
by

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ABSTRACT

Currently in its fourth year of operation, the Stopping Cyclical Homelessness in Infected Persons (SCHIP) program was in need of a summative evaluation that included participation rates and a description of the services provided to program participants. This paper will begin with a review of the literature concerning homelessness, health, and AIDS and a complete description of the SCHIP program. Analysis of program data provided by the AIDS Resource Center of Wisconsin (ARCW) indicated that the most often utilized services provided by this program were financial assistance for housing and transportation; however vocational assistance was rarely utilized. In total, 32 (62%) of clients were able to improve their housing status. Recommendations for the current program as well as for future programming are addressed.
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Chapter I: Introduction

Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) affect many people throughout the world, across the United States, and even here in Wisconsin. To help meet the unique healthcare, housing, and medical needs of those affected by AIDS and living in Wisconsin, the AIDS Resource Center of Wisconsin (ARCW) has developed a state-wide network of offices that employs case managers and staff who facilitate the coordination of case management services. Case management services range from medical and dental care to medication assistance to housing, vocational, and nutritional assistance. ARCW staff work in conjunction with other community based organizations to ensure that those living in Wisconsin who have been affected by AIDS are receiving the care they require.

Statement of the Problem

The AIDS Resource Center of Wisconsin (ARCW) has determined that of those affected by AIDS, the chronically homeless and recently incarcerated individuals are populations that are underserved by current housing programming provided by the agency. To address the needs of these populations, staff at ARCW developed a new program known as the Stopping Cyclical Homelessness in Infected Persons (SCHIP) program. This program was designed to facilitate improvements in housing status by providing financial assistance for rent, transportation, and vocational programming as well as provide housing case management services to clients eligible for the program.

Staff received funding from the U.S. Department of Housing and Urban Development (HUD) and the program initiated activities in April of 2004. The program was funded for three, one-year periods (grant years) that comprised one entire grant cycle (three fiscal grant years,
beginning on 4/1/04 and ending on 3/31/07). This funding was renewed for a second, three-year grant cycle (4/1/08 through 3/31/11).

In order to show evidence of program implementation and effectiveness, a yearly grant evaluation was required by the funding agency, along with a summary of outcomes at the end of the three-year grant period (3/31/07). Prior outcome evaluations have been completed by an internal evaluator for the previous years of the grant (2003-2004; 2004-2005; 2005-2006) but contained only basic, summary information.

ARCW elected to utilize an external evaluator to complete the evaluation for the first year of the second grant cycle (2007-2008) that was submitted to HUD in June of 2008. The following chapters present the literature review, methods, results, and interpretations of this external evaluation.

Purpose of the Study

The following report will summarize the program's activities during the first year of the second cycle (2007-2008) period as well as determine how effectively the program was in meeting its goals of improving housing situations, facilitating increases in income during the program, and coordinating other services to ensure client needs are being met. Specifically, HUD provided funding for the SCHIP program to meet the following goals and outcomes:

Goal 1: Provide intensified housing services coordination to 100 HIV/AIDS clients annually to assist them in establishing residential stability and an income stream.

Outcome 1: 80% of clients will have housing stability within 12 months and be able to transition to long-term supportive housing programs.

Goal 2: Provide employment services to 75 SCHIP clients in need of enhanced services.

Outcome 2: 80% of SCHIP clients will receive employment services and have regular income stream within 12 months of program admission.

Goal 3: Provide medical care and supportive services to 100 SCHIP clients on an annual basis.
Outcome 3: 90% of clients will be enrolled in appropriate medical care and supportive services upon discharge.

Definition of Terms

SCHIP. Stopping Cyclical Homelessness in Infected Persons, the name of the housing program that is being evaluated.

HUD. U.S. Department of Housing and Urban Development, provided funding for the SCHIP program.

ARCW. The AIDS Resource Center of Wisconsin. This agency is the creator and administrator of the SCHIP program.

MSM. An acronym for men who have sex with men

IDU. Injection drug user

WHO. World Health Organization

CDC. Center for Disease Control

AIDS. Acquired Immunodeficiency Syndrome is a progressive, deadly disease with no known cure

HIV. Human Immunodeficiency Virus, the virus that causes AIDS.

UNAIDS. Coalition of ten, international co-sponsoring organizations whose mission is to combat HIV/AIDS by engaging social and political resources.

Chronic Homelessness: The AIDS Resource Center of Wisconsin defines chronic homelessness as those who have experienced at least four incidences of homelessness in the past three years.

Limitations of the Study
This evaluation and those preceding it suffered from issues related to data availability and integrity. Specific examples of these limitations in previous evaluations follow.

- Different evaluators examine data from different perspectives, and this is exacerbated by the transition from an internal to an external evaluator. An internal evaluator is much more familiar with the workings of the program and, in this case, was not detailed enough in operationally defining program terms (e.g. what defines a program participant?). This prevents continuity from one evaluation to another; however this evaluator attempted to address this limitation by clearly defining each program term and goal with regard to measurable outcomes that can be used again for future evaluations.

- In addition, some data that would have provided excellent evidence to support the success of the program simply was not recorded in enough detail or at all (details of client contacts, for example). Some data that was recorded was not available to this evaluator in electronic form and would have required intensive research and manual data entry that simply was not feasible at the time of this evaluation. For example, each client set individual goals to meet during their participation in the SCHIP program. Determining whether or not clients met their individual goals would have provided excellent outcome data for the program, however this information was recorded in paper form and filed in each clients' individual record making it too difficult to access.

- Finally, transitions in staff members as well as data management programs resulted in inconsistent data entry as well.
Unfortunately, data integrity was an issue for the 2007-2008 grant year as well. Client profiles often contained missing data, and data entries that should have been consistent in both of the databases used by the agency did not match. For example, this evaluator requested an initial list of all clients who were reportedly active in the SCHIP program. When agency staff examined this list, however, they found that 10% of the clients included were not actually active SCHIP clients and were listed because of an error in data entry. These clients were then removed and the list was re-populated. In addition, one client was listed in the database twice and identified by two names. Issues such as these do indeed call the integrity of the data into question; however, this evaluator does not feel that these issues are common enough to yield all data analysis inappropriate.

Evaluation results presented in this paper will be discussed with caution. Specifically, they may under-represent the number of clients served because one might deduce that, if clients were incorrectly included, some clients may have been inadvertently excluded from program records. Analysis of the data known to be accurate, however, still speaks to program outcomes and areas for improvement.

Methodology

This paper will begin with a literature review to determine why the chronically homeless and recently incarcerated face unique challenges in obtaining stable housing and how that search is complicated by HIV/AIDS. The literature review will discuss approaches to homelessness programming as well as housing programs that are targeted towards both the homeless in general as well as homeless individuals living with HIV/AIDS. The program will then be discussed in-depth, and the data analysis plan will be summarized as well. Data will then be reported both for the 2007-2008 year of the grant cycle that ran from 4/1/07 to 3/31/08. Finally, results will be
discussed relative to the goals of the SCHIP program and the literature, and recommendations for future the program as well as data collection and analysis will be addressed.
Chapter II: Literature Review

This chapter will briefly trace the history of the discovery of HIV and AIDS as well as its prevalence, incidence, and mortality throughout the world, in the United States, and in Wisconsin. This chapter will also review pertinent literature and provide a sound justification for targeting chronically homeless and recently incarcerated individuals as clients for the SCHIP program. The connection between HIV/AIDS, homelessness, and health will be outlined as well as the connection between HIV/AIDS, homeless, health, and recent incarceration. In addition, this chapter will discuss two models currently being utilized for housing programs as well as discuss the effectiveness of a variety of housing programs targeted towards both infected and non-infected individuals. Finally, this chapter will conclude with a detailed discussion of the Stopping Cyclical Homeless in Infected Persons (SCHIP) program. The discussion will outline goals, outcomes, and funding options as well as walk through the program's process, from determining eligibility, being admitted to the program, participating in program activities, and transitioning to discharge.

HIV and AIDS: General Information

Pathology and Course

HIV and AIDS actually refer to two clinically unique sets of symptoms. HIV, or the virus that causes AIDS, is diagnosed via a blood test (known as a T-cell count) to determine if HIV antibodies are present. HIV slowly destroys white blood cells (T-cells) and weakens the immune system, resulting in the inability to fight off infections (Center for Disease Control [CDC], 2007). The diagnosis of AIDS comes only when an individual is infected with HIV, displays a low T-cell count, and suffers from an illness characteristic of AIDS as determined by the CDC. Common illnesses include invasive cervical cancer, Kaposi's sarcoma, pneumonia, and
tuberculosis (CDC, 1993). How quickly HIV segues into AIDS varies by case and depends on how early an individual becomes aware of his or her infection as well as how well an individual adhered to medical and nutritional treatment recommendations. If left untreated, the mean time from HIV infection to death as a result of AIDS is approximately 11 years (WHO/UNAIDS, 2007).

Transmission

HIV, the virus that causes AIDS, is primarily transmitted via the exchange of body fluids. The virus tends to target younger individuals, as they are more likely to engage in behaviors that put them at transmission risk. According to the CDC (1999), HIV is transmitted most commonly via sexual contact with an infected person (high-risk heterosexual or homosexual contact) or sharing needles with an infected person. Less common methods include transfusions of blood or clotting products and infection from a mother to a child during pregnancy and childbirth. HIV is not transmitted via air, water, or insects. Infectious levels are not found in saliva, tears, or sweat, and the HIV virus is not able to survive outside of a human host. The CDC recommends that IDU’s avoid sharing needles and those engaging in any sexual contact use latex or polyurethane condoms to effectively avoid infection (CDC, 1999). Continuing to engage in unprotected sexual contact or IDU are considered high risk HIV behaviors.

History of AIDS

While AIDS was first identified only in the early 1980's, retrospective analysis of several fatalities indicates that the AIDS deaths occurred as early as the 1950's. An English sailor who died in 1959 exhibited symptoms extremely similar to current AIDS patients and is thought to be the earliest known AIDS death. A trio of cases in 1976 also exhibited similar characteristics to current AIDS patients when a husband, wife, and child passed away from opportunistic
infections. Subsequent testing of blood samples revealed that all three were indeed HIV positive. Finally, a Danish surgeon who worked in northern Zaire died with clinical symptoms similar to AIDS patients in 1977 (Kallings, 2008). Additionally, Grmek (1989, as cited in Kallings, 2008) observes the co-occurrence of a malignant type of Kaposi’s sarcoma, meningitis, and pneumonia (common indicators of AIDS) in seasonal workers who traveled between Central and Southern Africa in the 1960’s. Complex analysis of genetics indicates that the existence of HIV-1 can be traced back to 1930 when the virus was transmitted in an unknown manner from a chimpanzee to a human (Korber et al., 2000). In his comments on Korber et al (2000), Hillis (2000) suggests that transmission of the virus from primates to human may have occurred as a result of hunting and eating an infected chimpanzee. The virus did not spread quickly in the human population likely because African tribes that hunted chimpanzees for food lived fairly isolated lives (Hillis, 2000).

**HIV Pandemic**

The HIV virus was not officially discovered until 1983 when a group of French researchers isolated the virus in blood samples of AIDS patients. These researchers, however, were unable to confidently demonstrate the causative relationships between HIV and AIDS (Barre-Sinoussi et al., 1983). Synthesis of research undertaken by American scientists eventually solidified support for the causal role of HIV in AIDS (Kallings, 2008). This identification of a medical marker precursor to AIDS allowed for earlier testing and treatment of HIV. Earlier testing – resulting in earlier knowledge of infection – would allow individuals to begin medication regimens and other treatment options (such as improving their diet and exercise habits) as soon as possible, slowing the progression from HIV to AIDS.
HIV is thought to have originated in Western Equatorial Africa, and new infections followed trade routes (Kallings, 2008). By 1995, infections had spread throughout Africa and to parts of North America. By 2005, few countries remained fairly unaffected by HIV.

HIV/AIDS first appeared in the United States in the gay population in California around 1981 (CDC, 1981). The gay cultures of the 1970's and 1980's resulted in the ideal context for HIV transmissions and resulted in HIV quickly becoming associated with the gay lifestyle. Today, HIV transmission continues primarily in high risk groups, particularly injection drug users in Western Europe, but has declined in gay populations as high risk behaviors have decreased (Kallings, 2008).

