shelter Plus Care, and Supportive Housing Program funds.



Source: Housing Assistance Provider Questionnaire

Other funding includes agency-generated unencumbered funds, low-income home energy assistance program, tenant rental payments, and donations.

SUMMARY OF FINDINGS AND POLICY IMPLICATIONS

Finding: Most grantees and housing assistance providers report some degree of coordination with Ryan White CARE Act and Continuum of Care systems.

Grantees and providers coordinate with Ryan White CARE Act and Continuum of Care systems on two different levels. One type of coordination happens at the grantee level, where it is possible to coordinate funding priorities and high-level community-wide decisions. At the project level, housing assistance providers have the opportunity to coordinate service provisions and make sure clients are not slipping through cracks in the system.

At the project level, there is evidence of coordination. For example, 92 percent of providers reported that they worked to link clients to assistance provided under Ryan White CARE Act programs. In addition, nearly 70 percent of all housing assistance providers surveyed participate in Ryan White CARE Act planning councils or consortia. Coordination generally occurs through case management and client needs assessments, with 76 percent and 68 percent, respectively, coordinating these activities with Ryan White CARE Act providers.

At the grantee level it is less clear if any real integration is occurring with regard to joint program planning and joint fund allocation decisions. There is evidence of meetings and data sharing, for example, but this evidence is insufficient to conclude that these activities are having an appreciable impact. Data sharing appears to be the most common activity, with over 90 percent of grantees surveyed indicating that they share data with Ryan White CARE Act planning councils and consortia and nearly 75 percent indicating that they share data with Continuum of Care agencies.

Policy Implications

Real integration of programs occurs when the benefits of coordination clearly outweigh the obstacles, including limited time and the difficulty of overcoming inconsistent program requirements. Coordination occurs at the project level because it is most directly beneficial to program clients. At the grantee level, where coordination occurs in a more complex and formal process, it is a greater challenge. Participating in meetings and planning processes where groups share information and data is helpful only in that it educates the community. However, unless beneficial outcomes for clients result, these sessions are of little consequence. Helping communities create plans and agreements that are workable and provide direct benefits to clients calls for sharing best practices and offering technical assistance.

Finding: Most HOPWA housing assistance providers develop local partnerships to make available a broad range of supportive services.

Most providers develop local partnerships and use several sources of funding to provide a wide array of supportive services. This range of services helps clients continue to lead as independent a life as possible. Nearly 90 percent of providers report providing case management services, while approximately three-quarters provide mental health, alcohol and drug abuse, and/or nutritional services. Just over one-half of providers are making available employment assistance to clients.

To connect clients with needed services, more than 90 percent of HOPWA providers provide referrals to other supportive service providers, over 60 percent have formal memorandums of understanding or linkage agreements with other providers, and more than 55 percent attend community planning meetings.

The range of services accessed by clients appears to be related to the type of housing assistance being provided. Generally, the more dependent the living situation, the higher the level of services. For example, residents of group homes generally use the most supportive services, while clients receiving short-term payments for rent, mortgage or utilities generally use the least. This may imply that the prevalence of short-term payments as a type of HOPWA housing assistance is related to its low cost in terms of both housing expense and the relatively low level of associated supportive services.

Policy Implications

Caution must be exercised in stating that HOPWA funds should be maximized for housing, as this diminishes one of the program's most appreciated characteristics—its flexibility. The allocation of funding to particular activities should remain a local decision based on a community's analysis of gaps in housing and services. However, as rising housing costs continue to outpace HOPWA funding allocations, it is becoming increasingly important that providers maximize the use of HOPWA funds for housing assistance and link clients to supportive services funded by other resources whenever possible.

Employment assistance provides an example of reliance on other funding sources for supportive services. As highly active anti-retroviral therapy (HAART) is allowing many persons living with HIV/AIDS to regain their strength and remain healthier longer, many are finding that they wish to return to work, and employment assistance is becoming more important. The impact of this trend is noticeably evident as 50 percent of providers responding to the survey indicated that they offer employment assistance to clients. However, only a small proportion of these providers are using HOPWA funds to provide employment assistance. Even that level of reliance on HOPWA funds might be higher than necessary. There may be

sufficient other resources available within a community (Department of Labor Workforce Investment Act funds, for example) so that no HOPWA dollars need be earmarked for this purpose.

Finding: On average, each dollar used for HOPWA housing assistance is being combined with a dollar for housing assistance from other government and private sources.

Most housing assistance supported with HOPWA funding is also being supported by other government and private sources. Funding sources other than HOPWA, on average, covered 52 percent of expenditures for housing assistance by providers responding to the Housing Assistance Provider Questionnaire. HOPWA housing assistance providers most often combine HOPWA with other funding for housing development projects and housing operating expenses, with the other funding providing, on average, 70 percent of housing development costs and approximately 58 percent of housing operating expenses.

Although providers are using many different sources of funds in combination with HOPWA for housing development efforts, most are using a very small percentage from each source. For example, HOME, a block grant program that allows State and local governments discretion to implement housing strategies, including assisting persons with special needs, is used by only 32 percent of providers and typically contributes only 11 percent of total development funding. As another example, Community Development Block Grant (CDBG) funds are only being used by 17 percent of providers and typically contribute only two percent of project total funding.

Policy Implications

Projects combining HOPWA and HOME or HOPWA and CDBG funds, for example, can help provide long-term affordable housing for persons living with HIV/AIDS. This is especially true for developing housing units, as these funding sources are large and are typically used for housing development projects. The fact that this linkage is only happening on a small scale and only by relatively few providers may suggest the need for more training and technical assistance on how HOME and CDBG can be used in AIDS housing development projects. Within most communities, however, HOME and CDBG have long-standing histories and established funding patterns, making it difficult to fit people living with HIV/AIDS into the equation. As a result, HUD should place more emphasis on ensuring that local Consolidated Plan processes are knowledgeable of, and take into account, the needs of persons living with HIV/AIDS and their families.

VI. SPECIAL PROJECTS OF NATIONAL SIGNIFICANCE (SPNS)

CHAPTER OVERVIEW

What Does this Chapter Present?

- ❒ Describes the findings from six site visits to SPNS projects that were evaluated in the application rating process as demonstrating innovation.
- ❒ Elaborates on the overall successes and the lessons learned from these programs.
- ❒ Discusses the replicability of the six programs.

Why is this Information Important?

- ❒ Underscores the goal of the SPNS projects--to identify effective practices that can serve as models for improving other HOPWA projects.

What are the Major Findings?

- ❒ The key to project success is regular collaboration and communication with partners and other local service providers.
- ❒ Special Projects of National Significance are providing effective models for replication.

OVERVIEW

By statute, approximately ten percent of the HOPWA funds appropriated by Congress each year are awarded on a competitive basis. The majority of projects funded by competitive awards are known as Special Projects of National Significance (SPNS), which, due their innovative nature or potential for replication, are likely to serve as effective models in addressing the needs of eligible persons. Unlike formula funding, all States, units of government, and nonprofit organizations may apply for SPNS grants.

While the previous chapters focused on HOPWA formula grants, this chapter examines whether competitive SPNS grants accomplished their goals, used innovative ideas or techniques, and provided effective models for replication. To address these issues, ICF conducted site visits to six competitive grantees that were evaluated during the application rating process as demonstrating innovation. While on site, the ICF team conducted interviews with the project director, staff members, and partnering agencies (as applicable) to learn the context in which each project operates, the degree to which the project used innovative ideas or techniques, the extent to which the project accomplished its intended goals and lessons for replicability.

The following sites were selected:[1]

- State of Connecticut (SPNS sites in Bridgeport, Hartford, New Haven and Waterbury)
  - Connecticut Department of Social Services (grantee)
  - Connecticut AIDS Residence Coalition (project sponsor)
- Key West, FL
  - City of Key West Community Development Office (grantee)
  - AIDS Help, Inc. (project sponsor)
- New York, NY
  - Episcopal Social Services of New York, Inc. (grantee)
  - Harlem United Community AIDS Center, Inc. and St. Mary's Episcopal Center (project sponsors)
- Portland, ME
  - The AIDS Project (grantee/project sponsor)
- San Antonio, TX
  - City of San Antonio Department of Community Initiatives (grantee)
  - House of Hope, Hope Action Care (project sponsors)
- Marin County, CA
  - Marin County Community Development Agency (grantee)
  - Marin County Housing Authority (project sponsor)

In addition to describing what was learned during the site visits, this chapter contains brief descriptions of each of these six projects, highlighted in text boxes throughout the chapter.

IMPLEMENTATION OF PROPOSED SPNS PROJECTS

This section examines the extent to which grantees were able to implement SPNS projects as they had proposed in their funding application. At four of the six sites that were visited—including Marin County,

[1] See Appendix 4 for information on the site selection process.

Portland, the State of Connecticut, and Key West—projects were carried out essentially as proposed. All four of these six grantees operate some variation of a rental assistance program, typically modeled after HUD's Section 8 Housing Choice Voucher Program. Marin County, for example, operates a capped rent subsidy program for persons living with HIV/AIDS, while the City of Key West offers both project-based and tenant-based rental assistance. Similarly, the Connecticut Department of Social Services and The AIDS Project in Portland, ME provide tenant-based rental assistance. The stated goals of the four projects were largely the same: to maximize independent living and self-determination while providing seamless delivery of housing and support services.

MARIN COUNTY, CALIFORNIA

Overview

Grantee: Marin County Community Development Agency
Location: San Rafael, California
Grant Year: 1995
Grant Amount: $1.1 million
Program Type: SPNS
Area Served: Suburban and rural areas of Marin County

Program Description: Marin County's SPNS program worked to maximize opportunities for individual living while meeting individual service needs in a cost-effective manner. Under the program, Marin County developed a rent subsidy program, which capped the amount of rent subsidy, an individual or family could receive. Case management and supportive services were also provided. The program promoted housing choice that protected privacy of the individuals and allowed for the program to be flexible in subsidizing different types of shared living arrangements.

Partnerships, Planning, and Coordination: The Marin County SPNS program works in cooperation with the Marin AIDS Commission, a collaborative of public and nonprofit providers. This Commission consists of many committees, including the HOPWA Working Group. Commission members include representatives from the Housing Authority, the Community Development Department and the Department of Health and Human Services.

Collaboration is Key to Successful Implementation

While organizational capacity and dedicated staff members no doubt play a significant role in each grantee's ability to carry out its proposal, perhaps the most important factor was the degree of collaboration and cooperation among partnering agencies.

Both Portland and the State of Connecticut, for example, have highly collaborative service networks for persons living with HIV/AIDS. In Portland, when the AIDS Project received their SPNS grant in 1994 they established the Housing Assistance and Volunteer Enlistment Network (HAVEN) collaborative to bring tenant-based rental assistance, comprehensive case management, home health care, family therapy, and other support services to persons living with HIV/AIDS. In addition to bringing together local resources and players, receiving the SPNS grant in 1994 gave the HAVEN collaborative instant credibility. With these funds, HAVEN was able to pull from a greater pool of resources and attract additional funders.

PORTLAND, MAINE

Overview

Grantee: The AIDS Project (HAVEN)
Location: Portland, Maine
Grant Year: 1994, 1997 & 1999 (renewals)
Grant Amount: 1994: $650,000; 1997: $1,064,149; 1999: $712,221
Program Type: SPNS
Area Served: Portland, Cumberland, York, Androscoggin and Oxford counties

Program Description: The Housing Assistance and Volunteer Enlistment Network (HAVEN) collaborative started in 1994, with a SPNS grant from the HOPWA program. The goal of the HAVEN Collaborative is to provide seamless provision of housing and supportive services to PWAs who are homeless or at risk of losing their homes within the Portland area.

The HAVEN collaborative includes four partners, including the AIDS Project (the official grantee), the AIDS Lodging House, Peabody House, and Shalom House. The grant allowed the collaborative to provide TBRA certificates, comprehensive case management services, home healthcare, volunteer training, family therapy and direct care. Two staff positions were also created under this grant. As the program evolved, the coordinators shifted program monies to emergency assistance, and also created an additional volunteer staff position. With the SPNS renewal in 1998, the program has added employment assistance services and additional case management services.

Planning, Partnerships, and Coordination: The HAVEN Collaborative worked extensively with community planning and partner organizations. Members of HAVEN are active on Continuum of Care committees, the ADAP board, Consolidated Plan meetings and Ryan White Care Consortium planning meetings. Additional partners include health clinics, local health department offices and mental health providers. Quarterly assessments are conducted through meetings with consumer and professional advisory committees. The program also instituted consumer satisfaction questionnaires to periodically evaluate programs and services.

Close coordination is also an important element of Connecticut's program. This program provides scattered-site rental assistance and case management to persons living with HIV/AIDS and their families in Connecticut's largest metropolitan areas, including Bridgeport, Hartford, New Haven, and Waterbury. The Connecticut Department of Social Services requested that the Connecticut AIDS Residence Coalition (CARC) act as an umbrella organization, taking the lead in administering the grant and providing technical assistance to the five housing and service agencies implementing the program. Each of these five agencies has its own network of local partners with which it works. Staff members explained that they typically attended community case management meetings or collaborative treatment meetings. Others commented that it was not uncommon for case managers from the five housing agencies to work with Ryan White CARE Act case managers on such tasks as client service plans.

STATE OF CONNECTICUT

Overview

Grantee:	State of Connecticut, Department of Social Services, Family Services Division
Location:	Hartford, CT
Grant Year:	1994
Grant Amount:	$1 million
Program Type:	SPNS
Area Served:	Metropolitan areas of Hartford, New Haven, Waterbury, and Bridgeport

Program Description: The Supportive Housing Opportunities project was first initiated with the 1994 HOPWA SPNS grant received by the Connecticut Department of Social Services (DSS). This program model included the provision of scattered site rental assistance and case management services to persons living with HIV and AIDS. An outreach component was also included to assist public housing authorities in identifying long-term housing resources.

DSS collaborated with the Connecticut AIDS Residence Coalition (CARC) which was given lead responsibility for overseeing program activities and providing ongoing technical assistance and support to the five agencies implementing the program. The design of the program has created additional housing and mental health coordinator positions. The Supportive Housing Opportunities project continues and is supported by State funds, including HOPWA formula funding.

Planning, Partnerships, and Coordination: Partnerships and close coordination result primarily from informal networks, serving on agency boards and community referrals.

"MODEL" PROJECT FEATURES

As explained above, SPNS grants are awarded to projects, which, due to their innovative nature or their potential for replication, are likely to serve as effective models in addressing the needs of eligible persons. This section describes features of projects that can provide such models for other housing and service providers.

Rental Assistance

Four of the six programs visited—the four that are still in existence today—received their SPNS grant to operate some variation of a rental assistance program. The Marin County Community Development Agency received a $1,100,000 grant, for example, to operate a capped rental subsidy program for persons living with HIV/AIDS. The Marin County Housing Authority (MCHA) acts as a project sponsor and administers the rental assistance program under contract to Marin County. Participants in the program are expected to pay 30 percent of their "adjusted gross income" toward rent.[2] The amount of assistance is based on the difference between that amount and the monthly rent, up to a maximum subsidy of $450 per

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[2] "Adjusted gross income" is the participant's income less such costs as childcare expenses, Medicare premiums, and excessive, non-reimbursable medical expenses.

month for individuals and $700 for families with children.[3] While these maximum subsidies result in some clients paying more than 30 percent of their adjusted gross income toward rent, they allow more households to maintain housing stability than would be possible if subsidy calculations were based on the difference between 30 percent of income and local Fair Market Rents.[4]

The Marin County program also gives participants a choice of having their monthly subsidy payment sent to their landlord (as a partial payment of the current month's rent) or to themselves (in the form of a rent rebate the month following the tenant's payment of rent). This not only protects the client's privacy, but it also offers clients a greater degree of housing choice as some landlords are unwilling to accept tenants they know are receiving rental subsidies. Thus HOPWA provides more flexible ways to provide rental assistance than more traditional programs.

Marin County believes that tenant-based rental assistance is the best model for meeting its goal of maximizing independent living opportunities and providing an individualized level of services in a cost effective manner. Unlike the development of AIDS residential facilities, a rental assistance program requires minimal lead-time, has a low initial cost, allows clients greater flexibility and independence, and avoids "Not In My Back Yard" (NIMBY) issues. And because rental assistance does not require a major capital investment, it can be implemented on a small scale in communities that have limited financial resources. Furthermore, many suburban and rural communities have a large enough AIDS population to warrant an AIDS housing program, but not enough individuals to fill an AIDS residential facility.

In contrast to the benefits of tenant-based assistance cited by Marin County, Portland, and Connecticut, the situation in Key West provides an alternative perspective. While the City of Key West offers both project-based and tenant-based assistance through their project sponsor, AIDS Help, Inc. (AHI), they have found project-based assistance to be a more cost-effective alternative. Because there is virtually no more undeveloped land on the island of Key West, there is a significant shortage of affordable housing. Housing costs are among the highest in the nation; the low-paying service sector jobs, and a local economy built on tourism make it difficult for many Key West residents—not just persons living with HIV/AIDS—to afford decent, stable housing. As a result, AHI determined that it would be more economical to buy property than to simply offer vouchers for use on the private market.[5] However, even though project-based assistance provides project sponsors with a greater ability to contain rising rent costs, it also hinders clients' mobility, which is one of the primary assets of tenant-based rental assistance. As one staff member commented, the only thing many of the clients have in common is the disease, so trying to house them all next to one another doesn't always work (particularly when individuals are at different stages of illness).

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[3] Subsidies were originally capped at $400 for individuals and $600 for families with children. Subsidies were increased in 1998 because of rapidly rising housing costs in the local market.

[4] In the San Francisco area, including Marin County, Fair Market Rents currently begin at $891 for an efficiency (0-bedroom) apartment.

[5] Today, AHI has five complexes with a total of 40 units, approximately 25 of which are HOPWA funded. In addition, AHI provides HOPWA-funded tenant-based assistance to approximately 20 clients.

One-Stop Shopping

The City of Key West designated a local community-based organization, AIDS Help, Inc. (AHI), to administer its HOPWA program. AIDS Help, Inc., in conjunction with the City of Key West, operates a very successful program. One of the predominant reasons for this is their "one-stop shopping" approach to service delivery. AIDS Help, Inc. is Monroe County's sole recipient of the State Department of Health and Rehabilitative Services' (DHRS) AIDS patient care funding.[6] As such, AHI has been the lead service agency for persons living with HIV/AIDS in Monroe County since 1986, providing such services as case management, health care services, hospice care, substance abuse counseling, patient transportation, mental health counseling, meal and nutrition programs, and mentoring/buddy programs.

