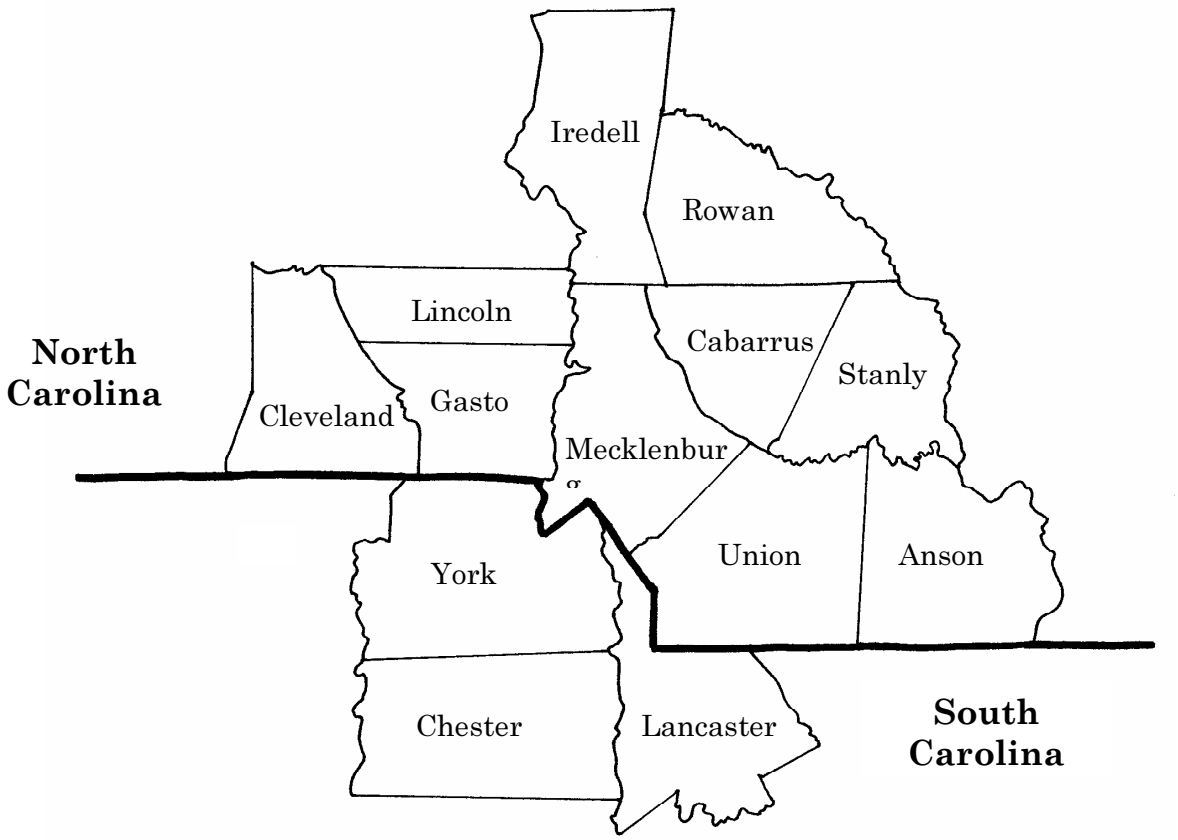
2007 Comprehensive Needs Assessment

Regional HIV/AIDS Consortium
Regional Housing Partnership, LLC



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Executive Summary

This Executive Summary includes an overview of the needs assessment and planning process, key findings, and the recommendations that were developed by the Steering Committee.

This *2007 Comprehensive Needs Assessment* was completed in June 2007 for the Regional HIV/AIDS Consortium Regional Housing Partnership by AIDS Housing of Washington, a national HIV/AIDS housing technical assistance provider based in Seattle. The geographic focus is the 13-county Charlotte NC/SC region (see cover for a map of this jurisdiction). The Needs Assessment was funded by the Regional HIV/AIDS Consortium.

Overview of the Needs Assessment and Planning Process

The HIV/AIDS housing and services needs assessment conducted during Spring 2007 provided an opportunity for approximately 200 community members to meet, discuss, and identify critical issues and strategies for enhancing HIV/AIDS housing and services in the region surrounding the City of Charlotte. Stakeholders from each of the 13 counties participated in the process, taking part in community forums and/or completing surveys.

The needs assessment includes research on demographic patterns, housing and homelessness, economic factors, and post-incarceration issues impacting people living with HIV/AIDS; a summary of the federal Housing Opportunities for Persons with AIDS (HOPWA) program and other regional HIV/AIDS resources, including an inventory of HIV/AIDS dedicated housing; a summary of findings from the surveys and focus groups; and a series of recommendations identified by the Steering Committee that stakeholders must implement to meet the housing and services needs of people living with HIV/AIDS in the Charlotte region.

For greater detail on the findings of each aspect of the research, please see the "Context of HIV/AIDS Housing and Services" and "Community Input Findings" sections of the Needs Assessment.

Critical Issues and Recommendations

The Steering Committee, Regional Consortium staff, and AIDS Housing of Washington (AHW) identified three categories of critical issues that stakeholders must address in order to better meet the needs of people living with HIV and AIDS in the 13 Charlotte region counties. They then crafted five to seven recommendations to address each of the three categories. These critical issues and recommendations are summarized here.

For greater detail on each of these recommendations, please read the "Critical Issues and Strategies" section of the complete Needs Assessment.

Coordination and Advocacy

1. Ensure that accurate and consistent information on availability and eligibility for housing and services programs is available to consumers living with HIV/AIDS and case managers.
2. Encourage active participation in federal Ryan White and HOPWA planning processes.
3. Encourage all HOPWA project sponsors serving homeless individuals to continue or begin to participate in local Consolidated Plan and Continuum of Care planning processes and in the Carolina Homeless Information Network (CHIN).
4. Continue to build relationships with area communities of faith to convene and participate in conferences on HIV issues, including stigmatization.
5. Foster the development of and participation in peer support initiatives.

HIV/AIDS Medical and Support Services

6. Ensure that people living with HIV/AIDS across the region have equal access to medical care and services.
7. Ensure that people living with HIV/AIDS are receiving the support services they need by:
   - Working with other housing and service systems.
   - Ensuring that every person eligible for case management in another system is enrolled in that system.
   - Conducting regular (at least annual) community-wide cross-trainings with staff from other service and housing systems.
   - Enhancing consumer self-advocacy skills through formal training and knowledge-building experiences.
8. Increase employment of people living with HIV/AIDS.
9. Research and develop relationships with potential partner agencies and funders to:
   - Increase transportation assistance availability for people living with HIV/AIDS.
   - Provide financial management training and services to low-income people in the region.
10. Increase access to dental care by people living with HIV/AIDS by building a broader network of dental providers.
11. Promote increased pharmacy assistance for people living with HIV/AIDS.
12. Seek increased access to existing reentry programs for people living with HIV/AIDS.

HIV/AIDS Housing

13. Ensure that the existing continuum of housing options remains available to people living with HIV/AIDS.
14. Seek opportunities to add new housing units to the regional continuum, including permanent supportive housing resources.
15. Seek opportunities to add new housing assistance programs, such as additional rental assistance vouchers and assistance with security deposits, to the regional continuum.
16. Coordinate with Regional Training Institutes and other training series and develop new educational opportunities for housing and services staff..
17. Increase opportunities for homeownership among people living with HIV/AIDS.
18. Research and partner with existing landlord/tenant programs to increase access to rental housing and improve housing stability of people living with HIV/AIDS.
19. Increase access to housing for people living with HIV/AIDS who have criminal histories, are discharged from public institutions such as hospitals, or lack legal documentation by:
    - Supporting the initiation of discharge planning.
    - Promoting flexibility in the eligibility requirements of existing housing assistance programs.
    - Encouraging housing authorities and AIDS service organizations to coordinate "pre-screening."
    - Developing a facility-based transitional housing program to serve people living with HIV/AIDS who are undocumented or have criminal histories.

Section 1:
Needs Assessment Findings

Context of HIV/AIDS Housing and Services in the Charlotte (NC/SC) Metropolitan Area

This section provides an overview of key statistics about the Consortium Region in relation to HIV/AIDS services and housing issues, such as population, HIV/AIDS epidemiology, income, poverty, housing, and homelessness.

Population

The population of the 13-county Consortium Region, approximately 2.08 million in 2005, has increased significantly since the completion of the 1998 regional AIDS housing plan. The *Charlotte Observer* reported in 2006 that "the nine-county Charlotte area grew by 29 percent from 1990 to 2000; only five U.S. metro areas of 1 million or more had a higher rate. The area grew an additional 10 percent from 2000 to 2004."[1] Among states, North Carolina had the ninth-fastest population growth in the country between 1990 and 2000, while South Carolina was 15th. [2]

The largest percentage population gain among counties in the region between 2000 and 2006 was in Union County (NC). It experienced a staggering 42 percent increase in population, to nearly double its 1990 population. In addition, Cabarrus, Iredell, Mecklenburg, and York Counties each grew by almost 20 percent between 2000 and 2006. However, growth in the region was uneven, with seven other counties growing only five percent or less. Chester County (SC) actually lost three and half percent of its population between 2000 and 2006.[3]

As of January 2006, the city of Charlotte's population was 601,598. The city has maintained a consistent ratio of approximately three-quarters of Mecklenburg County's population since 1998.[4]

Table 1 on the following page presents population totals of Consortium Region counties from 1980 through 2006.

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[1] George, Jefferson. *Charlotte's Growth Rampant, Like It or Not*, Charlotte Observer, May 21, 2006. Available online: http://www.realcities.com/mld/charlotte/news/14634778.htm?template=contentModules/printstory.jsp (Accessed: April 4, 2007). The nine surrounding counties are: Cabarrus, Catawba, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly, and Union.

[2] CensusScope.org. *Charlotte-Gastonia-Rockhill NC SC Population Growth*. Available online: http://www.censusscope.org/us/m1520/chart_popl.html (Accessed: April 4, 2007).

[3] U.S. Census Bureau. Available online: http://www.censusscope.org/us/m1520/chart_popl.html and http://quickfacts.census.gov/qfd/states/37000.html (Accessed: April 4, 2007).

[4] Ibid.

Table 1:

Population of Regional HIV/AIDS Consortium Counties and Percent Increase from 2000 to 2006

County	1980	1990	2000	2006	Percent Change 2000-2006
Anson	25,649	23,474	25,275	25,472	0.8%
Cabarrus	85,895	98,935	131,063	156,395	19.3%
Chester	30,148	32,170	34,068	32,875	-3.5%
Cleveland	83,435	84,713	96,287	98,373	2.2%
Gaston	162,568	175,093	190,365	199,397	4.7%
Iredell	82,538	92,935	122,660	146,206	19.2%
Lancaster	53,361	54,516	61,351	63,628	3.7%
Lincoln	42,372	50,319	63,780	71,894	12.7%
Mecklenburg	404,270	511,481	695,454	827,445	19.0%
Rowan	99,186	110,605	130,340	136,254	4.5%
Stanly	48,517	51,765	58,100	59,358	2.2%
Union	70,436	84,210	123,677	175,252	41.7%
York	106,720	131,497	164,614	199,035	20.9%
Total	**1,295,095**	**1,501,713**	**1,897,034**	**2,191,584**	

Sources: U.S. Census Bureau. Available online: http://www.census.gov (Accessed: April 4, 2007).
State of North Carolina Office of State Planning. *State Demographics*. Available online: http://www.ospl.state.nc.us (Accessed: April 4, 2007).
State of South Carolina State Budget and Control Board. *Statistical Abstract*. Available online: http://www.state.sc.us.drss/pop (Accessed: April 4, 2007).
U.S. Census Bureau. *2006 Population Estimates.* Available online: http://factfinder.census.gov/servlet/DTGeoSearchByListServlet?ds_name=PEP_2006_EST&_lang=en&_ts=195753589390 (Accessed: April 27, 2007).

