

## The Homeless HIV Outreach and Mobile Engagement (HHOME) Program

San Francisco Department of Public Health – HIV Health Services, Transitions Division, and Primary Care  
Asian & Pacific Islander Wellness Center  
San Francisco Homeless Outreach Team

### Policies | Procedures | Model of Care

Serving individuals who are experiencing homelessness and living with HIV through mobile integrated care: case management, navigation, HIV primary care, mental health and substance use treatment, and housing support

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## THE HOMELESS HEALTH OUTREACH AND MOBILE ENGAGEMENT (HHOME) PROGRAM AT A GLANCE

**San Francisco Department of Public Health (SFPDH)– HIV Health Services, Transitions Division and Primary Care Asian & Pacific Islander Wellness Center (API)  
San Francisco Homeless Outreach Team (SF HOT)**

**Geographic description:** The city of San Francisco has one of the largest HIV-positive populations in the United States with an estimated 15,995 people living with HIV. (SF HIV Annual Epidemiology Report 2015) and the second highest rate of homelessness in the United States (SF Homeless Point-in-Time Count & Survey 2015).

**Main challenges:** When HHOME started, 7% of all homeless individuals and 16 % of homeless high utilizers of health care were living with HIV (SF HIV Annual Epidemiology Report 2010). Among these individuals are some of the most difficult to engage and retain in care.

**Target population:** Individuals in San Francisco who are experiencing homelessness, medically fragile, facing complex, multiple co-morbidities and barriers who have previously resisted attempts to engage them in housing or HIV treatment

**Description of the model:** a public/private partnership implemented a mobile, multidisciplinary team-based intervention designed to engage and retain in care the most severely impacted and hardest-to-serve persons experiencing homelessness and living with HIV

**Medical home model staff:** Principal Investigator, Medical Doctor (Primary Care, Addiction Medicine, Mental Health Treatment), Program Manager, Peer Navigator, Housing Case Manager, Medical Social Worker, Clinical Supervisor, Registered Nurse, Evaluation Coordinator

**Clients served:** 106

**Impact:** The HHOME Program provided HIV mobile care to 108 unique clients; 61 of these clients contributed to the research conducted by the HHOME team. At time of entry, all HHOME clients were homeless and many had been for years; following the intervention, 62% are housed or have been linked to the appropriate level of residential care. Of this housed cohort, 37% have been connected to permanent housing. The SPNS grant and HHOME model has strengthened community partnerships between public clinics, medical and psychiatric urgent and inpatient hospitals, surveillance and linkage organizations, and the health program in our jail system; new partnerships were formed with Larkin Street Youth Services, our local homeless youth organization, and HIVE, an organization that seeks to improve the sexual and reproductive wellness for individuals and families affected by HIV.

# ABOUT THE SPNS INITIATIVE

## Building a Medical Home for Multiply Diagnosed HIV-Positive Homeless Populations, 2012-2017

People who are experiencing homelessness are disproportionately affected by HIV, and those who are also living with HIV are more likely to delay entering care, have poorer access to HIV care, and are less likely to adhere to antiretroviral therapy. In 2012, the Health Resources & Services Administration (HRSA), HIV/AIDS Bureau through its Special Projects of National Significance (SPNS) Program\* funded a national initiative with the goal of building a medical home for a vastly underserved population: those who are experiencing homelessness or unstable housing, living with HIV, and who face challenges of mental health or substance use disorders. Nine clinic and community-based organizations and one multisite coordinating center were funded to implement and evaluate service delivery models for this population. The two main goals of the models were to 1) increase engagement and retention in HIV care and treatment; and 2) improve housing stability. While each model was tailored to the environment in which it existed and the needs of the specific population served, the nine models all created a role of care coordinator/network navigator who worked with clients to access a networked system of services among HIV, housing, and behavioral health care providers. To measure achievement of project goals, the nine programs conducted a longitudinal multisite evaluation study of the models.

The San Francisco Department of Public Health was one of nine demonstration sites funded under this initiative. This manual describes the experience implementing and evaluating the Homeless Health Outreach and Mobile Engagement (HHOME) Program.

For more information about the initiative, visit <http://cahpp.org/project/medheart/>

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\*The Special Projects of National Significance (SPNS) Program is charged with the development of innovative models of HIV treatment, in order to quickly respond to emerging needs of clients served by Ryan White HIV/AIDS Programs. SPNS advances knowledge and skills in the delivery of health and support services to underserved populations diagnosed with HIV. Through demonstration projects such as the initiative that gave rise to the HHOME program, SPNS evaluates the design, implementation, utilization, cost, and health-related outcomes of treatment models, while promoting dissemination and replication of successful interventions. Learn more at <https://hab.hrsa.gov/about-ryan-white-hiv-aids-program/part-f-special-projects-national-significance-spns-program>



## INTRODUCTION TO THE HHOME PROJECT

### Challenges Faced in San Francisco

As the city with the highest per capita rate of HIV infection and the second highest rate of homelessness in the United States, San Francisco has been hit considerably hard by these dual crises. The city's public health system, particularly its hospital and clinic network, has been overwhelmed by the concurrence of these issues. Because the system was not constructed specifically to support those clients living with HIV and homelessness, both the client and the system suffer.

In response, the San Francisco Department of Public Health was awarded funding to develop and implement the Homeless Health Outreach Mobile Engagement (HHOME) Program – a mobile, multidisciplinary team-based model specifically designed to engage and retain in care the most severely impacted and hardest to serve persons experiencing homelessness and living with HIV in San Francisco.

While San Francisco is considered a leader in HIV primary care and homelessness resources, the care needed for this challenging population at the intersection required an innovative and mobile model. HHOME provides the appropriate level of care for the city's most

acute and readies them for traditional care at a four-wall clinic—meaning that HHOME serves a niche purpose and community, yet is focused on system sustainability.

Between 2006 and 2015 in San Francisco, approximately 11% of all newly diagnosed cases of HIV were among those experiencing homelessness (San Francisco Department of Public Health, 2015). At the outset of HHOME in 2012, 7% of all homeless individuals and 16 % of homeless high utilizers in SF were living with HIV (San Francisco Department of Public Health, 2010). This was and still is considerably higher than the national average of 3% for the general homeless population (Denning and DiNenno, 2010). HHOME Program purposefully targets those individuals experiencing homelessness who are the most difficult to engage and retain in care: individuals facing complex, multiple comorbidities and barriers who have previously resisted attempts to engage them in housing or HIV treatment.

### About HHOME

In 2012, the San Francisco Department of Public Health (SFDPH, <https://www.sfdph.org/>) sought and received Special Projects of National Significance (SPNS) funding to develop and implement the HIV

Homeless Outreach Mobile Engagement (HHOME) model. SFPDH HHOME staff has created a mobile, multidisciplinary team-based model designed to engage and retain in care the most severely impacted and hardest-to-serve persons experiencing homelessness and living with HIV in San Francisco. HHOME differs from prior mobile team models in that it explicitly focuses on individuals experiencing homelessness who are the most difficult to engage and retain in care, namely those facing complex, multiple comorbidities and barriers who have not previously or successfully engaged in housing and/or HIV treatment.

Our local iteration of this program emerged out of a unique public/private partnership model designed to support the services of the San Francisco Homeless Outreach Team (SF HOT), which engages individuals who are experiencing homelessness to provide support such as temporary housing and other basic needs. HHOME added the medical services of Tom Waddell Health Center, a public community health clinic with an established practice of caring for people experiencing homelessness, and a respected and highly trusted community-based organization, the Asian & Pacific Islander Wellness Center. Together, this partnership strengthens one of the core missions each entity has maintained on its own: to enhance the utilization of and retention in HIV medical care by underserved populations in San Francisco. See the section on Setting up the Medical Home for more about these partnerships.

### Purpose of Manual

This manual was designed to provide an alternative resource for health care providers to implement strategies to better serve a homeless, dually diagnosed HIV-positive community, and help facilitate consistency within the practice of the core activities detailed in this document. This manual serves as a comprehensive guide to establishing and operating the HHOME model and continues to be used as the training curriculum for clinical and non-clinical service provision. It reflects the adaptation of certain policies, programmatic shifts within HHOME, the evolution of team roles, the experiences of staff and clients, and the progress of resource collaboration citywide.

“HHOME deploys a multi-disciplinary team that set out to serve a caseload of 25 - 35 of the hardest-to-serve individuals experiencing homelessness and living with HIV in San Francisco at any one time. In reality, this program often has an active caseload of 35+, which speaks both to the continued need for and the success of the model.

### Mobile Care Model & Philosophy

HHOME deploys a mobile multidisciplinary team that set out to serve a caseload of 25-35 of the hardest-to-serve individuals experiencing homelessness and living with HIV in San Francisco at any one time. In reality, this program has often had an active caseload of 35 + which both speaks to the continued need for this adaptive and high level of care and the success of the model. Unlike other mobile models, the HHOME model mandates mobility from each member of the team, which consists of a physician, a registered nurse, a medical social worker, a peer navigator, a homeless outreach worker, and an evaluation associate. Mobile team members continually meet together to coordinate care and participate in weekly case conferences. The mobile team also seeks to form intense, one-on-one relationships with their client population, and maintain almost daily contact with the individuals they serve, including serving as proxy deliverers of HIV medications and conducting in-the-field medication observations to assess the degree to which clients are adhering to HIV treatment regimens.

Clients are continually assessed by the mobile team and are actively linked and engaged to the widest possible range of programs and services to achieve stabilization and successfully link clients to long-term medical care, housing, and behavioral health services. The HHOME model builds on San Francisco's unique multi-leveled system of integrated care for homeless and marginally housed HIV-positive populations, incorporating medical care, case management, behavioral health support, dental care, peer navigation, access to stabilization and permanent housing, expanded public insurance programs, and computerized patient registries.

Key outcome objectives of the project include:

- a) Linking at least 90% of HHOME clients to a patient-centered, culturally competent HIV medical home within one month of engagement in the program;
- b) Transitioning at least 65% of HHOME clients to long-term and supportive housing over the course of the program;
- c) Ensuring that at least 75% of clients with a psychiatric diagnosis will have a psychiatric assessment and will be on a monitored psychotropic regimen within three months of engagement with the multidisciplinary team; and
- d) Ensuring that at least 50% of chronic substance users will receive substance use treatment and/or addiction medicine services within three months of engagement with the multidisciplinary team.