KEY WEST, FLORIDA

Overview

Grantee: City of Key West
Location: Key West, Florida
Grant Year: 1994; 1998 (renewal)
Grant Amount: 1994: $1 million; 1998: $1,150,000
Program Type: SPNS
Area Served: Monroe County, Florida

Program Description: AIDS Help, Inc. (AHI), through the City of Key West, received a SPNS grant to provide rental assistance to persons with AIDS in Monroe County. The goal of the program is to maximize independent living and encourage maximum self-determination.

Modeled after HUD's Section 8 program, the program provided participants with rental assistance vouchers to be used in the private rental market or housing in one of AHI's community residences. The SPNS project funds were also used for rehabilitation of two residential facilities. The SPNS program has expanded to include a small job-training component to assist clients who wish to reenter the labor market. The City of Key West received a subsequent HOPWA SPNS grant in 1998.

Partnerships, Planning, and Coordination: AIDS Help, Inc. is the sole recipient of Ryan White CARE Act funds in Monroe County, and works closely with the Ryan White Consortium. AHI, the primary service agency for persons living with HIV/AIDS in Monroe County, contracts with various businesses and organizations to provide specific services and has also developed a network of health providers to which it refers clients.

AHI did not begin as a housing provider, but the need for housing assistance quickly became apparent. As a result, they expanded their mission, eventually adding staff members to assist with the additional responsibilities (i.e., they created two housing coordinator positions to help clients locate units, get Housing Quality Standard inspections completed, etc.) Because of this one-stop shopping, clients have the benefit of a truly seamless service environment. Furthermore, AHI avoids the challenges and complications of interagency collaboration that thwart the success of some other programs in fully achieving their goals.

[6] DHRS serves as a conduit for Ryan White CARE Act funds.

While a one-stop approach to service delivery is ideal, it is admittedly an unrealistic model for many cities, particularly in large cities such as New York and San Francisco with complex webs of service organizations. Nonetheless, the lesson from the Key West approach is that the more service providers can coordinate service delivery and bundle services, the easier it is for clients.

Collaboration Among Partners

While "one-stop shopping" may not be a realistic possibility in many areas, Marin County, the HAVEN collaboration in Portland, and the Connecticut Department of Social Services come close through high levels of collaboration among partners. As described earlier in this chapter, collaboration has been a key to the success of these three HOPWA grants. By establishing a network of service providers that coordinate service delivery "above" the client, the partners make sure that each client has access to needed services, ranging from housing assistance and case management to nutritional services and health care. This coordination not only promotes a more efficient use of resources within a given community and prevents duplication of services, but it also allows clients to spend more time focusing on their health as opposed to patching together needed services from agencies located throughout the city. As a staff member from one agency commented, "[t]his collaborative provides a lot of services to clients that would not otherwise be provided if we worked separately. By speaking to each other regularly, the collaboration ensures that each client receives a seamless web of services."

Staff of the agencies visited, however, also identified many challenges to collaboration. As Harlem United and St. Mary's in New York found, members of the HAVEN collaborative in Portland indicated that collaborating can be particularly difficult when agencies have similar missions and compete for both clients and resources. They stated that "minimizing the turf wars" between the organizations has at times proven difficult. For example, it may be particularly challenging for organization X to agree that HAVEN resources would be better spent if they were redirected to organization Y instead.

Agencies in Connecticut also explained that collaborating can be difficult, particularly because case managers from different agencies may be serving the same client. In Connecticut, collaborative members explained that they are always working on ways to avoid duplication of services and avoid "stepping on each other's toes" (e.g., identifying a "lead" case manager). Collaborating with other case managers helps to centralize the process and make it easier to identify gaps in clients' services, which is why they make the effort to work together. As a result, they use community case management meetings and collaborative treatment meetings as a way of maintaining open communication channels among staff of various agencies.

Marin County in particular has a model system for coordinating service delivery and providing streamlined case management. Marin County uses a "hierarchical" case management system in which clients have primary and secondary case managers. Upon acceptance to the HOPWA program, applicants are asked to identify their primary care provider or case manager. They are also asked to sign a release form authorizing the HOPWA coordinator to contact staff of other agencies to coordinate care services and prevent the duplication of assistance. The primary case manager is a client's first point of contact for assessing services, whereas a secondary case manager helps clients fill service gaps. Each agency has a "specialty." For example, the Marin Treatment Center works with clients who have substance abuse problems, while the Hospice of Marin typically serves clients at end-stage. The Department of Health and Human Services Specialty Clinic serves individuals without private health care insurance. Finally, the Marin AIDS Project, which provides services such as benefits counseling, transportation assistance, meal

programs, and return-to-work/job training assistance, serves as a secondary case manager for many Marin County clients. However, they also provide primary case management to individuals with a private health care provider and more basic needs. Together, the agencies designed a universal intake form. Case managers meet once a month to share client information and to ensure services and financial assistance are not duplicated.

Barriers to Implementation at Two Sites

The two other projects that were visited had less success in carrying out their original project designs. Again, one of the most significant factors proved to be the degree of collaboration between partnering agencies.

For example, the City of San Antonio Department of Community Initiatives was awarded a $1 million grant to provide short- and long-term housing to HIV/AIDS clients with substance abuse problems through the acquisition of three buildings.[7] The San Antonio project was to operate through the collaboration of two main agencies, Hope Action Care (HAC) and House of Hope. Although House of Hope and HAC continue to provide services independently, the agencies were not able to achieve the level of cooperation originally intended. For example, the funding application outlined a strategy whereby Casa Martín, HAC's transitional shelter, would provide services for at least 150 clients over a three-year period, including outpatient detoxification, substance abuse rehabilitation, and other support services. Clients were then slated for priority housing placement in long-term housing through the House of Hope. In practice, however, the two agencies were apparently unable to resolve philosophical differences centered on differing assessments of a client's readiness to maintain independent living, and, therefore, to implement the program according to its original design.[8]

Coordination between the agencies was central to the program because House of Hope is the largest housing provider for persons living with HIV/AIDS in the area, and they frequently would not accept people completing substance abuse rehabilitation at Casa Martín. This made it very difficult to find permanent housing for these individuals and free space to accept new people into rehab treatment.

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[7] One of the buildings was to be used for short-term housing during the detoxification and rehabilitation stages, while the other two properties were intended as long-term housing for clients upon completion of treatment.

[8] Philosophical differences revolve around substance abuse rehabilitation and at what point an individual is eligible for permanent housing. For example, House of Hope felt that the individuals completing the rehab program provided by HAC were not ready to live independently in permanent housing

SAN ANTONIO, TEXAS

Overview

Grantee: City of San Antonio, Department of Community Initiatives
Location: San Antonio, TX
Grant Year: 1994
Grant Amount: $1 million
Program Type: SPNS
Area Served: San Antonio, TX metropolitan area

Program Description: The City of San Antonio SPNS project proposed providing housing assistance and substance detoxification and rehabilitation services to homeless or low-income persons who are HIV positive and have a history of substance abuse. Under this SPNS project, partners Hope Action Care and House of Hope were to provide services including case management, substance abuse services and long-term and short-term housing assistance.

Partnerships, Planning, and Coordination: Although the House of Hope and Hope Action Care independently continue to provide long-term housing and case management as proposed in the application, they were not able to reach the level of coordination originally intended. As a result not all program components were achieved and only three clients completed the program.

In New York, Episcopal Social Services proposed to form a collaborative with the Harlem United Community AIDS Center, Inc. (Harlem United) and St. Mary's Episcopal Center to train persons living with HIV/AIDS to work as peer outreach workers to recruit formerly homeless and/or substance using persons living with AIDS for participation in AIDS treatment programs at Harlem United and St. Mary's Episcopal Center.[9] Special emphasis was placed on attracting residents of Harlem's single room occupancy (SRO) hotels. According to their 1994 grant application, just under 2,000 persons living with HIV/AIDS were residing in SROs in New York City, which were typically crime ridden and drug infested with few, if any, services existing on site. As a result, many SRO occupants were doomed to drift deeper into mental illness and/or substance abuse. Because Harlem United and St. Mary's were starting separate AIDS treatment programs—targeting potential clients from the same population in the same catchment area—the proposal presented an opportunity for a more efficient use of resources while testing the power of peer influence in helping persons living with HIV/AIDS with drug and mental health problems obtain needed services.

Shortly after receiving the grant in 1995, however, key staff who developed this proposal at Episcopal Social Services and Harlem United accepted positions with other organizations, and the nature of the project changed significantly. Most notably, Episcopal Social Services restructured the project to eliminate the emphasis on direct collaboration between St. Mary's and Harlem United, choosing instead to create two separate peer outreach programs to potential clients. Staff representatives indicated that trust can be a major challenge for organizations attempting to collaborate, particularly when organizations have similar

[9] Episcopal Social Services is a city-wide social services agency, primarily known for their care of the homeless. It operates programs for a variety of populations, including troubled youth, incarcerated individuals, and persons living with HIV/AIDS. Episcopal Social Services sponsored the development of St. Mary's Episcopal Center, which serves persons living with HIV/AIDS in Harlem. Harlem United is an AIDS Service Organization also located in Harlem.

missions and view themselves as competitors for clients and resources. Unfortunately, the two organizations were unable to overcome this obstacle.

NEW YORK, NEW YORK

Overview

Grantee: Episcopal Social Services New York, Harlem United Community AIDS Center, St. Mary's Episcopal Center
Location: New York City, NY
Grant Year: 1995
Grant Amount: $1.1 million
Program Type: SPNS
Area Served: Harlem neighborhood of New York City, NY

Program Description: In 1995, Episcopal Social Services received a SPNS grant for a collaborative effort with Harlem United and St. Mary's Episcopal Center. The program design included the training of peer outreach workers to recruit formerly homeless and/or substance using persons living with HIV/AIDS for participation in AIDS day treatment programs. Special emphasis was placed on attracting residents of Harlem's single room occupancy (SRO) hotels. The SPNS project had as a key objective the creation of a meaningful collaboration between Harlem United and St. Mary's Episcopal Center in outreaching to potential clients. Each were starting separate AIDS day treatment centers targeted to potential clients in the same hard-to-serve population in the same catchment area.

The SPNS grant provided resources and incentive to begin a peer outreach program and collaboration. Coordination between the agencies was not found to be very successful. After the loss of staff who designed the effort, the program was restructured to eliminate the emphasis on direct coordination and strengthen the separate outreach worker programs. The project has resulted in information sharing, with other NYC AIDS service providers implementing peer outreach programs. The SPNS model continues at both Harlem United and St. Mary's at reduced levels with a total of four peer outreach workers funded through general revenue.

Planning, Partnerships, and Coordination: The SPNS project sponsors work with local agencies and the City to receive client referrals and participate in the Ryan White and Consolidated Planning processes. Sponsors formed partnerships with the Adult Day Services Association, long-term care facilities and a local dental school to provide services to HOPWA clients.

Continuation of Projects Upon Expiration of SPNS Grant

The projects in Marin County, Portland, the State of Connecticut, and Key West all remain in operation using virtually the same design as originally planned and implemented. However, small modifications and/or additions have been made to reflect changing times. For example, advancements in treatment have increased life expectancy for persons living with HIV/AIDS, keeping individuals healthy for a longer period of time. As such, both Key West and Portland added job training and placement or "return-to-work" components to their programs. Others made small changes in program priorities. For example, the Center for Training and Special Programs withdrew form the HAVEN collaborative in Portland as the need for

mental health services was not as large as expected. HAVEN thus shifted funds previously earmarked for mental health services to emergency assistance/ homelessness prevention and a client services coordinator.

In contrast, the agencies in San Antonio and New York awarded the SPNS grant are still in operation, but the specific projects that were funded are not continuing. As mentioned above, the lack of collaboration between Hope Action Care and House of Hope was a particularly critical barrier to program success in San Antonio. A study conducted just prior to application for the 1994 SPNS grant found that 99 percent of injecting drug abusers receiving treatment in San Antonio reported sharing needles with others, while a substantial number of female substance abuser resorted to prostitution to support their drug habits. As such, San Antonio argued that the need to combine stable housing and support services with substance abuse treatment was critical to reducing the spread of the disease in the area.

The agencies were not able to achieve the level of cooperation originally intended because they maintained philosophical differences concerning the point at which an individual is rehabilitated and therefore eligible for permanent housing. Unfortunately, coordination and cooperation between the agencies was central to the program's survival, as House of Hope is the largest housing provider for persons living with HIV/AIDS in the San Antonio area. With few other options, recovering addicts had difficulty securing long-term housing, which in turn made it difficult for HAC to free space in their transition shelter and accept new clients into treatment.

Similarly, in New York, Harlem United and St. Mary's continue independently to provide services to persons living with HIV/AIDS, but the peer outreach project is fading as a tool in these programs. Part of the problem has been a low retention rate among outreach workers. Some outreach workers became frustrated by the low enrollment rates of SRO tenants they recruited for the AIDS treatment programs. Some became depressed and fatalistic as they saw peers become sicker and die. Others had their own health, mental health and substance abuse issues. As of April 2000, St. Mary's had one peer outreach worker on staff, while Harlem United had three part-time workers (down from ten each at the inception of the project).

Funding for Continuation of Projects

Because SPNS grants are demonstration projects that are awarded competitively and last for a period of up to three years, grantees must develop alternative sources of funding to sustain their projects. When asked whether receiving the SPNS grant helped attract additional funding, four of the six grantees indicated that it did not. Two grantees—Key West and Portland—felt that receiving the SPNS grant allowed them to demonstrate their capacity, positioning them to receive additional grants and providing them with a greater ability to leverage local funds.

Today, all of the grantees are funded by a variety of sources. Key West continues to be funded primarily by the SPNS program.[10] However, they also receive HOPWA formula funds through their EMSA, as do the programs in Marin County and Connecticut. Hartford also uses McKinney funds and State revenues. The HAVEN collaborative in Portland is funded primarily through the State Department of Mental Heath, HUD's Shelter Plus Care Program, and the United Way. The House of Hope in San Antonio receives HOPWA

[10] The City of Key West was awarded an additional SPNS grant in 1998.

formula funds as well as HUD Supportive Housing Program funds, and HAC operates at less than half their prior capacity on small donations. Finally, the peer outreach workers at both of the New York agencies are funded through the agencies general revenue. Most of the agencies also utilize Ryan White CARE Act funds and local donations/fundraisers.

Lessons Concerning Replicability

The potential for replication is of key importance in the SPNS funding process. Of the six sites visited, each program—or at least components of each program—could easily be replicated. The one aspect of the programs that were visited that would be difficult to replicate is the one-stop shopping approach used by AIDS Help, Inc. in Key West. This approach is probably only replicable in similarly small towns or cities where there is one main service provider and a geographic concentration of clients. The limitations of this model were evident even in Key West. While the program officially serves all of Monroe County (which extends from the Florida everglades to the City of Key West), AHI is generally not able to provide accessibility to the same level of services to individuals in the middle and upper Keys as to clients in Key West. Thus it seems apparent that the high quality of services provided by the program are at least in part dependent on the island's small geographic size.

In contrast, the tenant-based rental assistance models used in Key West, Marin County, Portland and major metropolitan areas in Connecticut are undoubtedly replicable virtually anywhere in the country. However, there are a few factors that contribute to the success of the programs in achieving their goals that may not be as easily replicated.

First, the relatively small size of the communities has a large impact on a grantee's ability to deliver services effectively and efficiently. For example, both Key West and Marin County have among the highest per capita incidence of HIV/AIDS in the country. However, the absolute number of cases is actually quite low. As a small, more rural community, the absolute numbers of cases is also low in Portland.

Moreover, both Key West and Marin County are relatively affluent. Key West in particular has had a unique ability to raise funds locally to assist persons living with HIV/AIDS. In fact, the city believes that it raises more dollars on a per capita basis than any other community in the country. As a result, both communities have been able to provide housing assistance for nearly every eligible HIV/AIDS client in the area.

In addition, in smaller communities with fewer service providers and a higher degree of specialization among those providers, grantees have been able to form well-functioning collaboratives. Although operating in a larger area, the Connecticut program was able to circumvent some of the problems larger areas generally experience in establishing meaningful partnerships by appointing an "umbrella" organization to provide ongoing technical assistance and support to the agencies implementing the program.

In contrast, the situation in New York highlights the challenges of operating in a large metropolitan area. Staff of the three agencies administering the SPNS grant in New York explained that one of the most significant barriers they encountered when implementing their program was bureaucratic delays. Staff explained that the City has a notoriously long procurement process, and that it often takes six to nine months to get straightforward contracts through clearance and approval. Moreover, staff also pointed out that City regulations make it difficult for clients to receive approval for health care costs. In their view, due to the long delays, fewer SRO tenants were enrolled in the AIDS treatment programs, and consequently,

the morale of the peer outreach workers was affected. Finally, receiving funds from the City is a problem. Because of delays with the Contracts Department, both Harlem United and St. Mary's stated that they experienced significant delays in receiving payments.

The social environment of a community may also impact the success of a program. The more aware and tolerant a community is, the easier it appears to be to establish an effective "big-picture" strategy to serve the variety of related service needs of persons living with HIV/AIDS. Key West, for example, is known for its open and tolerant atmosphere and its awareness of AIDS issues. As mentioned above, the City holds frequent fundraisers and the community has a history of providing support for programs servings persons living with HIV/AIDS. Similarly, Marin County, which borders San Francisco on the north, is an area noted for its diversity and social openness and tolerance. The importance of this factor cannot be overlooked, particularly when these jurisdictions are juxtaposed with San Antonio. Staff members of House of Hope and Hope Action Care noted that the conservative social climate in San Antonio poses unique challenges to providing housing assistance and supportive services to persons living with HIV/AIDS, as many citizens are intolerant or undereducated with regard to the disease and the needs of persons living with HIV/AIDS.

Finally, although the peer outreach program in New York had implementation problems, it is a program that can easily be replicated, particularly if agencies heed the lessons that can be learned from New York's experience. First, staff must be selective in hiring trainees. As staff of Harlem United and St. Mary's discovered, it is not a task that can be taken lightly. Not all persons living with HIV/AIDS make good outreach workers. In particular, trainees must be at a very stable point in their own substance abuse recovery process, otherwise they run the risk of relapse. Both Harlem United and St. Mary's also recommended starting out small and then increasing the number of workers as needed. This way, organizations can be more selective about which peer workers are selected, provide more hands-on training, and plan for seasoned peer outreach workers to help train newer workers. Finally, organizations should also be prepared to offer mental health counseling for their outreach workers.

