Chicago House

Performance Report Card FY2021

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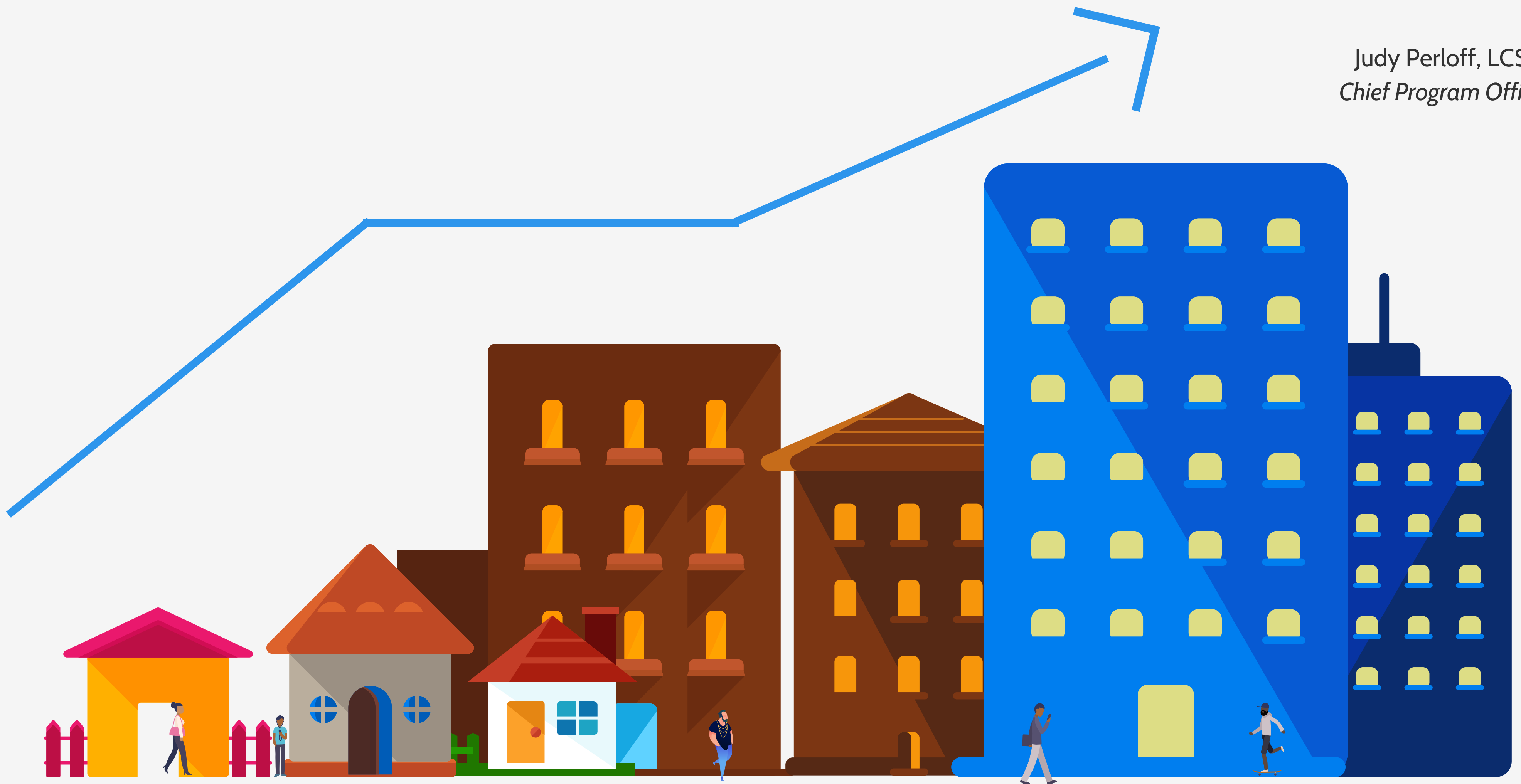


What's in this report?

Who We Serve

Each of Chicago House's funded programs serves a slightly different population. The diversity of our programs means it is important to understand who our clients are on a broader level. During this presentation, we encourage you to ask questions about who receives our services, and whether we are meeting their needs. Who are we not serving yet, and who could we serve better?

Indicators & Outcomes

Our goal is to improve housing, health, and employment for those living with and affected by HIV in Chicago. We evaluate our performance as an agency against external benchmarks as well as internal metrics. 2020 and 2021 were unusual years for everyone, so this report shows more comparisons of FY21 data to FY20 data to help us understand which changes may be stable, and which areas may still be in flux. **This year, with the release of the national *Ending the HIV Epidemic* (EHE) initiative, we also focus on benchmarks that are relevant to EHE target outcomes.**

Four Pillars of Care

Health:
Getting to Zero
Improving Access to Care

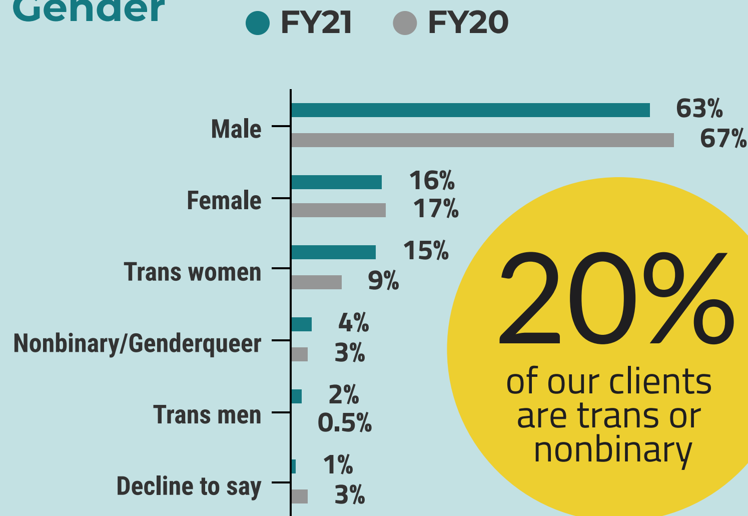
Housing:
Increasing Stability
Improving Retention