Ethnicity

As of 2005, nearly three-quarters of the federally defined Eligible Metropolitan Service Area (EMSA) residents were White (1,512,683 people), 21 percent were Black/African American (437,167), and seven percent were Hispanic/Latino. Percentages of other minorities are extremely low.[5]

The most recent national census data broken down by county (from 2000) showed the highest percentage of non-White residents in the region in Anson and Mecklenburg

[5] U.S. Census Bureau. *Charlotte-Gastonia-Salisbury, NC-SC Combined Statistical Area 2005*. Available online: http://factfinder.census.gov/servlet/ADPTable?_bm=y&-geo_id=33000US172&-context=adp&-ds_name=ACS_2005_EST_G00_&-tree_id=305&-_lang=en&-_caller=geoselect&-format= (Accessed: April 2, 2007).

Counties in North Carolina and Chester County in South Carolina, with 50 percent, 36 percent, and 40 percent non-White residents respectively.[6]

Table 2 shows race and ethnicity by county for the Charlotte EMSA as of 2000.

Table 2:

Ethnicity of Regional HIV/AIDS Consortium Counties

County	All	White	Percent	Black	Percent	Hispanic	Percent
Anson	25,275	12,519	49.5%	12,295	48.6%	211	0.8%
Cabarrus	131,063	109,127	83.3%	15,961	12.2%	6,620	5.1%
Chester	34,068	20,416	59.9%	13,168	38.7%	255	0.7%
Cleveland	96,287	73,955	76.8%	20,155	20.9%	1,433	1.5%
Gaston	190,365	159,965	84.0%	26,405	13.9%	5,719	3.0%
Iredell	122,660	100,785	82.2%	16,762	13.7%	4,182	3.4%
Lancaster	61,351	43,577	71.0%	16,479	26.9%	978	1.6%
Lincoln	63,780	57,557	90.2%	4,108	6.4%	3,656	5.7%
Mecklenburg	695,454	445,250	64.0%	193,838	27.9%	44,871	6.5%
Rowan	130,340	104,294	80.0%	7,066	5.4%	5,369	4.1%
Stanly	58,100	49,196	84.7%	6,657	11.5%	1,237	2.1%
Union	123,677	102,441	82.8%	15,480	12.5%	7,637	6.2%
York	164,614	127,162	77.2%	31,532	19.2%	3,220	2.0%
Total	**1,897,034**	**1,406,244**		**379,906**		**85,388**	

Sources: US Census Bureau. *North Carolina County Race*. Available online: http://factfinder.census.gov/servlet/GCTTable?_bm=n&_lang=en&mt_name=DEC_2000_PL_U_GCTPL_ST2&format=ST-2&_box_head_nbr=GCT-PL&ds_name=DEC_2000_PL_U&geo_id=04000US37 (Accessed: April 27, 2007).

US Census Bureau. *South Carolina County Race*. Available online: http://factfinder.census.gov/servlet/GCTTable?_bm=n&_lang=en&mt_name=DEC_2000_PL_U_GCTPL_ST2&format=ST-2&_box_head_nbr=GCT-PL&ds_name=DEC_2000_PL_U&geo_id=04000US45 (Accessed: April 27, 2007).

Epidemiology of HIV/AIDS in the Charlotte Metropolitan Area

According to the North Carolina Department of Public Health (DPH), 1,806 new individuals were diagnosed with HIV disease in North Carolina in 2005. In the last five years, the state has averaged approximately 1,700 new reports each year. The Centers for Disease Control and Prevention (CDC) reported 1,140 new HIV cases that had not progressed to AIDS in North Carolina in 2005, which is consistent with DPH's assertion that about one-third of the new HIV disease reports represent persons who were diagnosed with HIV infection

[6] US Census Bureau. *North Carolina by County: Race and Hispanic or Latino.* Available online: http://factfinder.census.gov/servlet/GCTTable?_bm=n&_lang=en&mt_name=DEC_2000_PL_U_GCTPL_ST2&format=ST-2&_box_head_nbr=GCT-PL&ds_name=DEC_2000_PL_U&geo_id=04000US37. (Accessed: May 14, 2007).

and AIDS at the same time.[7] North Carolinians comprised 3.2 percent of the total of 35,537 people diagnosed with HIV (not AIDS) in 2005 across the 38 U.S. states with names-based reporting.[8]

An estimated 29,500 persons were living with HIV or AIDS in North Carolina (including persons who may have been unaware of their infection) as of December 31, 2005.[9] Cumulatively, 28,485 persons were reported with HIV disease in the state through December 31, 2005.

In South Carolina, 8,604 people are currently living with AIDS (not HIV only) in South Carolina. [10] Since 1986, the state has tracked 21,321 cumulative HIV cases (including people with AIDS).[11]

According to CDC statistics, North Carolina and South Carolina were ranked 8th and 15th, respectively, within a list of 38 states for which information was available, in the number of HIV cases reported in 2005.[12] They ranked 5th and 9th among those same states in cumulative cases of HIV.[13]

Also for 2005, the CDC reported that 15.7 of every 100,000 people in South Carolina and 10.9 of every 100,000 in North Carolina had AIDS. Among 38 states reporting, South Carolina had the 9th highest rate, while North Carolina ranked 19th; the overall U.S. rate was 14 of every 100,000 people.[14]

North Carolina reported an overall rate of HIV infection in 2005 of 21.1 people per 100,000, and found dramatic disparities in rates of infection among Black and White people. The rate of HIV infection for Black non-Hispanic people (61.4 per 100,000) was more than seven times greater than for non-Hispanic White people (8.6 per 100,000). Among females, this disparity increased to a rate 12 times higher for Black non-Hispanic females than for white non-Hispanic females.[15]

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[7] North Carolina Department of Public Health. *N.C. Epidemiological Profile for HIV/STD Prevention and Care Planning (8/06).* Available online: http://www.epi.state.nc.us/epi/hiv/epiprofile0806/Chapter_2.pdf (Accessed: May 7, 2007).
[8] Kaiser Network State Health Facts. *HIV/AIDS Surveillance Report: Cases of HIV Infection and AIDS in the United States, 2005, National Center for HIV, STD and TB Prevention, Centers for Disease Control and Prevention, Department of Health and Human Services, 2006*. Available online: http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=HIV%2fAIDS&subcategory=Annual+Reported+HIV+Infections+%28Cases%29&topic=Annual+Reported+HIV+Cases+All+Ages (Accessed: May 11, 2007).
[9] North Carolina Department of Public Health. *N.C. Epidemiological Profile for HIV/STD Prevention and Care Planning (8/06).* Available online: http://www.epi.state.nc.us/epi/hiv/epiprofile0806/Chapter_2.pdf (Accessed: May 7, 2007).
[10] South Carolina Department of Health and Environmental Control. *HIV/AIDS/STD Data June 2006.* Available online: http://www.scdhec.net/health/disease/stdhiv/docs/HIVSTD%20Surveillance%20Report_06302006.pdf (Accessed: May 7, 2007).
[11] Ibid.
[12] Kaiser Network State Health Facts, 2006.
[13] Ibid.
[14] Kaiser Network State Health Facts, 2006.
[15] North Carolina Department of Public Health. *N.C. Epidemiological Profile for HIV/STD Prevention and Care Planning (8/06).*

Table 3 on the following page shows the demographic distribution of HIV and AIDS cases for the Charlotte EMSA specifically, across age, gender, and exposure category as well as by race/ethnicity.

Table 3:

People Living with HIV and AIDS as of December 31, 2006 and New AIDS Cases 2005-2006 in the Charlotte EMSA By Race/Ethnicity, Gender, Age at Diagnosis, and Exposure Category

Demographics	New AIDS Cases (2005-2006)		People Living with AIDS		People Living with HIV		People Living with HIV and AIDS	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Race/Ethnicity								
White, not Hispanic	85	28%	536	28%	839	24%	1,375	25%
Black, not Hispanic	195	64%	1,344	70%	2,506	72%	3,850	71%
Hispanic	23	8%	35	2%	113	4%	148	3%
Asian/Pacific Islander	0	0	6	<1%	14	<1%	20	<1%
American Indian/Alaska Native	0	0	3	<1%	8	<1%	11	<1%
Multi-Race	0	0	0	0	0	0	0	0
Unknown	*	<1%	4	<1%	0	0	4	<1%
Total	**304**	**100%**	**1,928**	**100%**	**3,480**	**100%**	**5,408**	**100%**
Gender								
Male	213	70%	1,474	75%	2,260	65%	3,734	69%
Female	91	30%	484	25%	1,227	35%	1,711	31%
Total	**304**	**100%**	**1,958**	**100%**	**3,487**	**100%**	**5,445**	**100%**
Age	Age at Diagnosis		Current Age		Current Age		Current Age	
Younger than 13	*	<1%	4	<1%	13	<1%	17	<1%
13-19	*	<1%	7	<1%	38	1%	45	1%
20-44	205	67%	1053	54%	2118	61%	3171	58%
45 and older	92	30%	888	45%	1310	38%	2198	40%
Total	**304**	**100%**	**1,952**	**100%**	**3,479**	**100%**	**5,431**	**100%**
Exposure Category								
Men who have Sex with Men (MSM)	89	29%	608	34%	906	26%	1,514	29%
Injection Drug Use (IDU)	17	6%	173	10%	343	10%	516	10%
MSM/IDU	5	2%	9	<1%	94	3%	103	2%
Heterosexuals	69	23%	485	28%	997	29%	1,482	28%
Other/Hemophilia/Blood Transfusion	4	1%	31	2%	31	1%	62	1%
Pediatric – Mother with/at risk for HIV	*	*	9	<1%	30	1%	39	<1%
Risk Not Known/Other	109	36%	495	27%	1,031	30%	1,526	29%
Total	**304**	**100%**	**1,810**	**100%**	**3,432**	**100%**	**5,242**	**100%**

Source: North Carolina Public Health. North Carolina HIV/AIDS 2006 HIV/AIDS Surveillance Report. Available online: http://www.epi.state.nc.us/epi/hiv/pdf/std06rpt.pdf (Accessed: May 7, 2007). Email communication from Terri G. Stephens, South Carolina Department of Health & Environmental Control, to Terry Ellington, RHAC, April 25, 2007.

Notes: * = less than four cases. Values less than 4 are not presented here in order to protect confidentiality; they are included in the

totals. Therefore, totals may not add up to 100 percent. North Carolina data does not qualify races other than White, Black, or Hispanic.

Table 4 shows the distribution of people living with HIV/AIDS across the counties within the EMSA region. Notably, Mecklenburg County is home to nearly two-thirds (65 percent) of EMSA residents living with HIV/AIDS, though the county holds less than 40 percent of total EMSA residents. No other county has a proportion of EMSA residents living with HIV/AIDS that is significantly higher than the percentage of the overall EMSA population it contains.