SUMMARY OF FINDINGS AND POLICY IMPLICATIONS

Finding: Collaboration is a key component to successful project implementation.

As indicated by site visits made to six communities awarded competitive HOPWA funds for Special Projects of National Significance (SPNS), regular collaboration and communication with partners and other local service providers is a key component to successful project implementation. Coordination not only promotes a more efficient use of resources within a given community and prevents duplication of services, but it also allows clients to spend more time focusing on their health as opposed to patching together needed services from agencies located throughout the city. While coordination proved to be crucial in four of the applicants' success in achieving their program goals, a significant factor in the limited success of two other SPNS recipients in fully achieving their goals proved to be an insufficient level of agreement between the partnering agencies as they implemented their activities.

Staff of the agencies that were visited identified various challenges to successful collaboration. Collaborating can be particularly difficult when agencies have similar missions and compete for both clients and resources. Collaboration can also be difficult when case managers from different agencies serve the same client. The size of the community may have a large impact on a grantee's ability to deliver services

effectively and efficiently. Where grantees were able to form well-functioning collaboratives, many have been in smaller communities with fewer service providers and a higher degree of specialization among those providers.

Policy Implications

Given the changes in the HIV/AIDS population (e.g., more women with children, more persons with substance issues, and more persons with mental health issues), a wide array of housing options and supportive services is required. Moreover, addressing the problems of HIV/AIDS clients often requires specialized expertise. Thus, it is increasingly critical that communities coordinate service delivery and bundle services to provide clients access to a broad range of services. However, interagency coordination can be extremely difficult particularly for service providers in large metropolitan areas that compete for both clients and resources. One option for circumventing territorial issues among service providers may be appointing an "umbrella" organization to provide ongoing technical assistance and support to the agencies implementing the program.

Finding: Special Projects of National Significance are providing effective models for replication.

Of the six grants reviewed on site, four were able to meet their stated program goals. These four appear to be replicable and should serve as effective models for other HOPWA providers. The two other programs had less success in carrying out their original project designs, largely because of administrative obstacles and difficulty collaborating with partners. Nonetheless, these programs provide lessons learned that should be shared with other HOPWA providers.

Policy Implications

While HUD provides examples of SPNS projects on its web site, these are presented as general project descriptions. When asked in the Housing Assistance Provider Questionnaire and during site visits to provide recommendations for strengthening the national HOPWA program, a number of providers stated that more technical assistance is needed, including, among other suggestions, the development of case studies with detailed descriptions of program design and implementation issues. HUD should consider augmenting its current, general project descriptions with that type of detailed case study, and/or other information that focuses on specific program design and implementation issues. In addition, HUD should pursue other innovative approaches to facilitate the replication of successful program models at the local level.

APPENDICES

Appendix 1: Comprehensive List of Research Questions

Appendix 2: Methodology

Appendix 3: Questionnaires

Appendix 4: Site Visit Selection Process

Appendix 5: Site Visit Locations

Appendix 6: Site Visit Protocol and Discussion Guide

Appendix 7: Grantee and Provider Views and Recommendations

Appendix 8: Glossary of Terms

APPENDIX 1: COMPREHENSIVE LIST OF RESEARCH QUESTIONS

This comprehensive list of research questions is organized into five major sections: Client Outcomes, HOPWA Implementation, Integration of HOPWA with Other Programs, Special Projects of National Significance, and Grantee and Provider Views and Recommendations.

A. CLIENT OUTCOMES

1. Who is being served?

   a. What are the demographics of the persons being served?

   b. Where do participants come from?

   c. Is there income targeting beyond basic eligibility?

   d. What percentage is working? What is the median number of hours worked? What are barriers to working?

2. What types of housing assistance are clients receiving, by percentage?

3. What proportion is permanent housing assistance?

4. What proportion is temporary/transitional housing assistance?

5. What are clients' views on the housing assistance they are receiving, including their views on how the housing assistance has affected their:

   a. Housing stability;

   b. Quality of life overall;

   c. Access to medical care;

   d. Access to other supportive services;

   e. Ability to afford non-housing expenses;

   f. Control over their own lives.

6. How dependent are clients on HOPWA for their housing?

   a. What are the outcomes for households that ceased receiving HOPWA housing assistance, by tenure of assistance (i.e., permanent, temporary/transitional, short-term payments)?

   b. What are clients' views on possible outcomes if they were no longer receiving HOPWA housing assistance?

7. How has HOPWA affected clients' housing stability?

   a. How long do clients wait between the request for HOPWA housing assistance and receipt of that assistance?

   b. How frequently is a change of address needed in order to receive HOPWA housing assistance?

   c. How long have clients been living in their current residences?

   d. What percentage of clients have long-term housing plans?

   e. What percentage of those plans are periodically reviewed and progress tracked?

   f. What services are clients receiving, by percentage?

   g. Is there a relationship between type of housing assistance and client access to services?

   h. What are clients' views on how these services have affected their quality of life?

B. HOPWA IMPLEMENTATION

1. What are the characteristics of formula grantees?

   a. What types of organizations administer HOPWA formula grants?

   b. Is there a relationship between the type of organization administering HOPWA funds and the types of HOPWA assistance provided?

2. How do formula grantees distribute funds?

   a. How do formula grantees set funding priorities?

   b. How much have priorities changed? How have priorities changed through the years?

   c. How prevalent is the use of subgrantees?

   d. How do grantees choose subgrantees?

   e. What processes are used by grantees to distribute funds?

f. What selection criteria are used by grantees and with what frequency?

g. What do formula grantees know about how subgrantees distribute funds and the selection criteria used by subgrantees?

3. What are the characteristics of HOPWA housing assistance providers?

a. What types, by percentage, of organizations serve as HOPWA housing assistance providers?

b. Is there a relationship between types of organizations and types of assistance provided?

c. How long have housing assistance providers been providing assistance to persons living with HIV/AIDS?

d. What percentage of housing assistance providers serve only persons living with HIV/AIDS?

e. What is the size of housing assistance providers, as measured by total annual budget?

f. What percentage of housing assistance providers' budgets are used to assist persons living with HIV/AIDS?

g. What percentage of those budgets is HOPWA funding?

C. INTEGRATION OF HOPWA WITH OTHER PROGRAMS

1. To what extent is housing that is subsidized with HOPWA formula funds also being subsidized with funds from other programs, in each of these cost categories:

a. Project development costs;

b. Project operating costs;

c. Leasing;

d. Tenant-based rental assistance;

e. Short-term payments?

2. What are the primary sources of the other funds?

3. What methods are used by HOPWA housing assistance providers to link clients with services?

4. What coordination is occurring between HOPWA programs and the Ryan White CARE Act programs?

a. What percentage of grantees report coordination, at the grantee level, between HOPWA and Ryan White CARE Act programs?

   b. What types of coordination are reported between HOPWA programs and Ryan White CARE Act Planning Councils/Consortia at the grantee level?

   c. What percentage of housing assistance providers report that someone from their organizations regularly participates in Ryan White Planning Council/Consortium meetings?

   d. What percentage of housing assistance providers report they link clients to assistance provided under Ryan White CARE Act programs?

   e. In what ways are these linkages accomplished?

5. How beneficial, from the grantees' perspective, is coordination with Ryan White CARE Act programs?

   a. What percentage of grantees report that this coordination has been beneficial? What reasons do they give?

   b. What percentage of grantees report that this coordination has not been beneficial? What reasons do they give?

6. What suggestions are commonly made by grantees for improving coordination with the Ryan White CARE Act programs?

7. What coordination is occurring between HOPWA programs and Continuum of Care homeless assistance planning?

   a. What percentage of grantees report coordination, at the grantee level, between HOPWA and Continuum of Care homeless assistance planning?

   b. What types of coordination are reported between HOPWA programs and Continuum of Care planning?

   c. What percentage of housing assistance providers report that someone from their organizations regularly participates in the Continuum of Care planning process?

8. How beneficial, from grantees' perspective, is coordination with the Continuum of Care process?

   a. What percentage of grantees report that this coordination has been beneficial? What reasons do they give?

   b. What percentage of grantees report that this coordination has *not* been beneficial? What reasons do they give?

9. What suggestions are commonly made by grantees for improving coordination with the Continuum of Care process?

10. What coordination is occurring between HOPWA programs and other planning processes?

    a. What percentage of housing assistance providers report that someone from their organization participates in community-wide planning meetings about the use of HOPWA funds?

    b. What percentages of housing assistance providers report that someone from their organization regularly participates in:

        (1) AIDS Housing Plan;

        (2) Consolidated Plan;

        (3) Other housing planning process;

        (4) Other AIDS planning process?

D. SPECIAL PROJECTS OF NATIONAL SIGNIFICANCE

1. Were the sample Special Projects of National Significance, as carried out, essentially the same as they were described in the competitive applications? If not, how did they differ? And why did they change?

2. What are the "model" features of these projects?

3. Did the projects continue after expiration of the SPNS grants? If yes, what was the source of additional funding?

4. Are the programs replicable? If not, why not?

5. Have they been replicated? If not, what have been the impediments to replication?

E. GRANTEE AND PROVIDER VIEWS AND RECOMMENDATIONS

1. What are the major strengths of the Federal HOPWA program?

2. What are the major weaknesses of the Federal HOPWA program?

3. How might the Federal HOPWA program be strengthened?

APPENDIX 2: METHODOLOGY

The methodological approach for this evaluation was determined by the research questions that had been laid out in HUD's original Request for Proposal (RFP). In attempt to provide the most accurate and appropriate answers to those questions within given time and budget constraints, ICF used the following approach.

Based on the research questions, a strategy was developed for collecting information through a variety of methods: mail questionnaires, site visits, telephone interviews, etc. Our strategies were refined based on discussions with an Advisory Board. This appendix describes what data was collected, how it was analyzed, and other information relevant to the background of how this HOPWA program research was conducted.

DATA COLLECTION

With any research or evaluation project, specific data is needed to adequately answer the research questions at hand. Data can be gathered through either secondary or primary sources. After comparing available secondary source data with our research questions, ICF determined that additional data collection would be necessary. In the end, five basic sources of data were used to conduct the evaluation:

- ❒ Secondary source data from HOPWA grantees;
- ❒ Primary source data collected from formula grantees;
- ❒ Primary source data collected from housing assistance providers;
- ❒ Primary source data collected from competitive grantees; and
- ❒ Primary source data collected from HOPWA clients.

Secondary Data Sources

HUD's Office of HIV/AIDS Housing collects information from grantees both during the initial application process and subsequently in their Annual Progress Reports (APRs). HUD originally maintained this information in a Microsoft Excel spreadsheet, but over the course of the project migrated the information to a Microsoft Access database. This database includes basic information on such things as the distribution of HOPWA funds among eligible activities and the numbers and characteristics of clients served. ICF used this database to maximize the number of grantees that were included in the evaluation, including those that entered data through the Integrated Disbursement and Information System (IDIS) as well as those submitting paper APRs.

In 1998, the Office of HIV/AIDS Housing also prepared a comprehensive, one-year profile on the accomplishments of the 83 active formula grantees operating HOPWA programs during that year. The data was collected for a report to Congress and may serve as a baseline for understanding the accomplishments of the program. ICF also used this one-year data to provide additional background information.

Primary Data Sources

Because not all of the data necessary to answer the research questions were available, ICF collected additional information from formula and competitive grantees, housing assistance providers, and clients (see Table 2-1). ICF Consulting developed the original questionnaire instruments based on the research questions. These questionnaires were then reviewed by an Advisory Board. Revisions were made based on Panel Board recommendations, and subsequently, the questionnaires were submitted to the Office of Management and Budget (OMB) for review and approval. The questionnaires were approved by the OMB without any modifications.

Table 2-1. Primary Source Data Collection Methods

Respondents	Number	Method
Formula Grantees	145	Written questionnaires distributed to the universe of past and present grantees.
Competitive Grantees	6	On-site interviews.
Project Sponsors	1,378	Written questionnaires distributed to all likely HIV/AIDS Housing Assistance Providers based on HUD and AIDS Housing of Washington (AHW) data[1].
Clients	50	Telephone interviews of a non-statistical, purposive sample.

Questionnaires to Formula Grantees

To complement existing APR information, ICF sent the Formula Grantee Questionnaire to all grantees that could be identified. The grantee list was created from the APR data, which included competitive grantees as well as government entities that may have been grantees in the past but are no longer grantees.[2] As a result, this mailing was sent to 145 organizations, 44 more agencies than the universe of formula grantees when the study was conducted (101 in FY 2000). The questionnaires focused primarily on descriptive research questions related to planning and coordination. The questionnaires were sent with ICF generated identification codes, which allowed us to match the individual questionnaires with data in the APR files.

Questionnaires to Housing Assistance Providers

HUD collects information directly from the HOPWA grantees only. Housing assistance providers, also known as project sponsors, do not submit forms directly to HUD; rather, each provider submits program

[1] AHW assembled its mailing list through what was described as a "snowball" process. AHW sent mail to organizations they knew were AIDS housing provider organizations and HOPWA and Ryan White CARE Act grantees. The mail requested the organization to identify other AIDS housing organizations they knew of. AHW would then contact these organizations, verify their status as an AIDS housing organization, and then also ask them what organizations they knew of. This process continued for multiple iterations until they no longer located new organizations.

[2] There are some places where the government agency acting as the grantee changed from one jurisdiction to another. For example, this was the case for the Washington, DC MSA.

performance information to the grantee providing their funds. The grantee then aggregates information from all of their project sponsors, submitting a single APR report to HUD. However, some of the research questions posed by HUD required us to collect information directly from the housing assistance providers.

While the names of some project sponsors are included in the APR data file assembled by HUD, those data are unfortunately incomplete. In many cases, either the grantees have not been submitting information for all of their provider organizations or they may not have submitted contact information for their provider organizations. In order to augment the list from the APR data, HUD arranged ICF's access to a mailing list compiled for the AIDS Housing of Washington (AHW)/Vanderbilt cost study. The AHW list contained 892 names of organizations known to be HIV/AIDS assistance providers. This list included both organizations that receive HOPWA funding as well as those not receiving HOPWA funds. Unfortunately, the AHW list did not distinguish between organizations based on funding sources.

To compile a complete list of HOPWA housing assistance providers, ICF reviewed the APR data, removing housing assistance providers that: (1) did not receive HOPWA funding from 1996 thereafter; (2) were already named on the AHW list; or (3) did not receive any HOPWA funds for housing. By combining the lists from the APR data with the AHW data, a list of 1,378 organizations was generated that were possibly HOPWA housing assistance providers at some point. Not all of the organizations on the list are active housing assistance providers. Many of the organizations only provide supportive services without any direct housing. In addition, the organizations listed may have been housing assistance providers in the past, but may no longer be functioning or acting as housing assistance providers. HUD's Office of HIV/AIDS Housing's original estimate was that there were approximately 700 HOPWA housing assistance provider organizations.

The housing assistance provider questionnaire included questions concerning the type of assistance provided, client characteristics and outcomes, how providers use HOPWA funds in conjunction with other resources available within their communities, and other qualitative questions on the strengths and weaknesses of the program. Although the provider data were analyzed on their own, the unique grantee identifier also allowed ICF to examine them relative to the data provided by their respective grantees.

Telephone Interviews with Clients

Without a control group, an analysis of the benefits of the HOPWA program to clients is extremely difficult and potentially inaccurate. Nonetheless, by sharing their perceptions of the program and information about their needs relative to the services offered by local providers, clients can provide insightful information about the strengths and weaknesses of the program and the program's ability to meet current needs. As a result, ICF conducted telephone interviews of clients to gain a different perspective of the program. The information elicited in the interviews was used to augment the other collected information.

Assembling a sample of HOPWA clients posed difficulties due to concerns about privacy and confidentiality. To obtain client feedback, ICF had hoped to conduct telephone interviews with 50 clients, but was able to conduct telephone interviews with only 36 clients. Due to how the sample was assembled, and also the size of the sample, it is not statistically valid. However, the results of client interviews do provide anecdotal information on the HOPWA program. These views provide much more of a personal context and flavor to help understand the HOPWA program.

The difficulty in assembling a list of clients and contacting them is one of identification. HUD does not have any client information. Housing provider organizations have contact information for the people they assist, but due to privacy concerns, will not release information to third parties without the clients' express permission. As a result, our client interviews were conducted with clients who volunteered to be interviewed after being informed about the questionnaire by their housing assistance provider.

Using APR data a list of providers was compiled, and a random sample was conducted to ensure a representative sample. The randomly selected providers received a letter requesting their assistance in distributing flyers to five clients asking the clients to participate in the questionnaire by calling an anonymous toll-free line to schedule an interview. An ICF staff person then called the client at the scheduled time to conduct the interview.

The interviews were conducted at a time convenient to the clients, including evenings and weekends. They were conducted in either English or Spanish, as desired by the interviewee. The interviewee was informed that his or her individual responses would be kept confidential by ICF and not released to his or her project sponsor, HUD, or any other person or organization.

Due to the sensitivities involved with HIV/AIDS and general privacy issues, specific questions were not asked about medical history, including potential substance abuse. Similarly, questions related to individual financial and insurance status were not included in the questionnaire. In addition, due to the individual client interviews not being a statistically valid sample, the value of information about medical history was expected to be low.

On-site Interviews with Competitive Grantees

One of the objectives of this evaluation was to assess the extent to which competitive grantees were able to accomplish their goals and use innovative ideas or techniques in their programs. To address this issue, ICF conducted site visits to a sample of six competitive grantees programs. These site visits also provided additional information about how the HOPWA formula program functions.

In 1996 and 1997, HUD and the Department of Health and Human Services (HHS) collaborated on the design and implementation of the HIV Multiple Diagnosis Initiative (MDI). This was a specialized outreach effort to persons who are living with HIV/AIDS who are also homeless and have chronic alcohol and/or other drug abuse issues and/or serious mental illness. ICF did not select projects in the MDI for the site visits. ICF also eliminated grantees from the 1998 and 1999 competitions because it was determined the programs may still be in the start-up phase. As a result, focus was placed on those projects funded under the HOPWA Special Projects of National Significance competitions in 1994 and 1995. This meant that visits were to established programs.

To ensure our sample contained those projects employing innovative ideas or techniques, ICF used the number of points awarded for innovation in the application rating process as the primary selection criterion. To further narrow the list, ICF also considered such factors as geographic location, target population, and project focus. The following six cities/grantees were selected:

- ❒ Key West, FL (City of Key West)
- ❒ San Antonio, TX (Department of Community Initiatives)

- State of Connecticut (Connecticut Department of Social Services, Family Services Division)
- Portland, ME (The AIDS Project)
- New York, NY (Episcopal Social Services of New York, Inc.)
- Marin County, CA (Community Development Agency)

While on site, the ICF team conducted interviews with the project director, staff members, clients, and partnering agencies (as applicable) to learn the context in which each project operates, the degree to which innovative ideas or techniques were used, and the extent to project goals were met.