**HIV Identification**

HIV infections can be recognized as soon as 14 days after infection by advanced testing for presence of the virus, however the most commonly used HIV tests actually determine if there are HIV antibodies present. Development of the antibodies can take between three and six weeks to reach testable levels (Kallings, 2008). As noted by Kallings (2008), this poses a challenge to prevention efforts as a person may be infected for as many as six weeks before developing antibodies that are recognized by the most common HIV testing method. Kallings (2008) also notes that this creates a problem for blood donors and transfusion recipients as blood donors are typically tested only for HIV antibodies rather than the HIV virus itself. While tests that measure the presence of the HIV virus have been created, their higher cost makes large-scale HIV virus testing unrealistic at this time (Kallings, 2008).
Global HIV/AIDS

Global Incidence

Southern Africa now accounts for two-thirds of HIV infections world-wide (UNAIDS, 2006a) and also experiences the largest numbers of new infections in the world. Of the 2.5 million new infections reported world-wide in 2007, 1.7 million were reported in Sub-Saharan Africa. There were 340,000 new infections in South and South-East Asia; 150,000 in Eastern Europe and Central Asia; 92,000 in East Asia; 46,000 new infections in North America; 31,000 in Western and Central Europe.

While new infections are decreasing in some countries, they continue to rise in others. The number of new infections in Sub-Saharan Africa dropped from 2.2 million in 2001 to 1.7 million in 2007. Decreases in infection rates were also seen in Western and Central Europe (32,000 in 2001 to 31,000 in 2007), Eastern Europe and Central Asia (230,000 in 2001 to 150,000 in 2007), and South and South-East Asia (450,000 in 2001 to 340,000 in 2007). East Asia experienced an increase of infections from 77,000 in 2001 to 92,000 in 2007, and North America experienced an increase in infection from 44,000 in 2001 to 46,000 in 2007 (UNAIDS, 2007).

Global Prevalence

According to the most recent information provided by UNAIDS (2007), there is an estimated 33.2 million people infected with HIV as of 2007. Approximately 1.3 million of those individuals reside in North America, compared to 22.5 million in Sub-Saharan Africa and 4 million in Eastern Europe and Central Asia. In contrast, there are only 760,000 individuals living with HIV in Western and Central Europe and 800,000 in East Asia. Approximately 5% of the population in Sub-Saharan is currently infected with HIV, however this is a drop from 5.8% in
2001. Infections in 2007 were 1% or less in all other regions of the world, however, demonstrating that Sub-Saharan Africa is still facing the most alarming rates of HIV infection in the world.

Global Mortality

Adult and child fatalities resulting from AIDS totaled approximately 2.1 million in 2007, a considerable increase from 1.7 million deaths in 2001. Sub-Saharan Africa reported 1.6 million deaths in 2007 (up from 1.4 million deaths in 2001), and South and South-East Asia reported 270,000 deaths in 2007 (up from 170,000 in 2001). There was an increase from 8,000 deaths in 2001 to 55,000 deaths in 2007 in Eastern Europe and Central Asia, and an increase to 32,000 deaths in 2007 from 12,000 in 2001 in East Asia. Western and Central Europe experienced a small increase from 10,000 deaths in 2001 to 12,000 deaths in 2007, and deaths in North America held constant at 21,000 deaths both in 2001 and 2007 (UNAIDS, 2007). Differences in numbers of infections and deaths are likely a function of population density, acceptance and effectiveness of preventive efforts, access to appropriate healthcare and nutrition, and social and cultural differences in sexual practices and drug use.

HIV/AIDS in the United States

Statistics on HIV and AIDS in the United States are somewhat difficult to estimate because only 33 states utilize an anonymous reporting system (CDC, 2008c). As a result, statistics reported by the CDC are either rough estimates or are only accurate for those 33 states who utilize the reporting system. The difference in actual versus reported figures may be significant because some areas with high rates of infection and morbidity – such as California and Illinois – do not utilize the reporting system.
United States Incidence

According to the CDC, the estimated rate of new infections between 2003 and 2006 in the 33 states participating in the confidential reporting system remained stable at approximately 18.5 new infections per 100,000 people (CDC, 2006). The estimated number of AIDS cases diagnosed between 2003 and 2006 also remained stable at 12.3 per 100,000 people (CDC, 2006).

When examining states who participate in CDC reporting, rates of HIV/AIDS infection tended to be highest (greater than 20 per 100,000 people) in New York, Maryland, North Carolina, South Carolina, Tennessee, Florida, Alabama, Louisiana, Mississippi, Texas, Nevada, and Arizona. Of the reporting states, the lowest HIV/AIDS infection rates (less than 10 per 100,000 people) were seen in West Virginia, Wisconsin, Minnesota, Iowa, North Dakota, South Dakota, Wyoming, Nebraska, Kansas, Utah, Alaska, and Idaho. In general, the South East experienced the highest rates of new HIV/AIDS infections while the Midwest experienced the lowest rates of new HIV/AIDS infections (CDC, 2006).

United States Prevalence

At the end of 2006, there were an estimated 436,693 individuals in the United States who were living with HIV/AIDS, an increase from the estimated 413,882 people living with HIV/AIDS in the United States at the end of 2005 (CDC, 2008d). States with the largest populations living with HIV include New York (43,021), Florida (35,723), Texas (25,003), New Jersey (16,212), and North Carolina (11,760). States with the lowest number of individuals living with HIV include Alaska (273), Idaho (356), Iowa (590), Nebraska (700), North Dakota (89), South Dakota (199), and Wyoming (88). States with the largest populations living with AIDS include California (61,555), Florida (46,663), New York (70,845), and Texas (34,063). States with the lowest populations living with AIDS include Alaska (331), Idaho (313), Maine (514),
Montana (205), North Dakota (74), South Dakota (140), Vermont (240), and Wyoming (103). It should be noted that while not all states report HIV infections, all states do report numbers of AIDS infections (CDC, 2006).

United States Mortality

According to the most recent information, the total number of HIV/AIDS related deaths in the United States decreased 17% from 16,948 in 2002 to 14,016 in 2006. The largest number of deaths occurred for those between the ages of 35 and 54, and the total number of HIV/AIDS deaths reported for all age groups between the years of 2002 and 2006 was 545,803 (CDC, 2006). Males accounted for 450,541 (83%) of the total deaths between 2002 and 2006, while females accounted for 89,895 (17%) of total deaths between 2002 and 2006 (CDC, 2006). Interestingly, males account for 83% of all deaths but only for approximately 74% of all infections. This might indicate that infected males are less likely to seek appropriate treatment or follow prescribed care regimens. Alternatively, this difference may be a result of a biological or genetic difference between men and women; however, there is no evidence to support any of the hypotheses at this time. Further investigation into this issue is needed.

United States National HIV/AIDS Demographics

Race. Currently, 47% of those living with HIV/AIDS in the United States are black. White individuals account for 24% of all infections, and 17% of individuals infected with HIV/AIDS are Hispanic (see Figure 1). The remaining 1% of people living with HIV/AIDS in the United States is comprised of Native American or Alaskan Natives. In the 33 states that reported anonymous information, 49% of new infections were in black individuals even though black individuals only comprised approximately 13% of the population (CDC, 2008). This
indicates that race may be a risk factor and provides strong evidence for targeting at-risk populations.

Race/ethnicity of persons with a new HIV diagnosis in 2006

![Race/ethnicity of persons with a new HIV diagnosis in 2006]

Figure 1 Race/ethnicity of persons with a new HIV diagnosis in 2006. Source: http://www.cdc.gov/hiv/topics/surveillance/pdf/us_media.pdf

Age and gender. Males account for 74% of HIV/AIDS infections in the United States; females for 26%. The age distribution for people living with HIV/AIDS peaks between the ages of 35 and 54. This is not really surprising, however, as this peak is mirrored in the general age distribution of the U.S. population as well (Meyer, 2001). Twenty percent of people living with HIV/AIDS in the United States are between the ages of 40 and 44, followed by 18% between the ages of 45 and 49, 15% between the ages of 35 and 39, and 13% between the ages of 50 and 54. Following this trend, 32% of new infections were in individuals aged 35 to 44, 25% in ages 25 to
34, and 20% in ages 45 to 54. Disturbingly, 15% of all new infections during 2006 occurred in individuals between the ages of 13 and 24 (CDC, 2008d).

Transmission methods. Fifty percent of all new infections in 2006 were the result of male to male sexual contact, and the second leading cause of infections (33%) in 2006 was high-risk heterosexual contact. Injection drug use accounted for 13% of new infections in 2006 (CDC, 2008d).

When examining transmission rates by gender, a slightly different picture appears. In males in 2006, male to male sexual contact accounted for 62% of new infections, injection drug use for 17% of all transmissions, and high risk heterosexual contact in 13% of new infections. In females in 2006, high risk heterosexual contact accounted for 73% of all new infections, while injection drug use accounted for 26% (CDC 2008e).

HIV/AIDS in Wisconsin

Wisconsin Incidence

Since 1983, there have been 9,929 reported HIV cases in Wisconsin, 407 of which were new in 2007. There is an average of 383 new cases of HIV infection reported each year, and as of 2007 there were approximately 7 new infections for each 100,000 people in Wisconsin. Counties reporting the highest rates of new infections were Milwaukee County with 166 new HIV infections in 2007 followed by Dane County with 66 new HIV infections in 2007 (Wisconsin Department of Health and Family Services [WDHFS], 2007).

Wisconsin Prevalence and Mortality

Counties with the largest numbers of individuals living with HIV/AIDS are concentrated around Milwaukee and surrounding counties: Green Bay, and Madison. Of the 9,929 reported HIV cases, 6,684 have progressed to meeting the clinical definition of AIDS. As of 2007, 3,635
people reported to be HIV positive have died while 6,294 are presumed to be living (WDHFS, 2007).

**Wisconsin HIV/AIDS Demographics**

**Race.** Infection rates for HIV during 2007 were highest in African Americans, with a rate of 43 infections per 100,000 African Americans. Hispanics experienced the second largest rate of HIV infection in 2007 with 23 infections per 100,000 Asian/Pacific Islanders and White individuals accounted for the lowest infection rates in 2007, with 9 and 4 infections per 100,000 people, respectively. There were no new infections in Native Americans reported during 2007. These state trends also follow national trends, with African Americans experiencing the highest rates of infections overall (Wisconsin AIDS/HIV Program, 2007).

**Age and gender.** In 2007, 79% of all new HIV infections were reported by males and 21% by female, percentages similar to those at the national level. Half of the individuals living with HIV in Wisconsin were over the age of 45. This indicates that programming needs to take the concerns of an aging population into account, along with the myriad of other issues faced by people living with HIV/AIDS (Wisconsin HIV/AIDS Project, 2007). The total number of males between the ages of 25 and 44 infected with HIV in the state of Wisconsin during 2007 was 189, compared to only 46 new cases in females (WDHFS, 2008).

**Transmission methods.** In 2007, approximately 64% of new HIV infections were caused by MSM compared to 17% of cases caused by high risk heterosexual contact and 12% IDU. While the numbers of cases caused by high risk heterosexual contact and IDU have declined by 3% and 1% respectively, the number of new HIV infections caused by MSM has increased by 8% (WDHFS, 2007). The primary cause of new infections in males is unequivocally MSM.
while the leading cause of new female HIV infections is high-risk heterosexual contact. It should be noted that these transmission statistics mirror those found on the national level.

**HIV/AIDS Related Organizations**

In 1986, the World Health Organization (WHO) was primarily responsible for HIV/AIDS related issues. However, it soon became clear that HIV/AIDS issues were too large to remain under the direction of the WHO. A single agency could not combat the spread of HIV on its own without the cooperation of other government, political, and social service organizations. As a result, in 1996 UNAIDS, a coalition of six other United Nations programs was formed. Four additional organizations later joined, resulting in cooperative efforts of ten organizations, or “cosponsors,” working together to combat HIV/AIDS. UNAIDS employs a systems-wide approach that utilizes resources from political and social networks across the world. Each of ten cosponsors has individual organizational goals, ranging from fundraising and financial support to technological support, educational information, and political advocacy (UNAIDS, 2006b).

