COMPREHENSIVE PLANNING COMMITTEE

MEETING AGENDA

Thursday, October 17, 2019

2:00 – 4:00PM

Office of HIV Planning 340 N. 12th Street Suite 320
Philadelphia, PA

Call to Order/Introductions

Approval of Agenda

Approval of Minutes (*September 19, 2019*)

Report of Staff

Report of Chair

Action Item:

- **Election of Co-Chair**

Discussion Items:

- **Housing Models**
  - **Review of Terms and Needs Assessment Data**
  - **Group Breakouts**

Old Business

New Business

Review/Next Steps

Announcements

PLEASE TURN ALL CELL PHONES TO SILENT.

The next meeting of the Comprehensive Planning Committee is ***November 21 from 2 to 4 pm*** *at 340 N. 12th Street, Suite 320, Philadelphia, PA 19107.* ***Please refer to the Office of HIV Planning calendar of events for committee meetings & updates (www.hivphilly.org). If you require any special assistance, please contact the office at least 5 days in advance.***

Philadelphia HIV Integrated Planning Council
Comprehensive Planning Committee
Meeting Minutes of
Thursday, September 19, 2019
2:00-4:00p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia PA 19107

Present: David Gana, Gerry Keys, Keith Carter, Mark Coleman, Pamela Gorman, Peter Houle

Absent: Dena Lewis-Salley, Eran Sargent, Evette Colon-Street, Gerry Keys, Gus Grannan, Janice Horan, Jeanette Murdock, Joseph Roderick, La'Seana Jones, Terry Flores-Sanchez

Excused: Gail Thomas

Guests: Jessica Browne (AACO), Lisa Spacek

Staff: Mari Ross-Russell, Nicole Johns, Sofia Moletteri

Call to Order/Introductions:
D. Gana volunteered to chair the meeting and called the meeting to order at 2:08 PM. Everyone introduced themselves.

Approval of Agenda:
Before approval of agenda, N. Johns added discussion of tobacco use on CBH (Division of Community Behavioral Health) substance abuse treatment sites. She recalled how this topic was revisiting a Directive to the Grantee from the Allocations process.

D. Gana presented the agenda—with the addition of the tobacco Directive to the Grantee discussion—for approval. **Motion**: K. Carter moved, P. Houle seconded to approve the agenda. **Motion passed**: All in favor.

Approval of Minutes (*August 15, 2019*): D. Gana presented the minutes for approval. **Motion**: K. Carter moved, M. Coleman seconded to approve the August 15, 2019 meeting minutes. **Motion passed**: All in favor.

Report of Staff:
N. Johns reported that there was an upgrade to the Service Directory, making it more navigable and mobile friendly, and there was a relaunch of the blog on the OHP website. The first new blog post was about Health Equity.

Report of Chair:
D. Gana reported that he had attended the United States Conference on AIDS. He reported on a HOPWA presentation that identified housing opportunities in around 70 facilities with vacancies. He said he would retrieve more information and share it with everyone soon.

Action Item:

—Election for Co-Chair—
D. Gana said that last meeting, no one had volunteered for co-chair. D. Gana asked if anyone was interested in the position. G. Keys volunteered P. Houle. P. Houle explained that he had stipulations for his current position that would not allow him to co-chair. P. Gorman suggested C. Steib, but N. Johns reminded the group that he was already co-chair of Prevention Committee. N. Johns said that G. Grannan might be interested since he already facilitated the priority setting process. For background, D. Gana commented on how G. Grannan is on the subcommittee for Prevention and was part of the PrEP Workgroup.

N. Johns said that there would continue to be conversations with interested individuals, and she would talk to the committee to gauge interest. P. Gorman said that they were having new members coming onto the council, so there might be new people interested in the position as well.

N. Johns asked if the committee just wanted to table the co-chair discussion. The group agreed to table the discussion for co-chair elections. The conversation would continue in an ad-hoc manner for the time being.

