

***FORGING USEFUL
SYSTEMS TO EMPOWER
(FUSE) PROJECT***

RIVER REGION HUMAN
SERVICES, INC.

Service Area

Jacksonville, FL, Duval
County

Grant Term

11/1/2011-10/31/2015

**Grant Funded HOPWA
Eligible Activities Include:**

- Tenant Based Rental Assistance
- Supportive Services
- Resource Identification

RRHS was awarded \$1,353,743 to provide tenant based rental assistance and coordinated linkages to comprehensive supportive services for 40 households headed by homeless persons living with HIV/AIDS in the Jacksonville, FL, metropolitan area. The project provided housing assistance and service coordination through a partnership with Ability Housing of Northeast Florida, Inc.

STRATEGIES

Increase Involvement with the local Homeless Continuum of Care (CoC) to Improve Understanding of the Needs of PLWHA

RRHS participated in the 100 Homes project (known nationally as 100,000 Homes) to house the 100 most medically vulnerable homeless persons in Jacksonville. This project provided an opportunity to directly work with the local CoC and strengthen the relationship. Leveraging the 100 Homes project, RRHS partnered with other homeless and housing service providers to pilot the Northeast Florida CoC Coordinated Intake process. In conjunction with the development of the CoC Coordinated Intake and Assessment process and oversight committee, RRHS engaged in the establishment of a CoC Planning Board, on which RRHS now serves and co-chairs. Strengthening this relationship with the CoC and being involved in the Coordinated Intake process was critical to ensure that PLWHA were considered in its development and implementation.

Improve Service Delivery and Coordination by Constructing a Databridge between CAREWare and HMIS

PLWHA may have more than one case manager, including a medical case manager, housing case manager, service coordinators, and peer navigators. Medical case managers as well as other Ryan White service providers are required to enter client characteristics, service and health data into CAREWare, while housing case managers and service coordinators as well as other homeless service providers are required to enter client characteristics, housing and homeless service data into HMIS. RRHS saw an opportunity for data system integration to streamline data entry and thereby streamline service delivery and case planning. The Database Managers for CAREWare and HMIS collaborated with the staff of the HMIS software provider (ClientTrack) to build a databridge that enabled more than 50 fields of client-level data in CAREWare to be accessed, processed and managed in the HMIS.

Enhance Coordination and Integration of Housing and Primary and Behavioral Health Services

RRHS saw that many of their clients needed not only primary health services, but behavioral health services. To improve that connection, RRHS developed an integrated case management system that assessed and linked clients to primary and behavioral health services. Additionally, RRHS partnered with Ability Housing of Northeast Florida and University of Florida Center for HIV/AIDS Research, Education and Service on a successful joint application for a five-year HRSA Special Projects of National Significance grant to implement a “medical home” model of integrated behavioral health, physical health, case management and such ancillary services as housing support for PLWHA. The coordination and integration of housing and services occurred on a planning level, as well as within and between service coordinators and peer specialists/navigators in each of the programs.

“Active participation, collaboration and building of partnerships among healthcare, housing, homeless service providers contributed substantially to FUSE successes in its service coordination and integration efforts.”

OUTCOMES

River Region Human Services' FUSE Project provided housing assistance and supportive services to a total of 50 individuals living with HIV/AIDS. Of those 50 individuals, 60.0% were between the ages of 31-50 years old, and 34.0% were between the ages of 18-30 years old. All were Female, 84.0% were Black, and 2.0% identified as Hispanic. All of the FUSE Project participants were low income, with 82.0% having incomes at or below 30% of the area median income (AMI), which means they were *extremely* low income. While some clients lived alone, the majority of clients (80.0%) had additional beneficiaries in the household. All clients were reported as having consistent contact with a case manager (100.0%) and health care provider (100.0%), with 84.0% documented as receiving ART therapy for HIV. A total of 72% of clients stated being "literally homeless" at the time of program entry, with 2.0% identifying as chronically homeless. See Table 11 below.

Table 11. FUSE Project Demographics & Additional Client Characteristics					
n=50					
Age		Race & Ethnicity		Additional Characteristics	
Younger than 18	0.0%	Black	84.0%	Consistent Contact with Case Manager	100.0%
18-30	34.0%	White	12.0%	Household included additional beneficiaries	80.0%
31-50	60.0%	Other/Multi	4.0%	Consistent Contact with Health Care Provider	100.0%
51 & older	6.0%	Hispanic/Latino	2.0%	Receiving ART therapy	84.0%
Gender		Household Income		Homelessness	
Female	100.0%	0-30% AMI	82.0%	Homeless Veteran	0.0%
Male	0.0%	31-50% AMI	18.0%	Chronically Homeless	2.0%
Transgender	0.0%	51-80% AMI	0.0%	Literally Homeless Prior to Enrollment	72.0%

The River Region Human Services, Inc. FUSE project provided Tenant-Based Rental Assistance (TBRA). Table 12 provides information on Viral Load at program entry across the 50 clients. Of those clients with CD4 counts reported, 52% saw improved or maintained CD4 counts during participation in the program. If an individual saw their Viral Load (VL) decrease and/or maintain viral suppression (71.4%), they are considered to have improved health. If an individual saw their VL remain the same (not suppressed) (4.8%), they are considered to have maintained their health. If an individual saw their VL increase (23.8%), they are considered to have declined health. All clients that did not have health data provided were excluded from the analysis and thus the denominator for the percentages in the chart below. Of those with health data collected, there is a high percentage with improved health outcomes under each service type and associated with positive HOPWA measures. See Table 12A and 12B below.

Table 12A. Health Outcomes by Assistance Type					
HOPWA Service Provided	Health Improved	Health Maintained	Health Declined	Virally Suppressed	Undetectable Viral Load
TBRA (n=21)	71.4%	4.8%	23.8%	61.9%	52.4%

Table 12B. Correlation between Health Outcomes & HOPWA Program and Accomplishment Measures		
HOPWA Measures	There is a Positive Relationship between these Measures and Improved Health Outcomes	Limitations of Health Outcomes Analysis
Length of Time in Program	Positive relationship between length of time and improved VL	29 clients excluded due to no health data at exit
Housing Stability Outcome	63% of those Stably Housed had improved VL	
Access to Care ⁶	71% of those with high Access to Care had improved VL	
Obtained Income-Producing Job	70% of those obtaining employment had improved VL	

⁶ A client's Access to Care refers to various aspects having a Housing Plan, consistent contact with a Case Manager and Health Care Provider, and continued access to sources of income and insurance)