Part of the goal of UNAIDS is to integrate resources from across the world to increase prevention efforts, such as education and HIV testing, as well as to ensure access to appropriate treatment for those who are infected with HIV/AIDS through channeling of financial support. Drastic decreases of infections in several areas – particularly Sub-Saharan Africa – indicate that the coordination of resources and focused leadership with regard to HIV/AIDS prevention and treatments efforts are proving to be effective.

**Prevention**

Prevention efforts can be classified into three levels: primary, secondary, and tertiary interventions. Primary prevention focuses on preventing a disease from ever occurring, and this
is by far the largest category of HIV/AIDS prevention efforts at this time. Secondary prevention focuses on early detection of the HIV virus in order to decrease the likelihood that HIV will segue into AIDS. Tertiary focuses on reducing the impact of the disease on those infected and preventing them from further spreading the disease.

Primary Prevention

Primary prevention efforts focus first and foremost on education. According to a 2005 survey, 50% of people between the ages of 15 and 24 did not know how HIV was transmitted (UNAIDS, 2006a). Educational interventions focus largely on informing individuals about how the HIV virus is spread and what precautions can be taken to ensure protection. Educational campaigns are often met with resistance, particularly as part of sex education courses, as discussing safe sex habits is generally taboo (see National Public Radio/Kaiser Family Foundation, 2003 for discussion).

Further complicating educational programming is that simply knowing information does not always prompt a change in behavior, particularly in cases where it would cause serious disruptions in a desired activity (Global HIV Prevention Working Group, 2008). For example, an IDU may be aware that clean needles reduce the risk of drug use; however it is not likely that he or she will resist using simply because clean needles are not available.

Non-educational primary prevention methods also exist. Kallings (2008) noted that treating other sexually transmitted infections, encouraging male circumcision, HIV testing and counseling, and encouraging condom use are effective methods of preventing new HIV infections. Treating sexually transmitted infections decreases the likelihood of blood to blood contact during intercourse, and male circumcision decreases the amount of tissue that is highly susceptible to HIV infection (CDC, 2008a). Testing for the HIV virus encourages those who are
already infected to take care not to continue spreading the virus. Finally, learning about condom use encourages individuals to consider how they plan to protect themselves not only from HIV but also from other sexually transmitted infections before engaging in sexual activity.

Primary prevention through the development of an HIV vaccine has been attempted, but has been hindered for several reasons. First, HIV is an extremely persistent infection. Even in the presence of HIV antibodies, the virus continues to attack and destroy infection-fighting white blood cells. Second, HIV mutates easily; it is thus able to quickly develop resistance to vaccinations (Kallings, 2008). This renders the traditional method of developing a vaccine via the use of weakened forms of the infectious agent both unrealistic and downright dangerous given the ease with which HIV mutates.

The earliest forecast of any vaccine is currently 2015, however confidence in this prediction remains questionable because of the aforementioned ability of the HIV virus to quickly mutate, and thus become immune to the vaccine. In addition, vaccinations usually require the injection of a weakened strain of the virus. This poses an extreme risk to patients in the case of the HIV virus again because of the ease with which the virus mutates. If developed successfully, careful consideration should be given to administering the vaccine only to people who are at high risk of acquiring the disease.

Secondary Prevention

Secondary prevention measures target at-risk individuals. They typically focus on getting such individuals tested, in order to begin antiretroviral treatment as early as possible. Much federal funding for HIV prevention has been at the secondary prevention level, as it has focused on facilitating HIV testing to ensure that those infected with HIV will be connected with the
appropriate resources to preserve their own health and prevent infecting others (Office of National AIDS Policy, 2007).

**Tertiary Prevention**

Tertiary prevention efforts focus on reducing the impact of the disease on those already infected. For those infected with HIV, the predominate form of tertiary prevention focuses on providing adequate care for individuals infected with HIV as well as education to decrease the risk that the infected individual will transmit the virus to new individuals.

**Prevention in Wisconsin**

Prevention efforts in the state of Wisconsin come from a variety of sources. As part of the Department of Health and Family Services, the Wisconsin HIV/AIDS Program works in conjunction with state and regional community and non-profit organizations to maintain accurate statistics about HIV/AIDS in Wisconsin; provide counseling, testing, referral, prevention and risk reduction services; education services; and medical assistance to individuals in Wisconsin living with HIV and AIDS. The Wisconsin AIDS/HIV Program is also responsible for appropriating Ryan White (see next section) and other state-level funding designated for HIV/AIDS advocacy and resources (Department of Health and Family Services [DHFS], 2008).

**Funding of Treatment and Prevention in the United States**

National HIV/AIDS prevention efforts are primarily coordinated through the CDC and funded by a combination of federal, state, and local governments. The largest national funding source for HIV/AIDS-related issues is the Ryan White CARE Act, named after the famous 13-year old AIDS patient who fought for the right to attend public school in the 1980’s. The Ryan White CARE Act is now known as Title XXVI of the Public Health Service Act as Amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006, or Ryan White Program. The
Ryan White Program was enacted in 1990 and provides funding for those who have no other options to fund their HIV/AIDS care. The most recent re-authorization of the act ensured that it will continue to provide support for HIV/AIDS patients up until October 1, 2009 unless Congress moves to renew it again (Kaiser Family Foundation, 2007).

Of particular relevance to this project is the Housing Opportunities for People with HIV/AIDS (HOPWA) Program. This program, started in 1992 and coordinated by the Housing and Urban Development’s (HUD) Office of HIV/AIDS Housing, works in conjunction with 44 state organizations to address the specific housing needs of those living with HIV/AIDS (HOPWA, 2008). As one of 44 participating states, Wisconsin is eligible to receive HOPWA funding as well as apply for competitive HOPWA grants and awards.

National funding for sex education, however, is currently limited to abstinence education only. As Ari Fleischer reported (Press Briefing, 2003), the Bush administration currently believes that abstinence “is a sound practice, that abstinence has a proven track record of working” despite multiple, contrary opinions of professional health and education organizations (see United States House of Representatives, 2004). This restriction of funding appropriation often impedes educators’ ability to effectively pass on preventive information about HIV/AIDS (ACLU, 2005).

The AIDS Resource Center of Wisconsin

The AIDS Resource Center of Wisconsin (ARCW) is one of the largest HIV/AIDS resources in Wisconsin. Providing medical care, dental care, mental health services, social services, legal services, housing services, and prevention services, ARCW is one of the most comprehensive HIV/AIDS service agencies in the country (ARCW, 1995). Offices are located in Superior, Eau Claire, Wausau, Green Bay, Appleton, La Crosse, Madison, Milwaukee, and
Kenosha, and staff often travel between offices to ensure that each county in Wisconsin has access to the appropriate and necessary services. Some services are provided by ARCW staff, such as dental services in Green Bay and Milwaukee, and other services are provided by additional community resources networked with regional offices.

As an HIV/AIDS organization serving individuals within a state participating in the HOPWA program, ARCW was eligible to apply for additional funding from the HUD's HOPWA program. A housing proposal was developed in response to the Notification of Funding Availability in 2003. The grant proposal was approved in a modified form and funded by a competitive grant in 2004. Funding was renewed in 2006 (HOPWA, 2006).

The program, entitled Stopping Cyclical Homelessness for Infected Persons (SCHIP), was designed to fill a gap in services provided to HIV infected clients in need of long-term housing assistance. Other programming provided by the agency served those with mental health issues and those in need of short-term housing and financial assistance, however no long-term services existed for those experiencing chronic homelessness – those who have been homeless or in a shelter at least four times in the past three years – or those who have been released from incarceration in the past 30 days.

Literature Supporting the SCHIP Program Theory

Prior to examining the theories behind the SCHIP model, it is important to review pertinent literature regarding the connections between AIDS/HIV, incarceration, homelessness, medical care, and overall health. Research indicates that housing assistance is a serious need for those infected with HIV/AIDS, and that housing has an impact on reducing transmission behaviors (National AIDS Housing Coalition, 2005). Literature also indicates that the second target population – prisoners – experience difficulty in locating stable housing upon release from
incarceration (CDC, 2001). Coupled with the fact that living with HIV/AIDS only increases the barriers faced in obtaining adequate housing, the literature presents a solid case for designing a program like SCHIP, a program that targets chronically homeless and recently incarcerated HIV/AIDS infected individual.

**HIV/AIDS and Homelessness**

Simple statistics indicate that homelessness is indeed a problem among the HIV/AIDS populations. The National Low Income Housing Coalition (2007) estimated that approximately half of people living with HIV/AIDS will need housing assistance at some point in their lives. According to Adams (1999), approximately one-third to one-half of the individuals living with HIV/AIDS are currently homeless or at risk of becoming homeless. In addition, a national study indicates that housing issues comprise the greatest category of needs in HIV/AIDS infected individuals (National AIDS Housing Coalition, 2005).

According to the National Coalition for the Homeless (2007), the homelessness rates for those infected with HIV/AIDS is between 3% and 20%, three times as high as the general population rate. Further, it is thought that approximately 3% of the entire homeless population in the United States is infected with HIV/AIDS (Adams, 1999). However, because homeless individuals are less likely to get tested for HIV, a 3% infection rate (compared with .3% in housed populations) is thought to be an underestimation (Allen, 1994). Particular sub-populations of the homeless reported alarmingly higher HIV infection rates – especially those with mental illnesses (Paris 1996; Susser 1993; Fournier 1996).

Although individuals with HIV/AIDS are protected by the Americans with Disabilities Act (The US Equal Employment Opportunity Commission [US EEOC], 2005), they still often face discrimination both in employment and housing because of their disease (ACLU, 2003). As
a result of discrimination, those with HIV/AIDS are often financially unstable which contributes to their additional difficulty in maintaining stable housing once it has been located. These additional barriers to stable housing only increase the likelihood that an HIV/AIDS infected individual will become, or remain, homeless.

**Link Between Homelessness and HIV/AIDS Transmission Risk**

Homeless individuals tend to be more likely to participate in high-risk activities. Salazar et al. (2007) conducted a study to determine if homeless, African American IDU’s were more likely to engage in behaviors associated with HIV-risk than stably housed African American IDU’s. Researchers employed a seeding technique that utilized nine, well-connected IDU’s who were given interview coupons and asked to recruit additional participants who were at least 18 years of age and self-reported IDU within the past 12 months. This technique resulted in 460 interviews, of which 343 were valid responses from African American men. Interview questions were designed to solicit information about their HIV status and participation in behaviors that put the participant at risk for HIV.

Results indicated that one in six participants was knowingly HIV positive, however this figure was similarly high for housed IDU’s as well. Overall, homeless IDU’s were 2.6 times more likely to report sharing needles, 2.4 times more likely to have had 4 or more sex partners in the past 12 months, and 2.4 times more likely to engage in sexual activity with other men. Homeless IDU’s reported unprotected sex with a casual partner twice as often as housed IDU’s.

Interestingly, homeless IDU’s who were aware of their HIV-positive status tended to avoid participation in behaviors that put them at risk of spreading HIV. The authors hypothesize that this indicates homeless IDU’s are not necessarily more likely to knowingly transmit HIV but instead at a greater risk of acquiring HIV from another IDU who is unaware of his HIV status. In
summary, this study indicates that homelessness increases the likelihood of IDU’s engaging in HIV-risk behaviors and provides support for targeting this population for HIV testing and housing programming.

A study conducted by Reback, Kamien, and Amass (2007) interviewed a sample of 20 homeless individuals who were accessing community based prevention services to assess, in part, behaviors associated with risk of HIV infection. Twenty-one percent of the interview sample reported being HIV positive, and 53% of participants reported exchanging sex for money or drugs in the previous 30 days. This study again indicates that the homeless are likely to engage in behaviors associated with transmitting and becoming infected with HIV and further emphasizes that homeless populations are logical targets for a variety of intervention services.