## Mission

HHOME is designed to enhance engagement and retention in quality HIV care for multiply diagnosed individuals who have experienced chronic homelessness in the city and county of San Francisco, California. The program forges a unique public and private partnership model in which the medical services of a public community health clinic are merged with a homeless outreach program and community service center. The Tom Waddell Urban Health Center, SF Homeless Outreach Team, the Transitions Division of SFDPH, and Asian & Pacific Islander Wellness Center collaborate to provide trauma-informed and holistic care

## Vision

HHOME creates a unique mobile medical care unit specifically designed to target the complex needs of chronically homeless and multiply diagnosed residents of San Francisco. In order to engage historically disenfranchised clients, the HHOME team meets individuals directly in the field, regardless of where they are situated, as well as other parts of the community to provide: health monitoring, linkage to needed services, housing assistance, mobile behavioral health care and addiction medicine, benefits acquisition, appointment escorts, and HIV medications adherence counseling. (See the *Service Delivery Model* section for details.)

The HHOME team forms intense, one-on-one relationships with their client population and maintains almost daily contact. The team strives to create multiple trust relationships with clients so that if one member of the team is not present on a given day or leaves the team, a strong relationship remains in place with other team members. (See the *Peer Navigation* description for details.)

A medical team from the Tom Waddell Health Center is out-based onsite at Asian & Pacific Islander Wellness Center, located directly within the San Francisco neighborhood with the highest concentration of residents experiencing homelessness. In order to engage this population and provide a high level of care to all clients, the team is available throughout the week at Tom Waddell Urban Health Center, the Asian & Pacific Islander Wellness Center, and offsite throughout the community.

## Core Values

Initially, this program was based on the standards of service delivery that had been established by the San Francisco Department of Public Health. Over the course of the initiative, these standards have evolved to a program specific set of core values. The following values embed best practices for HIV care and treatment while imbuing each with the HHOME philosophy:

### 1. Self-actualizing services:

- We ground the provision of services in the rights, values, and preferences of the client.
- We prioritize client self-actualization in their clinical and supportive care and in their life outside the clinic walls.

### 2. Mindful medicine:

- Medical care and clinical interventions are grounded in a psycho-social and holistic understanding of the client.
- By practicing mindful medicine, no session is like the other; the mobile medical team is there to determine what the needs of that particular dynamic and day are.
- The dynamic between providers and the client is ever-evolving.

### 3. Care coordination and continuity:

- We coordinate any and all types of services and assistance to meet the client's identified needs.
- We offer consistent and holistic care for people with HIV, within a comprehensive system of services, so that care is continuous from linkage to adherence

### 4. Destigmatizing care:

- We hold self-affirming and destigmatizing care as equally necessary and as pertinent to the client's care plan as more traditional aims of HIV care.
- We aim to mitigate the deleterious effects of stigma that our clients have formerly experienced regarding HIV, homelessness, substance use, mental health, sexism, racism, transphobia, etc.
- We create a psychologically and physically safe environment that amplifies the needs, visibility, and voices of our clients in the clinic community and the city, at large.

### 5. Harm reduction:

- We meet the specific and varied needs of all clients.
- We use a non-judgmental and non-coercive approach to providing services, in order to assist clients in minimizing risk in their environment.

## Innovation Behind the HHOME Model

In providing mobile care to our clients living with HIV, homelessness, and a multiplicity of other social and health factors, the HHOME team philosophy is comprised of these central tenets:

**Client Advocacy:** The HHOME model centers on the needs of the client, empowering the client to take control over their own care. This means that client treatment plans may depart from traditional approaches to HIV primary care. We help the client prioritize psychosocial, spiritual, familial, and emotional matters that will ultimately positively affect their engagement and retention with their clinical care.

**Appropriate Level of Care:** HHOME believes that all clients can succeed if they are given the appropriate level of care; this requires an acknowledgment that the type, frequency, and intensity of the care will change over time. For many clients, HHOME—and the provision of intense, wrap-around, mobile care—is a first step on a journey back to the traditional clinic environment. On the other hand, HHOME helps many acute clients transition into the long-term and intensive inpatient care they need.

**Healing the System:** HHOME understood that the project must heal client level and system level trauma. Because the medical system has asked that clients adapt to the needs of the clinic, rather than shifting the way the clinic provides care, both the client and the clinic have suffered. HHOME serves as an intermediary step that helps identify and meet the needs of the client, develop a long-term treatment plan, and transition clients into the appropriate clinic environment. As seen by stakeholder feedback, this has already saved the system—including hospitals and the linkage team—precious time and resources.

### **6. Community-centered:**

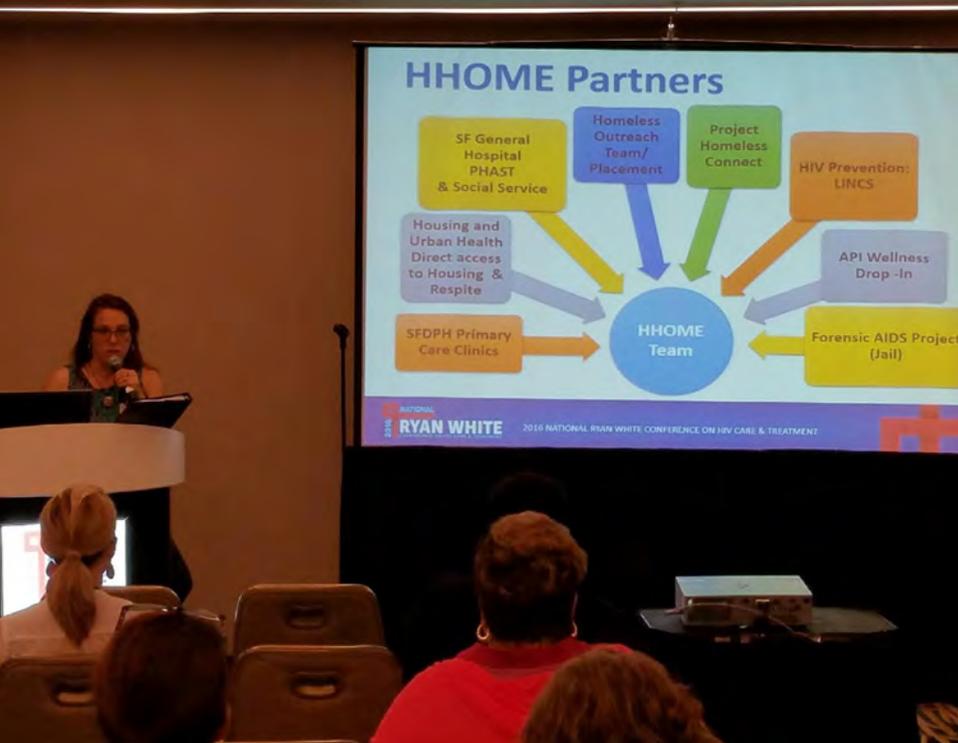
- We aim to create a non-hierarchical team dynamic, in which all input is weighted equally.
- Cross-training is at the center of our work.
- We prioritize the sharing of successes, treatment, and milestones among the staff-client community.

### **7. Radical health care:**

- We maintain a political commitment to improving health care for the homeless.
- Decrease systems barriers by creating a continuum of care among HIV providers in the city.
- Contribute to the growing body of research regarding homelessness, substance use, and mental health care.
- Stay informed about local and national policy.
- Effect change through example, provider training, data sharing, etc.

### **8. Trauma-informed care:**

- We have a client centered understanding that the effects of trauma on the client and system are the number one barriers to improved health.
- We prioritize self-care of staff and clients.



## SETTING UP THE MEDICAL HOME MODEL

### Partnership Background

In setting up the HHOME model, the SFDPH enlisted the help of key partners to enhance the utilization of and retention in HIV medical care by underserved populations in San Francisco.

HHOME’s mobile medical services are provided by staff of the Tom Waddell Health Center Urban Health Clinic (<http://www.sfhealthnetwork.org/primary-care-3/tom-waddell-urban-health-clinic/>), one of 12 public Federally Qualified Health Center (FQHC) neighborhood-based clinics and a facility that provides care to the most highly disadvantaged populations in the Tenderloin neighborhood of San Francisco. At its home clinic, the Tom Waddell Health Center provides care to nearly 9,000 residents of supportive housing in San Francisco per year, nearly all of them individuals coping with mental health diagnoses and substance use issues.

The Transitions Division provides clinical oversight as well as medical and care management support for the HHOME program. The goal of the Transitions Division is to ensure clients are stabilized in the most appropriate,

least restrictive setting in the most cost-effective manner. The Transition’s Care Coordination Program provides intensive support for clients with high utilization and complex care coordination between multiple partners and systems. The Placement program places clients in the appropriate level of housing and treatment (mental health, substance use, and conservership placement). The Street Medicine and Shelter Health Teams have been instrumental in clinically supporting HHOME clients with urgent medical care, primary care back up and medication adherence.

One of the program’s community partners is Asian & Pacific Islander Wellness Center (<http://apiwellness.org/>), a non-profit, multi-service community-based agency established to address the AIDS crisis in 1987. A&PI Wellness Center operates the HIV Care Program, which provides case management, mental health counseling, and substance use counseling for persons living with HIV, as well as a recently established Wellness Clinic providing free primary medical care to low-income, uninsured individuals one day per week. In addition to its long history of providing HIV

prevention and care services, A&PI Wellness Center has long operated the TRANS:THRIVE and Tenderloin Area Center of Excellence (TACE) programs and drop-in space. TACE provides medical case management to clients living with HIV who have less acute care needs than HHOME-eligible clients. Both programs offer continuity and support to HHOME clients. Many of the individuals who succeed in HHOME are discharged to TACE's lower needs in-house program.

Lastly, the HHOME partnership was established to augment the services and treatment model provided by the San Francisco Homeless Outreach Team (SF HOT). SF HOT is a public/private partnership involving the non-profit Public Health Foundation (PHF), the San Francisco Department of Public Health, and the San Francisco Human Services Agency (HSA). Since HHOME's inception, The SFHOT team is now under the Department of Homelessness and Supportive Housing. SF HOT staff reaches out to individuals who are experiencing homelessness and engages clients in emergency shelters, food programs, and even the public library. SF HOT has access to stabilization units that can move people off the streets into basic housing in less than 24 hours. By partnering with this team, HHOME has had unparalleled access to the city's most disconnected individuals and to temporary and permanent housing for these clients.