Employment:
Increasing Self-Sufficiency
Creating Careers

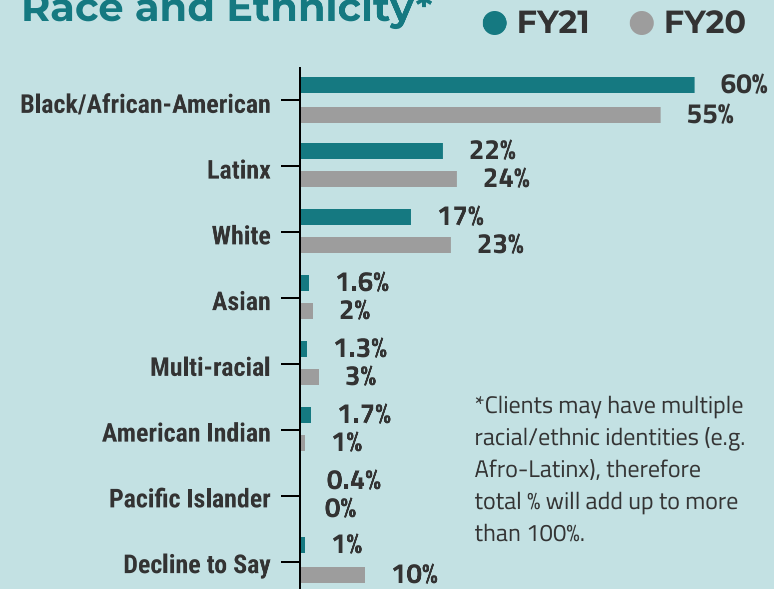
Equity:
Improving Care for Trans People, People of Color, and Clients over 50

Chicago House's client demographics changed in FY21 due to our move to new spaces on the South Side, and the growth of new programs.

Our biggest demographic shifts this year were increases in the proportion of Black/African-American clients we served and the proportion of trans women, trans men, and nonbinary clients.

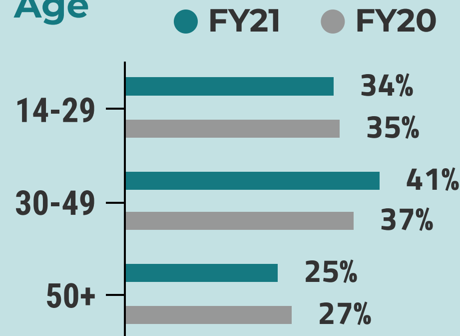


20% of our clients are trans or nonbinary

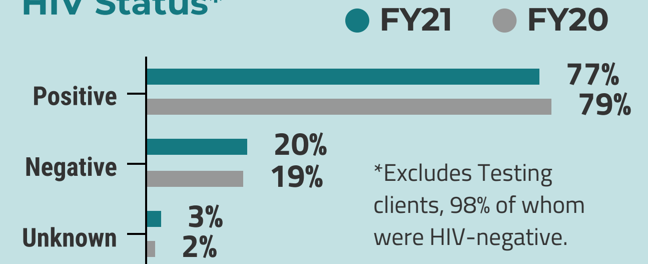


*Clients may have multiple racial/ethnic identities (e.g. Afro-Latinx), therefore total % will add up to more than 100%.

1,981
People Served in FY21
vs. 1,986 in FY20



25% of our clients are over 50



*Excludes Testing clients, 98% of whom were HIV-negative.

Program impact is more than just measuring client counts - every client can receive dozens or hundreds of individual service touchpoints per year.

This year, we made approximately:

22,450
Phone contacts with 460 Ryan White Medical Case Management clients

923
TransSafe Resource Line calls connecting 242 trans and gender-expansive clients with resources

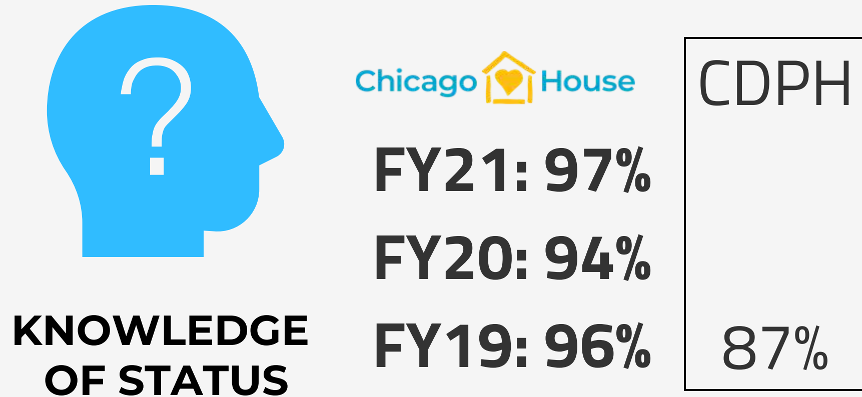
1,812
Appointment and Medication Adherence services delivered to 230 Care Coordination clients

In one year, one client may receive:

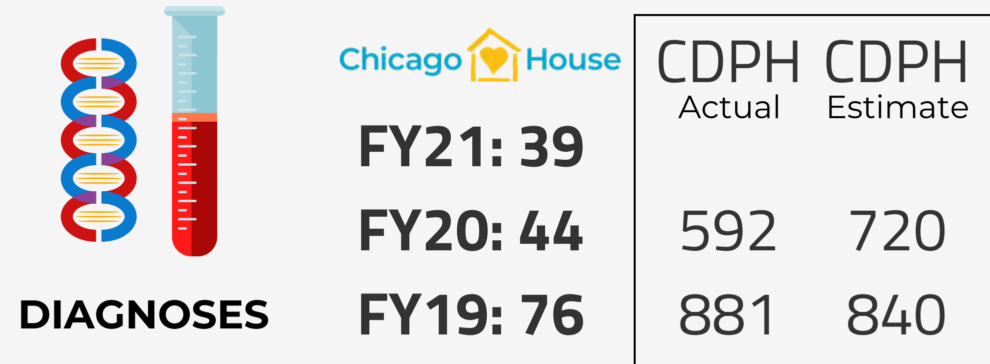
Housing Programs	365 nights of shelter
Pharmacy Services	12 door-to-door medication deliveries
	$200 or more in emergency financial assistance for unpaid utilities
Care Coordination	52 follow-up calls
	3 accompanied doctor's visits
Employment	25 or more virtual or in-person career counseling sessions
	100+ calls or emails with a Career Specialist
TransLegal	10+ hours of free legal assistance
Medical Case Management	20 or more referrals for medical, mental health, dental, education, food, and transportation resources
FSP Bridges Program	180 days of after-school childcare

Ending the HIV Epidemic: knowledge is increasing, new diagnoses are down

2020 saw the beginning of a federal initiative to *End the HIV Epidemic* (EHE), reducing new transmissions by 90% in the next 10 years. This once-in-a-generation effort has targeted additional expertise, technology, and resources to areas and communities most in need. Below, we compare Chicago House's progress on five of six EHE benchmarks with data from AHEAD, America's HIV Epidemic Analysis Dashboard (https://ahead.hiv.gov/), collected by CDPH.