Wohl, et al. (1998) noted that African American women tended to have the highest rates of HIV/AIDS infections not only in Los Angeles County, but in California as a whole. Wohl and colleagues attempted to determine potential indications for such an excessive infection rate by conducting a series of interviews with this population. An analysis of interviews of homeless, African American women diagnosed with HIV/AIDS conducted between 1990 and 1997 living in Los Angeles County revealed that these individuals reported more sexual partners, sought treatment for their HIV later, reported higher rates of other sexually transmitted infections, were more likely to trade sex for alternative resources, and were five times more likely to have used crack/cocaine than women of other races who were infected with HIV/AIDS. Again, these activities increase the likelihood both of transmission and contraction of HIV/AIDS infections.

Aidala, Cross, Stall, Hare, and Sumartojo (2005) performed a secondary analysis on a data set that was originally collected as part of a service delivery project for people infected with HIV/AIDS. This secondary analysis was designed to describe the connection between
homelessness and HIV transmission behaviors, examine the effect of receipt of medical care and other case management services on HIV transmission behaviors, and determine how a change in housing status affected HIV transmission behaviors. Their findings indicated a strong association between housing status and risk for HIV transmission. The homeless and unstably housed were four and three times, respectively, more likely to have used hard drugs prior to the baseline data collection. Homeless individuals were four times as likely to exchange sex for money or living necessities when compared to stably housed individuals. Follow up data indicated that locating stable housing had a significantly positive effect on reducing HIV transmission risk behaviors. Individuals whose housing status had improved (i.e. transitioned to stable housing) were half as likely to have shared needles and engaged in unprotected sexual contact compared to those who remained homeless. Participants whose housing status had worsened were five times more likely to have exchanged sex for money or living necessities than those who were stably housed. This study clearly shows that improving participants' housing situations significantly decreases the likelihood that they will continue to engage in behaviors that can potentially transmit HIV and indicates that effective housing programs can indeed slow the spread of HIV infections in homeless populations.

In summary, as the collective research indicates, homelessness not only increases the likelihood that individuals will engage in behaviors that expose themselves to HIV infection, but also increases the likelihood that an individual will actually transmit or contract HIV/AIDS. Further, improving stable housing actually decreases high-risk transmission and infection behaviors. While there are several other options for HIV/AIDS intervention and prevention programs – information and educational campaigns, medical treatment of HIV/AIDS related issues and other sexually transmitted infections, etcetera - research indicates that locating stable
housing may further facilitate the effectiveness of these programs. Additional literature has explored the relationships between stable housing and medical care, and studies indicate that maintaining stable housing does indeed improve health outcomes overall and specifically for those infected with HIV/AIDS (e.g. Wright & Tompkins, 2006; National Coalition for the Homeless, 2007). This literature will be presented next.

**Link Between Homelessness and Health**

A comprehensive literature review of homelessness (Wright & Tompkins, 2006) showed that the homeless tend to be sicker in general and suffer from co-morbidity (i.e. suffering from more than one illness at a time) and early mortality much more frequently than housed populations. Winkleby (1990) conducted interviews with a sample of 71 homeless individuals and determined that these individuals were significantly less likely to have health insurance, significantly less likely to receive preventive healthcare, and significantly more likely to smoke than a matched sample of housed, poor individuals. Homeless individuals also reported little access to even basic amenities that would encourage a healthy lifestyle - 90% of the interviewed sample reported no access to heated rooms, running hot water, or cooking facilities. Almost 40% of the homeless are reported to have some type of chronic illness (Plumb, 1997), and homeless individuals make more emergency room visits, comprising up to 30% of total emergency room visits (D’Amore, Hung, Chiang, & Goldfrank, 2001). Schanzer, Dominguez, Shrout, and Caton (2007) also found disease to be prevalent in the homeless. In particular, their sample experienced higher than normal rates of medical illness, psychopathology, and substance use disorders.

**Homelessness, Health, and HIV/AIDS**

Homeless individuals infected with HIV tend to be sicker than those with stable housing, face additional barriers to receiving proper medical care, and face unique challenges in (National
Coalition for the Homeless, 2007). In a statement addressing policies regarding homelessness, HIV care, and clinical practices, Song (1999) observed that antiviral medication is not universally available; limited access to healthcare prevents early diagnosis as well as comprehensive, continuous care; and lack of adequate healthcare increases the likelihood of opportunistic infections that facilitate the progression of HIV to AIDS. Hsu, Vittinghoff, Katz, and Schwarcz (2001) found that IDU or homelessness decreased the likelihood that an individual would begin Highly Active AntiRetroviral Therapy (HAART). Homeless individuals infected with AIDS suffer from an average mortality rate between 5.3 to 8 deaths per year, which is considerably higher than a mortality rate of housed HIV/AIDS patients that averages between one and two deaths per year (National AIDS Housing Coalition, 2005). This difference is not difficult to explain when one considers the combination of challenges faced by those HIV/AIDS and the challenges of being homeless. This research illustrates quite convincingly that living with HIV/AIDS and co-occurring homelessness results in much poorer health outcomes than found in those living with HIV/AIDS in stable housing.

The Role of Stable Housing in Improving Health in those with HIV/AIDS

Research has demonstrated that providing stable housing significantly increases the likelihood that individuals with HIV/AIDS will access both healthcare and case management services, the latter often provided by community based organizations (National AIDS Housing Coalition, 2005). Beginning in 1994, the Community Health Advisory & Information Network (CHAIN) of New York began tracking information on a sample of HIV-positive participants. According to a 2003 report, receipt of housing services positively correlated with entry into medical care, receipt of appropriate care, and adherence to medical directions. Utilization of other services, including mental health services and substance abuse services, also increased
when services were provided in combination with housing services (Abramson, Messeri, Aidala, & Sanger, 2003). Connover and Whetton-Goldstein (2002) reported that individuals who received housing and legal services were more likely to access primary care, however receipt of care was often hindered by transportation and inability to access appropriate substance abuse services.

Receipt of housing services is related not just with general health care and case management services, but also HIV specific health care. According to a National AIDS Housing Coalition (2005), improved housing situations were associated with improved access to antiretroviral therapy (ART), adherence to care regimens, and overall improved health outcomes. In addition, individuals with HIV/AIDS who improved their housing situation were six times more likely to be on ART and five times more likely to be accessing regular HIV/AIDS medical care (National AIDS Housing Coalition, 2005).

**HIV/AIDS and Prisoners**

Further review of literature revealed an additional population that is disproportionately affected by both HIV/AIDS and homelessness: prisoners. Prisoners do engage in high risk activities such as IV drug use and risky sexual behaviors that transmit HIV; however the extent to which this occurs is not yet clear (Hammett, 2006). According to the most recent figures available, there were 22,480 HIV/AIDS infected individuals incarcerated in state and federal correctional facilities across the country in 2005 (Department of Justice, 2007).

While the prevalence of HIV/AIDS in incarcerated individuals has been decreasing each year, they are still well above that of the general population (Department of Justice, 2007). Specifically, at the end of 2005, the infection rate in state and federal prisoners was approximately two-and-a-half times higher than the infection rates in the general public.
Between 2001 and 2005, there was an average of 13 AIDS-related deaths per 100,000 inmates compared to only 9 AIDS-related deaths per 100,000 individuals in the general public (Department of Justice, 2007). While additional research is needed regarding the actual methods of transmission and infection in correctional facilities, these figures indicate that HIV/AIDS is a serious issue in correctional facilities.

Prisoners, Homelessness, and Health

Prisoners also face a unique set of challenges both during and upon release from incarceration. While the prison system tries its best to provide adequate healthcare for those diagnosed with HIV/AIDS, prisoners still often face difficulties accessing care and maintaining a complicated treatment regimen (Frank, 2000). A 2003 study conducted by the American Civil Liberties Union (ACLU) interviewed approximately 40 community-based organizations whose goal was to provide resources to the incarcerated living with HIV/AIDS to assess barriers to receiving appropriate medical care for HIV/AIDS. Interviewees indicated that prisoners are prevented from maintaining the rigorous dosage schedule required to keep their HIV from becoming resistant or transitioning to AIDS.

Aside from the stigma associated with serving time in a correctional facility, inmates often leave correctional facilities with no money, no employment, no stable housing, and no health benefits immediately available to them (CDC, 2001). In addition, many inmates are suffering from substance abuse issues, mental health issues, or physical health issues such as HIV/AIDS. Although transitional resources are available, they are often fragmented and thus difficult to coordinate both for newly released inmates and for their social service coordinators (CDC, 2001). Furthermore, upon release from incarceration many former inmates are not
provided with enough medication to tide them over while they seek alternative funding sources for medication (ACLU, 2003).

According to Petersilia (2000), as many as 60% of former prisoners are still unemployed one year following their release from a correctional facility. Interestingly, 65% of employers indicated that they were unwilling to hire an ex-offender, regardless of their offense. Coupled with the fact that only 13% of the 75 to 80% of individuals suffering from a substance abuse disorder received treatment and one in five prisoners suffers from a mental health disorder (Petersilia, 2005), it is not difficult to see how former inmates easily become victims of homelessness.

**Understanding Housing Programs**

Research demonstrates the undeniable connections between HIV/AIDS, homeless, healthcare, and health outcomes. Because of the unique challenges faced by those individuals living with HIV/AIDS, there is a need for homelessness resources that are designed to provide a customized combination of services and case management. When examining literature on homelessness programs, it is first necessary to understand underlying goals of housing programs as well as the recent differentiation between “housing first” programs and traditional housing programs with admission or eligibility requirements.

**Goals of Housing Programs**

The goals of most housing programs are not simply to provide advocacy services to homeless individuals and provide them with referrals to shelters and transitional housing, but instead to help recipients develop long-lasting independence that will negate the need for future financial and housing assistance (Tull, 2002). Many housing program recipients are still at risk of becoming homeless upon completion of programming, and thus these services have done little to
end homelessness for the individuals they serve. Instead, homelessness ends when an individual
is placed in a stable home along with the resources necessary to allow them to remain in this
home (Tull, 2002).

Housing Program Models

Housing programs in general – regardless of their target population – tend to subscribe to
one of two different housing program models. Tull (2002) discusses the difference between the
traditional HUD model for continuum of care and the newer “housing first” model, which seeks
to place clients immediately into stable housing before attempting to address their other needs.

Traditional model. The traditional HUD model, as seen in Figure 2, demonstrates that
immediately after intake, all individuals seeking housing assistance are placed in emergency
shelter until alternative arrangements can be made. Clients then progress to a transitional housing location
(a halfway house or with relatives for example) before finally being placed in traditional housing (more permanent apartments or single family homes). Supportive services are provided as part of a community effort to combat homelessness, however these issues are often addressed prior to securing stable housing. Those who are in need of additional services before attempting to maintain their own household are often referred to some type of supportive housing that does provide limited services – such as a halfway house for drug users.

![Figure 2](http://www.mentalhealthcommission.gov/presentations/anyatull.ppt)
It is difficult to isolate the model to adequately evaluate its effectiveness, as most studies evaluating programs of this type within the context of the challenges already faced by the homeless (drug use, mental illness, financial instability, etc.). One study examined four U.S. homeless programs utilizing this model and identified a variety of strengths and weaknesses to the model (Research Highlight, 2003). Strengths included collaboration, a competitive application process, and a focus on long-term solutions to housing problems. Weaknesses included lack of resources for planning and the considerable responsibility placed on front-line organizations. Concluding thoughts suggested future research and more careful data tracking systems to allow for more in-depth analyses of program effectiveness (Research Highlight, 2003).

An extensive study by HUD (2002) identified 25 communities that had effectively implemented the continuum of care model and could “convey a sense of progress in meeting their goals,” however it appears that each community’s goals were different and the study did not go into quantitative detail with regard to these communities and their goals. The authors identified a variety of commonalities between these independent community programs that serve as best practices that could be modeled by other programs, and this report is extremely valuable from the process development perspective. Interestingly, the report concludes by acknowledging that it was not able to gather outcome data because reliable data tracking processes did not exist within the majority of the communities that were studied. The authors did note, however, that few if any communities actually reduced the number of homeless individuals that entered into the system, and to combat this issue, prevention efforts need to be integrated into every system that exists within a community (HUD, 2002).
Critics of this model generally argue that this process takes too long to find permanent housing and that it is disruptive, as clients must move through all three levels of housing (emergency, transitional, and finally traditional). Proponents argue that finding the right housing, while it may take time, is extremely valuable (Research Highlight, 2003). This model also fails to provide additional resources an individual or family requires to maintain permanent housing, such as vocational assistance or social service coordination (AIDS Foundation of Chicago, 2008).