### Organizational Structure of the HHOME Team

The table on the next page describes the roles of staff members that comprise the HHOME team

“Together, the partnerships among San Francisco Department of Public Health, Asian & Pacific Islander Wellness Center, and San Francisco Homeless Outreach Team strengthen one of the core missions each entity has maintained on its own: to enhance the utilization of and retention in HIV medical care by underserved populations in San Francisco.

## SETTING UP THE MEDICAL HOME MODEL

Role	Description
Principal Investigator (PI)	Responsible for the completion and dissemination of all multi-site and local evaluation findings. Leads the development of all publications and presentations on study progress and outcomes. Makes connections with community stakeholders and other care providers so that clients may be referred into the HHOME program with ease and, later, discharged into appropriate levels of care.
Medical Doctor (MD)	Provides colocated onsite and mobile primary care to the most acute clients and collaborates closely with RN. Trains team on all aspects of medical and behavioral health/addiction medicine. Provides medical advocacy.
Project Manager	Provides day-to-day oversight of HHOME program. Supervises direct service team members and evaluation staff. Coordinates referral and discharges, oversees quality improvement efforts. Builds and implements project management tools; creates and implements clinical and recruitment protocols; and organizes and convenes clinical, administrative, and community stakeholder meetings.
Peer Navigator	Innovative position and role within the team. Oversees team's outreach and engagement efforts. Accompanies clients to appointments (Medicaid, General Assistance, DMV, medical appointments), advocates for clients with other service providers, supports clients to build their own support networks, and provides risk reduction counseling to high-risk clients. Provides life skills training for clients. Works with MD and RN to promote medication and care adherence. Supports evaluator with accompanying clients to interviews to promote study retention.
Housing Case Manager	Provides housing case management and housing-related counseling to clients throughout the project. Connects clients and is responsible for referrals to emergency shelter, stabilization rooms, permanent housing, benefits acquisition, and treatment residencies. Provides support services to clients to help them transition into more permanent and stable forms of housing. Connects clients to psychosocial services and primary care services.
Medical Social Worker (MSW)	Conducts field-based assessments of client needs; conducts psychosocial and cognitive assessments; develops and updates collaborative client care plans. Provides referrals to health and psychosocial service resources and programs, provides informal, field-based short-term psychosocial counseling to address immediate client barriers to care, including mental health and substance use issues. Oversees SSI application, transitions of client to higher and lower levels of care. Completes field visits with MD to support the most medically-acute clients.
Clinical Supervisor	Plans, coordinates, supervises and evaluates the SF HOT integrated program and clinical services of HHOME. Represents SF HOT with community stakeholders, coaching to HIV service providers with informed referrals, training and guidance of HHOME team with housing, mental health, substance use and benefits issues.
Registered Nurse (RN)	Provides co-located onsite and mobile nursing care and complex care management. Oversees med adherence program within HHOME, medicine reconciliation and medical treatment plans. Responsible for overseeing clinical care for less acute clients; coordinates patient care with MD for more acute clients. Provides referrals to clients for additional care services. Provides health literacy education to clients. Tracks laboratory tests and client clinical data. Works closely with housing case manager, conducting at-home care to clients.
Evaluation Coordinator	Responsible for data collection and day-to-day management of the local evaluation and multi-site evaluation for national study. Works closely with PI and external evaluation teams to develop publications and presentations. Builds and maintains evaluation plan, client databases, project timeline and clinical records. Conducts in-person interviews with clients, onsite and in the community, to collect baseline and follow-up data, runs data analyses, and prepares summary reports.



### Integrating the Peer Navigator Role into the Medical Team

The HHOME model of HIV Care Navigation is focused on engagement and retention in care, improving access to ART and addressing barriers to care clients with known HIV infection. The traditional continuum of HIV care consists of testing, treatment, and eventual viral suppression. In reality, however, treatment is often more cyclical than linear--many patients drop out and re-enter care at different points. There are a significant number of people living with HIV in San Francisco who fall through the gaps in the care continuum and need an additional safety net to assist in re-entry.

A substantial part of this work is dedicated to searching the community to locate missing clients who fall out of the continuum of care. For this reason, the HHOME program purposefully sought a peer navigator who grew up in the local neighborhood, the Tenderloin, one of San Francisco's most impoverished and disadvantaged communities. An effective peer navigator in the HHOME program had to be someone who is not only familiar with and respectful of the local businesses, residents, and community leaders, but also understands how to effectively navigate a community plagued by organized crime and drug trafficking.

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Once the peer navigator role was identified, it was important to review the organizational setting in which the navigator would function. The team worked together to review the roles and responsibilities of all HHOME team members so that everyone understood how the peer navigator role complemented the roles of the rest of the team in engaging clients in care.



# RECRUITING CLIENTS INTO THE PROGRAM

## Eligibility Criteria

At minimum, each client enrolled in the program will meet the following 6 criteria, except for special populations listed in the table to the right:

HHOME CLIENT ELIGIBILITY PARAMETERS
1) Have received a previous positive HIV test result;
2) Be living on the street or in HRSA-defined unstable housing situations;
3) Have identified psychiatric disorders and/or mental health conditions;
4) Have active substance abuse and/or chemical dependency issues;
5) Be an individual who is not currently engaged in HIV treatment or therapy and has a detectable viral load and low CD4; and
6) Be an individual who is not currently linked to an identified medical home and would require mobile medical care to thrive.

Below are those special populations, who need not meet all of those above requirements.

SPECIAL POPULATIONS
<i>These populations do not require that all 6 criteria be met, but they must be in need of mobile medical services, HIV adherence support, mental health and behavioral support, navigation, and intensive case management.</i>
1) HIV-positive pregnant women
2) HIV-negative pregnant partner of HIV-positive individual; partner meets HHOME criteria
3) Transitional Age Youth (TAY), ages 18-25
4) Young adults aging out of TAY services (ages 25-30), homeless, and not in care
5) Individuals with eminent risk of eviction and meet other HHOME criteria
6) Patients that have been denied services at more than one clinic.

### Referral Network Design & Planning

The program manager, principal investigator, and clinical supervisor regularly hold a series of meetings with the program stakeholders to discuss how to improve the delivery system of HIV care for the City of San Francisco. The goals of the meetings are to design a system for referring clients to the HHOME team, improve client coordination across the care continuum, and transitioning undetectable clients into the appropriate level of care. Stakeholder meetings are split into two groups, one group focusing on developing administrative protocols and another discussing clinical client cases. Hospital and community-based stakeholders review and refine the Acuity Scale and Clinical Frameworks they developed and have implemented to ensure a seamless continuum of care for clients living with HIV.

For more details on this process, please refer to the Community Stakeholder process in the HIV Care Continuum document in the *Resources* section. The sidebar on the next page outlines how the acuity and chronicity tool was developed.

### Referral System: Introducing the Acuity Scale

The acuity scale is used to assess the severity of the client's needs and to project the chronicity of each client. This scale determines a client's need for HHOME team services and informs the client's individual care plan. Clients who score mostly 3's on the acuity scale are referred to the HHOME team for mobile medical care. (See the HIV Continuum of Care document in the *Resources* Section.) As the continuum highlights, these referrals primarily come from the emergency room social work staff, our citywide surveillance and linkage team, as well as our partners in Jail Health.

The HHOME team clinical staff meets with these hospital and community clinic partners on a quarterly basis to review mutual clients. Initially these meetings were established to train community partners on the function

of the acuity scale and how to best assess clients. They evolved into broader case collaboration sessions to better serve clients across all agencies.

Similarly, all HHOME team members were trained early on to assess for eligibility by using the acuity scale, so that caseloads are determined by the entire team. Once referrals are received from the community, the HHOME program supervisor presents them to the team during weekly clinical meetings, with supplemental information about the referred client, gathered from the referral source; various local agency databases such as San Francisco's local Coordinated Care Management System (CCMS) and electronic health record systems, such as LCR and eCW; and, the regional Ryan White Database—the AIDS Regional Information and Evaluation System (ARIES). After the referral is presented, the full team assesses eligibility.

### Outreach and Engagement

#### Outreach

When a referral is accepted into HHOME, a plan for outreach and engagement is created, and the referral source and the client's existing care team are informed of the client's admittance to the HHOME team's care. After the clinical team develops a plan for engagement, the team continues to gather any further information needed from various databases as they begin the process of locating the client. Once the client is located, a medical team member, accompanied by a support service team member, meets the client to conduct an initial assessment and begins engaging the client in care. The team attempts to build a rapport with the client by identifying goals such as housing, benefits, or access to other material resources not directly relating to medical care. These may include services related to emotional support, such as family and community reunification, and the equal prioritization of the client's psychological and social needs, in order to create an effective relationship between the team and the client.

After initial contact (See the First Contact Checklist in the *Resources* section) the team focuses on securing appropriate housing for the client, which may consist

### Developing the Acuity and Chronicity Scale

Borrowing from the Massachusetts Department of Public Health and their Peer Program (<http://cahpp.org/resources/HIV-MCM-acuity-tool>), HHOME adopted the Acuity Scale, iterating the framework along the way to suit the particular needs of its clients. Because of the simple number system (which uses a 0 to 3 scale), the Acuity Scale has been easily adopted by HHOME staff, their community partners, and now across divisions in the San Francisco system. There is now a longer version of the tool for clinical assessment and a short version for referrals. Because any edits to the tool are made in conjunction with community partners, this acuity framework functions as a shared clinical language and a living tool, which can adapt to the needs of our clients and system.

### Developing the Acuity and Chronicity Clinical Framework model

For each of the 5 domains, and subdomains of the acuity assessment tool, the HHOME team, in conjunction with the community partners, developed the clinical Framework guidelines. This has assisted with specific yet flexible integrated clinical recommendations for each patient. Given the chaotic nature of our clients lives, and their rapidly changing treatment plans, the Framework has aided the team in staying grounded, focused and coordinated. For example, with clients who have a score of “3” (high acuity) for adherence, the team is doing daily adherence, each team members roles are clearly spelled out. It also assists the team in planning for discharge. If someone’s ‘chronicity’ (highest level they can achieve) is a 2 for case management, the team will refer for higher level intensive case management services early in their engagement

### Working with the Team

From the start of the intervention, the HHOME team set out to build relationships with LINCS—our city’s surveillance and linkage team, mental health providers, emergency room social workers and other staff, and Laguna Honda—our city’s long-term inpatient facility for clients living with HIV. To sustain open communication, HHOME facilitated many meetings with the entire team to structure the working relationship, while assigning a specific HHOME staff member to regularly visit staff and clients at each facility. All community partners were invited to meet one another at quarterly stakeholder meetings, which were coordinated to: edit shared tools, discuss referred clients, and address any issues. Because our city’s hospitals and emergency rooms are operating at capacity and are a vulnerable point of transition for so many individuals, an overwhelming number of HHOME clients were referred from these partnerships.