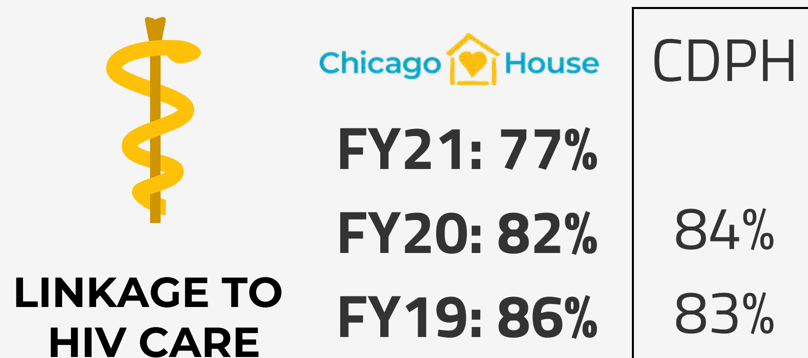
CDPH figure is an estimate of the number of HIV-positive individuals in Chicago who know their status. Since Chicago House has served communities impacted by HIV for over 35 years, it's not surprising that almost all our clients know their status - if they don't, we have been able to offer them free HIV testing since 2017, with convenient mobile testing options since 2019. **We are steadily increasing the proportion of Chicagoans who know their HIV status.**

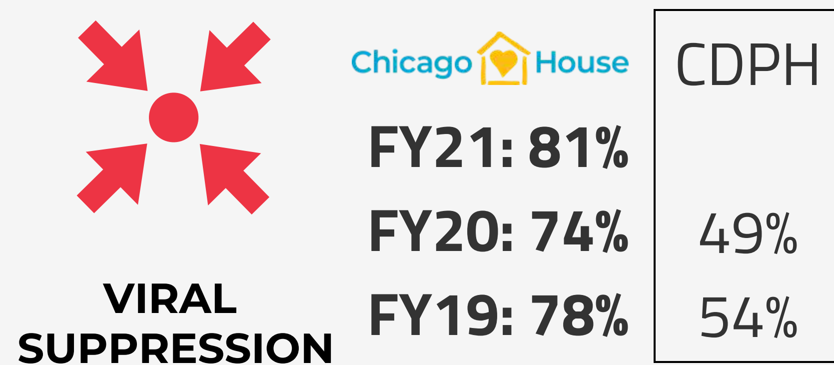


The number of newly-diagnosed people living with HIV has decreased over time in the communities we serve. At the same time, re-engagements with previously diagnosed people (shown later under Care Coordination) have increased. CDPH data shows actual new HIV diagnoses decreasing faster than estimates of HIV incidence. **Strategies to decrease new HIV infections are working.**

After diagnosis, linking clients to care is key to achieving viral suppression

Rapid initiation of antiretroviral therapy after HIV diagnosis is a key pillar of the national initiative, *Ending the HIV Epidemic: A Plan for America*. Full implementation of tele-health during FY21 has been a double-edged sword for our efforts to link clients to care quickly and securely - we have dramatically reduced our average linkage time and increased same-day linkage for HIV-positive clients from 22% in FY20 to 27% this year, but a higher percentage of clients were lost to follow-up before their first medical appointment. Studies show that delayed linkage to care can be predicted by poverty, housing insecurity, lack of insurance, and lack of primary or mental health care - common barriers for our clients.





The percentage of HIV+ clients linked to care by our Care Coordination program within 30 days of diagnosis has decreased this year, most likely due to the pandemic interfering with in-person medical care and labs. Linkage time is measured as the number of days between an initial positive test and the client's first HIV medical appointment. However, **from FY20 to FY21, our average linkage time decreased from 35 days to 12 days**, and the average number of Care Coordination contacts with the client between diagnosis and linkage increased from 8 to 11.

Our clients' viral suppression numbers are climbing again after a brief wobble in FY20, which was also reflected in regional data. This includes clients across all programs that serve people living with HIV - Care Coordination and Case Management clients' data is shown separately under HOPE department outcomes.

PrEP use is increasing among our HIV-vulnerable clients, and Chicago House is becoming better known as a PrEP provider

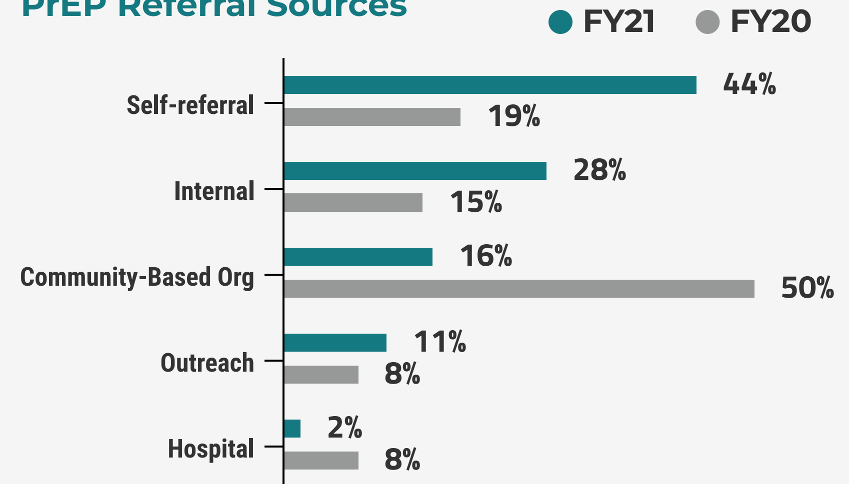
PrEP COVERAGE

Chicago House	CDPH
FY21: 27%	
FY20: 12%	31%
FY19: 3%	34%

The percentage of our HIV-vulnerable clients who were successfully connected to PrEP each year is increasing to meet CDPH's benchmark. This does not include clients who may have been educated about PrEP at Chicago House, but linked to PrEP through other Chicago-area clinics.