The need for future research of the traditional model is echoed by this author, as there were few resources that compared any of the models utilized in housing programs. One potential reason for the lack of empirical research may be that housing programs are often administered by non-profit organizations that have little funding to spare for solid evaluations of their programming. A simple Google search of housing programs yields countless personal testimonials but considerably fewer research studies. In the event that an organization does perform an evaluation, the evaluations are not always as comprehensive as they could be and may not be likely to be published in literature because of the time and funding it takes to do so. This trend is slowly shifting as granting agencies are requiring more and more empirical evaluations as a basis for future funding.

"Housing First" model. "Housing first" models seek to place individuals directly into permanent housing and then focus on providing necessary resources (e.g., vocational training or budgeting assistance) to maintain housing and address other issues the individual or family is currently facing (Tull, 2002). As seen in Figure 3, "Housing First" models bypass the emergency housing and transitional housing and place a homeless client directly into stable, permanent housing that provides service-enriched environments or home-based care management services.
This allows the client to focus immediately on the causes of his or her homelessness and receive appropriate services rather than struggle as he or she moves from emergency shelter to transitional housing and then finally to more permanent housing (Tull, 2004).

Advocates of the “Housing First” model believe families are more confident in their ability to improve their housing situation and responsive to programming activities in this intervention model (Tull, 2004). Opponents argue that providing automatic housing free of charge may in fact enable unhealthy and dangerous behaviors that caused homelessness in the first place. The following discussion will touch on research regarding “Housing First” programming.

The Effectiveness of “Housing First” Programs.

“Housing First” programming has been developed both for the general population as well as targeted sub-populations that are at particular risk of homelessness, such as the mentally ill or recently incarcerated. Discussion of research will first focus on programming targeted toward the general population (Pathways to Independence, Closer to Home Initiative, and Chicago Housing for Health Partnership) and then progress to programming that has targeted sub-populations of homeless who are infected with HIV/AIDS (Oregon Opportunities for Housing Partnership and...
Project Independence). This chapter will end with an in-depth examination of the current program under evaluation – the Stopping Cyclical Homelessness in Infected Persons (SCHIP) program.

**General Housing Programs**

*Pathways to Independence.* Research on “housing first” programs is fairly young. One of the first “housing first” programs that has been evaluated not only appears to be successful, but also has received a $10,000 prize and an Achievement Award from the American Psychiatric Association in 2005. The Pathways to Housing project (Pathways to Housing, Inc., 2005) provides immediate, permanent housing to homeless individuals who were suffering from any combination of mental health and substance abuse disorders. Subsequent to being housed, each client received individualized supportive services based upon their unique needs and was supported by a multidisciplinary team of professionals who assisted in stabilizing the individual’s illness(es) and building social and community support systems. Participation in these services was not, however, a condition of retaining housing services.

The program reports an 85% housing entry rate for clients who would not otherwise have had access to housing resources. An analysis of clients from a Brooklyn site yielded a 92% decrease in clients’ average length of hospitalization. A second study found that 80% of Pathways clients were able to enter and maintain stable housing during a 24-month tracking period compared to only 34% of clients in a control group (Tsemberis, Gulcur, & Nakae, 2004). A third study analyzed housing retention rates for 1,842 homeless clients suffering from psychiatric disorders in New York and found an 88% retention rate for Pathways clients. This is notably higher than the 47% retention rate found in the comparison group (Tsemberis & Eisenberg, 2000).
Closer to Home Initiative. An evaluation of the Closer to Home Initiative (CHI) also examined programs that each utilized some degree of “housing first” modeling. The CHI evaluation analyzed outcomes for six different housing programs that each had similar goals and were classified as “low demand” programs – meaning recipients were not required to participate in many activities to retain program benefits. Levels of demands actually varied from literally having no obligations to retain services all the way up to agreeing to abide by “clean and sober” and strict housing rules. Overall findings indicated that, after clients were housed, linking them with appropriate psychiatric services is an effective way to enable clients to maintain housing (Barrow, Rodriquez, & Cordova, 2004). Interestingly, the Corporation for Supportive Housing (2006) found that individuals who were not participating in “housing first” programs tended to have higher rates of social service utilization – probably because utilization was a condition of their housing. This may provide support for opponents of “housing first” programs who claim that making utilization of social programming a condition of housing assistance (the opposite of providing “housing first”) reduces the likelihood that homeless individuals will address the issues which caused their homelessness in the first place.

Chicago Housing for Health Partnership. In 2002, the Chicago Housing for Health Partnership (CHHP) was awarded a grant to implement a housing program based on the “housing first” model developed by the National Alliance to End Homelessness. Over the course of an 18 month research phase, the study tracked individuals who received “usual” housing care comprised of emergency shelters and a combination of social programs as well as a group of individuals enrolled in a new “housing first” program that focused on first providing stable housing and subsequently focusing on additional social services. Preliminary findings indicated that 73% of “housing first” participants remained stably housed at the end of the 18 month
research period compared to only 13% of “usual” care participants. While a formal report is due out later this year, this program appears promising and has been extended (CHHP, 2008).

**HIV/AIDS and Housing Programs**

*Oregon Opportunities for Housing Partnership.* Homelessness programming designed to target those suffering from HIV/AIDS has yet to completely embrace the “housing first” model. There are several programs currently in place that continue to use the traditional HUD model or some hybrid of the two aforementioned models. The Oregon Opportunities for Housing Partnership (OHOP) is a housing program that provides rental subsidy payments to low income individuals living with HIV/AIDS. The purpose of the subsidy is to directly assist recipients in maintaining stable housing and avoiding homelessness as well as indirectly to improve their access to and utilization of health care services. A survey asking program participants about their satisfaction and experiences in the program yielded an 80% return rate. Thirty-four percent of respondents indicated that they had or were very close to meeting their housing goals, and 66% of respondents indicated that they were either halfway or “had a very long way to go” to meet their housing goals. Ninety-two percent of respondents indicated that the program had either a “very big” or “moderate” impact on their attainment of their personal housing goals. Yet, no quantitative measure of housing status change in was provided, disallowing an objective evaluation of the program’s effectiveness. Responses from clients did, however, indicate success with regard to access to and utilization of health care services (Chaumeton, Drach, Maher, & Wilson, 2006).

*Project Independence.* Finally, Desinger and Spiegelman (2007) evaluated a program named Project Independence that provides shallow rent subsidies (between $125 and $475 depending on household size) and social services support to HIV/AIDS individuals with low
incomes in California. The philosophy of this program is to provide assistance to individuals and families that are already stably housed but in danger of losing housing in order to prevent homelessness before it becomes an issue. Researchers compared 185 Project Independence participants to 218 matched controls and found that non-program participants were 3.8 times more likely to leave their current housing at any point throughout the program. At a one-year follow-up, 92% of program participants remain stably housed compared to only 32% of the control group. Two years later, an impressive 96% of remaining Project Independence participants remained stably housed compared to only 10% of matched controls. Participants of Project Independence remained enrolled in the program and received financial support as long as they were eligible for the program. No information about the number of clients who transitioned out of the program was provided. The impressive maintenance of stable housing in clients of Project Independence provides support for the provision of shallow rent subsidies, and the program appears to be successful in preventing homelessness in an HIV/AIDS population with low incomes.

*Stopping Cyclical Homelessness for Infected Persons (SCHIPS) Program*

Of the homelessness programs described above, Project Independence bares the most resemblance to the SCHIP program currently being evaluated. While the philosophies of the programs differ – Project Independence assists stably housed individuals to prevent homelessness and SCHIPS works to transition homeless HIV/AIDS individuals into stable housing, the implementation of the two programs is extremely similar. Both programs provide variable shallow rental subsidies to HIV/AIDS clients, based upon assessment of their current income and Fair Market Value for their household. Project Independence, however, funds indefinitely while SCHIPS is only available to clients for a restricted period of time (12 months).
**SCHIP Program Description**

Staff members at ARCW provide housing services by utilizing a combination of programs, each with a different referral, acceptance, and operational procedures. Over the course of utilizing the programming, however, staff noticed a lapse in available resources for the HIV/AIDS populations who are either chronically homeless (four instances of homelessness in the past three years) or recently released from incarceration. To specifically address the needs of these populations, ARCW staff members designed a housing program comprised of housing assistance, vocational assistance, and public transportation assistance. Participants are provided with resources for up to 12 months while they address the issues that caused their housing instability.

**Goals of the SCHIP Program**

The overarching goal of the program is to transition participants into stable housing upon program discharge. This is accomplished through facilitating a combination of services designed to address the cause of a client's homelessness: lack of income, lack of employment, or lack of services to address other medical or psychological issues.

Specific goals and outcomes of the SCHIP grant as identified in the proposal include the following:

*Goal 1*: Provide intensified housing services coordination to 100 HIV/AIDS clients annually to assist them in establishing residential stability and an income stream.  
*Outcome 1*: 80% of clients will have housing stability within 12 months and be able to transition to long-term supportive housing programs.

*Goal 2*: Provide employment services to 75 SCHIP clients in need of enhanced services.  
*Outcome 2*: 80% of SCHIP clients will receive employment services and have regular income stream within 12 months of program admission.

*Goal 3*: Provide medical care and supportive services (from ARCW providers and affiliates) to 100 SCHIP clients on an annual basis.
Outcome 3: 90% of clients will be enrolled in appropriate medical care and supportive services upon discharge.

SCHIP Program Eligibility

After an ARCW case manager identifies that housing services are needed, clients are referred to a housing case manager who determines eligibility for housing programs. In order to be eligible to participate in the SCHIPS program, clients must first furnish proof of HIV-positive status as well as documentation of chronic homelessness or recent incarceration. Documentation of four incidences of homelessness in the past three years can be evidenced by verification letters from homeless shelters or other supportive services, and incarceration of at least 30 days can be verified by release documents. Clients are only eligible for SCHIP services if they complete application materials within 90 days of their release from incarceration.

Clients are eligible to participate in SCHIPS for any 12 months out of the three year grant cycle; however these months are not required to be consecutive. A client could receive benefits for 12 straight months or 4 months out of each year of a single grant cycle, provided they remained eligible for the program for the duration of their participation. In addition, clients are not eligible to receive SCHIPS benefits if they received benefits from another ARCW housing program within the previous ten weeks. These limits were placed upon participation to ensure that the SCHIP program was facilitating the development of independent maintenance of stable housing rather than acting as a permanent solution to a client's housing issue.

SCHIP Program Enrollment

After eligibility is verified, clients must complete an application packet. It consists of an ARCW housing program application and assessment documents, signature documents indicating they are aware of their rights and responsibilities, certification forms indicating that they will maintain a drug free household, and various release of information documents.
During the admission process, clients also develop a personalized Housing Service Plan in which they identify a variety of goals ranging from physical and mental health to substance abuse to relationship goals to money management or parenting goals. For each goal that is relevant to a client, he or she develops a list of barriers as well as an action plan to overcome each of these barriers. Maintenance of activities designed to overcome these goals is a requirement for remaining enrolled in the SCHIPS program. Housing case managers ensure that goals and action plans are indeed legitimate issues for each client and do pose a realistic threat to the client's ability to maintain stable housing.

**Housing Assistance**

The SCHIP grant allows clients to utilize funding for a portion of their rent as well as a portion of a security deposit. In order to determine how much funding each client receives, the SCHIP program utilizes a formula based on Fair Market Rent (or Fair Market Value for those who own their home) figures for the client's individual location. When a client first identifies a potential residence, housing case managers determine if the rate charged for rent is appropriate for that particular location using information provided by HUD. To determine the Fair Market Rent for any given area, consult [http://www.huduser.org/datasets/fmr.html](http://www.huduser.org/datasets/fmr.html).

After it is determined that a residence meets HUD financial eligibility requirements, housing case managers analyze each client's income. According to HUD, no more than 30% of an individual's annual income should be devoted to housing ([Community Planning & Development, 2008](#)). Based upon this guideline, housing case managers establish how much a client will pay for housing (equated to 30% of their income) and how much funding they will receive from the SCHIPS grant (the remaining rent balance). Clients of the SCHIP program can either access ARCW housing (facilities operated by ARCW for which they would pay rent) or
independent rentals (apartments or single family homes in which rent is paid to a landlord independent of ARCW).