Discussion Item:

—Tobacco Use for Outpatient Facilities—

N. Johns directed attention to the tobacco use letter addressed to "Comp Planning Group and the HIPC" at the top. She said that the letter was official policy from CBH regarding smoking/tobacco use in residential drug and alcohol treatment programs. C. Terrell had sent the letter over to the office. N. Johns explained that CBH is for Philadelphia only. She commented on the "residential"/inpatient aspect of the policy. N. Johns continued to say that RWHAP does not provide inpatient substance use programs anyways, so questions about outpatient should be a follow-up to the directive. They would specifically ask how and to what degree the policy affects outpatient programs.

She read the "medication/counseling" portion of the letter which indicated how the treatment sites aid nicotine users in cessation. The reason CBH prohibited nicotine use is because it is a leading cause of death for people who use drugs. There was also evidence of correlation between nicotine cessation and long-term substance use abstinence.

N. Johns recalled the concern HIPC had when discussing it during Allocations and the reasoning for the Directive. The council was worried that someone who could not or did not want to stop smoking would be refused service. She mentioned that G. Grannan was the one who brought up this issue and kick started the discussion. M. Ross-Russell recalled how the council also mentioned how it acted as a barrier since people might not even consider treatment because of the criteria. M. Ross-Russell said that the issue is that many smokers might think abstinence from substance use *and* nicotine use would make the process that much harder. The expectation that people can quit two things at once may be unreasonable for some.

M. Ross-Russell reiterated that the next step would involve looking at application of the policy for outpatient facilities and determining what HIPC could do for Part A. She explained that if someone is non-Medicaid and using Part A money, it is unlikely that they would have to adhere to the CBH

policy. P. Houle asked if the no nicotine policy went for staff as well. N. Johns affirmed this, explaining that no one can use or bring nicotine on campus, including staff.

P. Gorman acknowledged that smoking is hazardous, but she contested the policy on the grounds that smoking is behavioral, so it takes time to change/stop. P. Houle said that he knows of an AA meeting where 15 people smoke and then go into their AA meeting. P. Houle explained that for many people, if there is an attempt to detox and quit smoking, it would be one or the other.

P. Gorman explained that smoking involves oral fixation, physical addiction, and behavioral qualities combined. She noted that she did not see the data for achieving longer abstention for smoking. N. Johns said that the hypothetical person who can both quit smoking amongst other abstention practices is an extraordinary person with good resources and willpower. This sort of willpower may not be common.

K. Carter suggested that smoking can help with abstinence from other substances—it might act as a coping mechanism. D. Gana agreed, dubbing it a potential harm reduction technique. K. Carter said that quitting smoking is a process that has dips and changes, depending on stress and other factors.

M. Ross-Russell said that CBH oversees all mental and behavioral health provider contracts for Medicaid in the city of Philadelphia. She considered how other insurances might not have to follow the same criteria as Medicaid clients. In other words, it was best to look into whether or not non-Medicaid clients were expected to abide by CBH policy.

D. Gana asked if patients can be denied service if they bring nicotine products to the facilities. N. Johns said patients probably would not be denied service, but the facility would definitely confiscate the possessions. She reiterated how some individuals may not even consider the service because this barrier is already known to them. M. Ross-Russell said it may be helpful to search for any outpatient facilities solely funded by Part A that would not fall under the smoking ban set by CBH.

N. Johns said that all behavioral health providers fall under Medicaid. She also noted that the ban is for the facility as a whole, not just for inpatient our outpatient substance use programs. M. Ross-Russell reminded everyone that RWHAP is payer of last resort and covers those individuals who do not have Medicaid. She continued to say that if the only available facilities (for RWHAP funded outpatient) are also CBH inpatient facilities, that would be a problem.

P. Houle asked who sent the policy to the office. M. Ross-Russell said that she requested it from C. Terrell. She specifically asked for the official language around smoking and substance use facilities set forth by CBH. P. Houle asked if the policy was directly written by CBH. M. Ross-Russell said that the handout contained the official written announcement of the policy.