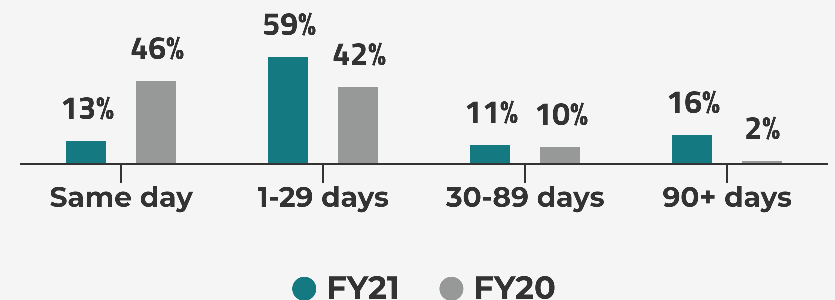
This year, amid Covid-19 restrictions, we tested 244 individuals, only 30% of the number tested last year. However, we are linking more clients to PrEP, and have more than doubled the number of successful PrEP referrals that are word-of-mouth, self-referrals, or internal referrals from testing and other programs. At the same time, our test positivity rate has gone up, showing that **we are reaching the right people: communities that are vulnerable to HIV, and are becoming more aware of what they can do to end the epidemic.**

PrEP Referral Sources



Same-day PrEP linkage, which requires in-person lab tests, was impacted by Covid-19. **PrEP clients are taking longer between expressing interest and starting a PrEP prescription**. Many clients who engaged with us in the winter of 2020-21 did not complete PrEP linkage until the summer.

PrEP Linkage Time



Chicago House

Health Programs Overview

Medical Case Management

Our case managers work one-on-one with individuals living with HIV to achieve healthy and independent lives through professional and therapeutic relationships. Case managers provide guidance through medical insurance, financial assistance, adherence to medical appointments and medications, behavioral health and substance use, oral health, nutrition, transportation, and other basic needs on an ongoing basis.

Prevention and Testing

Chicago House provides convenient HIV testing and linkage to medical care, including PrEP. Care coordinators help clients eliminate barriers to adhering to medications and connect them with supportive wraparound services, including: housing, employment, insurance and benefit navigation to individuals newly diagnosed, those who are highly vulnerable, and those who are living with HIV.

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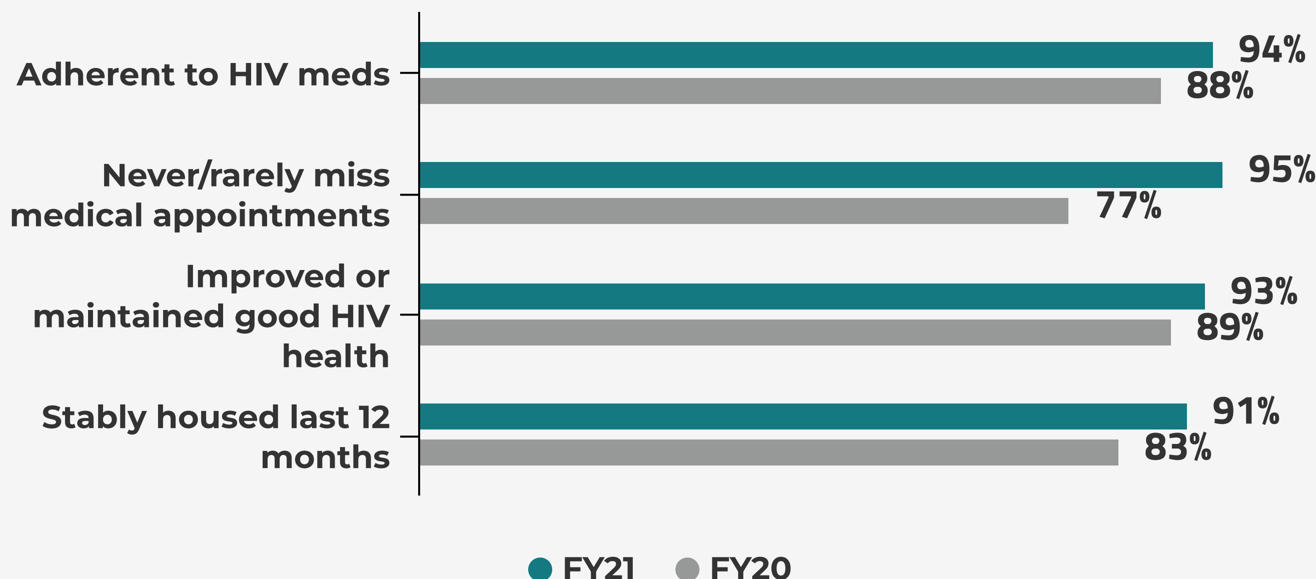
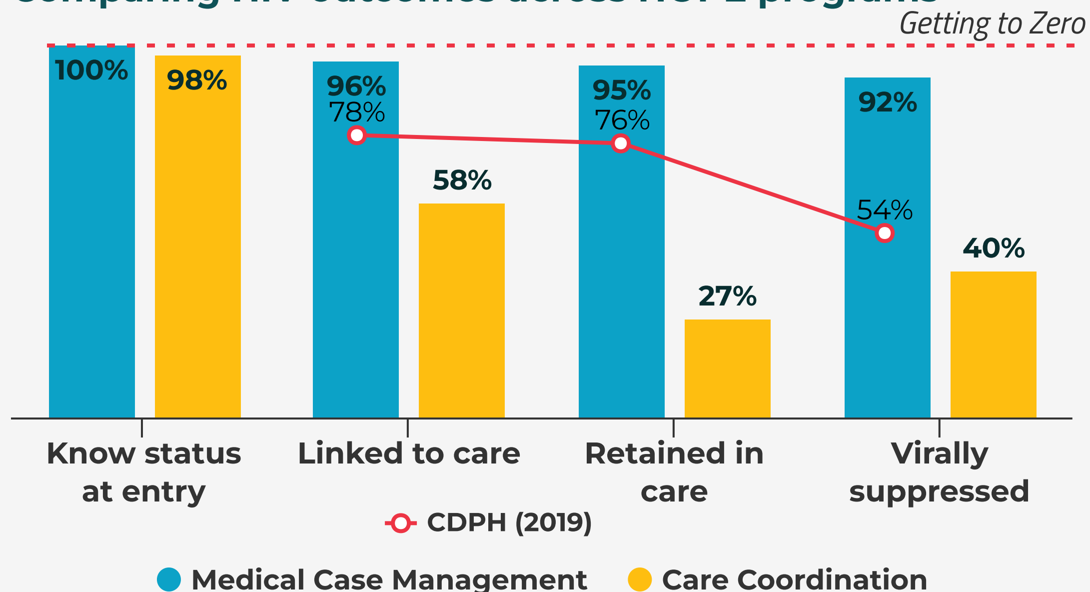
HIV health improves with stability, engagement, and time



Last year, we were impressed by our Medical Case Management clients' outcomes - both the traditional HIV care cascade items, and on measures of adherence and medical stability. **This year, Medical Case Management clients are doing even better.**



An unfair comparison?