By contrast, disproportionately small percentages of EMSA residents with HIV/AIDS diagnoses live in Cabarrus, Iredell, Lincoln, and Union Counties.

Table 4:

EMSA and County Total Population (2006) and People Living with HIV/AIDS (as of December 31, 2006), by County and Percent of Population

County	Total Population	Percent of EMSA Total Population	People Living with HIV/AIDS	Percent of EMSA Residents Living with HIV/AIDS
Anson County	25,472	1.2%	72	1.3%
Cabarrus County	156,395	7.1%	159	2.9%
Chester County	32,875	1.5%	63	1.2%
Cleveland County	98,373	4.5%	168	3.1%
Gaston County	199,397	9.1%	420	7.7%
Iredell County	146,206	6.7%	105	1.9%
Lancaster County	63,628	2.9%	125	2.3%
Lincoln County	71,894	3.3%	52	1.0%
Mecklenburg County	827,445	37.8%	3,532	64.9%
Rowan County	136,254	6.2%	218	4.0%
Stanly County	59,358	2.7%	61	1.1%
Union County	175,252	8.0%	115	2.1%
York County	199,035	9.1%	355	6.5%
Total	**2,191,584**	**100.0%**	**5,445**	**100.0%**

Source: US Census Bureau. 2006 Population Estimates. Available online: http://factfinder.census.gov/servlet/DTGeoSearchByListServlet?ds_name=PEP_2006_EST&_lang=en&_ts=195753589390 (Accessed April 27, 2007).

North Carolina Public Health. *North Carolina HIV/AIDS 2006 HIV/AIDS Surveillance Report.* Available online: http://www.epi.state.nc.us/epi/hiv/pdf/std06rpt.pdf (Accessed: May 7, 2007). Email communication from Terri G. Stephens, South Carolina Department of Health & Environmental Control, to Terry Ellington, RHAC, April 25, 2007.

Regional HIV/AIDS Resources

Federal HOPWA Program

In 1992, Congress funded and the U.S. Department of Housing and Urban Development (HUD) implemented the Housing Opportunities for Persons with AIDS (HOPWA) program. This program was established in recognition of the unique impact HIV/AIDS has on housing for persons with HIV/AIDS and their families. The HOPWA program is the only federal program dedicated to the housing needs of people living with HIV/AIDS and their families, and is a cornerstone for the HIV/AIDS housing continuum in most communities throughout the United States.

As HOPWA is a fundamental, yet limited, resource in providing AIDS housing and related services in most communities, sound program management and integration with local planning processes is essential. Other resources must be used to leverage HOPWA funding in order to create sufficient housing opportunities for persons with HIV/AIDS. Such leveraging is a fundamental tenet of the HOPWA program, which requires that its grantees participate and align goals and objectives in community-wide planning processes. The most important of these processes are the Consolidated Plan process and the Continuum of Care application, which span "mainstream" affordable housing and homelessness prevention initiatives funded wholly or partially by HUD.

Nationally, HUD estimates that every HOPWA program dollar is leveraged by more than two dollars of other funding to support people living with HIV/AIDS. For every HOPWA program dollar that is allocated to housing development, more than five dollars of other funding is utilized for HIV/AIDS housing programs.

In 2006, the Charlotte EMSA (specifically the City of Charlotte) received $597,000 in formula funding for Anson, Cabarrus, Gaston, Mecklenburg, and Union Counties in North Carolina, and for York County in South Carolina.[16] In addition, the North Carolina HIV/STD Prevention and Care Branch allocated $111,059 of state HOPWA funds to the Regional HIV/AIDS Consortium (RHAC) to provide services in Cleveland, Iredell, Lincoln, Rowan, and Stanly Counties. The Federal HOPWA program also awarded RHAC a three-year competitive Special Project of National Significance (SPNS) grant of $396,757 annually for Anson, Cabarrus, Cleveland, Lincoln, Rowan, Stanly and Union Counties, for a total of $1.1 million in all 2006 HOPWA funding for the Charlotte EMSA.

[16] U.S. Department of Housing and Urban Development, *HOPWA Grantee Information.* Available online: http://www.hud.gov/offices/cpd/aidshousing/local/nc/charlotte/ (Accessed: May 14, 2007).

Table 5 shows the 2006 HOPWA funding for services in the Charlotte EMSA.

Table 5:

2006 HOPWA Funding for Services in Charlotte EMSA

Year	Charlotte EMSA Award	RHAC Funding from North Carolina State HOPWA Award	SPNS Competitive Award
2004	$571,000	$51,680	——
2005	$565,000	$72,317	——
2006	$597,000	$111,059	$396,757*

Source: U.S. Department of Housing and Urban Development, *HOPWA Grantee Information.* Available online: http://www.hud.gov/offices/cpd/aidshousing/local/.

* 3-year grant, eligible for renewal in 2008.

Tables 6-8 show the distribution of HOPWA funding by type of assistance.

Table 6:

Charlotte EMSA HOPWA Formula Funding, by Type of Assistance (2006)

Type of Assistance	Agencies Funded	Funding
Short-Term Mortgage, Rent, and Utility (STRMU) Assistance	$93,150	15.6%
Supportive Services (Residential Substance Abuse Treatment)	$115,000	19.3%
Supportive Services (Housing Information Services)*	$23,000	3.9%
Supportive Services (Permanent Placement)**	$8,000	1.3%
Operating Expenses and Supportive Services***	$173,060	28.9%
Small Rehabilitation Projects	$1,000	0.2%
Tenant-Based Rental Assistance	$62,000	10.4%
Resource Identification	$80,000	13.4%
Staffing (Administration)	$41,790	7.0%
Total	**$597,000**	**100%**

Source: Regional HIV/AIDS Consortium, email communication, April 24, 2007.

*Client consultation with case manager

** Security deposits

*** Supportive services may include: health, mental health, assessment, permanent housing placement, drug and alcohol abuse treatment and counseling.

Table 7:

HOPWA Funding Awarded to the Regional HIV/AIDS Consortium from the North Carolina HIV/STD Prevention and Care Branch Funding by Type of Assistance (2006)

Type of Assistance	Agencies Funded	Funding
Short-Term Mortgage, Rent, and Utility (STRMU) Assistance	$62,500	56.2%
Supportive Services (Housing Information Services)	$20,392	18.4%
Resource Identification	$20,392	18.4%
Staffing (Administration)	$7,774.13	7%
Total	**$111,059**	**100%**

Source: Regional HIV/AIDS Consortium, email communication, April 24, 2007.

Table 8:

HOPWA Competitive Special Project of National Significance (SPNS) Grant Awarded to the Regional HIV/AIDS Consortium Funding by Type of Assistance (2006)

Type of Assistance	Agencies Funded	Funding
Tenant-Based Rental Assistance	$217,815	54.9%
Supportive Services (Housing Information Services)	$97,696	24.6%
Supportive Services (Residential Substance Abuse Treatment)	$62,493	15.7%
Supportive Services (Permanent Placement)	$7,200	1.8%
Staffing (Administration)	$11,553	3.0%
Total	**$396,757**	**100%**

Source: Regional HIV/AIDS Consortium, email communication, April 24, 2007.

Ryan White Treatment Modernization Act Programs

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 is federal legislation that replaces the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act in addressing the unmet health needs of persons living with HIV disease by funding primary health care and support services. In fiscal year 2006, Congress appropriated $2.06 billion,[17] down from $2.1 billion in 2005, for use under the CARE Act, which serves more than 500,000 people each year.[18] The Treatment Modernization Act is administered by the HIV/AIDS Bureau (HAB) of the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services.

The Treatment Modernization Act is split into titles with different focuses and eligibility criteria. Although the Act allows some flexibility in how grantees choose to allocate their resources, in 2005, HRSA outlined categories of core services to be prioritized by all Part A/Title I and Part B/Title II grantees. These core services are listed in the table below. The Treatment Modernization Act (the reauthorization of the CARE Act) requires that that Part A/Title I, Part B/Title II, and Part C/Title III grantees spend 75 percent of their funding in designated core medical services.[19]

2007 Ryan White Program Changes

In 2006, the Health Resources Services Administration (HRSA) designated the six-county Charlotte area (Anson, Cabarrus, Gaston, Mecklenburg, Union and York (S.C.) as a Transitional Grant Area (TGA). HRSA has awarded Ryan White Part A funding to the six-county TGA to augment the health care systems currently bearing the burden of HIV-related care. The Mecklenburg County Health Department will be administering the funds because Mecklenburg County has the highest number of HIV cases in the six-county area.. The amount of the initial grant is $2.85 million.

In order to maintain needed services for clients during the transition period from funding through Title II to the new Part A funding, the North Carolina Health Department AIDS Care Branch, The Mecklenburg County Health Department and the Regional HIV/AIDS Consortium agreed to a plan that will fund those agencies currently receiving Title II through February 29, 2008.

Table 9 below shows the reauthorized Ryan White core services.

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[17] U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau, *CARE Act Administration Fact Sheet.* Available online: http://hab.hrsa.gov/programs/Administration/index.htm (Accessed: March 2, 2007).

[18] U.S. Department of Health and Human Services, Health Resources and Services Administration*, Ryan White Comprehensive AIDS Resources Emergency (CARE) Act Appropriations History: FY 1991 to FY 2005*. Available online: ftp://ftp.hrsa.gov/hab/fundinghis04.xls (Accessed: May 31, 2005).

[19] U.S. Office of National AIDS Policy, *Fact Sheet: The Ryan White HIV/AIDS Treatment Modernization Act of 2006.* Available online: http://www.whitehouse.gov/news/releases/2006/12/20061219-4.html (Accessed: March 2, 2007).

Table 9:
Reauthorized Ryan White Treatment Modernization Act Core Services

Ambulatory Outpatient Medical Care	Medical Nutrition Therapy
AIDS Drug Assistance Program (ADAP)	Hospice Services
Pharmaceutical Assistance	Home and Community Based Health Services
Oral Health Care	Mental Health Services
Early Intervention Services	Substance Abuse Services
Health Insurance Premium	Medical Case Management
Home Health Care	

Source: Ryan White HIV/AIDS Treatment Modernization Act, U.S. Department of Health and Human Services Health Resources and Services Administration. Available online: http://hab.hrsa.gov/treatmentmodernization/ (Accessed: April 16, 2007).

The Regional HIV/AIDS Consortium received $2,335,194 in CARE Act funding between 2002 and 2006. ***Table 10*** illustrates how this funding was allocated among different service categories, while ***Table 11*** shows the distribution of awards among service providers.

Table 10:
Ryan White CARE Act Funding Allocation for Charlotte EMA, by Service Category (2002-2006)

Service Category	FY2002-2004 Funding	Percent	FY 2005 Funding	Percent
Face-to-face case management	$910,116	53%	$366,982	59%
Treatment adherence counseling	$240,549	14%	$82,144	13%
Food bank / home-delivered meals	$160,497	9%	$36,757	6%
Ambulatory / outpatient medical care	$70,048	4%	$79,331	13%
Mental health services	$70,961	4%	$14,213	2%
Client advocacy	$51,609	3%	$13,806	2%
Oral health	$49,343	3%	$10,457	2%
Transportation	$36,753	2%	$11,693	2%
Child care services	$26,045	2%	—	<1%
Emergency financial assistance	$20,574	1%	—	<1%
Legal services	$14,612	1%	$5,668	1%
Health education / risk reduction / prevention	$20,191	1%	—	<1%
Permanency planning	$16,580	1%	$210	<1%
Psychosocial support	$12,258	1%	—	<1%
Home health care (professional care)	$7,061	<1%	—	<1%
Home health care (para-professional care)	$4,247	<1%	—	<1%
Nutritional services	$84	<1%	$1,062	<1%
Substance abuse services (outpatient)	$577	<1%	—	<1%
Adult day or respite care	$418	<1%	—	<1%
Other support services	$208	<1%	$136	<1%
Referral: health care / supportive	$6	<1%	—	<1%
Total	**$1,712,731**	**100%**	**$622,464**	**100%**

Source: Regional HIV/AIDS Consortium, fax communication, April 18, 2007.