Option 1: ARCW operated housing. For Milwaukee clients, ARCW maintains a single-room housing facility (Wisconsin House) for individual clients as well as a small apartment building for clients with families. Both of these facilities can be utilized as part of the SCHIP program, provided clients agree to rules and living requirements for each facility. Rent is charged for both of these locations.

Option 2: private rental housing. Clients also have the option of choosing to live in private rental housing. After a prospective residence is identified, prospective landlords must provide information regarding the residence as well as information necessary to complete financial transactions. Housing case managers also inspect each property to ensure safe and healthy living environments are being provided to the tenants. Residences range from single family homes to apartments to simply sleeping rooms. Such intense contact with landlords raises the issue of confidentiality, and in order to preserve ARCW client confidentiality, all ARCW staff and business associated with ARCW housing programs operate under the organization name “Housing Services Program of Wisconsin.” ARCW staff is provided with a separate telephone line, business card, and mailbox, and in no way is Housing Services Program of Wisconsin associated with ARCW. While clients can discuss their HIV status and relationship with ARCW with their landlord, ARCW staff is not allowed to confirm or deny the client's association with ARCW.

Transportation Assistance

Clients of the SCHIP program are eligible to obtain vouchers for public transportation systems for the city in which they live. Payments for bus passes are issued on a bi-weekly basis.
and allow clients to ride unlimited public transportation. Transportation assistance is provided to
enable clients to travel to housing meetings, housing case management appointments,
employment interviews or work. Access to reliable transportation also increases the likelihood
that clients will be able to access services from other community organizations as well as
regularly attend their medical appointments.

Vocational Assistance

Clients of the SCHIP program have the opportunity to access employment and vocational
assistance as well. Residents of Milwaukee are welcome to attend vocational programming at
Wisconsin House, and any client wishing to attend is provided with free access to public
transportation. Clients located outside of Milwaukee and who do not have access to
programming at Wisconsin House are free to discuss potential vocational opportunities with their
housing case manager. The housing case manager, along with other SCHIP staff, decides if
proposed vocational opportunities will likely be productive for the individual client. Staff may
then choose to fund the opportunity either in entirety or to provide partial funding depending
upon the assistance requested by the client.

Housing Case Management Services

Not all clients of the SCHIP program receive financial assistance for rent, transportation,
or vocational training. Some clients simply make too much money and pay too little for their rent
to be eligible for funding based upon Fair Market Rent calculations. However, this indicates that
the client currently has enough income to comfortably pay for their housing.

Other clients choose not to take advantage of financial resources and instead focus on the
counseling and referral services provided by ARCW. Some clients are in need of assistance
locating stable housing within their income range, while others need coordination of alcohol and
drug services or mental health services. It is important to note that a client does not need to receive financial assistance in order to be enrolled in and benefitting from the SCHIP program.

**SCHIP Program Activities**

After a client has been admitted to the SCHIPS program and completes all relevant paperwork, he or she must simply continue to engage in activities identified in his or her personal housing service plan. Weekly contact with a housing case manager is required, and this contact is designed to function as a “check-in” with clients to assist in obtaining additional resources through ARCW or other community based organizations if necessary.

Housing case managers also check in with mental health providers, physicians, and other service providers to verify that clients are indeed attending scheduled appointments and activities. If a client is unemployed and a resident of Wisconsin House, the single-room facility for Milwaukee residents, he or she is also required to attend vocational programming several times weekly. Finally, case managers complete monthly home visits to ensure clients are maintaining a safe and hygienic residence.

An enrollment period can last anywhere between 1 and 12 months, and clients can remain enrolled for a total of 12 months provided they also remain income eligible for the program during a grant cycle. As a client nears completion of the program and exhausts his or her 12 months of available benefits, housing case managers provide transitional counseling to facilitate the maintenance of stable housing. This may require simply transitioning to paying one’s rent entirely or be as drastic as locating an alternative residence that is in a client’s unassisted income range.
**SCHIP Evaluation History**

The SCHIP program has undergone three previous evaluations undertaken by an internal evaluator at ARCW: 2004-2005, 2005-2006, and 2006-2007. However, only the 2005-2006 and 2006-2007 evaluations were available to this author.

The first available evaluation for the program was for the dates from 4/1/05 to 3/31/06 contains information on number of clients served, prior living situations, age and gender, race and ethnicity, and income levels. Additional information was provided summarizing the services provided to SCHIP clients. However, this information was often not separated from clients of other ARCW housing programs. A second evaluation for the dates from 4/1/06 through 3/31/07 contained only a summary of how much financial assistance each client received and information regarding Wisconsin House occupancy rates. The variability in the data reported in these two grants, coupled with the fact that this evaluator does not have access to the original databases from which data for the first two evaluations was taken, provides the current evaluator only basic information about the number of clients served per year for comparative purposes.

**Program Evaluation**

When discussing evaluation, it is important to determine if a formative or summative evaluation is most advantageous. Formative evaluations tend to focus more on the process or implementation of a program. In the case of the SCHIP program, a formative evaluation would examine how effectively participants are referred and accepted into the program, access to services, and what kinds of obstacles are faced by staff in meeting client needs throughout the program. In comparison, a summative evaluation tends to be slightly more outcome focused. In this case, it will focus on the specific goals and outcomes of the program as indicated above.
Prior years’ evaluations indicate that the program was not able to meet its target number of individuals served for any of its goals (see page 38), and no information regarding outcomes was documented in either grant evaluation that was provided to this author. It is unknown if the program truly did not serve the target number of clients or if the services simply were not documented. It is likely that the goals were not met as a result of both factors. Specifically, this author discovered during the course of this evaluation that some clients accessed services that were funded by the SCHIP program however were not recorded as SCHIP participants or enrolled within the SCHIP program.

An evaluator-led discussion with the program administrator, housing case managers, and client case managers indicated great interest in ensuring that the program run as efficiently as possible, and that several of the processes for enrollment, data tracking, and benefits administration could use some improvement. Based on this conversation, it appeared that the SCHIP program would greatly benefit from a formative evaluation. Because of time and funding restrictions, however, a substantial formative evaluation component was not realistic as a focus this author’s research study. Recommendations for future formative evaluation opportunities will be discussed later in this paper.

The current paper will focus on an outcomes evaluation of the 2007-2008 grant cycle. Outcomes of interest include the number of clients who received supportive services for housing, transportation, and vocational assistance as well as the number of clients who improved their housing status and increased their income while participating in the program. There was no data regarding the agency’s efforts to meet the health care needs of clients aside from discussion of supportive services.
Chapter III: Methodology

The SCHIP grant has been renewed for a second, three-year cycle, and this evaluation will focus solely on the outcomes of the first year of this second cycle, which ran from 4/1/2007 to 3/31/2008. The purpose of this evaluation is threefold: assess the program’s success in meeting its yearly goals to 1) assist 100 clients in obtaining housing and income stability, 2) assist 75 clients in obtaining vocational assistance, and 3) assist 100 other clients in accessing medical care and supportive services. Additionally, this evaluator will determine how many clients were able to transition into more stable housing during the 2007-2008 program year.

Participants

There were a total of N=52 clients who utilized transportation, vocational, medical, or housing case management services between April, 2007 and March, 2008. Thirty-five of these clients were new to the program, and 17 clients were previously enrolled and continuing activity into the first year of the second grant. Clients ranged in age from 25 to 61, with an overall mean age of 43.6 (SD 7.3). Eight-seven percent of clients served during the 2007-2008 grant year were male. Males ranged in age from 29 to 61, with an average age of 44.7 (SD 6.7). Thirteen percent of clients of the first grant year were female; they ranged in age from 25 to 48 with an average age of 37 (SD 7.8). As figure 4 indicates, first year clients were primarily African American in race (69%), followed by White Non-Hispanic individuals (21%), Native American or Alaskan Native (4%), Hispanic (4%), and Mixed Race (2%).
Design

This evaluator will utilize a within subjects, pre-test post-test of client income and housing status upon admission and while participating in the program or upon discharge from the program to conclude on how effectively the program accomplished its goal of increasing housing stability. These results will be compared to non-equivalent groups taken from the literature as well as state and national statistics regarding rates of homelessness in HIV/AIDS infected individuals.

An equivalent groups pre-test post-test design is not realistic for several reasons. The population of individuals infected with HIV/AIDS is relatively small and many are receiving or have received some sort of housing case management through ARCW, making untreated control groups impossible. In addition, ethical issues arise when matching subjects, as control subjects would both be eligible and demonstrate a need for housing assistance and denial of services does
not uphold the ARCW mission and values. Finally, data on individuals with similar circumstances as those participating in the SCHIP program are not readily available for comparative analysis, and collecting this data would be excessively costly and time consuming.

Procedures

Data regarding participants is collected using two database programs, Microsoft Access and Provide Enterprise. ARCW staff use the Microsoft Access database to generate all check requests, and each entry into this database records the participant name, grant number, financial disbursement, payment number, and category of payment (rental assistance, vocational assistance, or transportation assistance). It is important to note that this database contained information only about SCHIP participants who had received financial assistance and did not include any information regarding those who utilized case management services only. As noted earlier, one does not need to receive funding in order to be an active SCHIP participant.

The second data management program, Provide Enterprise (PE), is a more qualitatively oriented program in which housing case managers note the frequency, duration, and nature of contacts with clients. Each contact with a SCHIP participant is briefly categorized in this program as housing contact, vocational assistance contact, transportation assistance contact, coordination of other services, housing advocacy, housing counseling, home visits, and SCHIP contact. In some cases, an entry is linked to a more specific description of the contact in which the housing case manager enters a brief summary of what occurred during the contact. This program allows the evaluator to identify not only the frequency and duration of contacts with all clients, but also serves to identify SCHIP program participants who were accessing case management services but not receiving funding from the SCHIP fund.
Vocational services were tracked in one of two ways. Vocational services obtained independent of ARCW vocational programming would have been tracked as a service provided in Provide Enterprise, however no clients appear to have accessed external vocational programming. Clients of SCHIP who stayed at Wisconsin House were provided the opportunity to attended vocational programming at Wisconsin House – regardless of whether or not they were enrolled in the SCHIP program. Because the vocational programming at Wisconsin House is funded by SCHIP dollars, any recipient of these services is included in this analysis as a beneficiary of the SCHIP program. The names of these clients were recorded on attendance sheets, and this information was then relayed to the evaluator for inclusion in analysis related to vocational assistance.

Based upon reports generated by Access, the evaluator constructed a secondary database designed to integrate data taken from Access, Provide Enterprise, and attendance lists from vocational services sessions. Participants were given anonymous case numbers to ensure data from both programs would match to the correct participant, however all identifying information will be removed for final submission of this evaluation.

Information Stored in Researcher Created Secondary Database:

Prior to program entry. The newly constructed database contained demographic information regarding each client’s gender, age, and race as well as their monthly income and residence prior to admission to the program. Residence prior to program admission served as a baseline against which their housing status during participation in the program and upon discharge would be compared.

During program participation. Any changes in housing status or monthly income were documented along with the number and classifications of SCHIP assistance received. Financial
assistance information, taken from the Microsoft Access database, indicated the type of financial assistance a client received (rental assistance, transportation assistance, or vocational assistance), as well as how many payments, the average value of each payment, and the sum of all financial payments received by each client.

Housing case management assistance included information on the number of housing advocacy and counseling contacts took place, the number of home visits that occurred, and how many “other services” were provided. Other services consisted of coordination of AODA treatment, case management services, probation and parole assistance, crisis interventions, emergency housing assistance, and “other” services, which were not clearly defined but appear to be any services that fail to fit into any of the other categories. An example of an “other” service might include child care services or medical referrals.

Finally, Provide Enterprise was able to generate a report containing a summary of all contacts received per clients – including how many times housing documentation occurred per client. To gain a clear picture of how many actual client contacts occurred, the number of housing documentation events were subtracted from the total number of contacts. This allowed researcher to see how much individual attention a client was actually receiving without including activities such as generating check requests, which entail no actual contact with a client.