Case Management clients have been with Chicago House for 3 years on average - 40% longer than clients in Prevention programs. They are further along in their HIV journey, so it should not surprise us that only 27% of Prevention clients have met the standards for retention in care (2 HIV medical visits within a year) or viral suppression (viral load < 200 copies per mL). **Case Management clients' outcomes represent where Care Coordination clients are headed.**

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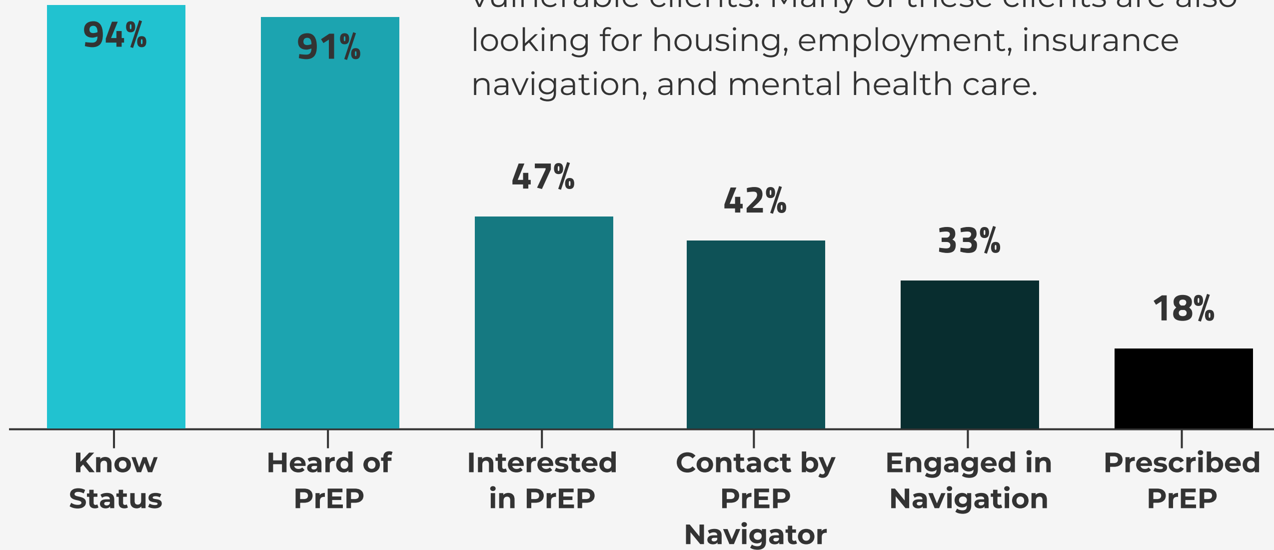
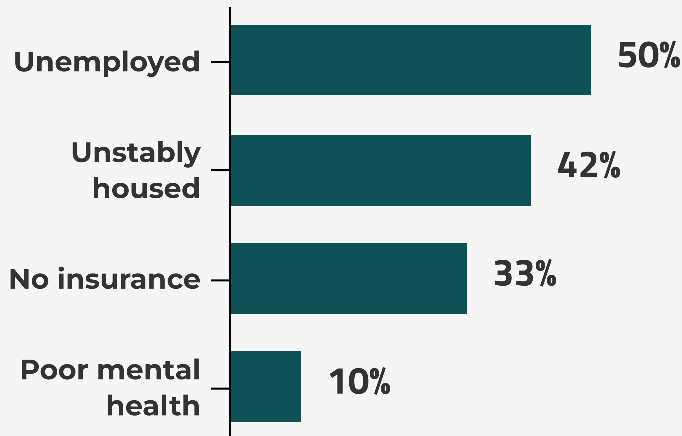
PrEP engagement rises when interest is present and other needs are met

Mind the Gap

Between PrEP education and having a PrEP prescription in hand, we lose 76% of qualified HIV-vulnerable clients. Many of these clients are also looking for housing, employment, insurance navigation, and mental health care.



HIV-Vulnerable Clients' Social Determinants of Health



The average time between first contact with a PrEP navigator and linkage to PrEP in FY21 was 44 days. 11% of PrEP clients took more than 2 months of patient engagement by PrEP Navigators and referrals for other services before they received a PrEP prescription. These clients were almost all in housing crisis, with no income. **Solving clients' most urgent problems can renew their interest in preventive health, and provide space for re-engagement with PrEP.**

Prevention Successes

312 **Referrals**
To other CHSSA services

2.5x **More contacts**
With Navigators vs. FY20

112 **PrEP Clients**
Saw a doctor about getting on PrEP

> **I got connected to insurance and the Employment program - a lot more than just PrEP.**
>
> *- L., new PrEP client*

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Health Programs: Lessons

Getting to Zero is Socially Determined

Clients in our Medical Case Management program show the best HIV health indicators of any Chicago House program. Clients in other programs are connected to care and receive treatment, but Medical Case Management provides social support for adherence as well as regularly connecting clients with resources to meet their changing needs.

PrEP Uptake is an Ongoing Challenge

47% of HIV-negative Prevention clients say they are interested in PrEP, yet only18% have filled a PrEP prescription. How can we close this gap? Many Prevention clients are unstably housed, a hard-to-reach population.