Table 11:
FY 2006 Ryan White Funding for Charlotte EMSA

Agency	Title II Grant Awards	Emerging Communities Grant Awards
Anson County Health Department	$12,250	—
Cabarrus Health Alliance	$9,500	$2,000
Cooperative Christian Ministry-Cabarrus	—	$6,000
Catawba Care Coalition	—	$108,549
Cleveland County Health Department	$28,000	—
C. W. Williams Health Center	—	$79,150
Friendship Trays	$20,000	$25,000
Gaston County Health Department	$8,500	—
Gaston Family Health Services	—	$8,550
GORE Community Development Corporation	—	$45,000
Hospice of Union County	$1,000	—
Jemsek CHARM Project	$64,600	$7,500
Legal Services of Southern Piedmont	$7,000	—
Living Waters Community Development	$27,000	$16,000
Mecklenburg County Health Department	$70,000	—
Metrolina AIDS Project	$32,526	$100,001
Rowan County AIDS Task Force	$5,250	—
Rowan Regional Home Health & Hospice	$42,808	$31,250
Stanly Community Christian Ministry	$3,500	—
Stanly County Health Department	$13,526	—
Total	**$345,460**	**$429,000**

Source: Regional HIV/AIDS Consortium, email communication, April 18, 2007.

Income, Affordability, and Post-Incarceration Issues

Income and Poverty

The median household income for the Charlotte EMSA ($44,402) was slightly below the national median of $46,242 in 2005. ***Table 12*** provides information on median household

income and the proportion of families in poverty in all counties of the EMSA, as well as (for comparison) the statewide figures for North and South Carolina.

Table 12:
Income and Poverty in the Charlotte EMSA (2005)

State and County	Median Household Income in Dollars, 2005*	Below EMSA Median	Percent of Families Living in Poverty
EMSA	44,402	—	11.9
North Carolina	40,729	X	15.1
Anson County	29,849	X	17.8
Cabarrus County	49,997		9.6
Cleveland County	34,628	X	18.5
Gaston County	35,247	X	13.2
Iredell County	44,200	X	13.3
Lincoln County	45,001		14.9
Mecklenburg County	50,215		11.3
Rowan County	39,676	X	16.1
Stanly County	36,898	X	10.7
Union County	50,072		12.2
South Carolina	39,316	X	15.6
Chester County	32,425	X	15.3
Lancaster County	34,688	X	12.8
York County	46,680		12.6

Sources: U.S. Census Bureau. American Community Survey 2005.
*Note: ACS data was not available for Anson, Chester, Lancaster, and Stanly counties; 2000 national census data was used.

The poverty rate varies throughout the Consortium Region from 9.6 percent of residents living in Cabarrus County to 18.5 percent in Cleveland County. The national poverty rate, which has risen every year since 2000, was 12.7 percent in 2004.[20]

Median household incomes in the counties served by the Consortium ranged from $29,489 in Anson County (2000 data) to $50,215 in Mecklenburg County.[21] However, racial disparities were significant. White households had incomes that were two-thirds higher than Blacks and 40 percent higher than Hispanics in 2005, paralleling the national trend.[22] The median White household income for the Charlotte-Gastonia-Salisbury area was

[20] The University of Michigan National Poverty Center. *Poverty in the United States.* Available online: http://www.npc.umich.edu/poverty/ (Accessed: May 7, 2007).
[21] US Census Bureau. *1990 Census Estimates: North Carolina and South Carolina*, Available online: http://www.census.gov/population/cencounts/nc190090.txt and http://www.census.gov/population/cencounts/sc190090.txt (Accessed: April 4, 2007).
[22] Charlotte Observer, November 14, 2006. "Racial gaps in income persist," Link no longer accessible.

$50,253 in the last quarter of 2006, compared with the median Black household income of $29,764. The area's median Hispanic household income was $34,552.[23]

The percentage of people living in poverty among all races in the EMSA (approximately 13 percent) is comparable to the national average; it is higher for non-Whites. Though the median household income for people of Hispanic origin is higher than that of Blacks, they are worse off in the percentage of households living in poverty.

Table 13 presents poverty status and median income by race.

Table 13:

Median Household Income and Poverty Rate by Race/Ethnicity in Charlotte EMSA* (2005)

Race	Median Household Income (2005)	Population Living in Poverty	Percent in Poverty
White (not Hispanic)	$50,253	119,299	8%
Black / African American	$29,764	100,298	23%
Hispanic	$34,552	36,670	27%
Asian	N/A	6,744	16%
Some other race	N/A	17,453	33%
EMSA Total	**$44,402**	**269,103**	**13%**

Source: US Census Bureau. *2005 American Community Survey*. Available online: http://factfinder.census.gov/servlet/STTable?_bm=y&-context=st&-qr_name=ACS_2005_EST_G00_S1701&-ds_name=ACS_2005_EST_G00_&-CONTEXT=st&-tree_id=305&-redoLog=false&-geo_id=33000US172&-format=&-_lang=en (Accessed: April 2, 2007).

People living with HIV/AIDS often experience fluctuations in their health, which directly affect their ability to work and earn an income. As a result, they may be expected to have lower median household incomes and higher rates of poverty as a group than the general population.

Cost of Living

When people lack income to meet all of their needs, they are forced to choose between critical necessities such as food, housing, and health care. Therefore, other important indicators of economic health or struggle in the region include the number of families receiving food stamps; the number of people lacking health insurance; and the percentage of income that people spend on transportation.

The number of food stamp recipient households in the Charlotte-Gastonia-Salisbury area was 65,883 in 2005, or eight percent of 822,150 total households. This number is consistent with the national average (in 2005) of eight percent of the US population

[23] Ibid.

receiving food stamps monthly.[24] Among households receiving food stamps, 66.7 percent were families with children under the age of 18, and 47.9 percent included one or more people with a disability.[25]

Also in 2005, North Carolina and South Carolina ranked 18th and 19th, respectively, among all states in the percentage of people without health insurance coverage, thanks to a rise in recent years in South Carolina's rate of coverage. The overall US rate of coverage (15.7 percent uninsured) falls directly between the rates in the two states (16.2 percent NC, and 15.6 percent SC).[26]

Post Incarceration Issues

Over the past two decades, prison populations have grown exponentially nationwide; in 2005 nearly 2.2 million people were incarcerated in the United States, and there are almost seven million people either or probation, parole, or in prison or jail. [27]

Approximately 475 individuals per week are released from corrections facilities to Mecklenburg County, most from jail.[28] In the year ending February 28, 2007, a total of 901 prisoners who were convicted in Mecklenburg County were released. There were 3,506 people released from all types of incarceration, including those coming off parole or probation who had been convicted in Mecklenburg County.[29] ***Table 14*** table shows the number of prison releases in that year, by race, to three counties in the region receiving high proportions of returning offenders.

Table 14:
DOC Releases, by Race, to Counties in the Charlotte EMSA
From March 1, 2006 to February 28, 2007

Race category	Mecklenburg	Gaston	Cabarrus
White	165	308	250
Black	673	199	201
Other	52	12	20

[24] United States Department of Agriculture. *Participation in Food Stamps Program Varies by State.* Available online: http://www.ers.usda.gov/AmberWaves/May07SpecialIssue/Indicators/food_onthemap.htm (Accessed: May 14, 2007)
[25] American FactFinder. *Food Stamps, 2005 American Community Survey*. Available online: http://factfinder.census.gov/servlet/STTable?_bm=y&-context=st&-qr_name=ACS_2005_EST_G00_S2201&-ds_name=ACS_2005_EST_G00_&-CONTEXT=st&-tree_id=305&-redoLog=true&-_caller=geoselect&-geo_id=33000US172&-format=&-_lang=en (Accessed: April 4, 2007).
[26] U.S. Census Bureau. *Income, Poverty, and Health Insurance Coverage in the United States: 2005*. Available online: www.census.gov/prod/2006pubs/p60-231.pdf (Accessed: April 4, 2007).
[27] Pew Charitable Trust. *State and Federal Prison Population.* Available online: http://www.pewpublicsafety.org/statistics/prisoner_population.aspx (Accessed: May 15, 2007).
[28] Eric Ortega, Energy Committed to Ex-Offenders (Charlotte), phone communication, May 11, 2007.
[29] North Carolina Department of Justice Custom Corrections Statistics. Available online: http://www.doc.state.nc.us/offenders/ (Accessed: May 11, 2007).

Total for these races	**880**	**509**	**471**

Source: North Carolina Department of Justice Custom Corrections Statistics. Available online: http://www.doc.state.nc.us/offenders/ (Accessed: May 11, 2007).

Minorities are highly disproportionately represented in the criminal justice system, as well as disproportionately affected by HIV/AIDS.[30] The overlap between these populations is very significant, suggesting the need for culturally competent services that take both sets of challenges into account. In North Carolina in 2004, Blacks made up more than 70 percent of all people living with HIV and AIDS, and about 60 percent of the state's 35,000 prisoners.[31] Research from the University of North Carolina found strong correlation at a county level between the rates of incarceration and HIV/STD infection.[32]

Many returning offenders have serious health problems, including HIV/AIDS, and few resources with which to address these issues; they face, and pose, a variety of risks from and to the cities and counties that receive them.

Between 2003 and 2004, the number of HIV-positive inmates in state and federal prisons fell from 23,663 to 23,046. The number of HIV-positive state and federal prisoners has fallen each year since 1999, when the number stood at 25,807.[33]

Prisoner reentry issues are gaining more attention; however, there are still few resources available to people in or being released from prison and jail. The North Carolina Department of Corrections contracted with the University of North Carolina (UNC) to operate weekday medical clinics in three of the state's 77 prisons.[34] In addition, UNC initiated the Bridges to Good Health and Treatment (BRIGHT) program, which employs three "transition facilitators" to assist offenders with HIV disease who are returning to three regions of the state, to test the effectiveness of a particular case management model. Following the close of a four-year study, UNC has found grant funding to continue the BRIGHT program for 2007; however, each full-time transition facilitator can only provide pre- and post-release case management for about 12 offenders at a time.[35] The standard provision for North Carolina prisoners with HIV approaching release is counseling, a 30-day supply of medications, a prescription for 30 more days, and contact information for health service organizations.[36]

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[30] For example, although black people represent 12% of the U.S. population, an estimated 43% of all persons living with AIDS in the United States are black (CDC. *HIV/AIDS surveillance report,* 2004. Vol. 16. Atlanta, GA: US Department of Health and Human Services, CDC; 2005. Available online: http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2004report/commentary.htm (Accessed: April 19, 2007).