### COMMUNICATION:

External: while a care/treatment plan is developed for each active HHOME clients, the care plans of high utilizers are included in the electronic health records database (eCW/LCR)—a stop-gap solution in a system which relies on multiple databases and, therefore, encounters communication barriers in sharing client information.

Internal: the HHOME team communicates client information with one another using a panel that was developed in-house, which tracks clinical variables, as well as psychosocial, adherence, and navigation measures. HHOME has often operated beyond capacity, and so the panel helps the team to review client status, progress, and facilitates transition and discharge processes.

of a stabilization room or a shelter bed. If the client has acute medical needs, the team prioritizes care by obtaining medical treatment. In the event a client is in the hospital, the team makes arrangements to meet the client at the hospital and arranges for mobile medical care. Since many prospective clients have co-occurring disorders such as substance use and mental health issues in addition to acute medical issues, a client may be challenging to engage, may refuse services after initial contact, and may require very low threshold service before they are ready to fully engage in care.

Clients may demonstrate concern and ambivalence toward receiving services, and separately, about being participants in HHOME. In these situations, the HHOME team continues outreach in order to build a positive rapport with the client. If unable to reach the client or the client refuses services, that client is placed on the “hover” list, which means that the client moves to the team’s outreach list, which the peer navigator uses to prioritize clients for engagement. If applicable, the referring agency is notified that the HHOME team is no longer looking for this client but willing to engage if they present again. An alert is placed in the LCR to notify the primary care provider on the team if the client appears in a city hospital or emergency room. The Peer Navigator continues to search for clients on the hover list by calling local jails and emergency rooms on a weekly basis.

### Client Engagement

Once a relationship is established and the client agrees to accept services, the client signs a number of forms consenting to receive services with the understanding their information may be shared with other providers in order to provide the most comprehensive services available. Clients interested in enrolling in HHOME are required to sign the following forms (See the *Resources* section for examples of some of these forms):

1. Consent for Case Management Services
2. Authorization for Use or Disclosure of Protected Health Information
3. Authorization for Disclosure of the Results of the HIV Antibody Blood Test or Other HIV Identifying Information

4. Statement of Client Rights
5. Program Expectations and Rights
6. Agency Expectations and Rights
7. Client Grievance Procedure
8. Income Statement
9. Summary Notice of HIPAA Practices
10. SF DPH Consent to treat

The peer navigator is assigned to transition the client into care with HHOME, though all team members play a critical role. Part of this process is to educate the prospective client about available services. The HHOME team refers back to the acuity scale for each active client on a monthly basis in order to provide an ongoing assessment of each client’s need and determine the most effective transition plan. What is an effective transition plan, of course, can vary widely by client. Some clients may always have high acuity and the goals of their treatment may just be palliative care. Other clients may be able to transition into a clinic setting for medical care and transition towards housing.

**If unable to reach the client or the client refuses services, that client is placed on the “hover” list, which means that the client moves to the team’s outreach list, which the peer navigator uses to prioritize clients for engagement. An alert is placed in the EMR (LCR) to notify the primary care provider on the team if the client appears in a city hospital or emergency room.**



## SERVICE DELIVERY MODEL

### Team Roles & Responsibilities

Below is a description of the activities of each team member as they pertain to delivery of services to clients:

#### Peer Navigation

**The peer navigator** assists case managers, benefits enrollment specialists, and other HHOME team members in linking clients to behavioral health and primary care services.

Primary duties include:

- Conduct outreach to identify and enroll clients in HHOME;
- Regularly update client file;
- Escort clients to appointments for behavioral health, medical treatment, social services, substance use counseling, and other government services such as DMV, court appointments, etc.;
- Provide clients with the life skills, emotional support, and guidance necessary for living with HIV;
- Assist clients to build social support networks and become more self-sufficient;
- Oversee appointment scheduling;

- Encourage peer and client-centered medicine adherence; and
- Reengage clients who are lost-to-follow-up.

The peer navigator currently serves all of HHOME's clients. A substantial part of this job is dedicated to searching the community in order to locate missing clients who fall out of the continuum of care. For these reasons, the HHOME Program purposefully sought a peer navigator who grew up in the local neighborhood, the Tenderloin, one of San Francisco's most impoverished and disadvantaged communities. An effective peer navigator is someone who is not only familiar with and respectful of the local businesses, residents, and community leaders, but also understands how to effectively navigate a community plagued by organized crime and drug trafficking.

The peer navigator also counsels clients in basic social skills such as how to communicate with others, build healthy friendships, and make better decisions for themselves. Many clients in HHOME lack the necessary life skills to make these healthy decisions. The peer navigator also encourages clients to get out of the Tenderloin neighborhood and experience the natural beauty of San

Francisco. This habit is emphasized in order to stop clients from continuing to be a product of the negative environment in which they may live.

The API Wellness Center staff and peer navigator have also recently begun hosting social events for clients. Previous events have included fish fries and barbecues; these activities offer clients the opportunity to congregate with other clients experiencing the same challenges and meet clinic staff in a more social environment. During these events, despite clients' physical and perhaps behavioral health challenges, most clients can be very social and outgoing. Substance use, however, may inhibit the experience for some.

In performing his/her duties, the peer navigator uses the Peer Navigator Checklist in the *Resources* section.

### Case Management

**The case manager** engages, counsels, and links HIV positive homeless clients who are no longer in medical care to appropriate medical, housing, mental health, and other services as needed. The case manager serves as a counselor and advocate for clients, providing clients with the necessary support in navigating the care service systems and finding a safe and secure living situation.

Primary duties include:

- Identify all services that the client currently needs as well as resources that are readily available to assist the client;
- Identify agencies that have the capacity to provide needed services to the client;
- Write and oversee integrated treatment plan for how the services will be accessed and coordinated;
- Conduct an initial interview (also referred to as the “client assessment”);
- Conduct outreach of individuals who are living with HIV and experiencing homelessness; assess their housing, benefits, medical, mental health, and substance use issues and needs;
- Complete morning rounds with MD and/or RN;
- Meet with clients regularly to assist in customizing and implementing a care plan;
- Confer with team members to develop engagement strategies and develop care plans for each client;

- Establish and maintain a caseload of clients and provide paraprofessional counseling, crisis intervention, evaluation, advocacy, linkage, and referrals;
- Work with clients to secure any needed benefits and insurance enrollment;<sup>1</sup>
- Conduct eligibility screening for ADAP;
- Advocate for resources that help stabilize clients, including housing, medical, and financial benefits, healthcare, and other social services, as needed;
- Keep and maintain up-to-date detailed records on each client;<sup>2</sup> and
- Transfer or discharge a client when appropriate. (See the Discharge and Transition section for details.)

An effective case manager is someone who is good at establishing and maintaining positive mutual support relationships with other service providers and community groups.

Most often the case manager generates the client assessment, which is the initial interview of an incoming client. Later, other team members contribute to the assessment; a complete client assessment includes a determination of the client's need for services such as housing, food, primary care, clothing, money management, benefits, visiting nurse and home healthcare,

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<sup>1</sup>This includes:

- Assessing insurance coverage;
- Assisting with enrollment into Healthy San Francisco, a health services program for uninsured residents of San Francisco;
- Obtaining SFDPH medical record number;
- Registering the client with Tom Waddell Urban Health Clinic, MediCal, MediCare, etc.
  - o Clients who are determined to need further assistance with insurance and/or other benefits (e.g., SSI, GA, and SSDI) are referred to an eligibility worker at the Tom Waddell Health Center or a benefits counselor from an outside agency (e.g., Positive Resource and the AIDS Legal Panel) for a more comprehensive assessment.

<sup>2</sup> These records are stored on a web-based client database.

hospice, legal services including immigration, employment/work entry and re-entry, and other services that offer practical support for daily living.

During the client assessment, the case manager will work with the client to:

1. Encourage clients to identify their primary and secondary needs;
2. Determine the extent and nature of the client's service needs;
3. Assess the client's support network;
4. Determine the extent to which other service agencies, including the client's primary medical provider, other social service providers, and other case management programs are involved in the client's treatment and support;
5. Assist the client to determine health education and/or other support needs in order to reduce HIV transmission risk;
6. Work with the client to develop a written care plan (discussed below) that prioritizes the client's identified service and support needs, as well as the frequency of face-to-face contacts; and
7. Work with the physician, registered nurse, and medical social worker to complete medical and mental health assessments. (See the medical social work and behavioral health section for details.)

The information collected during the client assessment is important for establishing a baseline profile for each client, developing a care plan for the client, and making initial service referrals. Comparing this baseline profile with information collected during follow-up and reassessment visits gives the Case Manager the ability to evaluate the client's continuing need for services and support.

In performing his/her duties, the case manager uses the Case Management Checklist included in the *Resources* section.

### Registered Nurse

**The registered nurse** delivers clinic-based and mobile medical care, administers client medication, oversees treatment plans, schedules and draws labs, and conducts

medication adherence counseling. Within two weeks of initial contact, the nurse evaluates the client and conducts the initial HHOME nurse screening. This can be done in lieu of or in preparation for a visit with the client's primary medical provider. This screening includes:

- Initial medical screening<sup>3</sup>
- Functional assessment of ADL and the need for durable medical equipment<sup>4</sup>
- Past medical history<sup>5</sup>
- Baseline biomedical labs<sup>6</sup> and lab schedule
- Food acquisition
- Complex care management
- HIV medication and prophylaxis<sup>7</sup>
- Monitoring medication side effects and response to treatment
- Adherence assessment and plan-using the acuity scale<sup>8</sup>

During this screening, the registered nurse assists the case manager with benefits, insurance enrollment, and obtaining a release of information form for the prior medical records of the client.<sup>9</sup>

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<sup>3</sup> Here, the registered nurse conducts a medical intake to identify any significant past medical history, medication history, allergies, recent admissions, etc.