M. Ross-Russell recalled HIPC's reaction to the smoking issue at the Allocations. She said that some members mentioned they had received outpatient substance use treatment and believed they would not have been able to continue treatment without smoking. M. Ross-Russell recognized the health benefits of not smoking, but HIPC's felt it best to consider which was the lesser of two evils. P. Gorman said that smoking cessation could also happen after recovery if possible.

K. Carter volunteered to call into outpatient centers to ask about smoking policy.

M. Coleman asked if the reason for banning nicotine use was due to complaints. N. Johns said that tobacco use is a public health problem, so the ban was not necessarily complaint-inspired. K. Carter said the phenomena of the smoking ban is commonplace now—e.g. smoking is not allowed in rehabilitation centers, and it is much more limited in prison. In outpatient, K. Carter clarified, patients have the opportunity to go home. He wanted to know if facilities offer breaks so people can leave and smoke off campus.

M. Ross-Russell said that once HIPC gets more information, they can talk to the recipient. P. Houle asked if the committee wanted to bring the issue to the full council. M. Ross-Russell said that during Allocations, there were several HIPC members that did not view a tobacco ban as a positive for the system. The follow-up for the Directive to the Recipient was to be sent to the Comprehensive Planning Committee. After information is fully provided to the Comprehensive Planning Council to present, then the full council can discuss funding and logistics.

For the follow-up, N. Johns explained that the committee can say that regarding RWHAP funding, smoking cannot be a barrier to patients. K. Carter pointed out that if the facility says no to allowing tobacco use, then they would not be considered a RWHAP provider anymore. N. Johns said this could also go the other way around and the grantee could cease the contract.

K. Carter asked if there were any other RWHAP services providers that ban tobacco use. D. Gana said that many other programs allow smoking outside facilities, so he did not anticipate many issues with other service.

M. Ross-Russell questioned how far of a distance people could go to smoke. Can people return to the facility after smoking—is reentry permitted? M. Ross-Russell said many buildings have smoking distance rules, but complete prohibition might be considered a barrier.

N. Johns said there would hopefully be more answers next month.

—Planning for 2019-2020—

N. Johns said that since it was September, it was time to plan what the committee would work on for the next months. She reminded the group that they would not do priority setting this year. There were excerpts of plans in packet that N. Johns pointed out to the group. She asked everyone to flip to the blue tables that showed activities and strategies from Integrated Plan. She said that Strategy 2.4.2 was in the plan for the committee to work on in 2019, so it was best to discuss the strategy with only a few months left in 2019.

N. Johns recalled how at the last meeting there was discussion around traditional and long-term housing. There was a conversation on care giving and how it impacted retention and viral suppression. N. Johns explained that the excerpts from the plan provided are about housing, drug use, homelessness. The plan's last update was 1.5 years ago, so it's fairly recent and still offers applicable information. N. Johns indicated that she thought it best for the group to discuss the plan about homelessness prevention (maintaining housing via DEFA, Direct Emergency Financial Assistance).

She pointed out that there was also an activity under 2.4.2 regarding Housing First. The activity focused on the possibility of expanding Part A capabilities to make room for Housing First. Regarding substance use services, she mentioned Strategy 1.2.3. One of its focuses was on expanding

syringe access throughout EMA. She mentioned that there is syringe access in Philadelphia, but the rest of the EMA is lacking. She did, however, note that Camden has syringe access program though it is somewhat undependable. No other official syringe access programs are supported by RWHAP in the EMA.

She said that there was talk about expanding MAT (Medication Assisted Treatment). There are a limited number of providers for that treatment, so the council could look into seeing how RWHAP can tackle that barrier. M. Ross-Russell mentioned that the committee also needs to consider how the EtE (Ending the HIV Epidemic) Plan can be folded into the integrated planning in the upcoming year.

N. Johns said they do not have to dig into the issues right now, but the committee should start to think about how they want to plan the future year. The Comprehensive and Prevention Committees will have involvement in the EtE. She informed the group that they should know their roles within the next two months.