Two ICF team members spent three days on site to gather information in each of the six cities. The site visits were conducted between February and May 2000. Prior to going on site, ICF worked with key program staff to collect background information on the projects and to identify individuals that should be included in the interview process. Visits were scheduled well in advance so that time on site could be used as efficiently as possible. Because two different teams of interviewers were conducting site visits, ICF developed an interview protocol to lend consistency to the process and ensure that specific topics were covered during each visit. The protocol is included as Appendix 6.

While the principal focus of the site visits was competitive grants, the ICF team also met informally with persons implementing formula grants in order to gain a deeper understanding of formula programs and to provide context to the information gathered through the national questionnaire instruments. Although these discussions focused on the same questions presented in the questionnaire, the visits provided staff members the opportunity for more in-depth responses.

Site visit summaries were developed after each visit and sent back to program staff to verify accuracy of the information. The summaries were not intended as stand-alone documents, but rather were used to supplement the other data gathered for this evaluation.

Advisory Board

An advisory board was assembled to provide expert advice and to help guide the study. The panel included a program client and six recognized experts from the HIV/AIDS housing community:

- Greg Mims, DC Cares (Washington, DC)
- Donald Chamberlain, AIDS Housing of Washington (Seattle, WA)
- Marie Herb, Executive Director, AIDS Housing Corporation (Boston, MA)[3]
- Leslie Leitch, Director, Division of Homeless Services, City of Baltimore
- Glenda Low, Shelter Partnership (Los Angeles, CA)

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[3] Marie Herb held this position while she was a member of the Advisory Board. During the study, she changed jobs, joining the Technical Assistance Collaborative, Boston, MA.

- Regina Quattrochi, Executive Director, Bailey House Inc. (New York, NY)
- Randy Russell, Executive Director, AIDS Alabama

Board members were asked to comment on the national questionnaire instruments, the client telephone interview guide, and the site visit protocol. They were also asked to comment on the draft evaluation report. Conference calls were used as a forum for receiving comments.

During the 1999 National Meeting of HOPWA Formula Grantees, held September 26–29, 1999 in Baltimore, MD, ICF conducted a breakout session for interested grantees to provide details about the HOPWA study and to solicit initial feedback on the research questions and questionnaire instruments.

DATA PROCESSING

The printing, mailing, and data entry of the formula grantee and housing assistance provider questionnaires was conducted by HumRRO—a data collection vendor subcontracting to ICF on this evaluation. HumRRO mailed a questionnaire to everyone on the grantee and provider mailing lists, and approximately three weeks later, mailed a second questionnaire to improve response rates. HumRRO also tracked the return of questionnaires to ensure that no duplicates were entered. Similarly, completed client interviews were sent to HumRRO to be entered into a database for analysis.[4] HumRRO then delivered the computer data files containing the questionnaire responses as well as all completed questionnaires to ICF.

When processing data as part of a research project, it is essential that no errors are introduced that may affect the outcome of the analysis. In addition to checking the validity of the data, ICF regularly reviewed the program logic in all code developed for the analysis to ensure that no errors were introduced.

When conducting a research project, it is also essential to ensure that the data is manipulated properly. Mistakes in the processing or interpretation of the data can lead to erroneous conclusions. Given that the data came from several different sources, care was exercised to ensure that the data were properly matched. The best method is to transform all data files into a single format, which can then be manipulated. ICF used the SAS statistical software to process and analyze these data.

ICF had three major sources of data from HOPWA program participants to combine and analyze. Data collected from the formula grantee, housing assistance provider, and client questionnaires was entered immediately into a SAS data file, while the existing data, such as APR data, had to be converted.

The APR data stored in Microsoft Access databases was converted and manipulated in SAS. The process was automated and saved so that updated data could consistently be converted into SAS. ICF manually checked the accuracy of the conversions by comparing the SAS output with the data from the database. In addition, ICF compared a small sample of the submitted APRs with the corresponding information the final dataset to ensure that numbers were not changed during processing.

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[4] Trained ICF staff conducted the client telephone interviews. An interview protocol was developed to instruct the interviewers how to code various responses. Interviewers recorded responses on a paper copy of the questionnaire.

ICF then merged the additional grantee data obtained through the national questionnaire with the existing grantee information from the APRs by using a unique identification variable. The augmenting of the APR information with this additional grantee information allowed analysis of issues that cannot be examined through the APRs alone. Examples of such information include sources and amounts of other funding, both in absolute terms and relative to HOPWA funding, and more information on types of services provided.

DATA ANALYSIS

Once ICF processed the data and verified its quality, data analysis began. The data analysis portion of this evaluation was conducted using four primary data sources: HUD's Annual Progress Report data collected from 1993 to 2000, the Housing Assistance Provider Questionnaire, the HOPWA Formula Grantee Questionnaire, and the HOPWA Client Questionnaire. Information gathered through site visits was also used to provide contextual information to the APR and questionnaire data. Data reported in *HUD's 1999 Report on the Performance of the Housing Opportunities for Persons with AIDS Program* was also used as a key source of information for this evaluation and is cited as such throughout this report. As mentioned, the statistical software package SAS was used as the primary tool of analysis, with other more basic statistics generated through the use of Microsoft Excel.

The analytical approach used for each of the four surveys was generally similar. Each dataset, however, presented a unique set of challenges and characteristics that required individual attention. Each of the four datasets is discussed separately in the following section – providing details about the data, a summary of important items to know about the dataset, and a discussion of the approach used to retain the integrity of the data while providing clarity and conciseness to the results. The general approach to the quantitative and qualitative data analysis is then provided in the last section.

The Datasets

HUD Annual Progress Report (APR) Data

HUD's Office of HIV/AIDS Housing collects information from grantees both during the initial application process and subsequently through APRs. Information is collected on such things as the distribution of HOPWA funds among eligible activities and on the numbers and characteristics of clients served. As Table 2-2 illustrates, the number of observations varies significantly from year to year, and so caution must be exercised in any year-to-year comparisons.

Table 2-2. HOPWA APR Dataset

Program Year	Number of Observations
1993	14
1994	47
1995	94
1996	120
1997	93
1998	66
1999	44
2000	1

Housing Assistance Provider Questionnaire

This questionnaire was mailed to 1,378 potential housing assistance providers whose names were collected from both HUD and AIDS Housing of Washington. This is in the context of an estimated 700 HOPWA housing assistance providers. Of those 1,378 questionnaires that were distributed, ICF received 148 completed questionnaires as of September 29, 2000. Of those 148 completed questionnaires received, one was completed by a provider that did not receive HOPWA funding and a second was completed by a provider that used HOPWA funds for the purchase of furniture. Because these two responses were eliminated, the final number of providers used in this analysis is 146. There were additional questionnaires returned due to invalid addresses and others who reported either not providing housing or providing housing but not using HOPWA funds.

The 146 providers used in this analysis represent approximately 20 percent of the estimated universe of 700 HOPWA housing assistance providers. This is a confidence level of approximately 80 percent +/- 5 percent. A confidence level of 80 percent +/- 5 percent says that with 80 percent certainty the sample is within 5 percent of the universe of HOPWA housing assistance providers.

The questionnaire contains 11 introductory questions, 16 questions pertaining to the provider profile and assistance provided (part A), and 10 questions referring to the providers' financial data (part B). The final dataset contains a total of 216 variables in addition to a set of documents that recorded respondents' answers to two free-response questions.

Formula Grantee Questionnaire

This questionnaire was mailed to 145 potential grantees across the country. There were 101 formula grantees in FY1999, and the mailing list also included competitive grantees and any organization that had been a grantee at any point. Of those 145 questionnaires that were distributed, 56 were completed and returned to ICF as of September 29, 2000. Of those 56 returned questionnaires, 11 were completed by grantees that received HOPWA funds through the competitive process rather than formula calculation. These questionnaires were deleted from the quantitative analysis and the answers to the qualitative questions were analyzed as a separate set of grantee responses. One (1) of the respondents completing the questionnaire was a subgrantee. This questionnaire was deleted from both the quantitative and qualitative analysis. The final number of grantees used in this quantitative analysis is 43. Qualitative answers from all 55 grantees, however, were analyzed as two separate groups: (43) formula and (11) competitive grantees.

The 43 HOPWA formula grantees used in this analysis represent approximately 43 percent of the formula grantees. Although there were not enough responses to establish a high statistical confidence level, the formula grantee sample is believed to be representative of the universe of formula grantees, as discussed in the section below titled, "Discussion of data and representativeness of the data." Due to the nature of confidence intervals, proportionally large sample sizes are required when the universe is small. In other words, a high proportion of respondents is required for statistical confidence when the total number of potential respondents is small. As a result, "high" statistical confidence intervals are rarely reached with small universes. This lack of a confidence level does not mean that the information should be ignored, rather the validity of the information must be considered and determined in other ways, such as checking to see if the sample is representative of what is known about the universe.

The questionnaire contained 11 introductory questions, 10 questions relating to planning, and five (5) questions pertaining to the funding process. The final dataset contains a total of 93 variables. There were also a series of 13 qualitative questions that were included in this questionnaire and analyzed for this evaluation.

HOPWA Client Questionnaire

This questionnaire was conducted as phone interviews with clients who were identified by participating housing assistance providers across the country. As of September 29, 2000, 36 clients had been interviewed and their questionnaire answers included in the analysis for this report.

The questionnaire contained four introductory questions, 14 questions about their housing, one question regarding services, and seven questions about demographics. The final dataset contains a total of 85 variables.

General Approach to Analysis

The quantitative data were analyzed using an initial set of simple frequencies and means procedures. This output was then analyzed to identify some of the most obvious data irregularities. The following bullets provide some general detail about these issues, the types of respondent error, and our approach to correct this irregularity.

- ❒ **Too much information provided by respondent.** There were several questions on the three questionnaires that asked respondents to "complete only if…" a certain requirement is true or to "check only one box." However, some respondents completed the set of questions even if they did not apply. Others checked more than one "box" when it was not appropriate. A three-step approach was used to address this data problem:

  - ➢ *Step 1. Determine if the data was entered correctly.* When these issues arose, ICF first identified the respondent reporting the irregular data and then looked at the original completed questionnaire that they had returned. If the data were entered incorrectly and the data on the original questionnaire answered the question more accurately, the incorrect data were corrected to reflect the actual data reported by the respondent. If no errors were made in the data entry, the process then proceeded to step 2.

  - ➢ *Step 2. Decide whether the additional data alters the results to disguise the true meaning and purpose of the question or if they simply added additional information for the analysis.* For example, the provider questionnaire asks private nonprofit respondents to identify their primary activity as housing, health care, or other (part A, question 1). As a result, the number of primary activities reported by private, nonprofit organizations exceeds the number of those organizations in the dataset. On the other hand, the provider questionnaire also asks respondents to report all sources and amounts of funding used for project development costs if HOPWA funds were used (part B, question 5). Many respondents, however, reported sources and amounts spent on project development, regardless of whether HOPWA funds were spent on this activity. As a result, the amount of funding from other sources used for project development is greater than the actual amount of funding leveraged by HOPWA funds for this activity.

- *Step 3. Adjust or retain the data based on the decision made in Step 2.* If it was determined that the extra data simply added additional information for analysis, the data were kept as reported. As in the first example above, it was decided that organizations could conceivably have more than one primary activity and that the extra data only served to better describe the organizations. In this case, the data were retained. If it was determined, however, that the extra data only served to cloud the initial intent of the question, the data were adjusted so that they more accurately reflected the respondents. As in the second example above, the additional data on other funding spent on project development when $0 HOPWA funds were used was not useful for understanding the combination of HOPWA funding with other sources. When discovered, these data were changed to reflect that the respondent did not answer the question because he or she did not meet the initial requirement of using HOPWA funds for this purpose.

- **Poor data provided by respondents.** There were also several questions that asked respondents to report, for example, the breakdown of their HOPWA expenditures. While many respondents reported accurate figures, there were also many whose numbers did not add to 100 percent. In these cases, a three step process was again followed to correct this data problem:

  - *Step 1.* Identical to step 1 above, check the original questionnaire form to ensure that there were no errors in data entry. If errors were identified, they were corrected to reflect the respondents answers. If no errors were found, the process moved on to step 2.

  - *Step 2.* Call the respondent to determine the correct data.

  - *Step 3.* Correct the data to reflect the information collected from the respondent upon follow-up.

- **Poor data provided by APR.** The APR provides a significant source of data, however many of the total figures that should equal the addition of several other variables are incorrect. In these cases, ICF created a new total variable that was used for all of the calculations and disregarded the total variable provided in the data.

After the data were "cleaned" and the most significant data errors were corrected, analysis began. The analysis generally examined each of the questions in each of the questionnaires separately and in comparison with questions that were closely related. The frequency of different responses was examined as well as the distribution of the answers as a whole. For example, it was thought important to examine not only how many grantees reported using between 60 and 80 percent of their HOPWA grant for housing assistance, but the average percentage spent for this purpose as well.

ICF also analyzed data in relation to other data to get a sense of the distribution of answers among different sub-sections of the respondents. For example, ICF looked at the average percentage of providers' total expenditures that was used to assist persons living with HIV/AIDS as well as that same average for only government organizations and private nonprofit organizations.

Finally, when possible, ICF also used questions that asked percentages of a whole in conjunction with data that reported the whole to determine the distribution of the whole. Examples of this almost always occurred with the budget figures. Providers were asked to report their total expenditures for the last fiscal year as

well as the percentage of that whole by HOPWA funds used for housing, HOPWA funds used for other services, other funds used for housing, and other funds used for other services. By multiplying the percentages with the whole budget number reported, the larger picture of funds spent for particular activities could be understood.

Within each of these analyses, ICF was often forced to deal with respondents who did not answer the question. For most of the analyses that was done for this evaluation, ICF chose to eliminate those "No responses" from the analysis and focus on those respondents who did answer the question. For example, if only 42 out of 44 grantees answered the question, "Did you allocate any of your HOPWA formula allocation to sub-grantees … for your most recently completed program year?" ICF reported those who answered "yes" and those who answered "no" as a percentage of 42 rather than 44. In instances when ICF chose to include the "No responses" in our analysis, a note details that fact.

Discussion of the Data and Representativeness of the Data

As discussed above, information was collected from a variety of sources. In no case was the data collected from the entire universe of potential respondents. Rather, the information collected was always a sample, or a portion, of the entire universe. Two issues are discussed in this section.

The first issue is the representativeness of the data. This refers to how "representative" or how similar the sample of the data is when compared to what is known about the universe of potential respondents.

The second issue is the overlap of the samples. The samples represent a proportion of the total universe. The issue is whether or not the samples represent the same proportion of the universe (overlapping) or different proportions of the universe (non-overlapping or disjoint).

Representativeness

It was possible to measure the representativeness for the grantees because there is exact information available about the number and characteristics of the governments that receive HOPWA formula grants from HUD. The characteristics of the universe were then compared with the characteristics of the respondents to the grantee questionnaire.

An examination of the grantee respondents showed that the respondents were similar to the universe of grantees in the characteristics examined. The characteristics examined were: Metropolitan Statistical Area (MSA) vs. State grantee, Census Region, size of MSA, and distribution of responses by State.

- Of the 101 formula grantees, approximately 66 percent are MSA cities while the remainder are States. In terms of respondents to the grantee survey, 65 percent were MSA cities.

- The Census Region breakdown is as follows:

Census Region	Percentage of Grantees Located in Region	Percentage of Respondents Located in Region
Midwest	17	12
Northeast	21	23
South	42	40
West	21	26

- To examine the distribution by relative population, ICF looked at the population of the MSAs. ICF then identified each MSA as having a population greater than or less than the median of 1.46 million in population for the MSA. (The actual median itself was counted in the greater than category.) Fifty-two percent of the MSA grantees were greater or equal to the median, while 48 percent of the MSA respondents were grantees with populations greater or equal to the median.

- To examine the distribution of responses by States, ICF looked at the State identified for the grantee. Of the 29 States with more than one grantee, 79 percent (23 States) had at least one grantee responding to the survey. Of the 14 States with more than two grantees, 100% had at least one grantee responding to the survey.

It was not possible to compare the characteristics of the sample of housing assistance providers with the characteristics of the universe of housing assistance providers because the latter information is not currently collected anywhere. ICF has made the assumption that the characteristics of the sample are representative of the characteristics of the universe.

Sample Overlap

Multiple sources of data were used about the same general population. For example, a sample of grantees responded to the APR collected by HUD while another sample responded to the Grantee Survey conducted by ICF. The sample is only a proportion of the total number of participants. It is possible that the samples are completely overlapping, meaning that the same grantees responded to the APR and the Grantee survey. However, it is also possible that the samples are not overlapping–are completely disjoint—or are partially overlapping. The situation is analogous for providers. This overlap, or lack of overlap, may explain some of the differences in responses to the same issue from different sources. ICF attempted to use as much information as possible to provide as much of a perspective as possible. However, due to the differences in samples, there may be information which superficially appears inconsistent but that can be potentially explained by the differences in samples.

STRENGTHS AND LIMITATION OF THE METHODOLOGY

With any data analysis project, the quality and appropriateness of the results are based on a collection of different issues, from the appropriateness of the original design and research strategy to the implementation of the strategy, the quantity and quality of the responses, and the interpretation of the data.

The strategy behind this evaluation was to obtain the largest amount of accurate and relevant information given the time and budget constraints. Overall, the evaluation aimed to examine the components of the

HOPWA program separately and as a whole. The evaluation also attempted to gather insight from numerous perspectives—large formula grantees administering the funds to community-based organizations implementing the programs to clients receiving services. This strength—the comprehensiveness of the study—may also be interpreted as a weakness, as the breadth of the evaluation at times hindered the depth that was able to be achieved. In other words, some areas of interest could not be examined as closely as some analysts and policy makers may have preferred. Discussion of some of the different components of the research follows.

Research Questions

The basic research questions posed by HUD in the original RFP guided the development of all subsequent stages of research. However, some of the research questions would have required an undue amount of effort for the value of the information attained. Others could not feasibly be addressed since organizations did not collect data on the topic. For example, one issue not addressed due to the difficulty in collecting information was the issue of why homeless individuals who are eligible for HOPWA assistance have decided not to participate. Furthermore, an example of a topic not explored due to a lack of data collected is the extent to which U.S. Armed Forces veterans have been participating in the HOPWA program.

