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

Homeless HIV Outreach and Mobile Engagement (HHOME) Program
San Francisco Department of Public Health, San Francisco, California

GEOGRAPHIC LANDSCAPE

San Francisco has one of the largest populations living with HIV in the U.S. with an estimated 15,995 people living with HIV,[1] and second highest rate of homelessness.[2]

THE CHALLENGE

The focus population includes individuals who are among the most difficult to engage and retain in care.

FOCUS POPULATION

People experiencing homelessness in SF who are medically fragile, facing complex co-morbidities/barriers, and not engaged in housing, HIV treatment, or behavioral health care

THE MODEL

- A mobile team-based intervention designed to engage/retain in care the most severely impacted and hardest-to-serve people experiencing homelessness and living with HIV
- Mobile team consists of a behavioral health clinician, a medical doctor, a nurse, a peer navigator and a case manager meeting patients wherever they are

PARTNERS

- **Asian & Pacific Islander Wellness Center** – Drop-in case management, mental health and counseling services, art therapy, and nutritional services
- **San Francisco Homeless Outreach Team** – Outreach, case management and housing for people experiencing homelessness in encampments, streets, parks and shelters
- **Tom Waddell Health Center, San Francisco Health Network** – Health Care for the Homeless integrated medical clinic offering urgent and primary care, mental health and addiction medicine services
- **Transitions Care Coordination, San Francisco Health Network** – Complex care management and coordination for high utilizers and underserved populations

IMPACTS

106 clients served

- **67% of clients are housed or have been linked to the appropriate level of residential care**
- **66% achieved viral suppression at least once while working with the program**
- **Strengthened community partnerships between public clinics, medical and psychiatric hospitals, the jail system, case management programs, surveillance and linkage organizations**

Learn more: http://cahpp.org/project/medheart

[1]SF HIV Annual Epidemiology Report 2015. Retrieved from https://www.sfdph.org/dph/files/reports/RptsHIVAIDS/AnnualReport2015-20160831.pdf
[2]SF Homeless Point-in-Time Count & Survey 2015. Retrieved from http://sfgov.org/lhcb/sites/default/files/2015%20San%20Francisco%20Homeless%20Count%20%20Report_0.pdf

This program was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number H97HA24957 (Special Projects of National Significance (SPNS) Initiative Building a Medical Home for Multiply Diagnosed HIV-positive Homeless Populations, in the amount of $300,000) awarded annually to San Francisco Department of Public Health. No percentage of this program was financed with non-governmental sources. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.