One issue that became evident during this component of the evaluation was that there are not standardized definitions for service categories or service titles. For example, what exactly constitutes housing “advocacy” versus housing “counseling?” What activities can be classified simply as “SCHIP contact” and do not fit into other categories of services.
Several entries appeared to be very similar as well. For example, Provide Enterprise considers “bus tickets” and “but tickets (housing)” to be two separate categories of services provided to clients. It is unclear if there is any actual difference in the service being provided to clients, and standardizing the way in which information is entered into PE will surely solve these classification issues and make future grant evaluations easier to analyze.

Upon discharge from program. When a client is discharged from the program, a program discharge document is filled out and recorded in Provide Enterprise. This discharge document includes information about a client’s date of discharge, monthly income upon discharge, reason for discharge, and housing situation to which the client is being discharged. For clients who have been discharged, this information was recorded in the newly created database. For clients who remained enrolled in the program, the most recent information regarding their housing status and monthly income was recorded.

Measure

Given that this study was archival, no measure was needed to gather new data. All original data for the study was gathered from existing databases. For the purpose of answering the evaluation questions of interest, the data were operationalized as follows.

Program Participation

For the purpose of this evaluation, a client is considered to be an active participant in the SCHIP program if he or she 1) received any financial assistance from the SCHIP account or 2) received any form of housing case management services. Housing case management services could consist of any combination of housing counseling or advocacy, home visits, SCHIP contact, or coordination of other services.
Rental Assistance

A client is considered to have received rental assistance if he or she received any financial assistance categorized as “rental assistance” from the SCHIP account. This information was recorded in the Microsoft Access database.

Transportation Assistance

A client is considered to have received transportation assistance if he or she received any financial assistance categorized as “transportation assistance” from the SCHIP account. This information was also recorded in the Microsoft Access database.

Vocational Assistance

A client is considered to have received vocational assistance if he or she received any financial assistance categorized as “vocational assistance” from the SCHIP account. Any client who attended vocational programming at Wisconsin House is also considered to have received vocational assistance, as they benefitted from vocational services that were funded by SCHIP grant money.

Changes in Income

Pre-program income is operationalized as the client’s income upon admission to the program as taken from admission documentation. For clients who are still enrolled in the program, their post-program income was operationalized as their most current income recorded in their case files. For clients whom have been discharged, the post-income was operationalized as their income listed on their discharge documentation.

Housing Status

A client’s pre-program housing status, recorded in an admission document, was classified into the following categories: living with family or friends, jail, prison, or juvenile facility,
homeless (on the streets or other location not meant for housing, such as bus station or rest area), transitional housing, rental housing, or substance abuse treatment facility.

Data Analysis

Descriptive Data

Descriptive data will be calculated for the 2007-2008 grant year in order to determine how effective the program was in meeting its yearly goals of assisting 100 clients in obtaining housing and income stability, assisting 75 clients in obtaining vocational assistance, and assisting 100 other clients in accessing medical care and supportive services.

Comparison Data

Income. To determine if there were any changes in monthly income, a client’s income upon admission to the program was compared to either their current income if they are still enrolled in the program or their income upon discharge if they had been discharged from the program.

Housing status. For the purpose of this analysis, improvements in housing will be defined as improving from incarceration, homelessness, transitional housing, or living with friends/family to living in a private, rented residence as transition to rental housing was the ultimate goal of this program. In addition, those who are homeless or were incarcerated who move into transitional housing, living with a friend/family, or a private, rented residence will also be considered “improved” in their housing status, as these housing situations are a vast improvement over homelessness or incarceration. Housing statuses that stay the same (e.g. admitted from rental housing and discharged to rental housing) did not meet the definition of “improvement” for the purposes of this analysis but would rather be defined as maintenance of housing status.
Chapter IV: Results

Enrollment

Between the dates of 4/1/07 and 3/31/08, housing management services at ARCW performed 42 SCHIP assessments, denied seven applicants for unknown reasons, and admitted 35 new clients to the SCHIP program. Adding these 35 new clients to the 17 clients previously enrolled and continuing activity into the first year of the second grant cycle brings the total number of clients actively enrolled in the SCHIP program to 52. Two of these clients had been previously enrolled, discharged from the SCHIP program, and then re-enrolled for part of this grant period. For this evaluation, information from their most recent enrollment has been utilized.

Pre-program Income and Housing Descriptives

Twenty-one of the 52 clients active in the SCHIP program during the 2007-2008 year reported monthly income upon admission – although their admission may have been prior to the 2007-2008 grant year. Reported incomes ranged from $46 to $1,175 and averaging $672 (SD $261). The remaining 31 clients left the income field blank or their income status was entered as “unknown.”

Prior to entering the SCHIP program, eight clients (16%) were reportedly living with friends or relatives, 18 (35%) clients were in a jail, prison, or juvenile detention facility, 14 (27%) were homeless (on the streets or in an emergency shelter), eight clients (16%) were living in transitional housing, three clients (6%) currently lived in a private, rented residence, and one client (2%) previously resided in a substance treatment facility (Figure 5).
Residence Prior to Entering the SCHIP Program

Figure 5. Client's reported residence prior to program admission.

Days Enrolled in the SCHIP Program

The number of days a client was actively enrolled in SCHIP during the 2007-2008 grant year ranges from 705 to 4. Clients enrolled for more than the 12 months allowed for program participation likely had their eligibility extended by their case managers. The average number of days a SCHIP client had been enrolled in SCHIP is 223. Original enrollment dates for the current sample begin in 2006. There appears to be a minor increase in the number of enrollees both in December 2006 as well as February and March 2008, as seen in Figure 6.
Figure 6. Enrollment figures for clients who were active during the 2007-2008 grant year.

**Rental Assistance**

Rental assistance was awarded to 33 clients and averaged approximately $1,783.83 per person. The average number of rental payments awarded for this year was 6.7, and payments ranged from $400 per month to $71 per month. The average rental payment per client receiving rental assistance was $262.80, and the total figure awarded for rental assistance to all clients between the dates of 4/1/07 and 3/31/08 was $58,886.42 (see Figure 7).
Average RA Payment

N=42

$350 to $400
$300 to $349
$250 to $299
$200 to $249
$150 to $199
$100 to $149
$50 to $99
$0 to $49

Figure 7. Average monthly RA payment to clients active in 2007-2008 grant year.

Transportation Assistance

Transportation assistance was provided in the form of bus passes to 26 of 59 participants between the dates of 4/1/07 and 3/31/08 and averaged approximately $243.38 per client. The average number of transportation awards per client for this year was 7, and payments ranged from $26 to $47 per month (usually distributed bi-weekly). The average transportation assistance payment per client receiving transportation assistance was $32.62, with payments distributed twice per month. The total figure awarded for transportation assistance to all clients between the dates of 4/1/07 and 3/31/08 was $6,328.00. See Figure 8.
Vocational Assistance

Vocational assistance was provided in the form of services rather than direct payments. There were five clients who utilized vocational assistance programming at Wisconsin House during the first grant year. No participants aside from residents of Wisconsin House utilized any direct payments for vocational assistance between the dates of 4/1/07 and 3/31/08.

Summary of Financial Assistance

Seventeen of 59 participating clients received funding for both rental assistance and transportation assistance. The total award distributed to clients accessing financial support ranged from $32 to $5,365, and averaged $1,552.65 per client receiving funding (see Figure 9). The total value of direct financial support awarded to clients between the dates of 4/1/07 and 3/31/08 was $65,194.42. Financial assistance was most often utilized for rental assistance and then transportation assistance.
Figure 9. Total financial assistance provided to 2007-2008 SCHIP clients.

Non-Funded Clients

An additional 11 clients enrolled in the SCHIP program between the dates of 4/1/07 and 3/31/08 did not receive any form of financial assistance; they did access housing and case management services from SCHIP program staff. For these 11 clients, the average number of SCHIP services received (minus housing documentation) was 25. For the entire N=52 clients, the average number of SCHIP services (minus housing documentation) received per client was 49. For all clients, the number of housing advocacy and counseling contacts averaged 28, and for clients receiving only housing management services the number of average housing advocacy and counseling contacts ranged from 1 to 110 and averaged 38. There were recorded home visits for only 22 clients (19 who were receiving financial assistance and 3 who were utilizing housing management services only), and the average number of home visits for these 22 clients was 3.5.

Coordinated Services

Records indicated 12 clients of the SCHIP program between the dates of 4/1/07 and 3/31/08 received assistance in coordinating additional services. Such services ranged from one to
six records per client, with an average of two coordination services per client. Finally, contacts classified as SCHIP contacts (which were not defined further) ranged from zero to 44 per client, and averaged 18 contacts per client during the 2007-2008 grant year (see Figure 10).

![Diagram](image)

**Figure 10.** Total services provided to 2007-2008 SCHIP clients.

**Program Discharge**

Of the 52 active SCHIP clients, 19 were discharged sometime prior to 3/31/08. As seen in Figure 11, the most common discharge reason was inability to reach the client, followed by clients moving out of service territory, client ineligibility to receive services, and client declining services by choice.
Reasons for Client Discharge (N=19)

Program Outcomes of Interest

Discharge destinations. Of the N=19 discharged clients, two were discharged to live with friends or relatives, three were discharged to jail or prison, five clients were discharged to private, rental housing, one to a substance abuse treatment facility, and eight clients were discharged to unknown locations. These statistics can be seen in Figure 12.
Figure 12. Destination to which 2007-2008 SCHIP clients were discharged

*(Image of a pie chart showing discharge destinations)*

**Client Discharge Destinations**

N=19

- Living with Friends/Relatives: 11%
- Don't Know: 42%
- Transient Housing: 6%
- Substance Abuse Treatment Facility: 5%
- Homeless: 0%

*Income.* Eighteen client records indicated an increase in income from the time they were admitted to the program. Increases ranged from $15 to over $1,200, and averaged approximately $642 (SD = $432). There was not enough information provided to determine net increases or decreases with any degree of confidence because so many client records were missing current income information. No maintenance of or decrease in income was reported for any client.

*Improvement in housing status.* Housing improvements were also of interest in this particular program, as the program's goal was to assist clients into improving their housing status and ultimately transition them into stable housing. Thirty-two of the 52 clients (61.5%) clearly improved their housing status after entering into the SCHIP program. Clients who did not improve their housing status often returned to incarceration, transferred from one transitional...
shelter to another, or continued to live with a friend or relative. Nine of the 19 discharged clients (47.4%) were able to improve their housing status when compared to their living circumstances upon enrollment in the program.
Chapter V: Discussion

Purpose of the SCHIP Program

The SCHIP program was designed to accomplish three things: provide housing services to 100 individuals per year resulting in residential stability and stable income in 80% of recipients, provide employment services to 75 participants resulting in 80% of recipients having regular income, and providing medical and supportive services to 100 clients resulting in 90% of recipients receiving appropriate medical care. The following discussion will address the program's success during the most recent grant year (4/1/07 to 3/31/08).

Enrollment

This most recent year demonstrated a slight increase in the number of SCHIP participants enrolled in the program (52 for the current year) when compared with the previous year (41 according to the previous year's evaluation). This increase may be a result of a more broad definition of what it means to be enrolled in the SCHIP program by this author or an actual increase in the number of clients in need of housing services and who meet the eligibility requirements for the SCHIP program. New enrollees totaled 36, and 23 clients continued to receive services after enrolling during a prior grant year. New enrollments appeared to spike during the winter months both this year and last year, indicating that these periods pose particular hardships to the recently incarcerated and chronically homeless and perhaps outreach efforts might be increased during these times.

Demographics

Participants appear to be primarily African American, again indicating that outreach efforts may be increased in predominately African American areas that have been affected by AIDS. Activities might include targeting African American IV drug users not only for housing
outreach, but for educational and preventive assistance as well. The larger proportion of men might speak to the fact that men are more likely to be in a position to access the SCHIP program and its benefits (i.e. recently incarcerated) or it may indicate that female clients tend to be underserved. There appears to be minimal discussion of taking family size and considerations into account in program literature, and further exploration is necessary to determine if the family friendliness of this program has affected female utilization of its benefits in any way.