[31] Clemetson, Lynette. "Links Between Prison and AIDS Affecting Blacks Inside and Out," New York Times, August 6, 2004. Available online: http://query.nytimes.com/gst/fullpage.html?sec=health&res=9E00E5DA123CF935A3575BC0A9629C8B63 (Accessed: May 7, 2007).

[32] Ibid.

[33] Bureau of Justice Statistics. *HIV in Prisons, 2004.* Available online: http://www.ojp.usdoj.gov/bjs/pub/press/hivmpjpr.htm (Accessed: May 15, 2007).

[34] Ibid.

[35] Allen, Bertha. University of North Carolina Medical Center, phone communication, May 11, 2007.

[36] Clemetson, 2004.

Employers, landlords, subsidized housing providers, housing authorities, and even supportive housing programs often screen out people with criminal histories. Formerly incarcerated people may also be ineligible for public assistance and other mainstream resources and opportunities. Without employment or a place to live, successful reentry into the community is very difficult.[37]

Housing and Homelessness

Housing Units

According to the American Housing Survey of 2002, the Charlotte EMSA has a total of 667,800 housing units, of which 424,200 (or 63.5 percent) were owner-occupied and 169,500 (or 25 percent) were renter-occupied. The median age of housing was 27 years, and 89 percent of housing units were occupied.[38]

Housing Affordability

Rents and home prices have risen quickly and consistently in recent years in Charlotte, where home sales grew by 14 percent from June of 2005 to June of 2006. This increase is greater than in other regions of the country, perhaps due to population increases reported above. Charlotte's active market reflects a larger statewide trend: across North Carolina, real estate sales were up 10 percent the first five months of 2006, compared with the same period in 2005. National sales were down six percent in that time. [39]

According to the 2000 U.S. census, Charlotte has a relatively low homeownership rate (57.5 percent) relative to both North Carolina (69.4 percent) and the rest of the nation (66.2 percent). The median value of homes in Charlotte was $134,300 that year, exceeding the median home values in North Carolina by 24 percent and the nation by 12.3 percent and likely making homeownership unaffordable to many EMSA residents.[40]

In March 2007, the average rent in Charlotte was $712 a month and the vacancy rate was 7.3 percent.[41] The national vacancy rate for first-quarter 2007 was 10.1 percent for rental housing and 2.8 percent for homeowner housing.[42] The Fair Market Rent (set by the U.S. Department of Housing and Urban Development, or HUD, to define the maximum

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[37] AIDS Housing of Washington, *HIV/AIDS, Incarceration, and Housing*, 2003. Available online: http://www.aidshousing.org/usr_doc/Incarceration_Factsheet_2003.pdf (Accessed: January 25, 2007).
[38] U.S. Department of Housing and Urban Development. *American Housing Survey for the Charlotte Metropolitan Area: 2002.* Available online: http://www.census.gov/prod/2003pubs/h170-02-63.pdf (Accessed: May 14, 2007).
[39] USA Today. *Close to Home: Charlotte and North Carolina sales stay strong*. Available online: http://www.usatoday.com/money/economy/housing/2006-07-17-close-charlotte_x.htm (Accessed: April 2, 2007).
[40] Nextag.com. *Charlotte N.C. Benefits from a Booming Housing Market.* Available online http://www.nextag.com/home-mortgage/0/Charlotte-N.C.-Benefits-from-a-Booming-Housing-Market.html (Accessed: May 15, 2007).
[41] AptIndex.com. *Apartment Real Estate.* Available online: http://www.aptindex.com (Accessed: May 15, 2007).
[42] United States Department of Commerce News. *Census Bureau Reports Residential Vacancies and Homeownership.* Available online: http://www.census.gov/hhes/www/housing/hvs/qtr107/q107press.pdf (Accessed: May 15, 2007).

allowable rent for HUD-funded subsidy programs) for a two-bedroom apartment in the Charlotte-Gastonia-Concord area was $707 in 2007.[43]

According to HUD guidelines, households which spend more than 30 percent of their income on housing-related expenses have a "housing cost burden." Households which spend more than 50 percent of their income on housing expenses have a "severe housing cost burden" and are at risk of homelessness. According to 2006 data from the National Low Income Housing Coalition, in order to avoid a housing cost burden in the Charlotte-Gastonia-Concord metropolitan area, "a household must earn $2357 monthly or $28,280 annually." In other words, a full-time employee working 52 weeks a year must earn $13.60 per hour to afford rental housing.

[43] HUD User. *Final Fair Market Rents 2007.* Available online: http://www.huduser.org/datasets/fmr/fmr2007f/FY2007F_SCHEDULEB_rev2.pdf (Accessed: May 15, 2007).

Table 15 shows the percentage of renter households in the EMSA, North Carolina, and South Carolina; Fair Market Rents for two-bedroom apartments in those jurisdictions; and the percentage of renters that cannot afford those rents.

Table 15:
2006 Renter Housing Cost Burdens in Charlotte Region

Geographic Area	2007 Fair Market Rent for a 2-Bedroom Unit	Percent of Households That Rent	Percent of Renters Unable to Afford Fair Market Rent for a 2-Bedroom Unit
Charlotte-Gastonia-Concord	$707	33%	39%
North Carolina	$656	31%	43%
South Carolina	$615	28%	43%

Source: National Low Income Housing Coalition. *Out of Reach Data.* Available online: http://www.nlihc.org/oor/oor2006/?CFID=11959835&CFTOKEN=33930337 (Accessed: April 2, 2007).

The figures in the table above corroborate data from the U.S. Census Bureau's 2003 American Community Survey, which indicated that 43 percent of renters in Mecklenburg County faced housing cost burdens.[44]

Because many people living with HIV/AIDS rely on Social Security (SSI) as their sole source of income, it is often a good indicator to use when determining whether or not people living with HIV disease can afford the housing in their area. In 2003, 18 percent of Charlotte area households received SSI, with the average income being $14,521 annually.[45] The Technical Assistance Collaborative publishes a bi-annual survey of rents in comparison to SSI income. They found that a person receiving SSI in North Carolina pays 95.1 percent of their monthly income towards the rent of a one-bedroom unit. In South Carolina, a person pays 89.6 percent of their monthly income. In the Charlotte-Gastonia-Concord area that number is 105.6 percent of the monthly SSI payment for a one-bedroom.[46]

According to the draft Charlotte-Mecklenburg Consolidated Plan for 2006-2010, more than half of Mecklenburg County households were priority needs households (that is, their income was 80 percent of area median income or less). Nearly two-thirds of priority needs renter households were low-income (making 50 percent of AMI or less), and half of

[44] American Community Survey Profile. *Population and Housing Profile: Charlotte City, Mecklenburg County NC.* Available online: http://www.census.gov/acs/www/Products/Profiles/Single/2003/ACS/Narrative/155/NP15500US3712000119.htm (Accessed: May 15, 2007).
[45] Ibid.
[46] Technical Assistance Collaborative. *Priced Out in 2006.* Available online: http://www.tacinc.org/Docs/HH/PricedOutIn2006.pdf (Accessed: May 7, 2007).

those were extremely low-income (30 percent or less of AMI).[47]

Among priority needs homeowner households, more than one in five were extremely low income. Among both owners and renters (non-homeless households), there were 28,028 special needs households, comprising 18 percent of all priority needs housing.[48]

The Consolidated Plan projected that the total number of priority needs households would grow by approximately 13 percent (23,549 households) by 2010, to comprise 52 percent of total households in Mecklenburg County.[49]

Homelessness Profile

The Mecklenburg Council on Homelessness states that there are over 5,000 homeless people each night living in the Charlotte–Mecklenburg area, and that half of the adult homeless population is employed.[50]

The Charlotte-Mecklenburg Ten Year Plan to End and Prevent Homelessness calls for creating 2,500 supportive and service-enriched housing units over the next ten years: 500 supportive units for chronically homeless men and women, and 2,000 service-enriched units for families and individuals.[51]

Public Housing Authorities and the Housing Choice Voucher (Section 8) Program

There are at least fifteen housing authorities operating in the Consortium Region, listed in ***Table 16***. Waiting lists for public and assisted housing can be long. Affordable housing is at a premium throughout the Region.

[47] City of Charlotte and Charlotte-Mecklenburg Consortium Five-Year Consolidated Plan (2006-2010) draft. Available online: http://www.charmeck.org/NR/rdonlyres/e2eattc4cktqp3qstnvn4b36gebi5yy2nn2qg6rfhrdj2frecd7ez47tihwrnw5pjyyuds6p4qqdnjrf5q4atjmyyuc/FY20062010ConPlan51305Draft.pdf. (Accessed: May 14, 2007).
[48] Ibid.
[49] Ibid.
[50] Mecklenburg Council on Homelessness. *More than Shelter: Charlotte-Mecklenburg's Ten Year Implementation Plan to End and Prevent Homelessness.* Available online: http://www.awayhome.org/MoreThanShelterExecSum.pdf (Accessed: May 14, 2007).
[51] Ibid.

Table 16:
Public Housing Authorities in the Charlotte EMSA

North Carolina	South Carolina
Monroe	Rock Hill
Salisbury	York County
Rowan County	Chester
Shelby	
East Spencer (Rowan County)	
Statesville	
Wadesboro	
Albemarle	
Belmont	
Charlotte	
Concord	
Gastonia	

Source: 1999 Regional HIV/AIDS Consortium Housing Plan, Appendix 1.

In 2003, the North Carolina Housing Coalition commissioned a report on Voucher Utilization among Housing Choice Voucher Programs in North Carolina.[52] The report surveyed 10 randomly selected North Carolina voucher programs, including four in the Charlotte region: the Statesville Housing Authority, Monroe Housing Authority, City of Albemarle Department of Public Housing, and the City of Charlotte Housing Authority. The surveyed programs issued an average of 1,261 regular allocation vouchers during the fiscal year prior to the report. Voucher amounts issued ranged from 310 to 4,039 vouchers per program.[53]

The report succinctly describes common issues related to long waiting lists among the programs:

> Administratively, the waiting list averages 1,080 families, though it ranges from 255 to 2,400 families (1 program not responding). Six of the programs stated that their waiting lists are currently open, though two stated that they are intending to close their list. Four currently have closed lists – mainly because the length of time on the waiting list is exceeding a program-designated standard, typically two years. For instance, Charlotte reports having approximately enough families on its waiting list for the next five years. When making selections from the

[52] Fogelman, Chad and Justin Powell. *Voucher Utilization among Housing Choice Voucher Programs in North Carolina* (2003). Available online: http://www.nchousing.org/housing_issues_nc/section_8 (Accessed: May 14, 2007).
[53] Ibid.

> waiting list, five programs do not use preferences allowed by HUD. Those who do use the preferences report that they most commonly use preferences for displaced homeless, the elderly, handicapped, working families, and for families displaced by natural disasters.
>
> Length of time on the waiting list varies significantly between programs. On average, families wait 17.4 months before being selected for a voucher, though this period can vary from 2 months to 39 months.[54]

The report further states that "once selected from a waitlist, families are given 120 days to secure housing … The turn-back rate (the number of vouchers returned unused after 120 days) was approximately 28.1%," (though it varied widely across the ten programs) due to families being unable to find housing within the allotted time frame.[55]

The Charlotte Housing Authority (CHA) operates over 5,000 units of senior/disabled, mixed income, and family congregate and scattered-site housing. Many of these projects were rehabilitated using a mixture of HUD HOPE VI, state, and other federal funds.56 CHA opened its Housing Choice Voucher (Section 8) waiting list in the form of a lottery between April 2 and 13, 2007, with the expectation of receiving far more applications than vouchers available. The waitlist is now closed again.