Research Strategy

The multi-pronged approach of site visits, questionnaires, and telephone interviews allowed ICF to collect both qualitative and quantitative information. Other data collected by HUD provided additional information. Each data collection method offers its own set of strengths and weaknesses.

The in-depth site visits allowed a detailed perspective of how the program is actually implemented. The visits afforded the opportunity to understand how a program worked from several different perspectives, and elicited information that would not have otherwise been captured by the questionnaires. While the purpose of the visits was to gather information about Special Projects of National Significance, staff also visited formula grantees where possible, to discuss questionnaire questions in greater depth.

The implementation of the Formula Grantee and Housing Assistance Provider Questionnaires was structured to elicit responses from all potential parties. There was no sampling or targeting, but rather surveying of every organization believed likely to have been a participant in providing HOPWA housing assistance at some point over the life of the HOPWA program. The strength of this method is that no organization or classes of organizations were excluded. However, the response rates were not as high as preferred, even with pre-questionnaire announcements and multiple mailings of the questionnaire.

The implementation of the client questionnaire was known from the start to not be representative of the population of clients assisted for housing overall. Unfortunately, the time, effort, and likelihood of success for doing such a representative questionnaire were not favorable. There are significant feasibility and personal privacy issues associated with just assembling a list of clients, much less contacting them. As a result, the client questionnaire is, purely from a design perspective, the weakest.

In addition to collecting data directly, ICF used APR data collected by HUD. The data here contain a wealth of information from the grantees, and limited amounts from providers and about clients. However, like all data, they suffer from the limitations of respondents and non-respondents. Nonetheless, these data provide some information that was not available elsewhere and therefore allows analysis of certain issues that might not otherwise be possible.

APPENDIX 3: QUESTIONNAIRES

CLIENT QUESTIONNAIRE

Complete Before Call:

Name of HOPWA client: ____

Telephone number of client: ____

Name of HOPWA housing assistance provider: ______________________________

Client Interview:

Hello, my name is ____________________, and I'm calling from ICF Consulting to conduct the interview you scheduled. As you may recall from a letter you recently received, we are working with the U.S. Department of Housing and Urban Development, or HUD, on an important national questionnaire of housing assistance provided by HUD. One of HUD's housing programs helps persons with HIV or AIDS obtain housing or stay in their existing housing. This program, which is called Housing Opportunities for Persons with AIDS (or HOPWA), provides funding to [*name of the project].*

HUD has asked ICF Consulting to evaluate how well the HOPWA program is performing. As part of this evaluation, we would like to get the thoughts of people, such as yourself, who have been receiving housing assistance or other services through the HOPWA program. We want to know how well the HOPWA program is working for you.

Thank you for your willingness to participate in this evaluation and to share your thoughts with us.

The questions I am going to ask should only take 10-15 minutes and your name and responses will be kept confidential both from HUD and from those providing your assistance.

Start of Interview:

Record interview date and time: ____________________________

The purpose of our evaluation is to help the U.S. Department of Housing and Urban Development and other policy makers better understand how the HOPWA program is performing. This evaluation will not evaluate or rate the agency assisting you.

This HUD-sponsored program provides funds to governments and other organizations to assist persons with AIDS or who are HIV-positive. This assistance usually takes the form of providing housing assistance, but it can also be in the form of supportive services such as counseling or access to medical care.

I recognize that you may not know the source of your assistance, but [*name of project*] receives HOPWA funds. I'd like you to answer these questions to the best of your ability.

Housing Questions: *(READ TO CLIENT)*

First I have some questions about your housing.

1. Which one of the following best describes the type of housing in which you are currently living?

_____ A group home in which common areas, such as the living room and dining room, are shared by unrelated residents
_____ A single room occupancy (SRO) building, in which each housing unit is designed for occupancy by one person. An SRO unit is usually a single room, but sometimes includes a bathroom and/or a food preparation area
_____ Your own home or apartment
_____ A shelter for homeless persons
_____ Hotel or motel
_____ Other *(Please specify):* ______________________________

2. Is this housing your permanent residence or are you living there on a temporary basis while receiving health care or other services?

_____ Permanent
_____ Temporary
_____ Don't know

3. Approximately how long have you lived there?

_____ Less than one month
_____ 1 to 2 months
_____ 3 to 5 months
_____ 6 months to 1 year
_____ More than 1 year
_____ Don't know

4. Which one of the following best describes the housing assistance you are currently receiving?

_____ Short-term payments to help cover your rent, mortgage, or utilities so that you can remain in your own residence
_____ A housing assistance certificate or voucher that helps you pay the rent on a residence you found
_____ An apartment provided to you by [name of project]
_____ A room (either your own or shared) in a group home
_____ A unit in a single room occupancy (SRO) building
_____ A bed in a shelter for homeless persons
_____ A hotel/motel voucher
_____ Other (Please describe): ______________________________
_____ Not receiving any type of housing assistance. *(If this answer is checked, skip to question 15)*

5. How long a period passed between when you requested the housing assistance you just described and when you actually started receiving that housing assistance? (*Don't read choices, just check appropriate one.)*

_____ Less than one month
_____ 1 to 2 months
_____ 3 to 5 months
_____ 6 months to 1 year
_____ More than 1 year
_____ Don't know

6. Was it necessary for you to move or change residences in order to receive this housing assistance?

Yes ___ No ____

If no, skip to question 8.

7. If you answered that you moved in order to receive the assistance, please describe where you were living before receiving assistance. *(Once the client indicates an answer stop reading the list.)*

_____ Not answered since unchanged from current
_____ Living with relatives/friends but paying no rent
_____ Rental housing, either alone or with roommates
_____ Home you own or owned
_____ Living on the streets
_____ Living in an emergency shelter
_____ Living in transitional housing
_____ Hospital or other medical facility
_____ Mental health housing
_____ Substance abuse treatment center
_____ Jail/prison
_____ Other *(Please specify)*: ____

8. I'm going to read you several statements related to ways in which your quality of life may have changed since you began receiving the housing assistance you described a few moments ago. For each one of these statements, you will be asked to respond using a scale from 1 to 5, with 1 being the most negative response and 5 being the most positive response.

Please respond using a scale of 1 to 5, where 1 is "significantly worsened," 3 is "no change," and 5 is "significantly improved." Please answer 0 if you don't know.

a. Has your *access* to medical care improved or worsened since you began receiving the housing assistance?

***Circle**: 0 1 2 3 4 5*

Please respond using a scale of 1 to 5, where 1 is "much harder," 3 is "no change," and 5 is "much easier." Please answer 0 if you don't know.

b. Has it been easier or harder for you to get supportive services since you began receiving the housing assistance? By other supportive services, I mean things such as counseling, food services, transportation assistance, substance abuse treatment, etc.

***Circle**: 0 1 2 3 4 5*

Please respond using a scale of 1 to 5, where 1 is "significantly less stable," 3 is "no change," and 5 is "significantly more stable." By "stable," I mean that you can remain in this housing as long as you choose or as long as the lease provides. Please answer 0 if you don't know.

c. (*If the client is in their own home or apartment, a group home, or an SRO)* Is your housing situation more stable or less stable now than before you began receiving housing assistance?

***Circle**: 0 1 2 3 4 5 Not Applicable*

d. *(If the client is in a shelter, hotel/motel, or transitional housing program)* Have your opportunities to obtain permanent, stable housing after you leave your current housing gotten better or worse since you began receiving assistance? By "stable," I mean housing in which you can remain as long as you choose.

***Circle**: 0 1 2 3 4 5 Not Applicable*

Please respond using a scale from 1 to 5, where 1 is "significantly decreased," 3 is "no change," and 5 is "significantly increased." Please answer 0 if you don't know.

e. Do you have more ability to pay for other things you need besides housing or shelter now than before you received housing assistance?

***Circle**: 0 1 2 3 4 5*

Please respond using a scale from 1 to 5, where 1 is "significantly less in control of my life," 3 is "no change," and 5 is "significantly more in control of my life." Please answer 0 if you don't know.

f. Do you feel more or less in control of your life now than before you began receiving the housing assistance?

***Circle**: 0 1 2 3 4 5*

Please respond using a scale of 1 to 5, where 1 is "significantly worsened," 3 is "no change," and 5 is "significantly improved." Please answer 0 is you don't know.

g. Overall, would you say your quality of life has improved or worsened since you began receiving the housing assistance? By "quality of life", I mean considering all factors together, living environment, health care, finances, etc.

***Circle**: 0 1 2 3 4 5*

9. Now I'm going to ask a couple of questions about the suitability of the housing where you are currently living.

   a. Does your housing unit meet your physical needs, considering your present physical condition?

      Yes ____ No ____

      If no, please explain

   b. If you are living with others, is your residence large enough for you and the others in your household?

      Yes____ No ____

10. How would you rate your overall satisfaction with the housing assistance you have received? *Please respond using a scale of 1 to 5, where 1 is "very dissatisfied" and 5 is "very satisfied." Please answer 0 if you have no opinion or don't know.*

    ***Circle**: 0 1 2 3 4 5*

11. What are some of the reasons for your (*satisfaction/lack of satisfaction)?*

12. Aside from the cost of your housing, what other factor is the most important to you about where you live or would most like to live?

    _____ Physical quality of unit
    _____ Location/neighborhood
    _____ Accessibility to medical services
    _____ Accessibility to supportive services (counseling, food services, substance abuse treatment, etc.)
    _____ Other *(Please specify)*: ____

13. I'm going to read a list of possible outcomes if you were no longer receiving HOPWA housing assistance. For each item, please say "yes" if you think it is a possible outcome and "no" if you think it is not.

   a. *If the client is in their own home or apartment, a group home, or an SRO*. Do you think you might:

	Yes	No
Remain in your current residence without a housing subsidy?		
Remain in your current residence receiving a different housing subsidy?		
Move to a less expensive housing unit?		
Move in with relatives or friends?		
Become homeless?		
Other (specify): ______________________________		

   Of the ones you said were possible, which do you think is most likely*?*

   b. *If the client is in a shelter, hotel/motel, or transitional housing program*. Do you think you might:

	Yes	No
Obtain a residence or place to stay without a housing subsidy?		
Obtain a residence or place to stay receiving a different housing subsidy?		
Move in with relatives or friends?		
Become homeless?		
Other (specify): ________________________________		

   Of the ones you said were possible, which do you think is most likely*?*

14. The next questions are about your future housing plans.

   a. A long-term housing plan is a plan that would have been developed by you and your case manager or housing assistance provider. It might be specifically related to housing or it could be part of an overall services plan. This plan would describe how long you expect to receive assistance and what steps you and your case manager or housing provider expect to take to make sure you can sustain housing. Do you have a long-term housing plan? Yes ____ No ____

   b. (If yes to a) Is this plan periodically reviewed and progress tracked? Yes ____ No ____

Services Questions:

15. Now I would like to ask you some questions about the services you are receiving.

    (a) Which of the following services are you receiving?
    - *Under the "Yes" column, check each service that the client receives.*
    - *If the client responds "No" to all of the services, skip to the next section. If he or she responds "Yes" to any service, continue to (b).*

    (b) How has your quality of life been changed by these service (compared to what you think it would have been without them)? Please respond using a scale of 1 to 5, where 1 is "significantly worse", 3 is "no change", and 5 is "significantly better." Please answer 0 if you do not know.

	Yes	0	1	2	3	4	5
Help identifying your needs and accessing services or benefits (i.e., case management)							
Help managing your daily life							
Nutritional services/meals							
Adult day care							
Personal assistance/attendant care							
Child care and other children services							
Education							
Employment assistance							
Alcohol and drug abuse services							
Mental health services							
Assistance adhering to new drug therapies							
Other health/medical/intensive care services							
Other *(Describe)*:______________________							

Demographics

I have a few final questions for you. This information is important, but if you prefer not to answer any of the questions, please say so.

16. Again, this is for demographic information: what sex are you? *(Don't read list, let client volunteer information.)*

    Male _____ Female _____ Transgender _____

17. I'm now going to read a list of age categories. Please indicate the category that applies to you:

    _____ 17 years or younger
    _____ 18 to 30 years
    _____ 31 to 40 years
    _____ 41 to 50 years
    _____ 51 years or older

18. Are you Hispanic or of Spanish-American origin? Yes ____ No ____

19. With which of the following racial categories do you most identify?

____ Asian/Pacific Islander
____ Black
____ Native American or Alaskan Native
____ White

20. Do you work regularly either for pay or on a volunteer basis? Yes ____ No ____

21. (*If yes to question 20*) In an average week, how many hours do you work? _______

22. If you are not working at all or as much as you would like, what are the barriers?

Thank you for your time; we appreciate it very much.
If you have any questions or concerns, please call our toll-free number: 1-877-346-8901.

Public reporting burden for this questionnaire is estimated to average 30 minutes per response. The burden estimate includes the time for reviewing instructions, searching existing data sources, gathering and maintaining the information needed, and completing and reviewing the form.

Burden means the total time, effort, or financial resources expended by persons to generate, maintain, retain, or disclose or provide information to or for a Federal agency. This includes the time needed to review instructions; develop, acquire, install, and utilize technology and systems for the purposes of collecting, validating, and verifying information, processing and maintaining information, and disclosing and providing information; adjust the existing ways to comply with any previously applicable instructions and requirements; train personnel to be able to respond to a collection of information; search data sources; complete and review the collection of information; and transmit or otherwise disclose the information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number is 2528-0208 and expires on 9/30/00.

FORMULA GRANTEE QUESTIONNAIRE

Dear Grantee,

ICF Consulting, under contract with the Office of Policy Development and Research, U.S. Department of Housing and Urban Development, is conducting an evaluation of the Housing Opportunities for Persons with AIDS (HOPWA) program to better inform HUD and other policymakers how HOPWA performs and functions. The evaluation includes questionnaires of grantees, HOPWA housing assistance providers, and clients. ***This is not an evaluation or assessment of your organization's performance***. All of your answers will be kept in confidence by ICF, and no identifiable characteristics will be submitted to HUD.

You currently submit Annual Progress Reports (APRs) to HUD, and we are already using that information. The questions in this questionnaire are designed to supplement the information already collected. They focus primarily on the HOPWA planning and funding processes and should only take about 30 minutes to answer. If you have any questions about this questionnaire or the evaluation, please call ICF Consulting toll free at 1-877-346-8901.

Please provide the following information about the HOPWA grants you receive.

Grantee Name: ____

Name of Agency Administering the Grants *(if different than above)*:

____

Name of Person Completing this Questionnaire:

____

Title or Position: ____

Address: ____

____

Telephone: ____

FAX Number: ____

E-mail Address: ____

May we contact you if we have additional questions? _____ Yes _____ No

1. Please indicate the category that best describes your agency or department: *(Check only one.)*

_____ Housing, community development, or economic development agency
_____ Health services agency
_____ Human services or welfare agency
_____ Executive branch of government (i.e. Office of Management, Chief Executive Officer, or Chief Elected Official)
_____ Other *(please describe)*: ____

2. Approximately what percentage of your HOPWA expenditures during your most recently completed program year was used for :

_____% Housing assistance
_____% Supportive services
_____% Administrative costs
_____% Other

100% **TOTAL**

PLANNING

3. Do you target assistance to subpopulations of persons living with HIV/AIDS within the overall population of low-income persons living with HIV/AIDS and their families? Yes ___ No ___
If yes, how are program decisions made about the subpopulations to target for assistance. Specifically, how are the ***policies*** *set?*

4. How are program priorities set about the types of housing or other housing assistance to provide with HOPWA funds?

5. Are there any formal HOPWA advisory groups involved in making these decisions? Yes ___ No ___

If yes, what types of organizations are represented in the advisory group(s)?

6. Since you first began receiving HOPWA formula funding, have program priorities changed?

Yes ____ No ____

If yes, how have they changed and why?

7. The next questions refer to possible coordination between the HOPWA program and the Ryan White CARE Act Planning Council/Consortium.

(a)	Are you receiving Ryan White CARE Act funding?	Yes ____	No ____
(b)	Do you share data?	Yes ____	No ____
(c)	Do you consult when establishing program or funding priorities?	Yes ____	No ____
(d)	Do you coordinate funding allocations or awards?	Yes ____	No ____
(e)	Do you coordinate housing placement or service delivery?	Yes ____	No ____
(f)	Other coordination? *If yes, please describe*.	Yes ____	No ____

8. If these types of coordination have been occurring, have they been beneficial? *If yes, why? If not, why not?*

9. What could be done to improve this coordination? (Examples: Better communication, more flexibility on rules, etc.)

10. The next questions refer to possible coordination between the HOPWA program and the homeless Continuum of Care planning.

    (a) Are you receiving Continuum of Care funding? Yes ____ No ____

    (b) Do you share data with Continuum of Care grantees? Yes ____ No ____

    (c) Do you consult when establishing program or funding priorities? Yes ____ No ____

    (d) Do you coordinate funding allocations or awards? Yes ____ No ____

    (e) Do you coordinate housing placement or service delivery? Yes ____ No ____

    (f) Other coordination? *If yes, please describe*. Yes ____ No ____

11. If these types of coordination have been occurring between the HOPWA program and Continuum of Care planning, have they been beneficial? *If yes, why? If not, why not?*

12. What could be done to improve this coordination? (Examples: Better communication, more flexibility on rules, etc.)

FUNDING PROCESS

Important Definitions

The term "project/program sponsor," as used in this questionnaire, means a public or private nonprofit organization that provides HOPWA assistance directly to HOPWA program clients. A project/program sponsor receives HOPWA funding from a HOPWA grantee or subgrantee.

The term "subgrantee," as used in this questionnaire, means a local government, a state or local government agency, or a nonprofit organization that receives an allocation of HOPWA formula funds from the grantee in order to distribute and manage the funds on the grantee's behalf. Subgrantees in turn provide funding to project/program sponsors.

13. Did you provide HOPWA funds directly to project/program sponsors during your most recently completed program year. Yes ____ No ____?
    If yes, please complete items a-c.

    (a) Approximately what percentage of the HOPWA formula allocation for your most recently completed program year was awarded directly to project/program sponsors? ____%

    (b) For that program year, please indicate which of the following processes you used to select individual projects/programs for funding, by entering the *approximate percentage* of funds that were provided under each option. Please be sure that the sum of the entered percentages equals 100%.