<sup>4</sup> This is documented on the medical acuity scale and includes a suggestion of the level of care needed.

<sup>5</sup> Including, but not limited to, surgery, medical history, health maintenance, immunization, PAP, STD screening, and opportunistic infections.

<sup>6</sup> Here, Standard HIV and general primary care labs are obtained. These include: CBC with differential, complete metabolic panel (electrolytes, renal function, and liver function tests); CD4 count, HIV viral load; resistance testing history; hepatitis serology (hepatitis A, B and C); Syphilis; TB/QFT; GC/C; and HLA-B5701.

<sup>7</sup> Including a review of the client's past medication, ARV readiness, insurance of prophylaxis, and resistance testing.

<sup>8</sup> Here, the registered nurse designs an adherence plan and goals.

<sup>9</sup> Including assisting with referrals to eligibility assessment for health to organizations such as SF MediCal, MediCare, Ryan White, and ADAP.

Primary duties include:

- Develops treatment plans for clients;
- Oversees medication management;
- Schedules, draws, and monitors labs throughout client's engagement;
- Conducts medication adherence counseling;
- Determines best intervention based on client acuity;
- Contacts pharmacies, schedules medication pick-up;
- Navigates client insurance;
- Conducts initial HHOME nurse screening; and
- Conducts morning rounds with case managers.

In performing his/her duties, the registered nurse uses the RN Checklist included in the Resources section.

### Primary Care Provider/Physician

**The PCP/physician** delivers clinic-based and mobile medical care.

The Initial HHOME physician screening takes place within the first week of client enrollment, unless there is an exceptional, noted circumstance. Before meeting with the physician, the client may have: (a) made initial contact with the case manager, and/or (b) scheduled or completed the client assessment with the case manager or the initial nurse screening with the registered nurse.

During the Initial HHOME physician screening, the HHOME physician:

- Assesses vital signs and chief complaint by the client, registered nurse, and any other recent medical evaluator;
- Reviews past medical history, social history, health-related behaviors, current medications, allergies, and other medical history;<sup>10</sup>
- Conducts a full physical examination;

<sup>10</sup> If the client has been admitted to the hospital recently or contacted a physician within the 3 weeks prior to the initial HHOME physician screening, the HHOME physician reviews any information from the hospital or from the client's current primary care provider and contacts the client's current primary care provider. For a client discharged from inpatient medical or psychiatric care, the HHOME physician speaks directly to the discharging physician and if possible visits client prior to discharge.

- Reviews available labs and imaging, including data collected during the initial HHOME nurse screening; coordinates with any provider from higher or lower level of care that has recently cared for patient
- Completes the medical portion of the acuity scale, including utilization patterns, chronic and acute medical issues, and health literacy; and
- Formulates a problem and priority list.

Client-centered care and formulation of a treatment plan include:

- ARV and prophylaxis start or plan
- Client priorities<sup>11</sup>
- Acute illness
- Chronic disease
- Pain assessment and plan
- Health literacy and activation assessment
- Addiction medicine treatment
- Mental health medical treatment
- Advance directives and palliative care assessment

After the initial HHOME physician screening, the HHOME Physician establishes a follow-up plan with the client. The follow-up plan includes: an outline of upcoming medical visits, a review of any medications prescribed, and any other medical needs as noted.

While the HHOME physician determines the upcoming medical visits by the acuity and urgency of the client's health needs, a general follow-up schedule after the initial visit includes weekly medical appointments with the HHOME physician or HHOME registered nurse for the first month,<sup>12</sup> and then every two weeks.<sup>13</sup>

<sup>11</sup> These are identified during the client assessment with the case manager. See the *Case Management* description above.

<sup>12</sup> During the first month of medical appointments, the HHOME physician or HHOME registered nurse encourages the client to attend clinic-based primary care. The expectation is that the client will attend clinic-based primary care on a monthly basis.

<sup>13</sup> If weekly medical appointments are not needed, the HHOME Team assesses whether the client should be discharged from the program. See the *Discharge & Transition* section for more information.

At each medical visit, the client has chief complaints, vital signs, and self-identified needs noted by the HHOME registered nurse. The HHOME physician evaluates the client and formulates a diagnostic and treatment plan with the goal of addressing:

- Street-based care engagement plan by HHOME team
- Urgent care issues
- Coordination with hospital or urgent and emergent care providers
- Medical communication with inpatient and residential programs
- Acuity scale
- Palliative care

For a full list of responsibilities, see *Primary Care Provider Checklist* in *Resources* section, which the HHOME MD uses to make sure she provides consistent care to each client:

### Medical Social Work and Behavioral Health

**The medical social worker** conducts field-based assessments of client needs; conducts psychosocial and cognitive assessments; develops and updates collaborative client care plans. Provides referrals to health and psychosocial service resources and programs, provides informal, field-based short-term psychosocial counseling to address immediate client barriers to care, including mental health and substance use issues. Develops long-term client transition plans and coordinates all discharge planning.

Primary duties include:

- Providing psychosocial assessments;
- Coordinating a medical care plan with the primary medical and oral health providers;
- Providing health education to the client;
- Supportive counseling;
- Intervening when a client is in crisis;
- Advocating for client benefits;
- Enrolling clients in ADAP;
- Coordinating services within HIV Care Services as assigned by the Case Manager;

- Directing client work and interacting<sup>14</sup> in the field and at the office;
- Developing advance directives;
- Coordinating transitions between higher and lower levels of care; and
- Completing a DSM IV interview with the client using the DSM IV-TR, **within the first week**

Clients will have the opportunity to meet with the medical social worker after entering the program. At initial enrollment, the case manager will have the discretion to facilitate earlier appointments for clients<sup>15</sup> to meet with the medical social worker.

### Mental Health Services

The medical social worker will conduct an in-depth psychosocial assessment to identify the client's needs and ongoing one-on-one sessions thereafter. The medical social worker may make additional referrals as needed to other services, support networks, and agencies. The medical social worker may also work with the primary care provider to refer clients to formal mental health care.

### Psychiatric Emergencies

Clients may have mental health emergencies. These include suicidal ideation, homicidal ideation, or a grave inability to care for self. The following are some clinical steps taken in the event that a client has a psychiatric emergency:

- A staff member is assigned to be with the client at all times;<sup>16</sup>
- Assigned staff member informs program supervisor and calls mobile crisis hotline;
- Clients are transferred via 911 to psychiatric emergency services at nearest hospital;
- The medical doctor is notified by pager immediately;

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<sup>14</sup> All interactions, assessments, and one-on-one sessions are documented in the client's record.

<sup>15</sup> Particularly for clients with more pressing psychosocial priorities.

<sup>16</sup> Client are not left unobserved if deemed to be in psychiatric emergency. Crisis intervention training is required in order to be a part of the HHOME Team.

and

- The clinical team meets to debrief, document the process, and plan for a follow-up.

In performing his/her duties, the medical social worker uses the *Social Worker Checklist* included in the *Resources* section.

## Cross-Training, Communication, and Collaboration

### Weekly Schedule

The team adheres to a weekly care provision schedule to maintain consistency with clients and their treatment plans, while maintaining an environment of accountability. The weekly schedule for the HHOME team is shown below.

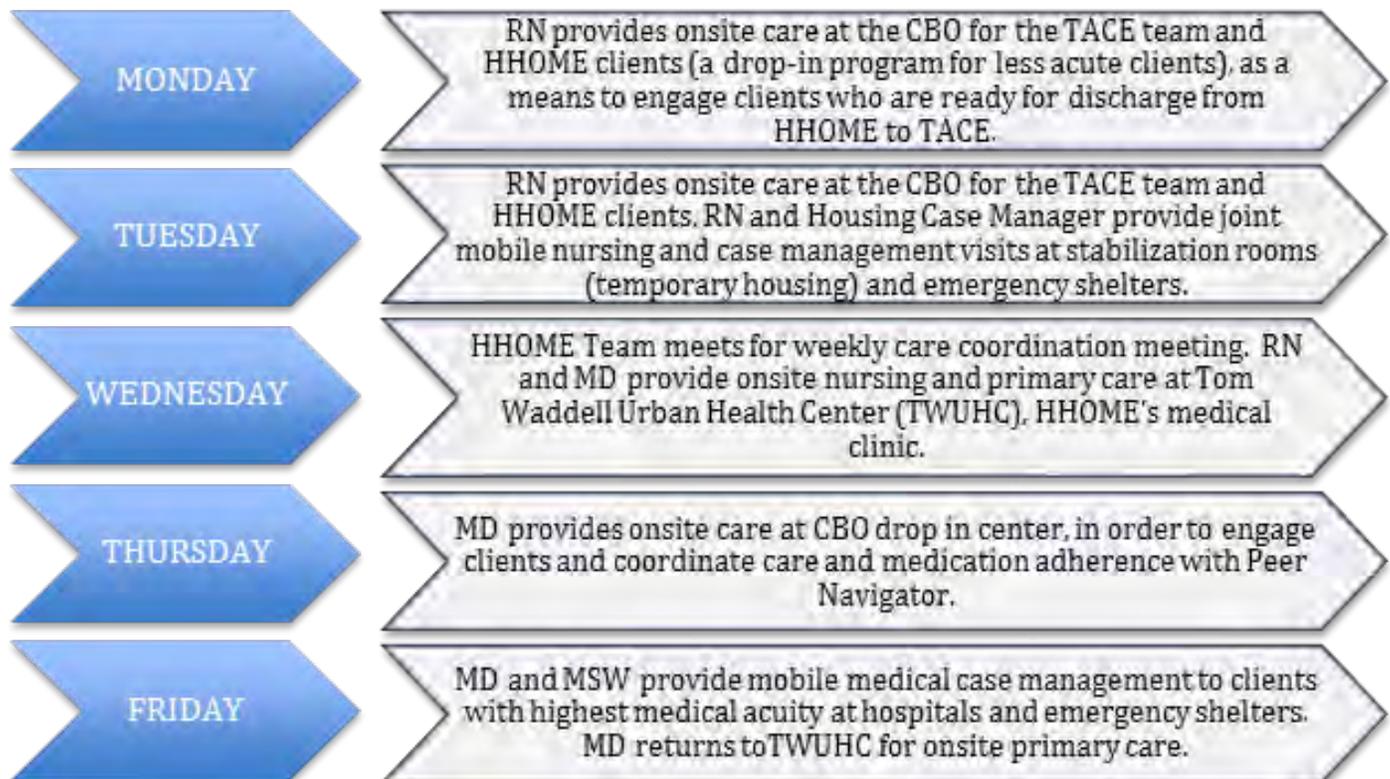
### Cross Training

In order to ensure optimal functioning of the integrated team we employ QI principles and cross training. All staff work with each other in ongoing dyads: RN-MD, Navigator –MD, or RN, CM-MD or RN, SW-MD or RN etc. the goal is to ensure cross training of skills as well as ensure a 360 view point to client care.