She suggested brainstorming topics and possibly starting with the housing conversation since it's on 2019's "plate" (as mentioned in Strategy 2.4.2). This conversation may help with understanding direction for the upcoming year.

K. Carter mentioned that there would be a community EtE meeting on September 24th in Philadelphia.

M. Ross Russell broke down the applications for everyone. She explained that there are three applications in total, all of which are happening simultaneously. N. Johns said the first two applications are similar. The third application also focuses on Philadelphia and is through the CDC.

M. Ross-Russell said that CDC had their first EtE application submitted last month, August, which addressed development of the Philadelphia EtE plan. This application covers 1 year.

The second application is for implementation of the plan and needs to be completed by December 2019. The actual plan language, however, has not been approved yet. It would be administered in October and covers four years.

The third application is due October 15th and is another application for eligible jurisdictions that receive Ryan White Part A and B. The application was from HRSA and would cover five years.

K. Carter inquired about extending timeframes for temporary housing. N. Johns replied that they cannot change the RWHAP definition and HIPC has no jurisdiction over HOPWA. However, the council can talk about the issue and create directives. N. Johns stated the HRSA definition which identifies temporary housing as a service that can be provided for up to 24 months with plans to move clients into permanent housing. However, there is also no allowance for forcing homelessness after a valid attempt to find permanent housing. Therefore, the actual timeframe is a gray area.

M. Ross-Russell noted how this was a huge issue in San Francisco where affordable housing is a rarity. The main reason people are concerned about the 24-month period involves limited housing areas with a small chance that permanent housing would be found in that timeframe. N. Johns read a selection from policy clarification notice 16-02 regarding the 24-month period. She noted that 24

months is not a mandated timeframe, it is only strongly encouraged. Though they are very definitive about the short-term housing.

N. Johns asked the group if they wanted to talk about Housing First for Part A and how Part A housing dollars are generally spent. They could look more into need and what could be done to better meet the need.

M. Coleman asked about short-term verses long-term services and which is more effective. N. Johns said that it could be either—sometimes people don't need long-term, they just need short-term. K. Carter asked how many people are currently in temporary housing.

J. Browne said that AACO could try to pull numbers to try to figure that out. K. Carter also wanted to find out how much time is typically spent in short term housing.

M. Ross-Russell explained how that there was a combination of issues related specifically to housing. There is simply a lack of actual affordable housing. She explained there are already Housing First models in Philadelphia, so there is this window for transitional housing. However, there is still the question about how long people stay in Housing First and if they transition out of it. M. Ross-Russell explained that the model is often used as a tool to help people move toward sobriety. M. Ross-Russell said that it costs 10k-12k per year for each household. M. Ross-Russell said there are reports from Philadelphia housing and shelter programs as well as data on CAREWare that information can be pulled from.

K. Carter asked about need for Housing First. N. Johns responded that HIPC does not need to identify need because housing is already a well-defined need for PLWHA. The HIPC needs to decide if they want to tackle the housing issue and if it's feasible with Ryan White funds. Then, HIPC would need to figure out how to use the Ryan White funds to provide housing.

M. Ross-Russell said that regardless of whichever way the committee goes with Housing First, they should be primarily focusing on its health outcomes. M. Ross-Russell knew of cost and health benefits that are already documented for the Housing First model.

P. Gorman suggested the committee research different models for housing and find an expert on the model to present to the committee. She figured it would be more helpful to have a wide selection of models. Once they investigate which populations Housing First mainly serves, so they can determine whether there was a need for a second model or even a different one altogether. D. Gana agreed, commenting on the large number of models nation-wide.

D. Gana offered to summarize and present on the information he received about housing from the United States Conference on AIDS. P. Gorman said that would be great for identifying models and finding experts to present. P. Houle asked what the ultimate goal was regarding the housing discussion. N. Johns responded that the Integrated Plan aims to house as many PLWH in the EMA as possible. N. Johns mentioned how the council has been talking about housing for a long time, so it is time to actually dig into it and figure out how to take action.