    ____% Requests for proposals where competition is limited to specific types of activities
    ____% Requests for proposals where competition is open to all types of activities
    ____% Noncompetitive set-aside for certain specified activities
    ____% Noncompetitive renewal of previously funded HOPWA projects
    ____% Other *(Please describe)*: ______________________________

    100% Total (like before) on page 2 of the Formula Grantee Questionnaire

(c) Using check marks, please rate the importance of each of the following criteria you used in selecting individual projects/programs for funding.

	Criterion					
	Not Used	Not Very Important	Moderately Important	Important	Very Important	Most Important
The relative need of the persons the program proposes to serve (e.g., the needs of homeless persons might be considered before the needs of persons at risk of homelessness; persons disabled by AIDS might be considered more needy than persons diagnosed with HIV, etc.)						
How well the program responds to unmet needs described in a HIV/AIDS assistance strategy						
Level of coordination among organizations that will be providing needed housing and services to clients						
Capacity of the program sponsor to carry out the activities and the organization's experience						
Feasibility of the program (e.g., financial resources, site control)						
Leveraging (e.g., the extent to which other resources are being brought to the activity from other public or private sources)						
Cost per unit						
Other *(Please describe)*						
Other *(Please describe)*						
Other *(Please describe)*						

14. Did you allocate any of your HOPWA formula allocation to subgrantees (see definition above) for your most recently completed program year? Yes ___ No ___
    If yes, please complete items a-e.

    a. How many subgrantees received an allocation of HOPWA formula funds for your most recently completed program year? _______

    b. Approximately what percentage of the HOPWA formula allocation for your most recently completed program year was allocated to subgrantees? ________%

c. How was the decision made on which organizations to fund as subgrantees?

d. Do you know what processes <u>any</u> of your subgrantees used to select individual projects/programs for funding during the most recently completed program year? Yes _____ No _____

If yes, please indicate the frequency that each process is used. Please respond by using a scale 1 to 5, where 1 is "least common" and 5 is "most common." Please answer 0 if the process is not used or you do not know if it is used.

_______ Requests for proposals where competition is limited to specific types of activities
_______ Requests for proposals where competition is open to all types of activities
_______ Noncompetitive set-aside for certain specified activities
_______ Noncompetitive renewal of previously funded HOPWA projects
_______ Other *(Please describe)*: ____

e. Do you know what criteria <u>any</u> of your subgrantees used to select individual projects/programs for funding?

Yes ____ No ____

If yes, please use check marks to rate the importance of each of the following criteria.

	Criterion					
	Not Used	Not Very Important	Moderately Important	Important	Very Important	Most Important
The relative need of the persons the program proposes to serve (e.g., the needs of homeless persons might be considered before the needs of persons at risk of homelessness; persons disabled by AIDS might be considered more needy than persons diagnosed with HIV, etc.)						
How well the program responds to unmet needs described in a HIV/AIDS assistance strategy						
Level of coordination among organizations that will be providing needed housing and services to clients						
Capacity of the program sponsor to carry out the activities and the organization's experience						
Feasibility of the program (e.g., financial resources, site control)						
Leveraging (e.g., the extent to which other resources are being brought to the activity from other public or private sources)						
Cost per unit						
Other *(Please describe)*						
Other *(Please describe)*						
Other *(Please describe)*						

As the final part of this questionnaire, we would like to know your opinions about the HOPWA program in general.

15. What do you see as the major three *strengths* of the national HOPWA program?

    (1) ____________________

    (2) ____________________

    (3) ____________________

16. What do you see as the major three *weaknesses* of the national HOPWA program?

    (1) ____________________

    (2) ____________________

    (3) ____________________

17. What three recommendations would you make for strengthening the national HOPWA program?

    (1) ____________________

    (2) ____________________

    (3) ____________________

Thank you for taking the time to assist us in the evaluation process. Your input is important.

Public reporting burden for this questionnaire is estimated to average 30 minutes per response. The burden estimate includes the time for reviewing instructions, searching existing data sources, gathering and maintaining the information needed, and completing and reviewing the form.

Burden means the total time, effort, or financial resources expended by persons to generate, maintain, retain, or disclose or provide information to or for a Federal agency. This includes the time needed to review instructions; develop, acquire, install, and utilize technology and systems for the purposes of collecting, validating, and verifying information, processing and maintaining information, and disclosing and providing information; adjust the existing ways to comply with any previously applicable instructions and requirements; train personnel to be able to respond to a collection of information; search data sources; complete and review the collection of information; and transmit or otherwise disclose the information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number is 2528-0208 and expires on 9/30/2000.

HOPWA HOUSING ASSISTANCE PROVIDER QUESTIONNAIRE

Dear AIDS Housing Provider:

ICF Consulting, under contract with the Office of Policy Development and Research, U.S. Department of Housing and Urban Development (HUD), is conducting an evaluation of the Housing Opportunities for Persons with AIDS (HOPWA) program to better inform HUD and other policymakers how HOPWA performs and functions. ***This is not an evaluation or assessment of your organization's performance.*** All of your answers will be kept in confidence by ICF, and no identifiable characteristics will be submitted to the HOPWA grantee providing your funding or to HUD.

HOPWA provides funds for housing and supportive services for persons and households affected by HIV/AIDS. HOPWA grantees distribute HOPWA funds to assistance providers who in turn provide support to HIV/AIDS clients. We have identified you as an organization acting as a "HOPWA Housing Assistance Provider," meaning you provide HOPWA-funded housing assistance to persons living with HIV/AIDS. **If this is incorrect, please indicate "no" for the question at the bottom of this page, and return the questionnaire so we may remove you from our mailing list and measure response rates accurately.** The following definitions will help you determine if you provide HOPWA-funded housing assistance:

- *Housing assistance* means providing housing units for HOPWA clients or providing financial assistance to HOPWA clients for housing.
- *Providing housing units for HOPWA clients* includes using HOPWA funds for acquisition, rehabilitation, construction, leasing or operation of one or more residential buildings or individual units within one or more residential buildings. It also includes using HOPWA funds for project-based rental assistance.[5]
- *Providing financial assistance to HOPWA clients* for housing includes tenant-based rental assistance,[6] hotel/motel vouchers, and short-term payments for rent, mortgage, and/or utilities to help HOPWA clients remain in their current residences.
- *Housing assistance* does not include housing counseling or other housing information services.

If you are a HOPWA housing assistance provider, please complete the following questionnaire and return it to us. Your program will not be identified in any reports we produce. If you have any questions about the questionnaire or the evaluation, please call ICF Consulting toll free at 1-877-346-8901. Someone will promptly return your call and answer your questions.

Do you provide housing assistance using funds from the U.S. Department of Housing and Urban Development's (HUD's) Housing Opportunities for Persons with AIDS (HOPWA) program?

_____ Yes _____ No

If yes, please continue. If no, please stop here and return this questionnaire.

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[5] Under project-based rental assistance, the housing assistance organization provides financial assistance to a landlord in return for the landlord setting aside one or more rental units for program-eligible households.

[6] Under tenant-based rental assistance, the client receives a housing certificate or voucher, which provides a government subsidy for part of the cost of the rental unit chosen by the client.

Organization Name: ____

Name(s) of HOPWA project(s): ____

____

Chief Executive: ____

Address: ____

____

Name of Person Responding to Questionnaire:

____

Title or Position: ____

Telephone: ____

Fax number: ____

E-mail address: ____

Name of Grantee providing your HOPWA funds: ______________________________

May we contact you if we have questions about your responses? ____ Yes ____ No

This questionnaire has two parts. PART A requests information about your organization and the housing assistance and services provided to your HOPWA clients. PART B requests financial information. It should take you approximately 30 to 40 minutes to complete both parts.

PART A: PROVIDER PROFILE AND ASSISTANCE PROVIDED

HOPWA Housing Assistance Provider Profile

1. Please indicate the type of your organization.

   Government Agency:

   _______ Housing
   _______ Health Care
   _______ Other type of government agency *(Please describe)*: ______________________________

   Private-Nonprofit

   Primary Activity (Check only one)

   _______ Housing
   _______ Health Care
   _______ Other supportive services[7] *(Please identify major services)*: _________________________
   ____

   Secondary Activity, if any:

   _______ Housing
   _______ Health Care
   _______ Other supportive services *(Please identify major services)*: __________________________
   ____

2. How many years has your organization been providing assistance (funded from any source) to persons living with HIV/AIDS? _______

3. Does your organization serve <u>only</u> persons living with HIV/AIDS and their families?Yes ____ No ____

4. What assistance does <u>your organization</u> provide to HOPWA clients using HOPWA funding and <u>other</u> (non-HOPWA) funding? *Check all boxes that apply*.

Assistance	HOPWA Funding	Other Funding
Housing		
Health Care		
Other Supportive Services		
Other *(Please describe)*:		

[7] "Supportive services" as used in this questionnaire refers to services that address the needs of HOPWA clients, including such services as case management (i.e., helping clients identify needs and access services or benefits), nutritional services/meals, adult day care and personal assistance, child care and other children services, education, employment assistance, alcohol or drug abuse services, mental health services, help adhering to new drug therapies, other health/medical/intensive care services, and permanent housing placement.

Housing Assistance

5. Please complete the applicable lines of this table to indicate the number of eligible households that were living in HOPWA-financed housing during the most recently completed program year (regardless of the year in which the financing was provided) or were otherwise receiving HOPWA housing assistance during that program year. Please note that HOPWA housing assistance is defined on page 1.

   Please provide the number of households by type of housing assistance received. Use the first column for housing that is intended as temporary or transitional, and the second column for housing that is intended as permanent. "Permanent" refers to housing in which the household can remain as long as it chooses or as long as it can afford the payments.

	Number of Households by Type of Housing Assistance	
Type of Housing or Other Housing Assistance	Temporary/ Transitional	Permanent
Single Room Occupancy (SRO) dwellings		
Community residence (i.e. group home)		
Apartments your organization leases		
Other housing facility		
Tenant-based rental assistance		
Short-term payments for rent/mortgage/utilities		
Emergency hotel/motel voucher		
Short-term facility (i.e. emergency shelter)		
Other (Please describe):		
TOTALS		

6. Of the total of all of these households served, please indicate the approximate percentage of households in each income range. The percentages should total 100%.

   ____% Less than 30% of Area Median Income (AMI) – extremely low income
   ____% Between 30 and 50% of AMI – very low income
   ____% Between 50 and 80% of AMI – low income
   ____% Greater than 80% of AMI
   ____% Don't know

   100% TOTAL

7. Of those households that previously received HOPWA housing assistance for permanent residences but are no longer receiving this assistance, please indicate the approximate percentage that:

(a)	Remained in the same housing with no further housing subsidy	______%
(b)	Remained in the same housing with another housing subsidy	______%
(c)	Moved to other housing with no further housing subsidy	______%
(d)	Moved to other housing with another housing subsidy	______%
(e)	Moved to a long-term care facility or hospice	______%
(f)	Moved to mental health or substance abuse program residence	______%
(g)	Became homeless	______%
(h)	Died	______%
(i)	Other *(Please describe)*: ____________________________	______%
(j)	Do not know	______%
(k)	Did not provide any assistance for permanent residences	______%
	Total	100%

8. Of those households that previously received HOPWA housing assistance for temporary/transitional housing but are no longer receiving this assistance, please indicate the approximate percentage that:

(a)	Obtained a residence or place to stay without a housing subsidy	______%
(b)	Obtained a residence or place to stay receiving a different housing subsidy	______%
(c)	Moved to a long-term care facility or hospice	______%
(d)	Moved to a mental health or substance abuse program residence	______%
(e)	Became homeless	______%
(f)	Died	______%
(g)	Other *(Please describe)*: ____________________________	______%
(h)	Do not know	______%
(i)	Did not provide any assistance for temporary/transitional housing	______%
	Total	100%

If your program involves short-term rent, mortgage, and/or utility payments to help clients remain in their residences, please answer questions 9 and 10. If not, please continue to question 11. "Short-term" means that a client receives assistance for not more than 21 weeks in any 52-week period.

9. For households receiving short-term assistance for rent, mortgage, and/or utility payments:

   (a) What percentage of households did not use their full 21 weeks of eligibility? _____%

   (b) For households that did use their full 21 weeks, how has housing stability been maintained beyond 21 weeks? Please indicate the percentage of households that fall into the following categories. *(Note that the total percentage may be greater than 100% due to multiple sources of funding being used.)*

      (1) Household income increased enough to remain in the housing ______%
      (2) Used Ryan White CARE Act funds to continue housing payments ______%
      (3) Used other public or private funds to continue the housing payments ______%
      (4) Waiver sought to exceed 21-week limit ______%
      (5) Client/household could not remain in the housing ______%
      (6) Do not know ______%

10. The following two questions refer to clients who received short-term assistance for rent, mortgage and/or utility payments from your organization more than once. This means that they received short-term assistance, had a period of not receiving short-term assistance, and then received short-term assistance again.

   (a) What percentage of your clients were repeat clients who participated two or more times in a 52-week period? For example, the household received assistance for 4 weeks, went off assistance for 16 weeks, and then received assistance for another 4 weeks. _____%

   (b) What percentage of your clients received additional short-term assistance when they again became eligible? In other words, they received short-term assistance for 21 weeks, went off assistance for 31 weeks (total elapsed time of 52 weeks) and then began receiving short-term assistance again. _____%

You have now completed the questions concerning housing assistance. The next questions focus on the supportive services available to your clients and the linkages between your organization and other organizations that provide services to your clients.

Supportive Services:

11. What services, provided by any organization, were available to clients during the most recently completed program year? *Please check all that apply.* Use the first column for HOPWA-funded services and the second column for non-HOPWA funded services.

	HOPWA Funding	Other Funding
(a) Case management/access to benefits and services		
(b) Life management (outside of case management)		
(c) Nutritional services/meals		
(d) Adult day care and/or personal assistance		
(e) Child care and/or other children services		
(f) Education (including GED)		
(g) Employment assistance		
(h) Alcohol and drug abuse services		
(i) Mental health services		
(j) Assistance under the AIDS Drug Assistance Program (ADAP)		
(k) Help adhering to drug therapies		
(l) Other health/medical/intensive care services		
(m) Permanent housing placement		
(n) Other *(Please describe)*: ______________________________		

12. In what ways have you, as a HOPWA housing assistance provider, linked clients to assistance provided under Ryan White CARE Act programs? *Check all that apply.*

_____ Do not link clients with assistance under the Ryan White CARE Act programs
_____ Coordinate client needs assessments
_____ Coordinate case management
_____ Other *(Please describe)*: ____
_____ Do not know

13 In what ways have you, as a HOPWA housing assistance provider, linked your clients to supportive services provided by other organizations in your community? *Check all that apply.*

_____ Do not link clients with other supportive service providers
_____ Memorandums of Understanding or other linkage agreements with other service providers
_____ Planning meetings
_____ Referrals to supportive service providers
_____ Other *(Please describe)*: ____
____
_____ Do not know

14. Do you or someone from your agency regularly participate in community-wide planning about the use of HOPWA funds? Yes ____ No ____

15. Do you or someone from your agency regularly participate in any other AIDS or housing-related planning bodies or processes including:

AIDS Housing Plan	Yes ____	No ____
Ryan White Planning Council or Consortia	Yes ____	No ____
Consolidated Plan	Yes ____	No ____
Continuum of Care Plan	Yes ____	No ____
Other Housing Planning Process *(Please identify)* ______________________	Yes ____	No ____
Other AIDS Planning Process *(Please identify)* ________________________	Yes ____	No ____

16. Which of the following housing-related activities, if any, did you carry out with HOPWA funds during the most recently completed program year? *Check all that apply.*

_____ Housing information services, including counseling, information, and referral services to assist eligible persons locate, finance, and/or maintain housing.

_____ Resource identification to establish, coordinate and develop housing assistance resources for eligible persons.

_____ Technical assistance in establishing and operating a community residence, including planning and other pre-development and pre-construction expenses.

The previous questions have dealt with your involvement in the existing program. As part of this questionnaire, we would like to know your opinions about the program in general.

17. What do you believe are the major three *strengths* of the national HOPWA program?

(1) ____

(2) ____

(3) ____

18. What do you believe are the major three *weaknesses* of the national HOPWA program?

(1) ____

(2) ____

(3) ____

19. What three recommendations would you make for strengthening the national HOPWA program?

(1) ____

(2) ____

(3) ____

PART B: FINANCIAL INFORMATION

1. When did your last fiscal year end? __________

2. What were your organization's total expenditures for the last fiscal year? $__________

3. Approximately what percentage of last fiscal year's total expenditures were used to assist persons living with HIV/AIDS (everyone, not just HOPWA-eligible)? ________%

4. Using the following matrix, please indicate the percentages of last fiscal year's total expenditures that were used for "housing" and "other services," based on sources of funding.

Activity	HOPWA Funding	Other Funding	Total
Housing	%	%	%
Other Services	%	%	%
Total	%	%	100%

***Buildings Assisted with HOPWA Funds**. The questions in this section refer to all housing units provided by your organization in all of your HOPWA facilities combined. If your project(s) involve(s) the use of HOPWA funds to provide housing units through such activities as acquisition, rehabilitation, construction, leasing, project-based rental assistance, or operations, please answer questions 5-7. If not, please continue to question 8.*

5. If HOPWA funds were used for project development costs, please indicate all sources and amounts of funding for these costs regardless of the year in which the costs were incurred.[8] If not, please continue to question 6.

(a) HOPWA $__________
(b) Home Investment Partnerships (HOME) program $__________
(c) Community Development Block Grant (CDBG) $__________
(d) Section 811 Program $__________
(e) Emergency Shelter Grants (ESG) $__________
(f) Supportive Housing Program (SHP) $__________
(g) Other federal housing funding (e.g., LIHTC) $__________
(h) State housing funding $__________
(i) Local government housing funding $__________
(j) Private housing funding $__________
(k) Other *(Please specify)* ____________________ $__________
____________________ $__________

TOTAL $__________

[8] *Project development costs*, as used in this questionnaire, means the costs associated with the development of housing, including "hard costs" such as acquisition of land or existing structures, site work, and construction or rehabilitation, and "soft costs" such as architectural and engineering fees, appraisals, and financing expenses.

6. If HOPWA funds were used for project operating expenses, please indicate all sources and amounts of funding for these expenses for the most recently completed program year.[9] If not, please continue to question 7.

(a)	HOPWA	$_________
(b)	Section 811 Program	$_________
(c)	Supportive Housing Program	$_________
(d)	Other federal funding	$_________
(e)	State funding	$_________
(f)	Local government funding	$_________
(g)	Private funding	$_________
(h)	Tenant rental payments	$_________
(i)	Other *(Please specify)* ________________________________	$_________
	____	$_________
	TOTAL	$_________

7. If your organization used HOPWA funds to lease residential space (e.g., apartments) during your most recently program year, please answer (a) and (b). If not, please continue to question 8.