There are 2,161 assisted units in York County, SC.[57] There are 438 units of assisted housing in Chester County (SC), of which 274 exist through United States Department of Agriculture Rural Development funds.[58] Lancaster County SC has 757 units of assisted housing, of which 352 exist through US Department of Agriculture (USDA) Rural Development funds.[59]

HIV/AIDS Housing Inventory

The lack of affordable and appropriate housing for persons living with HIV/AIDS and their families is an ongoing concern for AIDS services and housing providers, policy makers, and advocates across the country. Many people living with HIV/AIDS, at some point during their illness, find themselves in need of housing assistance and support services. Stable housing promotes improved health, sobriety or decreased use of alcohol and illegal drugs, and, for some people living with AIDS, a return to paid employment and productive social activities.

There are a total of 96 housing units, hospice beds, and housing vouchers dedicated to people living with HIV/AIDS in the thirteen-county region served by the Regional HIV/AIDS Consortium, an increase of 45 percent over the 2002 level of 66 units.

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[54] Ibid.
[55] Ibid.
[56] Charlotte Housing Authority. Available online: http://www.cha-nc.org/living/low_income.asp (Accessed: May 7, 2007).
[57] SC State Housing Authority. *Rental Results.* Available online: http://www.sha.state.sc.us/rentalinventory/inventory.asp (Accessed: May 7, 2007).
[58] Ibid.
[59] Ibid.

Table 17 on the following page provides an updated inventory of housing units or vouchers dedicated to people living with HIV/AIDS, organized by type of housing assistance.

Table 17:
HIV/AIDS-Dedicated Housing Programs in the Charlotte EMSA

Program	Number of Units / Vouchers	Type of Housing	HOPWA Funding?
Fort Mill Housing	4	Rental units (two duplexes)	X
The Havens	24	Rental units in HUD 811 Program apartment complex	X
House of Mercy	6	End-of-life care facility	X
Hospice of Union County	3	Hospice	X
McLeod Addictive Disease Center	10	Inpatient substance use treatment	X
Hope Haven, Inc	17	Substance use aftercare recovery program	X
HOPWA-MSA TBRA	12	Tenant-based rental vouchers	X
HOPWA SPNS TBRA	17	Tenant-based rental vouchers for rural counties	X
J. Marion Sims TBRA Voucher	3	Tenant-based rental vouchers	
Total	**96**		

Source: Regional HIV/AIDS Consortium, email communication, May 4, 2007.

Community Input Findings

This section provides a summary of input from key stakeholders. Three opportunities for input were provided: community forums, online provider surveys, and a survey of consumers. Findings from these forums and surveys are summarized here. A complete set of consumer survey results is included as an appendix to this report.

Community Forum Findings

The Regional Consortium invited participants from each county in the EMSA to attend community forums during February and March 2007 to discuss past, current, and future housing and support services assistance needs and experiences. A total of 60 people from all of the Regional Consortium's 13 counties participated in four consumer community forums, held in Charlotte, Gastonia, Rock Hill (SC), and Kannapolis.

All of the forums except the one in South Carolina (Chester, Lancaster, and York Counties) included people living with HIV/AIDS, service providers, and representatives from governmental organizations. The South Carolina meeting included service providers only. ***Table 18*** shows the community meetings in Charlotte, by location and number of participants.

Table 18:
Community Meetings in Charlotte EMSA

Location	**Charlotte**	**Gastonia**	**Rock Hill (SC)**	**Kannapolis**
Number of Participants	31	13	4	12
Participating Counties	Anson Union Mecklenburg	Cleveland Gaston Lincoln	Chester Lancaster York	Cabarrus Iredell Stanly Rowan

Service Needs

Participants in each community forum identified the need for case management for people living with HIV and AIDS; all but the Cabarrus, Iredell, Stanly, and Rowan Counties community forum prioritized it as one of the top three needs for people living with HIV/AIDS in the Charlotte EMSA. Three forums each also prioritized affordable housing and medical care. Other priority needs identified were mental health and substance abuse

treatment; medication assistance; transportation (identified as a need in all forums) and financial assistance.

> Clients who are not eligible for benefits or do not have employment or housing do not have means to sustain themselves while in transition … They need financial assistance to support their immediate living needs while they get their life together.
>
> - Cabarrus, Iredell, Stanly, and Rowan Counties community forum participant

Peer support and counseling were mentioned in three meetings. A number of participants articulated needs related to system responsiveness, including "swift handling of disability claims" (Cleveland, Gaston, and Lincoln Counties) and "getting doctors and other providers to know where you are coming from" (Anson, Union, and Mecklenburg Counties).

Barriers to Services

All of the forums identified stigma and prejudice as barriers to accessing services in their jurisdictions. Participants in three forums emphasized the barrier of poverty (lack of financial resources) among consumers; they also targeted inadequate funding or lack of funding flexibility for services as a barrier. Lack of transportation or scattered location of services was also cited as a problem in all but the Anson, Union, and Mecklenburg Counties forum, which was the only forum to identify language barriers and lack of services for undocumented immigrants as a barrier. All but the Chester, Lancaster, and York (South Carolina) forum identified some eligibility criteria—including the exclusion of people with criminal records, people who have poor credit histories, or those who are employed—as barriers to needed services.

Other barriers included system fragmentation and a lack of awareness or education around resources, as well as long waitlists or lag times to begin receiving benefits or access to services or housing. Stakeholders in the Anson, Union, and Mecklenburg Counties forum spoke of the need for a comprehensive AIDS housing and services plan and collaborative, proactive efforts.

What is Working?

Community forum participants were asked about the community assets that currently work to support housing stability and access to services among people with HIV: either "what helps maintain stability?" or "how does the system currently meet needs?"

Community forum participants mentioned many particular agencies or programs that have served them. However, a participant in the forum of South Carolina Counties noted that while many services are provided, the scale of assistance is not large enough. This sentiment was echoed in two other forums. These groups emphasized that adequate funding of relevant programs (AIDS Drug Assistance Program and other pharmaceutical assistance programs, Ryan White, HOPWA, and grant programs were all named) is a strategy that works to support housing stability and access to services.

Stakeholders in Anson, Union, and Mecklenburg Counties emphasized the role of case management (but raised the issue of "cherry picking" among different case managers, suggesting that case managers should ensure that even hard-to-serve clients receive assistance). Participants in the Cabarrus, Iredell, Stanly, and Rowan Counties forum mentioned crisis ministries and faith-based support, as well as clinics and informal or peer support.

Gaps in Services

All of the community forums emphasized that there was not enough housing or funding for housing assistance to meet needs. The Cleveland, Gaston, and Lincoln Counties forum mentioned that existing housing waitlists prioritized people other than those with HIV/AIDS, resulting in long waits for housing for people with HIV/AIDS. The Cabarrus, Iredell, Stanly, and Rowan Counties forum noted a lack of sustainability of housing assistance, as well as problems with quality and general availability.

The forums split regionally on other gaps in services. The South Carolina Counties and Cabarrus, Iredell, Stanly, and Rowan Counties forums identified gaps in medical care and other direct assistance, such as pharmacy and mental health care in South Carolina Counties, and dental care in Cabarrus, Iredell, Stanly, and Rowan Counties. Participants in three of the forums said that there were gaps around transportation. They described the difficulty of getting Medicaid or other programs to cover the costs of transportation to needed services, especially across county lines.

The Cabarrus, Iredell, Stanly, and Rowan Counties forum linked this need particularly to the lack of appropriate, targeted medical care in their region. Similarly, the Anson, Union, and Mecklenburg Counties forum mentioned lack of service availability for small counties, as well as for young adults.

> More [nursing care and assisted living facilities] are willing to take a person with Hepatitis C than HIV.
>
> -Cleveland, Gaston and Lincoln Counties forum participant

Gaps in knowledge and awareness were a theme for all four community forums. A stakeholder in the Cabarrus, Iredell, Stanly, and Rowan Counties forum noted that "networks are specific to counties, even clients." Others echoed the need for better information-sharing and collaboration among provider networks, to ensure strong service linkages. Some spoke of the need for additional efforts to raise public awareness of HIV/AIDS issues, and to diminish stigma.

Most Difficult Clients to Serve

Every community forum mentioned difficulties serving people with active substance abuse disorders, as well as people with limited English skills or Latino/Hispanic people. Three forums identified youth or adolescents and homeless or transient people as difficult clients

to serve. All but the South Carolina Counties forum described people with criminal histories, or who were presently incarcerated, as hard to serve.

The South Carolina Counties forum underscored the difficulty of serving consumers without transportation, as well as those who were uninsured (including people who were working, and thus did not qualify for many programs), people who lack family support, and those (like aging clients) with multiple needs.

Participants in the Cabarrus, Iredell, Stanly, and Rowan Counties forum highlighted difficulties in serving people with co-occurring disorders (such as mental health and substance use disorders). They also felt that it was hard to serve consumers who had unreasonable expectations for service providers. The Anson, Union, and Mecklenburg Counties forum participants noted issues related to bridging services; participants said that people with differing medical providers (AIDS Drug Assistance Program / Medicare / Medicaid) were hard to serve, as were people without case managers.

How Could the System Be Improved?

All four community forums described the need for simplifying access to services through single-point-of-entry or one-stop models, including hotlines or other information resources (South Carolina Counties discussed this under the topic of new services that are needed). Some participants referred to existing models within the region, including Just1Call and 211 telephone resources. The Cleveland, Gaston, and Lincoln Counties forum called for a centralized system for housing, while two other forums stressed fostering non-competitive relationships and collaborative problem-solving across the network of service providers and other stakeholders.

All but the Anson, Union, and Mecklenburg Counties forum said that the system could be improved through increased funding to fill gaps in housing or services, or removing restrictions on funding for services such as transportation. Participants in two community forums expressed a need for increased advocacy with political and community leadership, to promote awareness, reduce stigma, and earn funding priority. To this end, the South Carolina Counties forum suggested increased efforts to engage and work with the faith-based community. Participants also advocated the use of peer services.

New Services

> Things are not perfect with what we have here, but the glass is not half-empty, it is half-full.
>
> -Cleveland, Gaston, and Lincoln Counties community forum participant

While participants mentioned some specific service needs (for example, transportation and Section 8 housing assistance directed to people living with HIV and AIDS), the forums primarily focused on the need for promoting awareness of issues around HIV/AIDS and increasing advocacy on behalf of people living with HIV or AIDS. Various audiences were identified as needing additional education, including elected officials, children in the school system, Hispanic communities, and people living with HIV or AIDS themselves, who

participants in the Anson, Union, and Mecklenburg Counties forum believed could use increased health literacy. One forum participant described the need for a balance of prevention, intervention and recovery.

Two sets of forum participants acknowledged the disparate needs of the regions by emphasizing the need for county-specific activities in HIV/AIDS planning processes, and for system leaders to find ways to enable rural areas to tap into urban resources. Their calls for transportation and one-stop-shop models underscored these geographic disparities.