### Staff Communication Procedures

The HHOME team finds the following internal and external communication procedures effective in ensuring the progress of the HHOME Project and in providing supportive, effective care to clients:

- **Weekly Phone Huddle:** Once a week the HHOME team calls into a conference line to discuss urgent medical, mental health, and housing needs. This team call is also a forum for developing tasks to manage urgent client needs, such as clients being discharged from a facility.



Note: At any urgent times throughout the week, the medical team is available to provide this same level of care on a mobile, offsite basis.



(Photo left) Program staff offer bracelets imprinted with the HHOME phone number to clients so that they have contact information readily available if they need to reach anyone on the team--a literal symbol that someone has their back. (Photo center) Staff also give gifts of nail polish, a small luxury that makes a person feel pampered. (Photo right) One client found the bracelet helpful in making sure a beloved pet doesn't get lost!

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- **HHOME Clinical Meeting:** The interdisciplinary team meets for 1.5 hours a week to triage client's urgent needs, case conference, and review new referrals. A list with client data is updated weekly and distributed at this meeting for review and discussion.<sup>17</sup>
- **HHOME Bi-weekly Transition Meeting:** This meeting is held collaboratively by the HHOME Team and the TACE team to discuss transitions and discharges of clients from HHOME primarily into the TACE team.
- **Group Text Message:** The HHOME team uses a group text<sup>18</sup> to update one another during business hours. This group text is used for problem solving and quick decision making about client issues.
- **Client Registry:** Updated weekly to reflect up-to-date client data.
- **Progress Notes:** Prepared by each HHOME team member.
- **Email:** Daily use of email correspondence to discuss client updates.

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<sup>17</sup> See the Care coordination and integrated care management section

<sup>18</sup> The interdisciplinary team complies with HIPAA by using nicknames or initials to discuss client related issues.

## Care Plan, Care Coordination, and Housing Procedures

### The Care Plan

The care plan includes the client's individual goals, objectives, and timelines. The care plan reflects the needs that the client and the case managers have identified during the client assessment.<sup>19</sup> It should be modified as necessary, depending on the client's current condition and/or need for services.

The Care Plan includes:

- The client's individual goals and objectives;<sup>20</sup> pertaining to:
  - Medical care and treatment
  - Psychosocial and behavioral health
- A clear definition of the role of the case manager in implementing the care plan; and
- An estimate timeframe for accomplishing each goal, objective, and activity/task of the care plan with the client and/or the client's caregivers.

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<sup>19</sup> Development of the Care Plan is an interactive process that encourages the client to actively participate in the decision-making process related to the client's care, support, and treatment.

<sup>20</sup> The client and Case Manager establish and prioritize the goals and objectives.

The purpose of the care plan is to:

1. Set and prioritize long and short term goals, which the client and case manager identify;
2. Promote continuity of care at a level that is desirable to the client;
3. Set realistic expectations of what the client and the case manager can accomplish together for the benefit of the client;
4. Define the role of the case manager in implementing the care plan;
5. Plan for how the needed services will be accessed and coordinated; and
6. Set an estimate time frame for accomplishing the goals, objectives, and tasks under the care plan with the client and the client's caregivers.

### Implementation of the Care Plan

Like all other aspects of HIV case management, implementation of the care plan requires that the case manager and the client, in coordination with the multidisciplinary team, work closely together to achieve the goals and objectives of the care plan. Providing encouragement to the client is as much a part of implementing the care plan as the actual brokerage and coordination of services for the client.

To implement and strengthen the care plan effectively and efficiently, the Case Manager (along with the rest of the HHOME team) should:

- Take steps to minimize the barriers to obtaining needed services;<sup>21</sup>
- Support and encourage the client to take action on the client's own behalf;
- Monitor the progress of the care plan by reviewing it regularly with the client and revising it as necessary based on any changes in the client's situation needs,

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<sup>21</sup> E.g., contact other providers to make arrangements for client referral, arrange transportation for client, contact client to determine whether referral appointments have taken place, make arrangements directly with service programs to provide services to client, escort clients to appointments if necessary, and encourage the client to advocate on their own behalf.

strengths, and limitations of the client as documented in the client assessment; and

- Ensure the care plan is a realistic reflection of what the client and the Case Manager can accomplish together for the benefit of the client.

### Follow-up and Monitoring

Regular follow-up and monitoring of the client by the case manager helps to determine whether the goals and objectives of the care plan are being met. In addition, by regularly following-up with the client, the case manager can assess if there have been any changes in the client's situation and revise the care plan if necessary. When following up with and monitoring a client, the case manager<sup>22</sup> should:

1. Review the care plan with the client to determine its relevance and adequacy;
2. Ensure that treatment and support are being coordinated to avoid duplication or any gaps in services;
3. Record the progress and any changes that have occurred in certain areas;<sup>23</sup>
4. Address, as appropriate, any changes that have emerged in the client's condition or circumstances in order to avoid crisis situations;<sup>24</sup> and

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<sup>22</sup> The HHOME Team also monitors the client through its integrated care management system. See the section on *Care Coordination and Integrated Care Management*.

<sup>23</sup> The areas include:

- Basic needs (e.g., food, housing, transportation, clothing, income, and social and practical support systems);
- Physical health and health care (e.g., change in HIV disease status [e.g. stabilization, progression, improvements], other health care or medical problems, contact with primary medical provider);
- Mental health (e.g., change in mental health status, adequacy of mental health care); and
- Substance use (e.g., status of any new or ongoing substance use problems, adequacy of current treatment or need for new treatment).

<sup>24</sup> Or conversely, address any changes that create opportunities for transition toward autonomy and independence.

5. Maintain client contact on a regular basis in order to build communication, trust, and rapport with the client.

### Reassessment

A comprehensive reassessment of the client's medical, psychosocial, and financial condition and service needs should be conducted at least once every six months. Such regularly scheduled, periodic reassessments of the care plan with the client are necessary to determine whether the appropriate level of care is being delivered as a client's situation changes over time.

Reassessment is an important opportunity to work with the client to reevaluate the client's conditions and make appropriate adjustments to the level and intensity of the services being delivered.

When conducting a reassessment, the case manager:

1. Documents in the client record any changes that have occurred in the client's physical, mental, and psychosocial status since the client assessment was conducted;
2. Reviews with the client the adequacy of client's social support network;<sup>25</sup>
3. Assesses changes in client's financial status or benefits that may affect the client's ability to meet expenses;
4. Discusses (if applicable) with client any legal and financial arrangements, such as durable power of attorney, living will, and guardianship of children/dependents;
5. Determines if the client has any additional or further need for services;
6. Determines the care plan progress and what goals the client has achieved since the previous assessment was conducted;
7. Assesses the satisfaction of the client with the level of care and services currently being provided;
8. Assesses whether client requires an increase or decrease in the intensity of case management services;

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<sup>25</sup> Including adequacy of caregiver support, ability of caregivers to provide needed psychosocial and practical support in light of any changes in client's condition.

and

9. Assesses client's capacity to begin or continue transition toward greater autonomy and independence through vocational rehabilitation, job training, and/or employment service.

## Care Coordination and Integrated Care Management

A significant part of a care plan for client might include care coordination with other providers. This occurs for the highest acuity clients—particularly, those clients who are referred to HHOME with an overall acuity of a 3 and, for any number of reasons, will remain a 3. For these particular clients, HHOME may be acting as agent of coordination or advocate for referring client into a more appropriate and higher-acuity level of care, such as skilled nursing and palliative care.

When clients are accepted into HHOME and meet all eligibility requirements, coordination with other providers is still a crucial element of their care plan.

The purpose of integrated care management is to:

1. Document, organize, and plan for comprehensive support services for the client;
2. Promote continuity of care at a level that is desirable to the client;
3. Identify the services that the client currently needs, as well as the resources that are readily available to assist the client;
4. Identify the agencies that have the capacity to provide the needed services to the client;
5. Plan for how the needed services will be accessed and coordinated; and
6. Set an estimated time frame for accomplishing the goals, objectives, and tasks under the care plan with the client and the client's caregivers.

## Housing Procedures

Housing is directly linked to dramatic reductions in individual morbidity and mortality and is the single most important factor in ensuring the long-term health and well-being of clients. The HHOME Project uses

a complex, multi-pronged approach to ensure access to housing options in San Francisco through working in close collaboration with a variety of housing resource programs including medical respite care, emergency shelter housing, short-term and permanent supportive housing, and SRO housing. The HHOME Project has access to two dedicated stabilization rooms through the San Francisco Homeless Outreach Team. When the HHOME team makes contact with an eligible client, the clinical supervisor at San Francisco Homeless Outreach Team makes the final determination if the client receives a room. Upon receiving a room the client is required to sign a Stabilization Room Agreement.<sup>26</sup>

San Francisco has individually tailored emergency shelters<sup>27</sup> for various populations in the city of San Francisco, specifically Transgender/LGBT individuals, single men, single women, women with children, youth from ages 18-24, families, women fleeing domestic violence, and children.<sup>28</sup> Specific types of housing for the target population of the HHOME team are listed below:

- **Emergency Housing**— This program is designed as a short term, 28-day housing intervention for HIV-positive San Francisco residents that can be used once every 12 months. This housing stabilization program is administered by Lutheran Social Services with the goal of transitioning clients to a more stable housing situation.<sup>29</sup>
- **Housing for People Living with AIDS (HOPWA Housing)**—This program is also administered by Lutheran Social Services. This 16-month program<sup>30</sup> is tailored to HIV positive clients who

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<sup>26</sup> The Stabilization Room Agreement allows a client to stay up to 28 days.

<sup>27</sup> Short-term and accelerated entry process for these shelters.