   (a) What was the amount of HOPWA funds expended on leasing for that program year? $______

   (b) In that same program year, were there any other funding sources that were combined with your HOPWA funds to provide the lease payments? Yes ____ No ____
   If yes, please identify the sources and amounts of additional funding.

***Tenant-Based Rental Assistance**. If your HOPWA program provides tenant-based rental assistance, please answer questions 8 and 9. If not, please continue to question 10.*

8. For your most recently completed program year, what was the amount of HOPWA funding for tenant-based rental assistance? $_________

9. In that same program year, were any other funding sources combined with your HOPWA funds to provide the rental assistance? Yes ____ No _____
   If yes, please identify the source(s) and amounts of additional funding.

[9] *Project operating expenses*, as used in this questionnaire, means the costs associated with the day-to-day operation of housing, including such costs as housing management, maintenance, insurance, repairs, security, utilities, furnishings, and equipment. Project operating expenses for this question does **not** include expenses for supportive services or health care for residents.

***Short-Term Payments**. If your program involves short-term rent, mortgage, and/or utility payments to help clients remain in their residences, please answer question 10. "Short-term" means that a client receives HOPWA assistance for not more than 21 weeks in any 52-week period. Other funding sources may be used within or beyond the 21 weeks.*

10. For the most recently completed program year, what were the sources and amounts of funding for your short-term rent, mortgage, and/or utility payments?

(a) HOPWA	$_________
(b) Ryan White CARE Act	$_________
(c) FEMA's Emergency Food and Shelter program	$_________
(d) HUD's Emergency Shelter Grants program	$_________
(e) Other federal funding	$_________
(f) State funding	$_________
(g) Local government funding	$_________
(h) Private funding	$_________
(i) Other *(Please specify)* ______________________________	$_________
______________________________	$_________
TOTAL	$_________

Thank you for taking the time to assist us in the evaluation process. Your input is important.

Public reporting burden for this questionnaire is estimated to average 60 minutes per response. The burden estimate includes the time for reviewing instructions, searching existing data sources, gathering and maintaining the information needed, and completing and reviewing the form.

Burden means the total time, effort, or financial resources expended by persons to generate, maintain, retain, or disclose or provide information to or for a Federal agency. This includes the time needed to review instructions; develop, acquire, install, and utilize technology and systems for the purposes of collecting, validating, and verifying information, processing and maintaining information, and disclosing and providing information; adjust the existing ways to comply with any previously applicable instructions and requirements; train personnel to be able to respond to a collection of information; search data sources; complete and review the collection of information; and transmit or otherwise disclose the information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number is 2528-0208 and expires on 9/30/00.

APPENDIX 4: SITE VISIT SELECTION PROCESS

OVERVIEW

One of the objectives of the HOPWA Program evaluation is to examine competitive grantees to assess whether they are accomplishing their goals and are using innovative ideas or techniques. To effectively evaluate this, ICF will conduct a case study of six different competitive grantee's programs that received points for innovation in the HOPWA application rating process.

While on site, the ICF team will conduct interviews with the project director, staff members, clients and partnering agencies (as applicable) to learn the context in which each project operates, the degree to which the project uses innovative ideas or techniques, and the extent to which it accomplishes its intended goals.

Although the principal focus of the site visits will be the competitive grants, the ICF team will also meet informally with persons implementing formula grants in order to gain a deeper understanding of formula programs than can be obtained through the national questionnaire instruments alone.

SITE SELECTION PROCESS

In order to assemble the sample we compiled a list of all competitively awarded grantees from 1994 through 1998. We eliminated the 1997 and 1998 grantees since it is unlikely that these programs have been operational for a long enough period of time to determine the effects, if any, of the innovation. We also eliminated the 1996 grantees since during this year a different standard for scoring was used. During this year, HUD and the Department of Health and Human Services (HHS) collaborated on the design and implementation of the HIV Multiple Diagnosis Initiative (MDI). This was a specialized outreach effort to persons who are living with HIV/AIDS who are also homeless, and have chronic alcohol and/or other drug abuse issues and/or serious mental illness.

This left 18 possible competitive grantee's projects, all in 1994 and 1995. We then eliminated any programs that focus only on supportive services. This brought the sample to a final list of 14 possible grantees.

The following table lists the eighteen grantees from 1994 and 1995, including the four projects that only provide supportive services. Sampling from these years ensures that the project has been operating for enough time to realize success, take steps to overcome any obstacles, put in place procedures to incorporate community and client participation, and have results data and client satisfaction data.

The list is primarily sorted by points and secondarily by geographic region. We also took into consideration the type of grantee, target population and project focus. The possible number of points in 1994 was 10 and in 1995 it was 20. In order to standardize this measure, we weighted the points creating a highest possible score of 20.

APPENDIX 5: SITE VISIT LOCATIONS

Year	Region	Location	Project Name	Target Population	Project Description	Points	Weighted Points
1994	West	Tarzana, CA	Tarzana Treatment Center	Parolees	Supportive Housing	10	20
1994	South	Key West, FL	City of Key West	None	Rental Assistance	10	20
1994	Midwest	Detroit, MI	Patterson Residential Care, Inc.	Men	Supportive Housing	10	20
1994	East	Brooklyn, NY	Southside Community Mission	Family	Supportive Housing	10	20
1994	East	Hartford, CT	Connecticut Department of Social Service	None	Supportive Housing	10	20
1994	East	Trenton, NJ	New Jersey Housing and Mortgage Finance Agency	None	Supportive Housing	10	20
1994	East	Portland, ME	The AIDS Project	Rural	Supportive Housing	10	20
1995	East	Brooklyn, NY	Community Counseling and Mediation	Families	Supportive Housing	20	20
1995	East	New York, NY	Episcopal Social Services of New York, Inc.	Homeless	Supportive Housing	20	20
1995	East	New York, NY	Greyston Foundation, Inc.	None	Supportive Housing	14	14
1995	West	San Rafael, CA	County of Marin	None	Rental Assistance	13	13
1995	East	Philadelphia, PA	Asociacion de Puertorriquenos en Marcha	Latinos	Supportive Services	12	12
1994	West	San Francisco, CA	San Francisco Black Coalition on AIDS	Indigent African Americans	Supportive Housing	5	10
1994	South	Houston, TX	Houston Regional HIV/AIDS Resource Group, Inc.	Adolescents	Supportive Services	5	10
1994	South	San Antonio, TX	City of San Antonio	Substance Abuse	Supportive Housing	5	10
1994	South	San Juan, Puerto Rico	Municipality of San Juan	Women	Supportive Services	5	10
1994	East	New York, NY	Housing Works	Homeless	Supportive Housing	5	10
1994	East	Albany, NY	New York State Department of Health	Rural	Supportive Services	5	10

Based on this table we recommend conducting the following site visits. We believe these projects provide the best mix of geographic distribution, target population and project focus.

1. Key West, FL

City of Key West

- ❒ Example of a rental assistance program
- ❒ Scored highest possible points for innovation
- ❒ Represents Southern region

2. Detroit, MI[10]

Patterson Residential Care, Inc.

- ❐ Example of supportive housing program for men
- ❐ Scored highest possible points for innovation
- ❐ Represents Midwest region

3. State of Connecticut

Connecticut Department of Social Services, Family Services Division

- ❐ Example of a State program
- ❐ Scored highest possible points for innovation
- ❐ Represents Eastern Region

4. Portland, ME

The AIDS Project

- ❐ Represents a rural supportive housing program
- ❐ Scored highest possible points for innovation
- ❐ Represents Eastern Region (rural)

5. New York, NY

Episcopal Social Services of New York, Inc.

- ❐ Represents a supportive housing program for homeless persons
- ❐ Scored highest possible points for innovation
- ❐ Represents Eastern Region

6. Marin County, CA

Community Development Agency

- ❐ Represents a rental assistance program
- ❐ Scored 13 out of 20 possible points
- ❐ Represents Western Region

---

[10] Although originally selected as a site visit, the Detroit, MI, location was later replaced with San Antonio, TX. During the process of setting up the Detroit visit, ICF learned that the supportive housing program operated by Patterson Residential Care, Inc. was no longer in operation. In order to maintain a mix of geographic distribution, target population and project focus, San Antonio, TX, was selected as the replacement site visit location.

APPENDIX 6: SITE VISIT PROTOCOL AND DISCUSSION GUIDE

One of the objectives of this evaluation is to examine whether competitive grantees accomplished their goals and used innovative ideas or techniques. To address this issue, ICF will conduct site visits of six competitive grantees that received points for innovation in the HOPWA Special Projects of National Significance (SPNS) application rating process. While on site, the ICF team will conduct interviews with the project director, staff members, and partnering agencies (as applicable) to learn the context in which each program operates, the degree to which the project has used innovative ideas or techniques, the extent to which it has accomplished its intended goals, and lessons for replicability.

ON-SITE PROCEDURES

Each site visit will begin with an "entrance interview" with the Executive Director and key program staff of the grantee agency and the agency providing services. This meeting will allow us to explain the study, HUD's objectives, and the structure of the site visit to everyone at once. We will again emphasize that the study is not an evaluation of any individual project or organization's performance, but rather of the HOPWA program in general. The entrance interview will also allow us the opportunity to obtain an overview of the project and the grantee's organizational structure.

After the entrance interview, we will proceed with individual interviews with the Executive Director, key program staff, project sponsor staff (in situations where the grant recipient does not deliver services itself but rather distributes the HOPWA funds to other community-based organizations), partner agencies, and finally, if time allows, formula grantee staff. Because of limited time, and because it is desirable to have the same basic information from each individual interviewed, a standardized open-ended format will be used. We have prepared a discussion guide to ensure that the same general information is obtained at each of the sites.

One team member will take the lead in conducting each interview; the other will take detailed notes and will be responsible for ensuring all questions are covered. Assuming permission is granted, we will use micro-recorders to tape all interviews. The tapes will not be transcribed; they will only be used to verify information.

Each evening, the primary notetaker for each interview will type up his or her notes. Team members will meet to discuss the information collected during the interviews and whether there are any outstanding issues that need clarification or futher explanation. At the end of each site visit, we will conduct an "exit interview" with the Exectuive Director of the grantee agency and the contact person (if applicable). The exit interview will allow us the opportunity to ask any remaining questions and provide the Executive Director with a brief summary of what was learned.

At the end of each site visit, we will conduct an "exit interview" with the Exectuive Director of the grantee agency and the contact person (if applicable). The exit interview will allow us the opportunity to ask any remaining questions and provide the Executive Director with a brief summary of what was learned. A copy of the site visit report will be sent to the grantee agency so the staff may review the document for inaccuracies and answer any additional questions we may have. The site visit reports will not be stand-

alone documents, but rather summaries of the interviews used to help interpret questionnaire results and inform the writing of the final report.

After returning from the site visit, the site visit team will organize the notes into an informal site visit report. A copy of the site visit report will be sent to the grantee agency so the staff may review the document for inaccuracies and answer any additional questions we may have. The site visit reports will not be stand-alone documents, but rather summaries of the interviews used to help interpret questionnaire results and inform the writing of the final report.

QUESTIONS FOR GRANTEES AND PROJECT SPONSORS

Pre-Site Visit Questions

- ❒ How many years has your organization been providing assistance to persons living with HIV/AIDS?
- ❒ Was the project in existence before your organization received the HOPWA SPNS grant? If yes, how was it funded?
- ❒ Is the project still in operation? If yes, are there staff who have been with the project from the planning phase that we could talk with?
- ❒ If the project was terminated, why was it terminated? Are there staff who worked on the project who would be able to discuss the project from design through implementation?

Project Design

A. Project Description

- ❒ What assistance does the project provide and how, if at all, has the assistance changed from original project design?
- ❒ What are the goals and objectives of the project and how, if at all, have they changed from the original program design?

B. Local Context

- ❒ Describe other local programs and services available to persons living with HIV/AIDS. In general, how long have these programs been available and are they meeting current need?
- ❒ Are there any issues specific to the area that affect the provision of services/housing for Persons living with HIV/AIDS? For example, lack of public transportation, high housing or service costs, availability/quality of health care or even lack of political support.

C. Determining Need

- ❒ What process was used to determine the need/demand for the assistance provided by the SPNS grant?

Prompt: Which organizations were involved in this process? Is need evaluated on a regular basis?

D. Marketing and Client Selection

- ❒ How are individuals in your community informed about your program?
- ❒ Who is eligible to participate in the program or receive the service?
- ❒ How are participants selected?

E. Planning and Coordination

- ❒ In what ways do you coordinate planning and implementation of the SPNS activities with activities funded through the Ryan White Care Act program? Continuum of Care homeless assistance? AIDS Drug Assistance Program (ADAP)? Others?
- ❒ Do you partner with other local organizations to provide services to clients?

Prompts: Who? How did you approach these organizations? What services do these organizations provide? What role do they play in the planning process? Do you have formal agreements (MOUs, contracts, etc.) or informal arrangements (referrals)?

- ❒ If you did coordinate with other organizations, what do you see as the benefits of coordination and what do you see as the challenges?
- ❒ What techniques did you use for involving the community or persons living with HIV/AIDS in program design?

F. Leveraging Resources

- ❒ Are other funds used in conjunction with your SPNS grant to provide the housing and/or services? If so, what are these sources and what percentage do they comprise of the total funding?

Project Outcomes

A. Evaluation

- ❒ What process do you use to evaluate the project and determine client outcomes?

Prompts: Who is responsible for project evaluation? What data do you collect? How is this data collected?

- ❒ Do you have any results? If so, what are they?

B. Sustainability

- ❒ If the project is still in operation, what source(s) of funding now support the project?
- ❒ How, if at all, did receiving the SPNS grant attract additional or subsequent funding?
- ❒ How is the project different, if at all, from when the project was receiving SPNS funding and what is the reason for the change(s)?

Prompts: Are the goals objectives and activities the same? If not how are they different? Are the same partners involved? Is the demographics of the people being served the same?

C. Replicability

- ❒ What obstacles, if any, did you encounter when implementing the program and how did you overcome them?

Prompts: Could the barriers have been avoided?

- ❒ How easy or difficult would it be for other HOPWA assistance providers to replicate this project?
- ❒ Are there unique circumstances that limit the replicability of this model?

Prompts: What advice would you give others attempting to implement a program similar to yours?

QUESTIONS FOR PARTNERING ORGANIZATIONS

Pre-Site Visit Questions

- ❒ What service(s) does your organization provide?
- ❒ How many years has your organization been providing this assistance?
- ❒ Was the service you provide in partnership with Agency x in existence before you began the partnership. If yes, how was it funded?
- ❒ Is the service still in operation? If yes, are there staff who have been with the project from the planning phase that we could talk with?
- ❒ If the service was terminated, why was it terminated? Are there staff who worked on the project who would be able to discuss the project from design through implementation?

Project Design

- ❒ What assistance does the service provide and how, if at all, has the assistance changed from original project design?
- ❒ What are the goals and objectives of the service and how, if at all, have they changed from the original project design?
- ❒ What was your organization's involvement in the planning and design of the project?
- ❒ What do you see as the benefits and challenges of partnering?
- ❒ Describe other local programs and services available to persons living with HIV/AIDS. In general, how long have these programs been available and are they meeting current need?
- ❒ Are there any issues specific to the area that affect the provision of services/housing for Persons living with HIV/AIDS? For example, lack of public transportation, high housing or service costs, availability/quality of health care or even lack of political support.

Project Outcomes

- ❒ What is your ongoing relationship, if any, with agency x?
- ❒ Do you still provide the service to the community?

APPENDIX 7: GRANTEE AND PROVIDER VIEWS AND RECOMMENDATIONS

INTRODUCTION

The Formula Grantee Questionnaire and the Housing Assistance Provider Questionnaire requested that respondents answer the following three questions:

(1) What do you see as the major three strengths of the national HOPWA program?

(2) What do you see as the major three weaknesses of the national HOPWA program?

(3) What three recommendations would you make for strengthening the national HOPWA program?

The following is a discussion of the responses received. This discussion is grouped by categories of comment in order to show the strengths and weaknesses of specific aspects of the HOPWA program as respondents perceived them.

MEETS A CRITICAL NEED

The most frequently stated strength of the HOPWA program is that it meets a critical need, with twenty-two grantees and twenty-eight providers responding in this way. Similar responses included that it is important to have a housing program dedicated to HIV/AIDS. One provider noted that the program provides assistance for people who would otherwise be discriminated against. Five respondents indicated that specific funding for people with HIV/AIDS is one of the major strengths of the program. It was also noted by grantees that the program helps reduce competition for other scarce housing resources.

FLEXIBILITY/LOCAL CONTROL

Flexibility was another frequently mentioned strength. One grantee appreciated that there were "not a lot of unnecessary regulations or micro management" in the program. The broad spectrum of eligible activities, including rental assistance, short-term mortgage and utility assistance, construction, and supportive services, was cited by twelve service providers and two grantees as a key strength of the program. Two service providers related the program's flexibility to its ability to serve rural areas. Similarly, five grantees indicated that the regulatory flexibility allows communities to adapt their service strategies to meet changing needs and local housing market conditions. Finally, ten providers and one grantee appreciated the fact that HOPWA guidelines allow for local control and priority setting and encourages community participation.

In contrast, four grantees mentioned that the same flexibility discussed above can actually make it difficult to focus on housing at the local level, since all eligible activities can be perceived as high priority. Because the rules lack specificity, grantees stated that it can be difficult to prioritize. This also relates to the criticism that HUD has provided little written program guidance. Five grantees mentioned "lack of guidance" as a programmatic weakness of HOPWA, including confusing guidelines and a lack of training. Finally, two providers mentioned that local rule setting is a problem as it relates to such things as drug and criminal histories of clients and subsidizing different types of living arrangements.

SUPPORTIVE SERVICES

Three grantees and nine providers stated that one of the program's strengths is that it ties housing assistance to supportive services. More specifically, they reported that this allows for continuity, facilitates greater treatment adherence, and encourages the maintenance of healthy behaviors.

Improvements to clients' quality of life is another strength cited by providers and grantees. Thirteen grantees reported that HOPWA prevents or reduces homelessness, while twelve providers indicated that the program makes housing more affordable or provides financial stability. One provider said that the program was "a safety net for mothers and children." Six providers mentioned the self-esteem and hope that HOPWA assistance can bring to people living with HIV/AIDS. Providers also liked that HOPWA allows clients to live where they choose, provides safe, sanitary, and affordable housing, and helps those having trouble paying their medical bills. Four providers mentioned the importance of confidentiality for their clients, stating that HOPWA affords more privacy than do more traditional housing programs such as Section 8.