P. Houle understood that the goal, then, is to house as many people as possible in stable housing. He mentioned that HOPWA does not have the same housing stipulations as RWHAP. P. Houle said that the waiting list for HOPWA is now about a year in Delaware. He mentioned how his organization hired a housing case manager to help find people who have been on the program for an extended

period of time. The housing case manager met with the seniors, and they have already transitioned 27 people into other programs, leaving the 27 slots now open for others. He explained that his organization does not look at it that way that involves targeting certain demographics or dividing up individuals. He said that it may be important to focus on youth and transgender in metropolitan areas, but his organization looks more at totality instead of subpopulations. He thought that the model may be inspiring in some way. P. Gorman thought the model was great and felt he should further share that information.

P. Gorman said that she wanted to know the percentage of persons who received EFA and how many that received it last year are now in stable housing this year.

K. Carter asked if people get picky with their housing. P. Houle went into the process of his organization, essentially saying that they have a lot of decent options for clients regarding apartments that allow assistance.

P. Houle mentioned how just as there is a PrEP navigator, it should be the same with housing. There should be case managers specific to the service. P. Gorman mentioned the presentations on data or housing models, asking if they would present to HIPC or the Comprehensive Planning Committee. M. Ross-Russell and N. Johns responded with Comprehensive Planning Committee. P. Houle said he could have his housing director talk about how the program's progress and the interworkings of the model. P. Gorman said that would be great and OHP could also present the info that they have uncovered.

N. Johns said the next meeting would be October 17th. P. Houle said his board meeting would be that day, neither him not his director would be able to present. They could develop a list and have more models and presentation ideas by November 2019. N. Johns agreed that November would be an excellent date, and she also suggested P. Houle present then as well. P. Gorman added that she would be able to help provide information. N. Johns said that S. Heaven or someone else could also come to talk about HOWPA. Pathways was also a viable option for a speaker, as they could talk about Housing First and their HIV-specific program. She recommended that they could bring different people on at different times so that they don't have too many presenters at once.

N. Johns reminded the committee that the plan for Housing First is to decide whether or not it's feasible. The committee does not need to have a plan by December, but everyone should be actively discussing and working on the housing issue.

N. Johns said D. Gana could give a report at the October meeting, and the committee can also contact S. Heaven or someone else about HOPWA. She would look into finding someone to discuss Housing First, likely from Pathways, and they could present that research. P. Houle said that he would keep in contact about his part regarding the November meeting.

N. Johns said that the committee does not often meet in December, but they can talk about that meeting in November. For now, the committee won't plan the meeting. N. Johns asked if after the committee was done with their housing discussion, if they wanted to tentatively look into syringe access. The group agreed with that proposal.

P. Houle mentioned that the state of Delaware has a really successful syringe access program. The CDC did a site visit and was amazed by the process. P. Gorman suggested that the syringe access

program discussion follow the same steps the committee is taking for the housing discussion with research, experts, and presentations.

Old Business:
None.

New Business:
None.

Review/Next Steps:
None.

Announcements:
D. Gana announced that Calcutta House is closing due to financial issues. Fortunately, they were able to relocate all residents. P. Houle inquired if all the Calcutta houses were closing, and D. Gana replied that it was just Philadelphia.

Adjournment: D. Gana called for a motion to adjourn. **Motion:** P. Gorman moved, P. Houle seconded to adjourn the September 19, 2019 Comprehensive Planning Committee Meeting. **Motion passed**: All in favor. Meeting adjourned at 3:43 PM.