<sup>28</sup> See San Francisco Matrix of Single Adult Shelters and Resource Centers, Providence Foundation Family Shelters, San Francisco Homeless Family Emergency Shelter System, 2014 in the *Resources* section.

<sup>29</sup> Referrals must come from specific HIV providers.

<sup>30</sup> The client or case manager needs to complete an application.

 Housing is the single most important factor in ensuring the long-term health and well-being of clients.

have recently been released from jail. It is administered by Lutheran Social Services and requires the client to attend weekly meetings and obtain a Rep Payee for money management.

## Discharge and Transition

Transfer or discharge from case management programs occurs when the clinical team and the HHOME Project no longer serve the needs of the client. This occurs when either (i) a client has progressed to a more advanced stage of disease and needs more intensive case management; (ii) a client's health status has improved to a level where they are capable of greater self-sufficiency; or (iii) a client leaves the area, transfers case management responsibility to another program, refuses further participation in the program, or is otherwise no longer eligible for the program. It is also necessary for the HHOME team to initiate discharge procedures when a client has exhibited threatening or dangerous behavior. Actions that may qualify a patient for discharge include pointed threats to a medical provider, becoming banned from a provider's building by security, or selling drugs in a medical facility.

It is important to ensure that transfer and discharge are carried out in a planned and carefully executed process that takes into account the needs of and does not unnecessarily disrupt services to the client and the client's caregivers, family, and support network.<sup>31</sup> Before

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<sup>31</sup> See Acuity Frameworks and the Discharge Checklist in the *Resources* section. The HHOME Team uses these tools at the bi-weekly Transition & Discharge meeting. See the *Cross-Training, Communication, and Collaboration* section for more information on team meetings.

“A client is not likely to make a linear transition from one milestone to the next, but rather progress in a cyclical pattern toward the overall goal of increased self-sufficiency.

undertaking the transfer or discharge of a client from case management services, providers take the following steps:

1. Consult with the supervisor and other members of the multidisciplinary care team in order to develop a plan for discharging or transferring the client;
2. Discuss with the client and the client's caregivers the decision to discharge the client from the HHOME program;
3. Inform the client of other agencies that might better meet the client's needs for treatment and support and make arrangements to refer the client to another agency;
4. Document in the client's file reasons for the planned transfer or discharge and document in progress notes discussions with the client about planned transfer or discharge;
5. Set a reasonable timeline for discharge or transfer that allows sufficient time for the client or the client's caregivers to make other arrangements for care or treatment; and
6. Discuss and document the process for reinstatement of services should it become necessary and appropriate in the future.

A client is considered ready for less intensive case management services if he or she demonstrates one or more of the following indicators:

- Client has an undetectable viral load;
- Client is now residing in long-term stable supportive housing;
- Client is stably linked to a medical care facility; or
- Client with a diagnosed mental health condition is taking prescribed psychotropic medications and maintaining regular appointments with a treatment provider.

The above indicators are long-term goals in an ongoing process. A client is not likely to make a linear transition from one milestone to the next, but rather progress in a cyclical pattern toward the overall goal of increased self-sufficiency. A client may achieve an individual goal but experience additional barriers to full recovery. Common barriers include institutional limitations such as a lack of funding for assistance programs, mental and physical health limitations associated with long-term homelessness, and self-esteem issues. A client may also experience a drug relapse or additional psychological trauma, which are often part of the recovery process. Due to the vulnerability of this client population, any number of events can result in a client's serious setback. In a high cost area such as San Francisco, many clients are particularly vulnerable financially such that even a short disruption in income can result in a return to homelessness. The goal is to work with the client to put him/her in the most appropriate services available, and for the client to take control over their own care.

## Handling Conflict with Staff and Clients

### Conflict Resolution

In the event of a conflict or controversy between members of the clinical team, the Principal Investigator provides direction and guidance to resolve the issue. In the event of an administrative or financial conflict between the collaborating agencies in the team, San Francisco Department of Public Health – HIV Health Services provides direction and guidance to resolve the issue. In the event of a conflict or controversy regarding housing, the San Francisco Homeless Outreach Team provides direction and guidance to resolve the issue.

In the event that a client perceives or experiences conflict or miscommunication with the staff, they are encouraged to file a grievance report,<sup>32</sup> which the project manager will follow up on.

### Denial of Services

The majority of HHOME clients have had many interactions with the San Francisco Department of Public Health Clinic system. Subsequently, many clients in our target population are either high users of medical services (HUMS) who use multiple health services in the most expensive and inefficient manner or they may simply drop out of care and receive no medical care for serious chronic conditions in addition to living with HIV/AIDS. One role of the HHOME clinical team is to work with other DPH providers to re-negotiate the denial of service directives so clients receive much needed medical care. Services are provided anywhere outside the clinic site such as in the client's home or in the community, and this is noted in the client's file. The HHOME team works with providers to address problematic behaviors and help a client access any grievance or appeal process. The goal is to help every client access services while making every effort to ensure the safety of providers.

### Stakeholder Model and Referral Network

See the HIV Care Continuum Document in the *Resources* section for an in-depth look at our citywide Stakeholder Model & Referral Network

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32 See Grievance Form in the *Resources* section



## EVALUATION AND QUALITY CONTROL

In addition to the nationwide multi-site evaluation described in the multisite manual for the larger HRSA SPNS project, the Asian & Pacific Wellness Center conducted a local evaluation of the HHOME Project, which is nested within and informed by the larger cross-site process.

### Overview of the Local Evaluation

The local evaluation consists of both process and outcome measures, and it employs both quantitative and qualitative methods. It focuses on interagency collaboration and developing systems to track and serve hard-to-reach clients. HHOME focuses on individuals who may have interacted with multiple health and human service agencies in California, but have fallen through the safety net. A key component to the efficacy of this model is the ability for programs and organizations to work together to serve the greater needs of the client. Therefore, the local evaluation is an important factor in informing the community and relevant project stakeholders of the continuous improvement of HHOME.

### Local Evaluation Projects

The local evaluation plan is two-pronged:

#### 1. Tracking and Analyzing Nursing Visits and the Effect on Viral Suppression

One component is tracking the correlation between nursing visits for all of our clients (those enrolled in the multi-site component, as well as those who are only a part of our aggregate client data) and viral suppression. The nurse works with the client and team using a stepwise clinical framework. Interventions range from daily medication dispensing on the street or in a drop in center, weekly mobile and clinic based nursing visits, to monthly dispensing and include adherence counseling. We will measure nursing visits and client exposure to these, in addition to other clinical factors already measured in the multi-site study, as the independent factors with viral suppression as the dependent factor.

### 2. Medical Utilization as a Proxy for Cost Analysis and Policy Implications

The other component of evaluation involves an analysis of medical utilization as a proxy for health care costs. Many of our clients are considered San Francisco's highest users of medical services (HUMS) and fall within the top 1-5% for patient utilization. Because of the integration of the HHOME intervention into other city systems, including the Emergency Room of San Francisco General Hospital, which accounts for a substantial percentage of HUMS costs, preliminary information shows that utilization has shifted from ER to primary care, which has saved and will continue to save money for the city and county. Policy implication: by linking the psychosocial-medical integration model of HHOME to utilization and cost savings, we are in a position to ask for a commitment of preventative care dollars from the city and county to CBO's and FQHC clinics who commit to this model of care.

#### Analysis Plan

The Evaluator at Asian & Pacific Wellness Center and medical students working on HHOME conducted the quantitative and qualitative data analysis under the supervision of the Principal Investigator, Dr. Deborah Borne. Quantitative data are being analyzed using SPSS, after it is pulled from electronic medical records (eCW and LCR), as well as a utilization tracking database (CCMS).

Themes have been discussed and brought to APIWC SPNS team for feedback and clarification. Focus groups were recorded and transcribed. The evaluator and the behavioral scientist are analyzing the recordings and transcriptions for emerging themes.<sup>33</sup>

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<sup>33</sup> Relevant findings are presented at state and national conferences, and help inform the Healthy San Francisco Health Plan in development. Additionally, relevant findings may be included in peer-reviewed journal articles.



Because of the integration of the HHOME intervention into other city systems, including the Emergency Room of San Francisco General Hospital, which accounts for a substantial percentage of costs from highest users of medical services, preliminary information shows that utilization has shifted from ER to primary care, which has saved and will continue to save money for the city and county.



## HHOME IMPACTS AND CHALLENGES

HHOME successfully provided HIV mobile care in a system that had previously been ineffective in serving homeless individuals with HIV. Over the course of the intervention, HHOME served 106 unique clients. These referrals and linkages to care are testament to the enhanced communication system-wide. In order to bridge referring entities, stakeholders, and the greater provider network, HHOME implemented a shared framework, which allows network entities to discuss, refer, and ultimately place clients according to their medical, psychosocial, and navigation acuity.

In order to contribute to the body of research of this SPNS intervention, the HHOME team enrolled 61 of these 100 clients into the study component. Clinical, interview, and intervention exposure data from these enrollees allowed HHOME to track the effect of the mobile model on both the client's medical metrics, as well as metrics regarding quality of life, belonging, and stigma. For those remaining 39 clients, eligibility for the study was compromised by substance use, severe mental illness, and transience. In order to capture the experiences of these clients, HHOME partnered with the community engagement program at API Wellness, developing a podcast about the multiplicity of stigma for these most acute communities.

At time of entry, all HHOME clients were homeless and disconnected from care. At baseline, many of these clients had been unstably housed for much of their adult lives. Following the intervention, 62% have been housed and/or linked to the appropriate level of residential care. Of this housed cohort, 37% have been connected to permanent housing. Others have been connected to substance use treatment programs, are in stabilization rooms awaiting permanent housing, or are in shelters, receiving the appropriate level of hands-on care.

The SPNS grant and HHOME project has strengthened community partnerships between public clinics, surveillance and linkage organizations, and the health program in our jail system. Additionally, new partnerships were formed with Larkin Street Youth Services, our local homeless youth organization, and HIVE, an organization that seeks to improve the sexual and reproductive wellness for individuals and families affected by HIV. As HHOME seeks to make itself replicable and sustainable within the San Francisco area, these partnerships provide testimony to the effectiveness of this new and innovative model.

# APPENDIX: GLOSSARY

**AIDS Regional Information and Evaluation System (ARIES):** a centralized HIV/AIDS client management system that allows for coordination of client services among medical care, treatment, and support providers and delivers comprehensive data for program reporting and monitoring. The ARIES system is used by Ryan White-funded service providers to automate, plan, manage, and report on client data. ARIES is one of several databases used by the HHOME Project to track clients and monitor referrals.