Points of Interest

88%
HOPE clients are satisfied with services

30%
HOPE clients also access other Chicago House programs

76%
Care Coordination clients stayed in care during FY21

Housing Programs Overview

Scattered Site Housing

Chicago House's Scattered Site Housing programs are largely funded by HOPWA. These programs provide HIV+ adults and those vulnerable to HIV with stable, subsidized housing in community, working with local landlords. Housing case managers focus on building tenancy skills and economic stability, as well as improving physical and mental health. Community Housing Navigators/Skilled Assessors help clients access housing options outside Chicago House through the Coordinated Entry System (CES).

Residential Programs

The three residential programs - Supportive Living, Independent Living, and the Family Support Program - provide housing in buildings that Chicago House owns. Clients in these buildings have access to in-house medical case management, on-call building maintenance, and the support of other clients and families who are also living with HIV.

Points of Interest

Scattered-Site Housing Capacity
240 UNITS

Clients entered in CES
373

Newly housed in 2021, all housing programs
39

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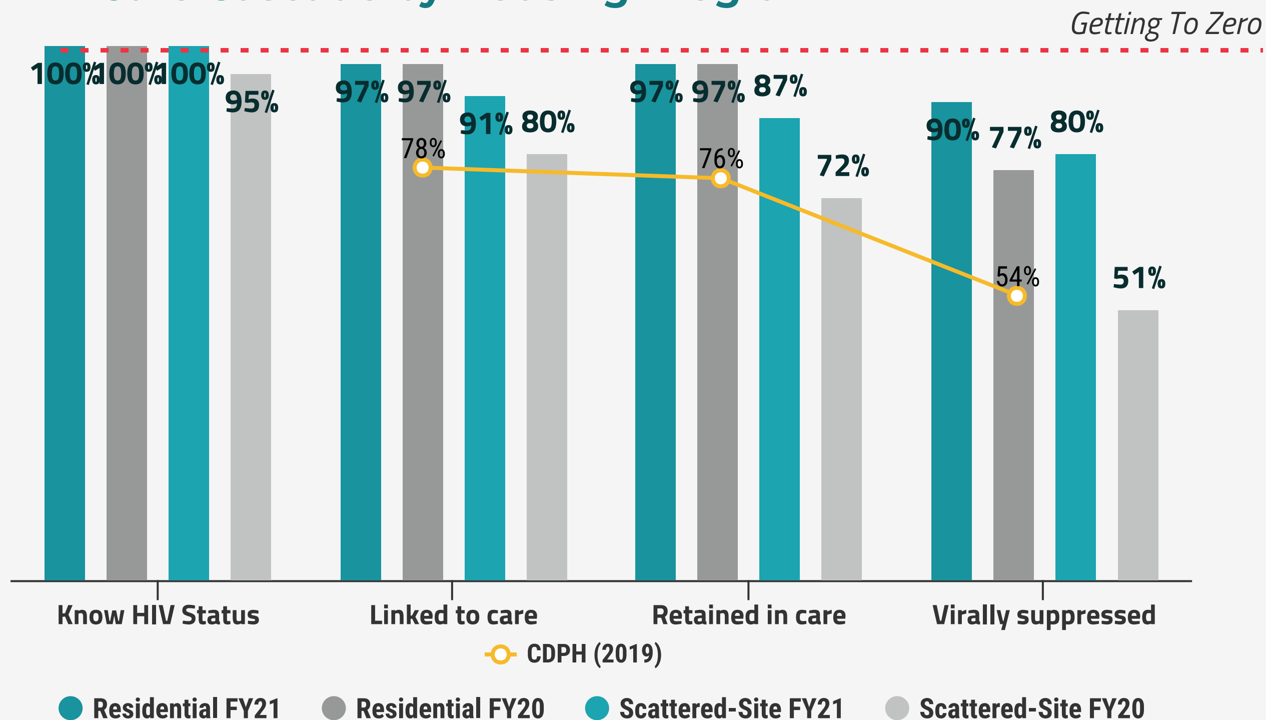
Housing clients' HIV health and engagement in care has improved this year



Last year, many of our Housing clients had trouble maintaining their HIV health - only 77% of Residential clients and 51% of Scattered-Site clients achieved viral suppression, and many clients couldn't get updated lab work to determine their viral load. We've reversed that trend in FY21.

One of our key performance indicators is how much we are helping clients maintain or increase their housing stability. In FY2021, our programs consistently helped clients maintain stable housing, or increase the stability of their housing. Clients whose housing stability decreased were more likely to have started out with unstable housing, and were younger than the average Chicago House client (37 vs 41).

[I'm grateful for] the feeling of putting a key in my own door every day.

Residential Housing client

Housing Stability Among Our Clients

37% Increased
Housing Stability

44% Maintained
Stable Housing

6% Decreased
Housing Stability

71% **Retained**
in stable housing for 12 months

Housing Programs: Lessons

Wrap-Around Care Works

While we've seen dramatic improvement this year, HIV health outcomes for Residential Programs clients are still better than those for Scattered Site Housing clients. Both of these programs serve a high-need population; closing the gap in medication adherence and health stability is a priority for FY2022.

Older Clients are Overrepresented in Permanent Supportive Housing Programs

45% of housing clients at Chicago House are over 50 - compared to 25% of our general client population. This matches the trend for HOPWA clients nationwide (average age 44.5). Permanent supportive housing programs are confronting the needs of clients who wish to "age in place," requiring adaptations and accommodations to aging-related disabilities. As Chicago House moves forward, we are keeping the changing needs of our housing clients in mind.

Points of Interest

3.3 years
Average Length of Service with Chicago House

30%
Housing clients also access other Chicago House programs

45%
Housing clients are over 50

Chicago House

Employment Programs Overview

Career Counseling

Our staff works with a host of employers in the Chicago area to connect individuals to job opportunities. Services include resume and cover letter guidance and review, networking and career building workshops, drop-In computer lab access , and one-on-one career counseling sessions with a career specialist.