Respectfully submitted,

Sofia M. Moletteri

Handouts submitted at meeting:

- September 2019 Comprehensive Planning Meeting Agenda
- Meeting Minutes from August 15, 2019
- CBH Policy Letter to Comp Planning Group and the HIPC
- From Section I A (Epi) of Integrated Plan Update
- 2019-2020 Planning Calendar
- Fact Sheet: Housing First

Notes for Comprehensive Planning's conversation on housing need
October 2019

From AACO:

EMA estimate of 3,050 PLWH were homeless in 2018

- Philadelphia annual point-in-time count identified that there were 5,788 individuals who were homeless in Philadelphia in 2018.
- Over half (51.7%) of PLWHA at their client services intake reported a need for housing assistance
- More than 11.4% (1,836 individuals) of PLWH receiving Ryan White services in the EMA are reported to have unstable or temporary housing
- 2015 MMP data indicate that 9.9% of PLWH in care were unstably housed in the last 12 months
- The recipient estimates that 3,050 PLWH in the EMA were temporarily or unstably housed in 2018. In addition, nearly three-fourths (73.3%) of PWLH were at or below 138% of FPIG.
- Fair market rent for a 2-bedroom apartment in the NJ counties of the EMA averages $1,465 a month. In order to afford this level of rent and utilities without paying more than 30% of income on housing, a household must earn around $58,600 annually.
- Housing costs in the PA portion of the EMA are also far above the incomes of most PLWH: the fair market rent for a 2-bedroom apartment is $1,015 a month, making it necessary for a household to earn about $50,600 annually.

From Metraux 2017 study:

MMP study findings:

An estimated 25.5% or about one quarter of the care-receiving HIV/AIDS population in Philadelphia showed housing need, including homelessness (6%), over the course of a year. Specifically, an estimated 2,449 Philadelphia residents with HIV/AIDS (25.5%) engaged in medical care, experienced housing need. This number includes an estimated 571 persons (6%) who experienced homelessness. While it is difficult to find a comparison group, this rate can be considered as substantially higher than that of the overall population. Just looking at homelessness, annual prevalence rates are typically around one or two percent for general populations.

Among those who indicated housing need, large majorities were already seeking assistance, either through case management or behavioral health (substance abuse or mental

health-related) services. Sixty-eight percent of those indicating housing need received case management services, and 80.7% received either case management, mental health, and/or substance abuse services. This indicates that, for the most part, people with housing difficulties sought out support services, and particularly case management services. PWLA who received case management services will be the focus of the second study (Chapter 3 of this report, and summarized in subsection 1.3).

From AACO CSU Intake

Transitions from institutional settings increase risk for housing need. The largest subgroup in this study group to express a high degree of housing need were those who had exited institutional settings, particularly drug treatment and incarceration facilities, and have high levels of housing need as part of their settling back into the community. The three transitions that were most prevalent here – substance abuse, severe mental illness and incarceration – are all well-known risk factors for housing need and homelessness, and they also include disproportionately high rates of people with HIV/AIDS.

Housing need is associated with Black race and transgender identity. Two demographic groups showed particular housing difficulties. Transgender persons, a small subgroup in this study, were associated with the highest risk for indicated housing need. Black race, which describes two-thirds of the case management applicants, increased the odds of having housing need by 75%. These findings support how race and gender (as well as having an HIV/AIDS diagnosis) contributes to increased difficulty in finding housing.

Material factors are a protective factor against housing need. The findings here suggest that two protective factors that reduce the risk of declaring a housing need are living in subsidized housing and being employed. While this is hardly surprising, it does underscore the importance of having subsidized housing and vocational assistance available to persons with HIV/AIDS who have housing need.

PLWH and Shelter Stays

Among PLWHA as of the end of 2014, 6.9% experienced a shelter stay over a seven-year period (2007-13). These rates are complementary to, but different than the homelessness rate reported based upon the MMP data both in that the MMP data includes all forms of homelessness (not just shelter use) and MMP findings are based upon self-report rather than the record match used here. As such, MMP findings on homelessness were more comprehensive.

Among the adults staying in shelters between 2007-14, 4.6% and 2.7% of the male and female sheltered population, respectively, were living with HIV/AIDS. These rates were substantially higher than rates in the overall population.