On the contrary, several respondents mentioned client- and service-related weaknesses, including difficulty in placing families with children, difficulty in determining client eligibility, inconsistency with eligibility requirements of other programs, lack of awareness of the program, and concern about abuse of, and dependency on, the program. Three grantees reported that because HOPWA is easily accessible through their AIDS service organization, clients do not want to move on to other traditional housing programs (and therefore free up space for new clients). One grantee suggested implementation of a system to facilitate transferring a client's subsidy from one program to another (e.g., from HOPWA to Section 8).

TECHNICAL ASSISTANCE

Eight grantees and five providers mentioned excellent support and technical assistance (TA) from the HUD staff in DC. One grantee specifically praised the experience and commitment of HUD staff, while another praised HUD's efforts to establish a national sense of mission among HOPWA grantees and providers nationwide. Several providers specifically mentioned the ease of the program development process, and found it a major strength that HUD provides funding for TA.

In contrast, seven providers and two grantees stated that the program could be strengthened by improving support and technical assistance. Specific suggestions include the development of "best practice" case studies, more specific program guidelines, and additional guidance on program policies and fund usage. Eight providers and two grantees mentioned that TA could be improved, mentioning that more targeted TA would help improve the program. One grantee stressed the importance of having field staff work more efficiently with HOPWA providers.

OVERSIGHT AND EVALUATION

Another strength of the program includes aspects related to oversight and evaluation. Several respondents praised the ongoing assessment of the HOPWA program. Five providers deemed the program evaluation and reporting process "simple" or "manageable." Respondents mentioned that the monitoring process allows for identification of service needs and assessment of agencies providing services.

On the contrary, several grantees and providers mentioned weaknesses related to HOPWA reporting mechanisms and requirements, reporting that data elements for annual reports are too cumbersome and difficult to collect. Several providers mentioned weaknesses related to monitoring and information sharing., including a lack of formal review of direct entitlement communities' usage of HOPWA funds. Other providers stated that the cost of the program's application and other paperwork is a weakness.

Finally, five grantees and three providers reported that the program could be improved through smoother or simpler data gathering methods. Specific suggestions include clarification and training on HUD's data needs for the program, supplying sub-grantees with the most recent information on a monthly or quarterly basis, and providing a link to the HOPWA APR on the HUD Web site for electronic submission. Four providers suggested fewer forms or less paperwork. One grantee specifically stated that IDIS should be simplified and updated for program use.

FUNDING

The most frequently mentioned weakness of the HOPWA program is a lack of adequate funding in comparison to housing costs and community needs. Ten grantees and thirty-one service providers mentioned funding resource limitations. The funding structure is also seen as a weakness by respondents. Seven providers reported that the timing of the HOPWA grants is a weakness; respondents stated that the funding cycle does not match the fiscal year or permit 12 months of payments, which is problematic in that it causes payments to be held up at the beginning of the contract year. Five more providers mentioned the delay in receiving funds and length of processing time.

The length of assistance for clients is also seen as an area of weakness for HOPWA, with eight providers commenting how the available funding can restrict the length of time a person can be assisted. Comments made by grantees include that funding is often a "temporary band-aid," and that short-term assistance requirements are ill-matched to the epidemic. Two grantees stressed the hardship in maintaining benefits for families once a family member with AIDS has died, and benefits are only available for a short time thereafter.

Several grantees reported problems with funding allocations. One viewed it a weakness that allocations are based on new cases of AIDS reported to CDC. Another reiterated this, stating that Federal funds flow towards the place of diagnosis as opposed to the place of treatment. Three mentioned that the percentage of funding has not increased as new communities have become eligible EMSAs. One grantee stated that "some of the very large metropolitan areas of the country are sitting on very large piles of HOPWA funds because they can," and suggested a re-allocation of funds or the creation of an incentive system. This sentiment was echoed by other grantees.

Additionally, thirteen grantees and seventeen providers stated that the HOPWA program could be strengthened through increased funding. Specific suggestions regarding funding vary, but include changing to a long-term or sliding-scale funding structure, increased funding based on total HIV/AIDS cases (as opposed to new cases), and redistributing unused funds.

Changes to the funding formula were also suggested by respondents. Due to the funding formula, one provider noted that they must keep a certain amount of money in reserve to accommodate fluctuations. Additionally, providers and grantees alike would like further guidance on how to coordinate HOPWA and Ryan White CARE Act funding streams.

In contrast, four grantees and seven providers mentioned that one of HOPWA's strengths is that it is a well-funded or continuously funded program, where money is quickly and readily available. Strengths listed by other providers include that the funding supplements Ryan White CARE Act money and allows for expansion of services and the provision of start-up funds. Adequate funding also allows providers to reach a wider service area. One provider reported that it is able to provide assistance to an eight-county area.

COORDINATION

Another weakness often cited by grantees is the program's coordination with other Federal programs, constituencies, and organizations. Grantees indicated that weaknesses include HOPWA's lack of structured coordination with complementary grants, a lack of mutual understanding between Ryan White CARE Act and HOPWA constituencies, and the inability to broaden the type of organizations willing to participate in the HOPWA program. A lack of coordination with Federal job training programs was also mentioned as a major weakness.

Moreover, four grantees and one provider stated that the program could be improved by implementing better communication with all interested and affected government agencies. Three other respondents gave similar responses, citing open coordination with service providers, greater HUD oversight of grantee procedures, and better collaboration with the local HUD office as key to improvement.

Finally, four providers and one grantee stated that the program could benefit from improved planning at the local level. Comments include working with the grantee through the Consolidated Planning process, involving sub-grantees in comprehensive planning, and requiring communities to develop an AIDS housing plan.

ADMINISTRATIVE PROCEDURE

Finally, the questionnaires elicited several comments relating to administration. Six grantees and four providers reported that a major weakness of the HOPWA program is insufficient administrative funds. More specifically, four respondents mentioned that administrative layers diminish the program's funding. Several providers mentioned that the administrative cap is set too low and that there is a general lack of administrative funds. Similarly, one grantee and five providers stated that funds should be granted more directly as opposed to through the largest or most populous city. This, according to respondents, increases administrative costs.

In contrast, four respondents stated that the program allows for relatively easy administration. Some grantees appreciated that the program allows for administrative expenses and does not require mandatory HOPWA committees. Along similar lines, one provider mentioned that HOPWA's regulations are "very straightforward and not cumbersome," while another indicated that the program "is solely help-oriented without red tape."

APPENDIX 8: GLOSSARY OF TERMS

Acquisition: Gaining possession of real property by purchase, long-term lease, donation or otherwise.

Administrative costs: Costs for general management, oversight, coordination, evaluation and reporting on eligible activities. Each grantee may not use more than 3 percent of the grant amount for its own administrative costs. Project sponsors receiving amounts from grants may not use more than 7 percent of the amounts received for administrative costs.

Adult day care: Service provided to an eligible adult individual in a group setting an on a regular basis to maintain independent living as long as possible, prevent or delay entrance into 24-hour care, or reduce the length of stay in 24-hour care.

Affordable housing: Housing that costs an owner or renter no more than 30 percent of his or her income. Paying over 30 percent for is considered a "rent-burden" for the household.

AIDS: Acquired Immunodeficiency syndrome (AIDS) and related diseases. The disease of AIDS or any conditions arising from the etiologic agent for AIDS. A disorder of the immune system believed to be caused by HIV.

AIDS housing plan: Plan developed by local AIDS housing providers in a community to coordinate services and housing placement.

Annual Progress Report (APR): Completed by both formula and competitive grantees to capture yearly performance data use The APR. The report is designed as a management tool to assist efforts in evaluating program performance, including the performance of project sponsors and contracted service providers, in identifying recommendations for program improvements, and in setting future objectives for the community efforts. Grantees are required to submit a completed APR to HUD within 90 days after the end of each operating year. Among other items, the APR contains information on numbers and characteristics of clients served and types of assistance provided.

Appropriation: Provision of law providing budget authority that enables an agency to incur obligations and to make payments out of the treasury for specific purposes.

Assisted housing: Housing where the monthly costs to the tenant are subsidized by Federal or other programs.

"At risk of being homeless": Having the potential to become homeless due to inadequate income to support the housing costs or paying too high a percentage of income on rent.

Case management: The process of assisting clients to assess their needs, to apply for benefits, to obtain services from providers in the community, and to track progress toward achievement of personal goals. This includes coordination of provision of housing assistance and supportive service assistance as well as providing referrals to other programs or acting as a resource.

CDC: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services.

Competitive grantee: A grant for which organizations and units of government must undergo a competitive application process. Under the HOPWA program, ten percent of the appropriated funds are awarded by competition.

Community residence: A community residence is a residence designed for eligible persons to provide a lower cost residential alternative to institutional care, to prevent or delay the need for such care, to provide a permanent or transitional residential setting with appropriate services to enhance the quality of life for those who are unable to live independently, and to enable such persons to participate as fully as possible in community life.

Consolidated Plan: The Consolidated Plan is a planning document (comprehensive housing affordability strategy and community development plan) developed by local governments, and approved by HUD. The Consolidated Plan incorporates documents for the Community Planning and Development formula grant programs that provide formula grants to states and local governments (Community Development Block Grants, Emergency Shelter Grants, HOME, and HOPWA).

Continuum of Care: An approach that helps communities plan for and provide a full range of emergency, transitional, and permanent housing and service resources to address the various needs of homeless persons. Designed to encourage localities to develop a coordinated and comprehensive long-term approach to homelessness, the Continuum of Care consolidates the planning and application documents for HUD's Shelter Plus Care, Section 8 Moderate Rehabilitation SRO Program and Supportive Housing Program.

CPD: Office of Community Planning and Development in HUD. The Assistant Secretary for Community Planning and Development administers the grant programs that help communities plan and finance their growth and development, increase their capacity to govern, and provide shelter and services for homeless people. HOPWA is one of these programs.

Disabled person: A person who has a physical, mental or emotional impairment that is expected to be of long-continued and indefinite duration, substantially impedes his or her ability to live independently, and is of a nature that such ability could be improved by more suitable housing conditions. In addition, most programs have specifically included persons with developmental disabilities and those living with AIDS or any conditions arising from the etiologic agent for AIDS, including infection with HIV.

Eligible activities: Activities permitted to be undertaken with HOPWA program funding. Eligible activities include but are not limited to housing information services, resource identification services, the acquisition, conversion, lease and repair of housing units, new construction, tenant rental assistance, short-term rent, mortgage and utility payments, supportive services, administrative costs, and technical assistance.

Eligible person: A person who can participate and receive benefits through the HOPWA program. Person with AIDS or related diseases, who is a low income individual, and family of such person. A person with AIDS or related diseases, or family members, regardless of income, is eligible to receive housing information services.

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

Emergency housing can consist of homeless shelters, hotel or motel vouchers, short-stay apartments, or group living situations.

Eligible Metropolitan Statistical Area (EMSA): Metropolitan statistical area that has a population of more than 500,000 and has more than 1,500 cumulative cases of AIDS.

Extremely low-income: Household income at or below 30 percent of area median income, as defined by HUD, with adjustments for larger and smaller households.

Facility-based assistance: Financial assistance that helps meet the development or operating costs of housing units in order to indirectly subsidize the housing expenses of HOPWA clients.

Fair Market Rents (FMRs): HUD's estimate of the actual median market rents for apartments of varying sizes in the conventional marketplace. FMRs are calculated for different market areas and are issued yearly.

Family: Household composed of two or more related persons. The term family also includes one or more eligible persons living with another person or persons who are determined to be important to their care or well being, and the surviving member or members of any family described in this definition who are living in a unit assisted under the HOPWA program with the person with AIDS at the time of his or her death.

Formula grantee: A grant for which recipients and funding are determined by set variables. Ninety percent of the HOPWA program is allocated by formula. The formula based grants under HOPWA are awarded to EMSA that have at least 1500 cumulative cases of AIDS as of March 31st of the preceding year, and metropolitan areas that have a population of at least 500,000. One quarter of the formula is awarded for metropolitan areas that have a higher than average per capita incidence of AIDS.

Group home: Another term used to identify a "community residence."

Housing assistance: All forms of assistance that subsidize clients' housing expenses, including housing development/production projects that serve to indirectly subsidize housing expenses, and direct housing subsidy programs, such as tenant-based rental assistance.

Housing assistance provider: A nonprofit or government agency that receives HOPWA funds from a grantee to provide housing assistance.

HIV: Human immunodeficiency virus. HIV diminishes the body's response to infectious organisms and certain cancers. HIV is believed to cause AIDS.

HIV Care Consortium: The local oversight body for Ryan White CARE Act Title II Funds: An association of public and nonprofit health care and supportive service providers and community-based organizations that plans, develops, and delivers services for people living with HIV disease.

Homeless person: An individual or member of a family who lacks a fixed, regular, and adequate nighttime residence; who has a primary nighttime residence that is a publicly supervised or privately operated shelter designed to provide temporary living accommodations or an institution that provides a temporary residence for individuals intended to be institutionalized or a public or private place, not designed for, or ordinarily used as a regular sleeping accommodation for human beings.

HOPWA: Housing Opportunities for Persons With AIDS. The HOPWA program is a Federal housing program targeted to serve those persons who are living with HIV/AIDS and their families. The program is authorized by the AIDS Housing Opportunity Act (42 USC 12901) as amended by the Housing and Community Development Act of 1992 (PL 102-550, approved October 28, 1992). Funds were appropriated in FY 1992 and for subsequent years. The program is governed by the HOPWA Final Rule, 24 CFR Part 574.

HOPWA 1999 Performance Report: The 1999 Report on the Performance of the Housing Opportunities for Persons With AIDS program was issued on October 6, 1999. This report provides a review of the HOPWA program, program narratives, and a one-year profile of data from formula grantees.

Housing development costs: The costs associated with the development of housing, including "hard costs" such as acquisition of land or existing structures, site work, and construction or rehabilitation, and "soft costs" such as architectural and engineering fees, appraisals, and financing expenses.

Housing operating expenses: The costs associated with the day-to-day operation of housing including such costs as housing management, maintenance, insurance, repairs, security, utilities, furnishings, and equipment. Project operating expenses for this question does not include expenses for supportive services or health care for residents.

Housing referral services: Assistance to individuals who need help in finding or securing housing.

HRSA/HHS: Health Research Service Administration, U.S. Department of Health and Human Services.

HUD: United States Department of Housing and Urban Development.

Leveraging: The use of a potential funding source, such as HOPWA program funds, to attract additional sources of funding to a project.

Low income: Household income at or below 80 percent of the area median income, as defined by HUD, with adjustments for larger and smaller households.

MSA: Metropolitan Statistical Area. Basic census unit for defining urban areas and rental markets.

Multiple diagnoses: Persons living with HIV/AIDS who also have histories of other disabilities, typically chronic alcohol and/or other drug abuse problems and/or serious mental illness.

New construction: The building of a structure where none existed or an addition to an existing structure that increases the floor area by more than 100 percent.

Non-profit organization: Any nonprofit organization which is organized under state and local laws, has no part of its net earning inuring to the benefit of any member, has a functioning accounting system, has among its purposes significant activities related to providing services or housing to persons with AIDS.

Permanent housing: Housing that does not place a limit of the length of time a resident is able to live there. Within this broad category, there are many different housing programs and housing types, such as small group homes, single room occupancy residential hotels, and individual homes/apartment units, either clustered in one building or scattered throughout the community.

Project-based rental assistance: Rental assistance provided for a housing project, not for a specific tenant. A housing project is generally a development of housing units.

Project sponsor: Any nonprofit organization or governmental housing agency that receives HOPWA funds under a contract with the grantee to carry out eligible activities under this part.

Provider: Another term used to identify a "housing assistance provider."

PWA/PLWA: Persons with AIDS; Persons living with AIDS.

Rehabilitation: The improvement or repair of an existing structure, or an addition to an existing structure that does not increase the floor area by more than 100 percent.

Rental assistance: Rental subsidies used to bridge the gap between the rent such households can afford and the amount needed by property owners and landlords to ensure that their properties are economically feasible.

Ryan White Comprehensive AIDS Resources Emergency (CARE) Act: Under the Ryan White CARE Act, two programs are used often by AIDS housing providers. These are Title **I** and **II**. Ryan White Title **I** HIV Emergency Relief Grant Program, is a grant program which provides emergency assistance for the provision of health and support services to metropolitan areas that have been affected by the AIDS epidemic. Ryan White Title **II**, HIV Care Formula Grants provide States and territories with formula grants to enable the improvement of the quality, availability, and organization of health care and supportive services.

Section 8: Section 8 vouchers allow persons to rent their own apartments or homes, utilizing a voucher to cover all or part of the rent up to the HUD Fair Market Rent.

Short-term Rent, Mortgage and Utilities Payments: Payments for not more than 21 weeks in any 52-week period that provide immediate assistance with rent, mortgage or utility expenses to enable a tenant to stay in their unit.

Single Resident Occupancy (SRO) housing: A housing unit, located in a multi-unit residential building, which is for occupancy by one person. The unit need not, but may, contain food preparation or sanitary facilities, or both. When an SRO unit does not have its own bathroom, then their are shared bathrooms in the building. Often in rehabilitated hotels, an SRO can be used for emergency, transitional or permanent housing.

Special needs housing: Housing for people with special needs, such as persons who are homeless, elderly, or disabled, including persons living with HIV/AIDS.

Special Projects of National Significant (SPNS) grants: HOPWA competitive grants awarded for projects that due to their innovative nature or their potential for replication elsewhere, are likely to serve as effective models in addressing the needs of HOPWA clients.

Supportive housing: Permanent or transitional housing that is affordable, safe and sanitary, and is provided in conjunction with supportive services. Supportive housing is provided for homeless persons and persons with disabilities; including mental illness, chronic substance abuse, physical handicaps, and HIV/AIDS to help stabilize their lives and assist them live as independently as possible.

Supportive services: Services that address the needs of HOPWA clients, including such services as case management, nutritional services/meals, adult day care, personal assistance, child care and other children services, education, employment assistance, alcohol or drug treatment, mental health services, help adhering to medications, and other health/medical/intensive care services.

Tenant-Based Rental Assistance (TBRA): Housing assistance provided to a client in the form of a housing voucher or certificate that provides a government subsidy for all or part of the cost of a rental unit chosen by the client.

Very low income: Household income at or below 50 percent of the area median income, as defined by HUD, with adjustments for larger and smaller households.