Residence Prior to Admission

The fact that such a large proportion of clients admitted to the SCHIP program between 4/1/07 and 3/31/08 were coming from incarceration indicates that this program has indeed been successful in serving a specific sub-population with housing needs. Individuals who are homeless or in transitional housing make up the second most frequent groups of clients served, indicated that the chronically homeless are also a population whose needs can and are being met by this program. Although only three clients enrolled in the program to maintain their already stable housing, the SCHIP program is working to accomplish its goal of not only improving housing stability, but maintaining housing stability as well. Restricting assistance to only the chronically homeless may decrease the number of clients eligible to receive assistance in maintaining their stable housing. The program might consider expanding its eligibility requirements to include those in danger of becoming chronically homeless or finding alternative methods to increase the number of eligible recipients for this program. Regardless of ARCW's decision to alter eligibility requirements, this evaluator encourages ARCW staff to ensure that the needs of clients who are not eligible for SCHIP are still being met via alternative programming.
Receipt of Financial Assistance

Rental assistance. Data analysis reveals that 42 of the 59 SCHIP participants were receiving financial assistance from the SCHIP program. This indicated that there is indeed a realistic need for the financial assistance provided by the SCHIP program. The average amount of monthly rental assistance was primarily in the range of $200 to $300, also demonstrating that SCHIP participants are receiving only a portion of their rent rather than using this program as the sole basis on which they rely to meet their housing needs. This is a strong indication that the program is working collaboratively with recipients to build self-reliance and maintain independence as well as personal responsibility.

Transportation assistance. Approximately half of the participants receiving rental assistance also received transportation assistance. Again, this indicates that transportation is an issue for SCHIP participants and that transportation needs of some SCHIP clients are at least partially being met utilizing public transportation. Yet, after speaking with housing managers and program staff, it appears that the program is perhaps a bit too inflexible to meet the transportation needs of all SCHIP clients – particularly those who are unable to use public transportation or live in locations that do not provide effective public transportation infrastructures.

Vocational assistance. The fact that such a small number of participants were accessing vocational services may be an indication that it is necessary to re-evaluate the vocational needs of SCHIP clients. Only five residents of Wisconsin House accessed vocational services. Yet, it is unknown exactly how many of the remaining 47 clients were actually in need of vocational services. This information could be assessed by examining individual SCHIP service plans designed by clients. Examining this data in terms of proportion of successful service provision
would likely yield greater need information. Based on the presently available and analyzed data for this reporting period, this evaluator encourages ARCW staff to carefully consider how it is utilizing funding for vocational services and to determine if there is perhaps a better way to use such funding. This evaluator first suggests that staff ensure that clients are aware that funding is available for vocational assistance, and if funding remains underutilized it might be advantageous to divert that funding to a greater client need.

Coordination of Additional Services

Fourteen clients were provided with approximately 40 additional services of which they were in need. While this falls short of the target number of clients served, it is important to remember that not all clients will be in need of services aside from housing or transportation – in fact many clients may be utilizing this program only for the housing and transportation services. To gain a clearer picture of how successful the program is in meeting client needs for additional services, it would be best to examine individual client service plans and determine exactly how many clients actually needed services aside from transportation, housing, or vocational assistance. Examining the proportion of needs met rather than an arbitrary number of clients served would be much more effective in demonstrating the success of the SCHIP program. The SCHIP program may only admit 15 clients per year in need of additional services, but meeting every one of those clients' needs is a success even though the program did not meet its target of serving 75 clients.

Discharge

Reasons: Clients' status upon discharge is a topic of great interest, especially when considering the potential this program has not only to be continued, but to be replicated should it be shown successful. Unfortunately, discussion about the reasons for client discharges in this
report is limited because of questionable data interpretation. It is not clear what a successful “completion” of the program looks like, however several clients did become “ineligible for benefits.” This could have occurred for two reasons: either the client has secured enough income to deem himself or herself ineligible to receive benefits (a good outcome), or the client has exhausted his or her eligibility for benefits by reaching his or her $12^{th}$ month. The differentiation is not clear based on the data available to this evaluator. Twenty-seven percent of clients who were discharged during the first year of the second grant cycle were discharged because of lack of contact between themselves and their housing case managers. More investigation is needed into this matter to determine exactly why clients are lost to follow-up and to determine ways in which the program might avoid losing such clients in this fashion.

**Destinations.** Outcomes appear to be slightly more optimistic when examining the destinations of discharged clients. Specifically, no clients were discharged back to homelessness or transitional housing. This is a program accomplishment, indicating that clients are at least receiving adequate services to prevent them from returning to the conditions under which they entered the program. Twenty-six percent of discharged clients were destined for private, rental housing – ideal destinations and indications that this program accomplished its goal for these clients. A client discharged to a substance abuse treatment facility indicates that the SCHIP program is effectively connecting at least some of its clients with additional services they need.

Unfortunately, the discharge destinations of 42% of clients was unknown, however this may be a function of automatic discharge based on non-contact with a housing case manager. Again, future programming should focus on maintaining client contact with housing case managers.
Improvement in housing status. Finally, a considerable number of clients were able to improve their housing status after enrolling in the SCHIP program. This indicates that, while not all clients will be successful in transitioning to private, rental housing, the program is still successful in its quest to improve the living situations of its clients. The significance of this improvement in housing status will be discussed later in this report, but these findings do appear to be quite strong evidence of the SCHIP program's effectiveness at least in the short-term.

Recommendations for the SCHIP Program

Setting Realistic Goals

Overall recommendations for this program are to re-administer a needs assessment to determine the seriousness of need for vocational assistance as well as to determine a more realistic number of estimated clients that will be served. While it would be beneficial to state goals in terms of proportions (i.e. 95% of clients with employment service needs will be successfully assisted) rather than numbers, evidence of need will still be strongly supported by an effective needs assessment.

Formative Evaluation

A second recommendation for this program would be to utilize a formative evaluation. This will allow staff and clients to analyze the implementation of the program in a participatory manner that will result in process improvements, and explanations as to why some problems are occurring. For example, a formative evaluation may yield some insight as to why so many clients are being discharged because of lack of contact with their housing case manager. Did these clients move away? Did they misunderstand the requirements of the program? Were their needs not being met effectively? Answering questions like these will allow for the improvement in
programming desired by ARCW staff and will ultimately allow the SCHIP program to help clients more effectively.

*Data Integrity*

As indicated in this report, routine data gathered as part of the SCHIP program continues to have multiple data integrity issues. Unfortunately, the causes of these issues are not entirely clear. Staff training still appears to be at least somewhat of an issue; program staff indicate that the issue may primarily lie with newer staff who are unfamiliar with data entry systems and programs.

Recommendations for improvement include the following. If not in place already, this evaluator suggest a manual with flow charts to demonstrate exactly how and where data should be entered so that even individuals who are unfamiliar with the programs would be able to accurately enter data. In addition, staff should operationally define how to classify the variety of services provided to clients in order to make clearer conclusions in future evaluations. Increasing the confidence in the integrity of the data will only strengthen the confidence in the benefits of the SCHIP program.

*Data Management Software*

The data management program currently in place (Provide Enterprise) is extremely slow and somewhat inflexible. If ARCW continues its attempt to combine Microsoft Access and Provide Enterprise, it is highly suggested that the program’s functioning speed be addressed as it likely poses a barrier to accurate and timely entry of data. The program itself is also somewhat inflexible for data gathering, as much of the data for this report had to be gathered by going into individual client profiles and entering data into a third spreadsheet, customized for this
evaluation. Much time and energy could be saved with a more flexible and faster data management program and would likely increase the accurate and timely entry of data.

Data Collection Plan

In addition, staff should carefully examine the goals of the SCHIP program, determine how exactly the program plans to provide evidence of accomplishing a goal, and then ensure that the appropriate data is being accurately entered into the appropriate database(s). Is there a realistic way to determine exactly how many clients were in need of housing or vocational or transportation assistance aside from digging through handwritten service plans? How will the program and data show that clients' vocational needs are being met? How will SCHIP contact and service entries be consistently classified by program staff across the state? Staff taking these issues into consideration should experience much less difficulty in drawing conclusions about the SCHIP program in the future.

Longitudinal Tracking of Clients

Finally, this evaluator suggests that ARCW staff develop a system or plan to track clients even after they have been discharged from the SCHIP program – if even only for their housing status information. Developing such a system and regularly gathering data should allow ARCW to provide more accurate and timely answers when asked about how program effectiveness.

Discussion Related to Literature

Support for the SCHIP Program

Synthesizing the findings of this study and the results of previously discussed studies, one finds even stronger support for the SCHIP program. Thirty-two clients were able to improve their housing status upon entering into the SCHIP program. According to the National Coalition for the Homeless (2007), that's 32 more HIV/AIDS infected individuals who are now less likely
to be sick, have reduced the barriers they face to receiving adequate care, and are now more likely to adhere to their medication regimens. According to the National AIDS Housing Coalition (2005), that's 32 SCHIP clients who have just reduced their chances of dying from HIV/AIDS related illnesses.

*Appropriate Target Population*

Literature indicates that prisoners are a high risk group, which the SCHIP program seems to be serving. The SCHIP program even adds the benefit of coordinating additional services, such as AODA and healthcare, that is often lacking in the lives of newly released inmates (ACLU, 2003).

Petersilia (2000) reported that as many as 60% of inmates are still unemployed one year after their release; yet, the results of this study indicates there is no immediate utilization of vocational services by those enrolled in the SCHIP program. This again brings up the question as to whether there are more pressing needs or if vocational assistance is simply not desired by SCHIP clients. Further investigation and needs assessments will likely yield answers to these questions.

*Traditional and “Housing First” Models*

The SCHIP program is based on the traditional HUD model rather than the newer, “Housing First” model discussed earlier in this report. Based upon discussions with ARCW staff, it appears unlikely that funding to run a housing program based on the “Housing First” model will be available in the near future. At this point, the organization wants to be sure that those who receive funding are indeed serious about accessing services and maintaining their health and not simply taking advantage of the program. However, as more research on these programs develops, the staff at ARCW may wish to seriously consider revising the SCHIP program to incorporate a
“housing first” component. It is possible that by providing “housing first” benefits rather than requiring eligibility and compliance as is currently being practiced, there will be a reduction in the number of clients who are discharged because of lack of contact with their housing case manager.

*Advantage of Longitudinal Tracking*

Developing a longitudinal data tracking system will also be helpful in comparing the success of the SCHIP program to other similarly minded programs. At this point, the outcomes are based only on the situation to which a client is discharged. A client who loses his or her permanent housing and again becomes homeless is still considered a success in the eyes of the program because they were discharged to stable housing. Yet, realistically, the client was unable to maintain that housing without the assistance of the SCHIP program.

*Broadening Eligibility*

With regard to the success of the Project Independence program (Desinger & Spiegman, 2007), the SCHIP program may want to consider widening its eligibility to include those in danger of losing their stable housing rather than waiting until clients are homeless and in need of emergency assistance. While other programming may also address some of these needs, it seems to be advantageous to approach the problem of homelessness proactively and focus on assisting those who are stably housed in maintaining their stable housing.

*Conclusion*

The SCHIP program appears to be effective in accomplishing its goal to improve the housing status in 54% of the clients it served during the first year of the second grant period. Additional investigation is needed to determine the reasons for alternative outcomes, and future grant applications may wish to utilize another needs assessment to appropriately allocate
resources. It would also be beneficial to restate goals and present them in proportions along with a needs assessment to ensure that needs are not being overstated and clients with HIV/AIDS are not being underserved.

The AIDS Resource Center of Wisconsin continues to strive for improvement in its data entry and tracking processes, and this evaluator again recommends training for new staff as well as the development of supplementary data entry instructional aids. A more user-friendly and quicker database management program is highly desired; however realistic requests might include simply increasing operating speed or providing more flexibility in running reports.

A formative evaluation as well as the development of a longitudinal data tracking plan would benefit not only the SCHIP program, but other housing and ARCW programs funded by grant dollars. Proactively addressing these concerns as soon as realistically possible will increase the organization's efficiency as well as its ability to serve the needs of clients affected with HIV/AIDS who are in need of housing and case management services. The AIDS Resource Center of Wisconsin has the ability to meet almost any need a client may have, and ensuring the continuation of programs such as the SCHIP will ensure ARCW will be a resource in the future.
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