**Adherence:** an HIV care regimen following the recommended course of treatment by taking all prescribed medications for the entire course of treatment, attending medical appointments, and obtaining lab tests when ordered. Nurses and case managers help clients identify and remove barriers that prevent them from taking medications properly and with a high degree of consistency. Maximizing the effectiveness of treatment is dependent upon identifying all of the elements in a client's life, which affect their ability to follow the recommended course of treatment. This assessment includes six areas of client functioning: 1) health literacy; 2) motivation; 3) self-efficacy; 4) barriers to performance; 5) remembering; and 6) side effects.<sup>34</sup>

**Be on the Lookout (BOLO):** a notice containing demographic information such as age, race, gender, sex, date of birth, and a picture if the client has used a homeless shelter in San Francisco. This notice is sent to HHOME Project partners when attempting to either recruit or locate a current or prospective HHOME client. BOLO's are initiated via phone call, or a BOLO form is scanned/faxed to local agencies and typically issued to the Engagement Specialist Team at San Francisco Homeless Outreach Team (SF HOT). A BOLO is active (indicating HHOME is actively searching for the client) for as long as it takes or up to five contacts during the outreach process.

**Coordinated Case Management System (CCMS):** a composite database system of integrated medical, psychological, and social information about high-risk, complex, and vulnerable populations who are often high users of multiple public health, emergency, and criminal justice system. The CCMS database also offers a comprehensive profile of clients who are no longer receiving coordinated care services. CCMS is used by the San Francisco Department of Public Health and the HHOME Project to document client records and track the use of emergency services in the City and County of San Francisco.

**Client Contact:** a one-on-one interaction between a client and a staff member. In-person contact locations include streets, parks, open spaces, mobile vans, client residences (both permanent and temporary), outreach program offices, social service agencies, medical settings, residential treatment program, correctional facilities, and community agencies. Contact can be in-person, via telephone,<sup>35</sup> email, text message, social network, or not face-to-face (e.g. seeking a client). Client contacts are documented in the Intervention Encounter Form. Client confidentiality is insured during client-staff phone contacts by requiring the client to confirm the client's identity with the client's date of birth, SSN, or MMR number.

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<sup>34</sup> Oregon Health Authority, 2013.

<sup>35</sup> Requiring the client to confirm the client's identity by date of birth, SSN, or MMR number before client-staff phone conversations ensures client confidentiality.

**Client Record:** a collection of printed and/or computerized information on a client's use of services. The client record includes a physical chart, signed consent forms, assessment instruments, Intervention Encounter Forms, medical records, diagnostic instruments, clinical progress notes, as well as a digital record. This digital record includes client-specific information in the LCR, CCMS, and ARIES databases. The digital record and physical chart are regularly updated by the HHOME team to ensure coordination of care across agencies and to reflect the most recent assessment of client functioning, conditions, and needs.

**Housing:** a primary goal of HHOME is to ensure that clients are housed as rapidly as possible. Several types of housing that may be appropriate for HHOME clients are:

- Medical Respite/Sobering Center provides recuperative care, temporary shelter, and coordination of services for medically and psychiatrically complex homeless adults in San Francisco. Clients are primarily admitted from SF General Hospital and Trauma Center as well as from the City's private hospitals and the VA Medical Center.
- Ryan White Emergency Housing offers single room occupancy (SRO) in hotels where a person can stay up to 28 days.
- Emergency Shelter Housing: The City of San Francisco has individually tailored emergency (short-term and accelerated entry process) shelters for various populations, specifically Transgender/LGBT individuals, single men, single women, women with children, youth from ages 18-24, families, women fleeing domestic violence, and children.<sup>36</sup>
- Supportive housing consists of a SRO or an apartment housing formerly homeless families. San Francisco has housing dedicated to Housing for People Living with AIDS (HOPWA). Supportive housing utilizes case managers and money management services to stabilize and help clients retain housing.
- Direct Access to Housing (DAH) is master leased SRO hotels. Master leasing allows SFDPH to engage in long-term leases with building owners who retain responsibility only for large capital improvements after lease-signing, and has allowed SFDPH to bring large numbers of housing units online rapidly.

**Outreach:** a broad term in reference to specific case-finding activities conducted both in the office and the field by HHOME staff to identify people with HIV that may be eligible for HHOME enrolment (e.g. walking through client hangout locations to make face-to-face contact, making telephone calls to local agencies where client has been spotted, putting out BOLOS and Clinical Alerts).

**Referrals:** the connections, both formal and informal, between HHOME staff, HOT Team, API Wellness Center, and external service providers to meet client needs. Formal referrals are created by HHOME staff to medical, substance use, crisis, and social services (often with referral forms and the exchange of relevant eligibility information between agencies) while informal referrals may include protected and well-maintained relationships and channels built between HHOME-related services and other local agencies that facilitate easier client navigation of necessary services and resources (e.g. local options for free food, showers, social activities, libraries).

**Transition:** process of graduation and discharge from the HHOME project when a client has reached

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<sup>36</sup> See San Francisco Matrix of Single Adult Shelters and Resource Centers, Providence Foundation Family Shelters, San Francisco Homeless Family Emergency Shelter System, 2014 in Appendix.

a clinically determined level of stability, self-sufficiency, and wellness such that the HHOME Project level of care is no longer necessary and the HHOME team determines that more appropriate services (either lower level care or less intensive) will meet the client's needs. Thus, linkage within the HHOME Project is when the HHOME team links a client to non-HHOME agencies and services.

**LCR:** Lifetime Clinical Record (LCR) maintained by the San Francisco Department of Public Health (SFDPH) that serves as a shared, but limited, medical record between San Francisco General, SFDPH health centers and SFCCC health centers. The LCR houses patient data including registration information, lab, pharmacy, radiology, and diagnostic data. The HHOME Project uses the LCR to attach a unique identifier in order to track a client's use of medical services in San Francisco.

**Medical Acuity:** a spectrum under which medical triage occurs. In the context of the HHOME project a client with high medical acuity has a significantly disabling or possibly life threatening physical condition. These clients are prioritized for connection with immediate or urgent medical care in order to maintain or create safety, minimize risk, and improve functioning. Below are some factors contributing to medical acuity. Initial (baseline) acuity is obtained using the Enrollment Severity Index Form and more detailed acuity is assessed using the Nursing and Psychosocial Acuity Scales. Factors determining medical acuity are:

- Number of symptoms
- Number of severe or possibly life-threatening or contagious symptoms
- Infections
- Wounds/Bleeding
- Serious unaddressed injuries
- Detox/withdrawal
- Number of co-morbid conditions/diseases
- Renal failure/compromise
- Hepatic failure/compromise
- Advanced HIV/decreased immune system
- Extent that a physical illness disables a client
- Restricted movement
- Limited or impacted cognition/understanding

**Out of Coordinated Care:** status given to a client receiving care from multiple providers who may or may not be communicating in order to develop a coherent treatment plan. Indicators that a client is not in coordinated care include:

- A non-virally suppressed person receiving medical care but not HIV/AIDS medical care.
- Client is seen in the emergency room multiple times in a thirty day period for medical issues that can be better addressed in a community clinic or with a primary care physician.

**Homeless/Unstably Housed:** broad term referring to an individual who lacks a fixed, regular, and adequate nighttime residence (literally homeless), unstably housed individual who has not had a lease, ownership interest, or occupancy agreement in permanent and stable housing with appropriate utilities (e.g., running water, electricity) in the last 60 days; or; has experienced persistent housing instability as measured by two moves or more during the preceding 60 days; and can be expected to continue in such status for an extended period of time.

**Positive HIV Test Result:** verification of HIV status established by either 1) a signed letter from the client's prescribing physician verifying the client's status, a year of positive HIV diagnosis, AIDS status/ date of diagnosis, CD4 count, a viral load within the prior six months, and the type of viral load test performed (PCR, bDNA, NASBA); or 2) a physician's completion of the Diagnosis Information Form.<sup>37</sup>

**Panel Management:** shared responsibility among the HHOME team to continuously update at least once a week a spreadsheet reflecting the previous week's client contact and outcomes (date, type, staff, outcome, referral and treatment status). A wide range of team members, including Outreach Case Managers, Peer Navigators, Medical Social Workers and other medical personnel conduct panel management activities.

# RESOURCES

The following resources from the Building a Medical Home for Multiply Diagnosed Homeless People Living with HIV/AIDS model can be found on the Center for Advancing Health Policy and Practice website. All resources from the initiative Building a Medical Home for Multiply Diagnosed HIV-Positive Homeless Populations can be found on the web at <http://cahpp.org/project/medheart/resources>

[Acuity Scale and Frameworks](#): This tool was developed to determine the client's level of need and kinds of services that should be provided

**Service Provision Checklists:** The below checklists are used to ensure that all needed services are being provided during the interaction with a client

- [Primary Care Provider Checklist \(.pdf\)](#)
- [Registered Nurse Checklist \(.pdf\)](#)
- [Medical Social Worker Checklist \(.pdf\)](#)
- [Peer Navigator Checklist \(.pdf\)](#)
- [HHOME First Encounter Checklist \(.pdf\)](#)
- [HHOME Client Discharge Checklist \(.pdf\)](#)

[Panel Process and Template \(.doc\)](#): This document was used to help us manage the specific client level data that each staff person tracked and updated.

[HIV Continuum of Care & Stakeholder Document \(.doc\)](#): This resource tracked the flow of clients from referral source to HHOME and outlines the relationship we have with these community partners

[Mental Health Assessment Packet \(.doc\)](#): Used primarily by the team's medical social worker, this packet contains all the necessary tools for assessing the mental health status and needs of clients

**Consent Forms:** These forms ensure that the client has a complete understanding of her participation in the program and consents to involvement with the HHOME program

- [ARIES consent form \(.docx\)](#)
- [A&PI community agreement \(.docx\)](#)
- [A&PI consent for services \(.docx\)](#)
- [A&PI emergency contact consent \(.docx\)](#)
- [A&PI grievance policy, SFDPH \(.docx\)](#)
- [A&PI HIPAA privacy notice, SFDPH \(.docx\)](#)

[Matrix of Adult Shelters and Reservations](#): This resource reflects San Francisco's network of shelters

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