Linkages Between Agencies and Systems

All of the forums produced examples of particular agencies that were fostering connections in their region; participants at two forums praised the SAMHSA initiative at the Regional Consortium, for bringing together two systems to provide for clients. One noted that it "made all the difference that players were there in a timely way." A participant in the Anson, Union, and Mecklenburg Counties forum praised one agency's mandatory training on how to make referrals.
But some participants revealed frustration with the level of interagency collaboration. The Anson, Union, and Mecklenburg Counties forum heard the comment that "there is no general buy-in"—that linkages depend on personal relationships among staff at the various agencies—though in the South Carolina Counties forum, developing strong relationships through personal contacts was held up as the ideal.

Another forum participant identified a challenge inherent to the model of interagency communication: that such communication might inappropriately take the place of tracking and following through with clients, because it was easier. A participant in the Cabarrus, Iredell, Stanly, and Rowan Counties forum made the related comment that it was difficult to prioritize networking when clients present with immediate needs. Another felt that the ability of case managers to "intervene with housing issues" was limited.

The same two forums that made those comments on challenges also recognized lowered workloads for providers as a reward of creating interagency linkages and sharing resources. The South Carolina Counties forum noted that such efforts could improves quality of life for clients, while a Cabarrus, Iredell, Stanly, and Rowan Counties forum participant believed that this work could increase knowledge about HIV, thus breaking down stigma.

Regional Variation

The service providers who participated in the **South Carolina Counties** forum noted that the overall level of services was insufficient, and that increased advocacy was needed to attract funds and prioritization. They identified many different types of clients who were hard to serve, suggesting the need for flexible program options. They advocated for county-specific activities in the planning process, and for building personal connections as a way to strengthen the network of housing and service providers.

The **Cabarrus, Iredell, Stanly, and Rowan Counties** forum identified priorities that are consistent with an HIV-infected population that has access to some resources, but not enough to meet consumer needs. Poverty itself or the cost of services was not identified as a barrier, but participants spoke of lag times for receiving benefits, inability to meet program eligibility criteria, and difficulties associated with scattered services and lack of transportation.

One representative example of need expressed by this forum was for medication assistance. North Carolina has among the strictest income eligibility criteria in the country for participation in the AIDS Drug Assistance Program (ADAP)—previously 125 percent of poverty-level income, raised in 2006 to 200 percent—likely making it hard for people struggling on the cusp of poverty to either pay for drugs or qualify for help.

This forum pressed the theme of removing restrictions on funding for support services such as transportation, and praised the effectiveness of crisis ministries and faith-based support, as well as clinics and informal or peer support.

Needs and issues raised by the **Cleveland, Gaston, and Lincoln Counties** community forum participants were generally similar to those raised in other forums. Alone among the forums, however, they prioritized transportation above medical care among the most critical needs for people living with HIV and AIDS in their region. They also highlighted the long waiting lists for housing assistance, and the need for a centralized housing system.

The **Anson, Union, and Mecklenburg Counties** forum highlighted issues characteristic of people living with HIV or AIDS in a more urbanized area. Participants spoke of barriers for an ethnically more diverse population, such as language barriers and lack of services for undocumented immigrants. Presumably because of the concentration of services in the urban core, lack of transportation or scattered location of services was less problematic for this group than for the others. Instead, the importance of case management (to help people navigate the network of services) was emphasized. Participants also commented on the need for a comprehensive plan and collaborative, proactive efforts system-wide to support a balance of prevention, intervention, and recovery.

Key Stakeholder Survey Findings

Seventeen providers responded to a needs assessment survey. Two respondents were staff of government agencies, and 15 were staff of a range of private or nonprofit agencies. One respondent was also a person living with HIV/AIDS.

Needs of People Living with HIV/AIDS and Service Gaps

Providers indicated that the most critical needs of people living with HIV/AIDS were rental assistance or housing subsidy (15 respondents), transportation, and case management (10 respondents each). Medical care, housing search or move-in assistance, and financial

management assistance were also emphasized. However, a range of other responses (from utility assistance to mental health and substance abuse treatment to dental care) indicated a broad spectrum of need among consumers.

Among these needs, providers indicated that critical gaps in services included rental assistance (12 respondents), transportation assistance (9 respondents), and substance abuse treatment and housing search / move-in assistance (8 respondents each). Write-in responses included dental and prescription medication assistance, as well as simply "helping them to live with HIV/AIDS."

> I think we are missing a big need our clients have now … Our clients are not as sick anymore and need fun and socialization. They need an outlet for their energy and help learning new life patterns. They need help learning healthier eating behaviors and budgeting. We need to focus more on helping clients LIVE with HIV and helping them become more productive members of society.
>
> - Service Provider

Barriers to Stability

Nearly all respondents (16 of 17) chose low income as a primary *personal* barrier keeping people living with HIV/AIDS in the Charlotte region from achieving stability and access to housing and services. A strong majority (11 respondents) also indicated that criminal records and poor credit posed barriers. Substance abuse and a lack of knowledge of resources were also widely cited (9 respondents each).

Among systemic barriers, most providers (82 percent) felt that a lack of affordable housing options was critical. 65 percent cited lack of transportation as a barrier. Opinion was divided on the impact of a number of other barriers, including restrictions on HOPWA, Ryan White, and other funding; lack of clean and sober housing; and lack of knowledge of housing options among providers.

Partnerships with Other Organizations

Surveyed providers emphasized connections with housing and homelessness organizations among the partnerships they described.[60] Most also named partnerships with mental health and substance abuse treatment agencies, and more than half of respondents to this question (5 of 9) said their agencies partnered with corrections agencies. They also mentioned partnerships with churches and other faith-based organizations, hospitals, private property owners, county departments of social services and health, and crisis assistance.

AIDS service providers described the partnerships they had with other types of agencies primarily as referral arrangements for general assistance (11 of 12 respondents). Few of

[60] Due to technical difficulties, a question on partnerships was asked separately from the main survey and got a smaller response.

these partnerships were described as formally contracted. None of the providers identified agreements for priority placement of consumers with HIV/AIDS into housing.

All of the respondents identified themselves as participating in the HOPWA planning process, but only slightly more than half (56 percent) said that they participated in Ryan White CARE Act systems planning, and only one respondent said their agency participated in the Consolidated Plan process. Just under a third participated in the Continuum of Care homelessness services planning process.

Consumer Survey Findings

People living with HIV/AIDS greatly contributed to the needs assessment process by providing information about their housing situations through participation in the Steering Committee, involvement in focus groups, and completion of a housing survey.

Housing surveys, comprised of 23 questions (see Appendices for a copy of the survey tool and complete survey results), were distributed to people living with HIV/AIDS by the following HIV/AIDS service providers:

- Cleveland County Health Department
- Rowan Regional Home Health and Hospice
- Anson County Health Department
- The Charm Project
- Gaston County Health Department
- Gaston Family Health Services
- GORE CDC
- Cabarrus Health Alliance
- Living Water CDC
- Catawba Care Coalition
- Regional AIDS Interfaith Network (RAIN)
- Brother 2 Brother
- Metrolina AIDS Project (MAP)

One hundred seventeen people living with HIV/AIDS completed surveys.

Respondent Personal Information

As is characteristic of populations infected with HIV/AIDS across the United States, the majority of survey respondents were male. However, the percentage of female respondents (39 percent) was significantly higher than the percentage of females among

all known people with HIV/AIDS in the region (31 percent), and a significant number (four percent) described themselves as transgender.

More than half (52 percent) were 40 years old or older; nearly a third (31 percent) were 30-39, compared with a slightly younger median age of 35.5 among the general population in the Charlotte region.

Two-thirds of survey respondents were Black. While not reflective of the racial demographics of the EMSA at large, which is 74 percent White and 20 percent Black, the racial prevalence of respondents does reflect the HIV/AIDS community in the Charlotte region, which is approximately 70 percent Black and 25 percent White. Very few members of other minorities responded, which does reflect EMSA-wide demographics.

Total Survey Respondents

Number	Percent	Race
77	65%	Black
36	31%	White
5	4%	Latino/Hispanic

The largest number of respondents were from Mecklenburg County, North Carolina (37 people) or York County, South Carolina (18 people) with the rest of the respondents coming from surrounding counties. Only Stanley County (NC) had no respondents. Of the 76 people who responded to the questions of what city they lived in, 30 people, or 25 percent, lived in Charlotte. One in five respondents lived in South Carolina.

Only 32 respondents (27 percent) said there was something that made their day-to-day life difficult, but when asked about specific problems, 74 (63 percent of all survey respondents) said financial problems and 57 (48 percent) said HIV/AIDS made their day-to-day life difficult.

Nearly a third (30%) cited problems with transportation. In combination with the fact that forty-five percent of respondents said in response to a separate question that they had to travel 11 to 20-plus miles from their home to the nearest HIV clinic, these transportation issues are likely to influence the level of care that people are receiving.

Living Situation

When asked to describe their current living situation, nearly 60 percent of respondents said that they rented the place where they live, including nine percent in mobile homes. Fourteen percent reported owning a mobile home, house, or condo, while only two percent listed a shelter as their primary residence and no respondents lived on the streets. No one currently living in drug treatment facilities or corrections settings was surveyed.

Income

Respondents most frequently named Social Security Disability Insurance (SSDI) as a source of income (37 percent). However, it is interesting to note that more than one-quarter (27 percent) of survey respondents stated that they did work for pay – exactly the same percentage as received food stamps. Additionally, 17 percent of respondents (20 people) stated that they neither received benefits nor had any other source of income. Other answers included other public assistance (such as Medicaid or cash assistance), with small numbers of respondents citing veterans' benefits, alimony, or child support.

Housing History

Thirty-six people (nearly one-third) said that they had been homeless in their lifetime, and of those 36, 15 had been homeless within the past year. Slightly fewer (33 respondents) had been incarcerated, with only five percent of respondents released within the previous year.

Have you ever been homeless?

Number	Percent	Response
34	13%	Yes
83	16%	No

Have you ever been in jail or prison?

Number	Percent	Response
33	28%	Yes
80	68%	No

Information provided by survey respondents revealed a range of housing needs in the region. When asked to identify the top five housing needs in their community, HIV/AIDS-specific housing and more Section 8 type housing ranked as the most important. The table below shows the top five responses in order of prevalence.

What are the top 5 housing needs in your community?

Number	Percent	Response
89	76%	Housing specific for people living with HIV/AIDS
88	75%	Section 8 type vouchers where rent is based on income
74	63%	Housing Authority public housing
66	60%	Homeownership opportunities
64	54%	Emergency shelter for people living with HIV/AIDS

When asked to list the top five issues that cause people living with HIV to have housing problems in their community, the largest number of respondents (more than three out of four) indicated inability to afford rent. Nearly as many cited inability to work due to disability, and nearly two-thirds (64 percent) cited loss of employment. Opinion varied as to other priority challenges; between 30 and 40 percent of respondents identified (in descending order of prevalence):

- just moving to area and having no money, friends, or family
- discrimination
- family or partner problems
- use of alcohol or drugs
- being discharged from a medical or care facility with no housing arranged

Respondents displayed a greater degree of consensus in identifying the types of housing assistance needed in their communities; the five most frequently cited types were all cited by approximately two-thirds or more of survey participants. A full 85 percent selected chose help getting security deposits for rent or utilities as a priority need in the community. Three out of four called for housing specifically for people living with HIV and AIDS. Assistance with helping correct bad credit history, assistance getting disability or other benefits, and assistance getting employment rounded out the top five.

Support Services

The survey respondents were asked a variety of questions on available and needed support services in their communities. The first question asked respondents to list all needed services. Of a wide range of answers provided, respondents most frequently identified dental care and financial assistance.