TransWorks

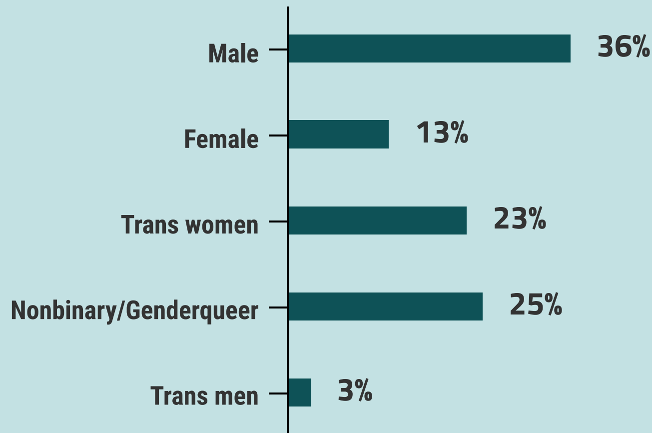
TransWorks is dedicated to providing transgender and gender non-binary individuals with career help, both at the individual level and by training employers to provide a more accepting workplace. This program offers skill-building workshops, one-on-one career coaching and mentorship match programs to advance employment and work opportunities.

Community Health Apprenticeship Program (CHAP)

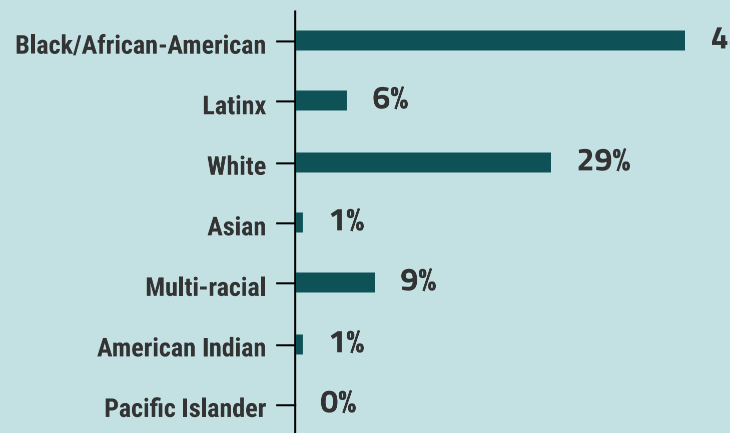
The Community Health Apprenticeship Program is a hands-on training and certification program for young people from communities most affected by HIV to start their career as a community health worker in the HIV field, providing education, testing, prevention and care.

Employment clients have some important differences from Chicago House's general population: younger, more likely to be trans/nonbinary, and less likely to be HIV-positive

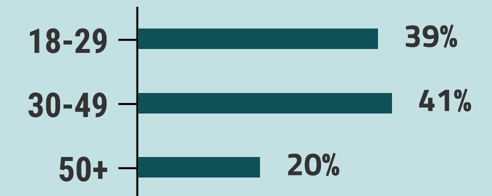
Gender



Race and Ethnicity



Age



HIV Status

121
People Served in FY21

50%
Employment clients are trans or nonbinary

<u>Programs Included</u>
Career Support
Employment Drop-In
TransWorks Drop-In
CHAP
HOME: Housing and Employment

In FY21 Employment served more nonbinary/genderqueer clients, fewer Latinx clients, and more clients who did not disclose their HIV status than in FY20.

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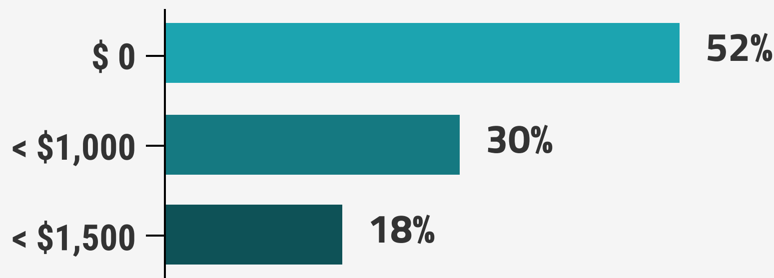
48% of Employment clients have income, but are ready to move beyond "just a job"

Career Specialists work with clients to develop themselves as professionals, and find a career that will increase their self-sufficiency and fit their talents, skills, and interests.

Monthly income at entry



14% Above
Chicago's $15 minimum wage

$17.04

Average hourly wage, jobs obtained/held in FY21

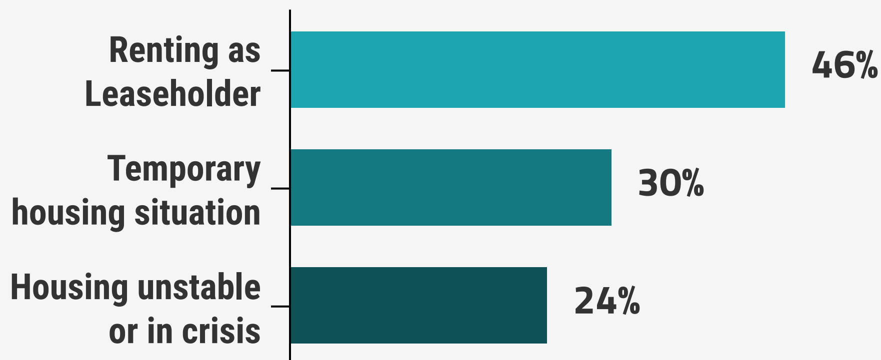
Rent in Chicago has decreased over the past 2 years, but the median rent for a 1-bedroom apartment is still over $1,500 - out of reach for most of our clients.

Employers

People 2 Point 0
Illinois Attorney General's Office
Colman, Brohan & Davis
Amazon
Yelp Digital Marketing

Health and Social Services:
Pivot Health
Center on Halsted
Association House
Heartland Alliance
CALOR
Haymarket
Deborah's Place
Cook County Health
Rush Hospital
Simple Laboratories

Current Housing Status



Community Health Apprenticeship Program

27 Apprentices
Enrolled in FY21

81% Certified
As Community Health Navigators

62% Employed
in Healthcare or Social Services after attending CHAP

"Having educational guests talk to us about academia and connecting it to what we are doing [showed] us that **we can go further.**"

- C., Apprentice

Chicago House

Being able to access multiple services in one visit is part of what makes TLC a success for clients

Our TransLife Care program is targeted at serving the needs of the trans community through a Resource Line, TransSafe Drop-In that connects clients with medical, employment, legal, and housing resources, and TransHousing options. This year, TLC was evaluated as part of a CDC research grant. Researchers conducted 14 interviews; their findings are summarized below.

79% of participants endorsed TLC's medical services

36% use all core services: medical, housing, legal, and employment

Clients feel affirmed, important, supported, impressed

"My impression is that it's been something that's been needed for a very long time and I guess the biggest thing is that I finally found access to it."

