The Homeless HIV Outreach and Mobile Engagement (HHOME) Program

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Model Description

Target Population: People living with HIV/AIDS (PLWHA) in San Francisco, who are experiencing homelessness, facing complex co-morbidities including mental illness and substance use, and who have been unable to engage in housing, HIV medical treatment, nor behavioral health care.

Special Populations: PLWHA who are transitional age youth (18-30), at risk for eminent eviction, denied services at more than one medical clinic, experiencing end-of-life, pregnant; and sero-discordant pregnant couples.

HHOME Program Staff: Administrative Team: Medical Director/Principle Investigator, Clinical Supervisor, Program Manager, and Evaluation Coordinator; Mobile Team: Medical Doctor, Registered Nurse, Peer Navigator, Housing Case Manager, and Social Worker.

Description of the Model: Mobile, team-based intervention designed to engage and retain the most severely impacted and hardest-to-serve PLWHA in HIV primary care, behavioral health services, and housing.

HHOME aims to stabilize and transition individuals into a 4-wall primary care clinic with less intensive support services.

HHOME Partners:

- API Wellness: Community-based drop-in case management, navigation, substance use services, mental health and counseling services, art therapy, nutritional services, and acupuncture.
- SF Homeless Outreach Team: Outreach, case management, and housing for people experiencing homelessness in encampments, streets, parks, and shelters.
- Tom Waddell Urban Health Center, SFDPH: Health Care for the Homeless Clinic providing urgent and primary care, mental health and addiction medicine.
- Transitions Care Coordination, SFDPH: Complex care management and coordination for high utilizers of urgent and emergent services and underserved populations.

Patient Demographics

(study participants, N = 61)

- RACE
  - 42.6% White
  - 29.5% Black/African American
  - 11.5% Multiracial
  - 4.9% Alaskan Native/Native American
  - 1.6% Asian/Pacific Islander
  - 9.8% Other
- GENDER
  - 72.1% Male
  - 16.4% Female
  - 3.3% Transgender male-to-female
  - 8.2% Other/Something else
- HOUSING (at study entry)
  - 100% homeless or unstably housed

HHOME Schedule

MON
- Social service morning huddle
- Referral huddle
- RN provides onsite care at API Wellness, during a drop-in program for less acute individuals, as a means to engage HHOME participants preparing for discharge

TUES
- Social service morning huddle
- RN provides onsite care at API Wellness
- RN and Housing Case Manager conduct visits to participants in the field, predominantly in stabilization rooms and emergency shelters

WEDS
- HHOME team weekly case conference
- RN and MD provide onsite nursing and primary care at Tom Waddell Urban Health Canter

THURS
- MD provides onsite care at API Wellness to engage clients and expedite coordinated care

FRI
- Social service morning huddle
- MD and medical social worker provide mobile medical & case management to clients with highest medical acuity in hospitals, on the street, and in emergency shelters
- RN and MD provide onsite nursing and primary care at Tom Waddell Urban Health Canter

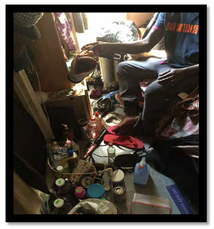
Team conducts intake, outreach, and field work throughout the week as needed



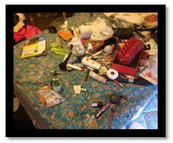






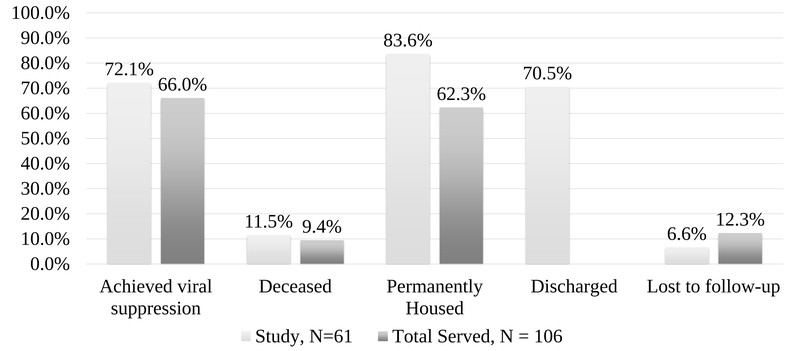





Metrics	Individuals in the Study, N =61	Total Individuals Served, N =106 (includes those unable to consent for the study at point of entry and currently active in HHOME Program)
Achieved viral load suppression at least once during intervention	44	70
Deceased	7	10
Permanently housed or linked to the appropriate level of supportive-living	51	66
Permanently housed – signed lease	45	57
Successfully discharged to standard level of medical care and less intensive support services.	43	N/A
Lost to follow up	4	13

HHOME Metrics



Successes and Challenges

Successes

- System-Wide Coordination
  - Creation of the SF HIV Care Continuum Task Force – insures that system-wide referrals and linkages for PLWHA are timely and appropriate
- Integrated, team-based navigation
- Adapting to the forever-changing political landscape: sustaining continued access to emergency stabilization and permanent housing
- Championing palliative care and advanced care planning
- Recognized as a leader in trauma-informed medical care in SF
  - Training medical students, residents, and fellows
- Spin-off programs initiated:
  - New intensive case management programs
  - HHOME Life Skills – peer led program designed to retain PLWHA in housing
  - Encampment Health – program providing low barrier PrEP, STI testing, and HIV testing and Rapid treatment for encampment communities in SF
  - Obstetric Mobile Care

Challenges

- City-wide reorganization, affecting homeless health care and service access
- Discharging clients: no permanent/long-term care equivalent of HHOME
- Staff retention and turn-over, both programmatically and city wide
- Staff skill building: care coordination, palliative care, trauma informed leadership
- Lack of support available for newly housed individuals

Partnerships Built

- Safety net medical clinics
- Medical and psychiatric emergency rooms and inpatient hospitals
- Surveillance and linkage organizations
- SF county jail health program
- HIVE – services for pregnant women living with HIV/AIDS and/or discordant couples
- Project Open Hand – nutritional services and meal delivery for people living with disabilities and/or chronic illnesses

Sustainability

This HHOME program will be sustained through the city of San Francisco as originally designed.

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