What are the top 5 most needed services in your community?

Number	Percent	Response
73	62%	Dental care
71	60%	Financial assistance to help pay medical, housing, or other bills
67	57%	Medical care
47	40%	Help with an emotional or mental problem
44	37%	Help getting food
40	34%	Legal services to obtain benefits like Medicaid or SSDI
39	33%	Transportation to find housing or to other appointments

Other commonly identified service needs, each selected by slightly fewer than 60 percent of respondents, included medical care, help with an emotional or mental problem, and help with substance use problems.

Respondents then were asked to rate the top five most needed services in their communities. The most prevalent choices were nearly identical, with only help with substance abuse problems falling out of the top five, being replaced in the rankings by food assistance. The table at left shows items that were prioritized by at least a third of respondents, in order of prevalence.

The survey also asked respondents to list the top five barriers to services—factors that stop people living with HIV/AIDS from getting the services they need in the community. As in the earlier question about housing barriers, participants most frequently identified poverty (inability to pay for services), with nearly seven of 10 citing this barrier. Transportation was also a key hardship for nearly three out of five survey respondents (59 percent).

The next most prevalent barriers were closely related: "not wanting others to know about the problems they are having" and "people think everyone will know their 'business'" each claimed responses from 48 percent of those surveyed. Other barriers named by more than one-third of respondents included an emotional or mental problem; a substance abuse problem; and not having information about the services in the community.

What types of care and support services are available in your community?

Number	Percent	Response
26	22%	Legal assistance (Legal Aid)
41	35%	Meals assistance (Meals on Wheels)
42	36%	Home health or hospice
43	36%	Health and/or medication education
49	42%	Dental care
50	42%	Substance abuse counseling

Participants were also asked about what types of support services were currently available in their communities. While the majority of respondents said that primary medical care, hospitals, and case management were available, less than half knew or believed that several other types of services that were listed were available in the community. This table shows the answers named by the least amount of respondents – that is, the types of support services that people living with HIV/AIDS had little access to or were least aware of.

Section 2: Critical Issues and Recommendations

Critical Issues and Strategies

This section includes the HIV/AIDS housing and services strategies that have been agreed upon by the stakeholders and the Regional HIV/AIDS Consortium. These strategies were proposed by community members during community forum meetings and surveys conducted as part of this needs assessment process.

The HIV/AIDS housing and services needs assessment conducted during Spring 2007 provided an opportunity for approximately 200 community members to meet, discuss, and identify critical issues and strategies for enhancing HIV/AIDS housing and services in a 13-county area surrounding the City of Charlotte. Stakeholders from each of the 13 counties participated in the process, taking part in community forums and/or completing surveys.

The strategies in this section are intended to be utilized as a guide for program planning and implementation of HIV/AIDS housing and services in the 13-county region. It is crucial that the Regional Consortium, the Regional Housing Partnership, LLC, and other community stakeholders utilize the data gathered in this plan and the strategies that were developed based on this data in coordinating HIV/AIDS housing and services delivery.

This plan, and these strategies, will be effective only with the ongoing commitment of the Regional Consortium, the Regional Housing Partnership, LLC, and other community stakeholders collectively and individually to ensure implementation. Strong advocacy, oversight, and dedication are required to enable these strategies to take shape and blossom. Please also note that these strategies are intended to be built upon over the coming months and years. As a next step, the committee should consider creating action plans for these recommendations via housing and services task forces or during regular meeting times.

Critical Issues

Overall, participants in this needs assessment process identified an ongoing need for improving coordination between HIV/AIDS and mainstream housing and services programs and increasing access to these services for people living with HIV/AIDS across the region. Many people with HIV/AIDS live in poverty and face obstacles to basic necessities: a safe, healthy, affordable place to call home; a job and/or sufficient income to pay the bills; and support for when they are not able to help themselves. While they had words of praise for the array of programs and organizations from which they currently receive help, people living with HIV/AIDS and those who assist them were clear that more work must be done to ensure that stigma and other barriers to services can be overcome, and a basic standard of living attained for all consumers in the Charlotte region.

After reviewing the findings of the needs assessment and drawing upon their experience in administrating, delivering, and seeking access to HIV/AIDS housing and services, participants determined that there were three categories of issues that must be addressed.

These three critical issues categories were as follows:

1. Coordination and Advocacy
2. HIV/AIDS Medical and Support Services
3. HIV/AIDS Housing

Broad strategies have been developed to guide HIV/AIDS housing and services advocates and consumers in addressing the critical issues in each of these categories. Local stakeholders should establish action steps, assignments of responsibilities, and timelines to assure implementation of these broad strategies.

Coordination and Advocacy

1. **Ensure that accurate and consistent information on availability and eligibility for housing and services programs is available to consumers living with HIV/AIDS and case managers** inside and outside of the HIV/AIDS service system, by developing and maintaining informational exchanges. These mechanisms could include regular case manager trainings on available resources and a regularly updated resource guide, both online and in print. Additionally, ensure connections with the regional and statewide services directories and networks (especially virtual one-stop models), such as 211 or Just1Call and www.socialserve.com.
2. **Encourage active participation in Ryan White and HOPWA planning processes** by HIV/AIDS housing and service providers, people living with HIV/AIDS, and other HIV/AIDS housing and services advocates to ensure ongoing coordination of Ryan White medical care and services with HOPWA-funded housing assistance and related services. To the extent possible, coordinate funding award processes to foster non-competitive relationships among regional HIV/AIDS service providers.
3. **Encourage all HOPWA project sponsors serving homeless individuals to continue or begin to participate in local Consolidated Plan and Continuum of Care planning processes and in the Carolina Homeless Information Network (CHIN)** as a means of improving coordination with housing and homeless service providers and increasing opportunities to leverage HOPWA funds with other funding sources. In particular, seek opportunities to participate in the rural Continuum of Care consortiums in order to develop linkages that may result in new housing programs for people living with HIV/AIDS in those counties.
4. **Continue to build relationships with area communities of faith to convene and participate in conferences on HIV issues, including stigmatization.** Utilize these forums to educate people about HIV disease and consumer needs, improve prevention efforts, and to motivate faith-based leaders and community members to become involved through volunteering or donating to HIV/AIDS housing and services programs.

5. **Foster the development of and participation in peer support initiatives** for people living with HIV/AIDS, with a focus on educating and empowering consumers to have their voices heard and valued. Provide space and support for meetings in conjunction with education and training sessions around topics highlighted by consumers or other service delivery.

HIV/AIDS Medical and Support Services

6. **Ensure that people living with HIV/AIDS across the region have equal access to medical care and services** by advocating for a planning process that includes input from a wide array of consumers and results in equitable distribution of Ryan White funding across the region.
7. **Ensure that people living with HIV/AIDS are receiving the support services they need by:**
   - Working with other housing and service systems, particularly the homelessness and mental health systems, to develop formal linkages and operating agreements.
   - Ensuring that every person eligible for case management in another system (*e.g.,* mental health, aging and disability, youth services, veterans) is enrolled in that system.
   - Conducting regular (at least annual) community-wide cross-trainings with staff from other service and housing systems about housing and services issues for people living with HIV/AIDS and resources available through other housing and service systems.
   - Enhancing consumer self-advocacy skills through formal training and knowledge-building experiences.
8. **Increase employment of people living with HIV/AIDS** by identifying education and job training resources (such as through community colleges and Workforce Development Consortiums in Charlotte-Mecklenburg and throughout the region), supporting clients to go back to school or get a job, and coordinating educational sessions regarding public benefits and employment. Such steps are critical to increasing consumer empowerment in sustaining health and being integrated into the larger community.
9. **Research and develop relationships with potential partner agencies and funders** to**:**
   - Increase transportation assistance availability for people living with HIV/AIDS in areas of the region where public transportation is limited.
   - Provide financial management training and services to low-income people in the region.
10. **Increase access to dental care by people living with HIV/AIDS by building a broader network of dental providers,** including initiating partnerships with regional dental professional associations. Survey dentists who do and who do not serve people living with HIV/AIDS to determine if the dentists are able (and if any kind of incentives from the service provider would make the dentists willing) to take one or more clients (likely using Medicaid or with no insurance). In addition, provide education for dentists about the dental needs of this population, and for people living with HIV/AIDS about oral and dental health and preventive care.
11. **Promote increased pharmacy assistance for people living with HIV/AIDS** through both additional funding and expansion of eligibility for the federally supported

AIDS Drug Assistance Program (ADAP), as well as advocating for medication assistance through other programs and funding streams. In addition, help clients who are seeking employment to find insurance options to support their medication costs.

12. **Seek increased access to existing reentry programs for people living with HIV/AIDS** who are released from correctional facilities or other public institutions. In addition, advocate for people living with HIV/AIDS in state and local reentry initiative planning.

HIV/AIDS Housing

13. **Ensure that the existing continuum of housing options remains available to people living with HIV/AIDS** according to their preferences and current service needs. Work with mainstream housing assistance providers to consider formalizing relationships with HIV/AIDS providers and negotiate for priority placement of people living with HIV/AIDS.
14. **Seek opportunities to add new housing units to the regional continuum, including permanent supportive housing resources**, with a prioritization of developing units that are integrated into mainstream housing facilities, such as set-aside units. These projects will require partnerships between organizations experienced in developing affordable housing and organizations with the capacity to provide strong support services to people living with HIV/AIDS. Ensure that people living with HIV/AIDS with barriers to existing housing programs are eligible for these new units.
15. **Seek opportunities to add new housing assistance programs, such as additional rental assistance vouchers and assistance with security deposits, to the regional continuum** by cultivating new partners and funding sources. Ensure that people living with HIV/AIDS with barriers to existing housing programs are eligible for these new vouchers.
16. **Coordinate with Regional Training Institutes and other training series and develop new educational opportunities for housing and services staff, including:**
    - Training for mainstream housing providers and others, including landlords, community development corporations, and the state Housing Finance Agency, on fair housing as it relates to HIV/AIDS education, discrimination, and confidentiality a
    - Training for HOPWA stakeholders and other community members on topics such as the HOPWA program, HIV/AIDS resources, agency capacity building, and integration of the HIV/AIDS service system with other service systems.
17. **Increase opportunities for homeownership among people living with HIV/AIDS** by partnering with local community development organizations, local housing authorities' Section 8 Homeownership Programs, and local and state governmental entities.
18. **Research and partner with existing landlord/tenant programs to increase access to rental housing and improve housing stability of people living with HIV/AIDS.** Model programs will educate landlords and tenants about renter rights, responsibilities of good tenancy, and rental assistance program requirements to improve housing applicants' ability to interact with landlords and enhance their capacity for housing stability.
19. **Increase access to housing for people living with HIV/AIDS who have criminal histories, are discharged from public institutions such as hospitals, or lack legal documentation by:**

- Supporting the initiation of discharge planning to obtain appropriate housing significantly prior to a person's release from a public institution.
- Promoting flexibility in the eligibility requirements of existing housing assistance programs, where possible, to serve post-incarcerated and undocumented people living with HIV/AIDS.
- Encouraging housing authorities and AIDS service organizations to coordinate "pre-screening" so as to not refer people who will clearly be ineligible for housing programs based on their criminal history and undocumented status.
- Developing a facility-based transitional housing program to serve people living with HIV/AIDS who are undocumented or have criminal histories.