"It was actually beautiful. They helped me get on hormones right away."

"I was like, hey Sis, literally I need to use the bathroom. Do you have a razor? Before we started our meeting, [a Chicago House staff member] gave me a snack, gave me coffee, and here's a razor. Here's a toothbrush. Go do what you need to do… That felt really affirming."

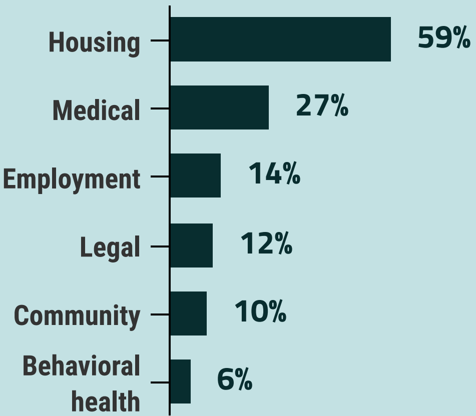
Ideas for new programs:

Navigating dating and relationships	Medical education, health literacy	Building community and connections
Mental health services	Art and music programs	Beauty and spa days

TLC Resource Line

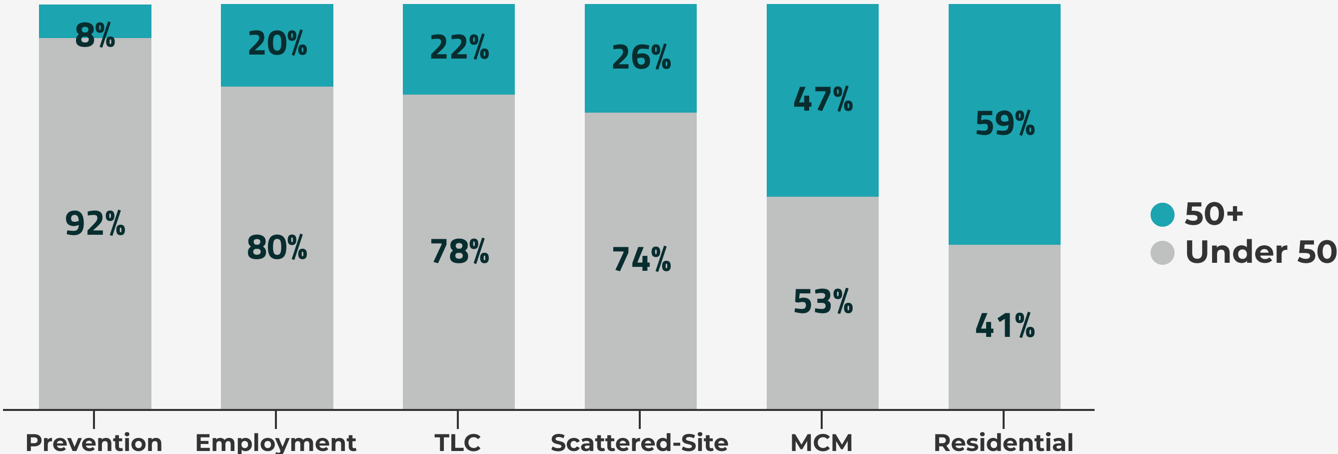
Calls to our TLC Resource Line show that trans clients are in search of housing more than any other resource. We are working on expanding our Scattered-Site program to include more housing options that meet trans clients' needs for safety, community support, and overcoming documentation and legal barriers.

The graph below shows what resources TLC Resource Line callers were looking for during FY2021. On average, each caller was linked to 2 or more resources, at Chicago House or elsewhere.

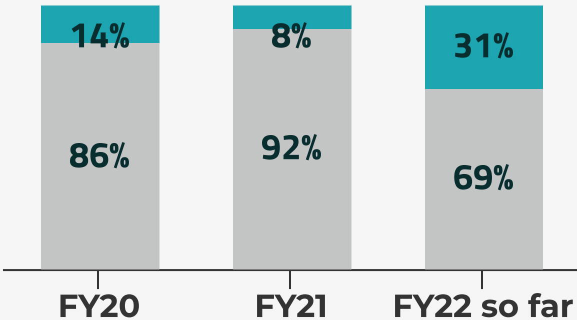


Clients over 50 are the core of our most stable programs, but their needs may be changing

Older clients are concentrated in our Medical Case Management and Housing programs, but make up at least 20% of every department except HOPE-Prevention. In FY2022, we will interview clients in this group about how Chicago House can continue to be their home for care, support, and stability.



Prevention Clients by Age



Chicago House's share of clients over 50 is relatively stable over the last 3 years, between 22-27%, mostly in Residential Housing and Medical Case Management programs. However, these clients may need different services from year to year. 8% is an unusual low for the Prevention department, down from 14% in FY20. **Prevention programs have already served 3 times as many clients over 50 in the first half of FY22 as in all of FY21.**

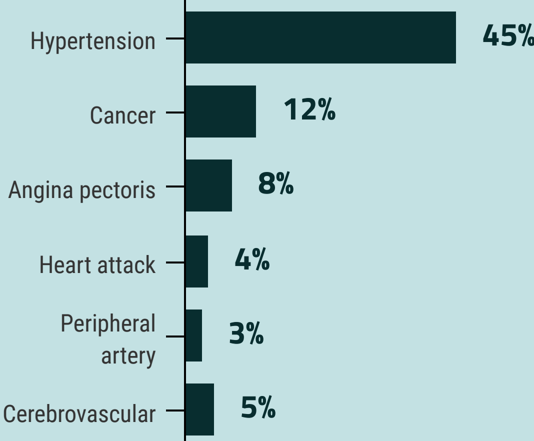
Wrap-around care including medical case management helps Residential clients manage their HIV health well, in addition to any age-related conditions. Further training for our Medical Case Managers, on managing common comorbidities of HIV and multiple medication regimens for chronic conditions would be one way to help clients manage increasingly complex health issues.

Aging with HIV

Getting older can bring with it a host of new medical concerns. People living with HIV into their 50s and beyond face higher rates of inflammation, cardiovascular problems, and cognitive decline than their HIV-negative peers.

As HIV becomes a survivable, chronic condition, it is crucial to educate people living with HIV on how it will impact them as they age.

Age-Related Disease Rates in HIV+ Individuals over 50



Source: AGE-HIV study (2013)