Notes for Comprehensive Planning's conversation on housing need
October 2019

Women with HIV/AIDS have different housing needs and risks than men. While women have lower rates of HIV/AIDS diagnosis both overall and among sheltered populations, the female shelter population is at increased risk for having an HIV/AIDS diagnosis when compared to their overall population risk. Women living with HIV/AIDS also have a modestly elevated risk for experiencing a shelter stay, compared to men. Finally, women with HIV/AIDS diagnoses are much more likely than their male counterparts to be accompanied by family in a shelter.

Black and multi-racial PLWHA were at substantially higher risk of entering shelter. All three studies in this report found a significant and substantial racial disparity in homelessness risk. This differential in risk is consistent with continuing discrimination and residential segregation in housing among persons of Black race.

Those who identified as transgendered were at substantially higher risk of entering shelter. This is consistent with findings from the AACO case management data (study #2). Taking these two studies together, there is clearly an acute housing need among the relatively small group of persons diagnosed with HIV/AIDS who identify as transgender, and this likely reflects the substantial discrimination, in housing and other areas, that they experience.

Notes from Table 3.8 in Metraux

…Given that, the findings in the regression models on Table 3.8 that I recommend receive further consideration in addressing housing among persons with HIV/AIDS include:

- Being in substance abuse treatment. In the first model, this was associated with a 62% increase in the odds for indicating housing need. In the second model, a more general measure for residential treatment was associated with a 61% increase in these odds (compared to those paying market rent). In addition to these treatment effects, alcohol and cocaine use both had modest impacts on increased odds for indicated housing need.
- Having mental health disorders. Diagnoses such as bipolar disorder, depression, and schizophrenia all had some link with higher odds for indicating housing need, although mental health treatment did not have a significant impact.
- Demographics. Being transgender, representing a very small proportion of MCM applicants, had more than a twofold increase (111%) in the odds of having an indicated housing need. In contrast, a large majority of MCM applicants were Black race, which was associated with a 75% increase in the odds of having an indicated housing need.
- History of incarceration. This had a strong effect (+88%) on increasing the odds of indicated housing need.
- Source of income. Receiving wage income substantially decreased the odds (-48%) for indicated housing need. Conversely, receiving welfare (+25%) and disability benefits (+67%) both increased these odds.
- Paying subsidized rent. Compared to market rent, having a rental subsidy reduced the odds of indicated housing need by 77%.

Table 3.8 – Logistic Regression Model that Estimates Impact of Variables on Indicated Housing Need.

	Model 1 (n=7,668)		Model 2 (n=6,954)
	Odds Ratio		Odds Ratio
Demographics			
Black	1.75		1.80
Hispanic	1.41		1.40
Female	n.s.		n.s.
Transgender	2.11		2.23
Age	0.98		0.99
HIV/AIDS Diagnosis			
Decade of Diagnosis			
1980s	1.39		1.45
1990s	1.47		1.57
2000s	1.51		1.53
Has AIDS Diagnosis	1.21		1.26
Receiving HIV Care	1.31		1.43
No Medical Issues	0.88		0.85
Substance Use & Mental Illness			
Alcohol Use	1.14		n.s.
Cocaine Use	1.36		1.31
Heroin Use	n.s.		n.s.
Bipolar Disorder	1.37		1.24
Depression	1.28		1.24
Schizophrenia	1.38		n.s.
In Drug Treatment	1.62		
In MH Treatment	n.s.		
Income Source			
Employment	0.52		0.52
SSI or SSDI	1.25		1.34
Welfare	1.66		1.56
Other	0.64		0.62
None	0.81		0.68
Incarceration History	1.88		1.61
Housing			
Housing Status			
Owns Home			0.30
"Doubled Up"			n.s.
Subsidized Rent			0.23
Residential Treatment			1.61
Eviction Notice			2.71
Utility Shutoff			n.s.

All odds-ratios reported here are statistically significant at the $p<.05$ level.
"n.s." indicates a statistically non-significant association with the outcome measure.
The set of four "housing status" measures are all compared to the category of paying market rent.
The set of three "decade of diagnosis" measures are all compared to the category of 2010's decade.