HIV Continuum of Care for Homeless and Marginally Housed HIV Clients

DRAFT

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**Continuum of Care for Difficult to Engage Homeless and Marginally Housed HIV Clients**

**Introduction:**

Purpose of this working document is to construct a road map for how we wish to proceed as a team to improve the system of referral and placement of homeless and marginally housed HIV clients who are difficult to engage in care.

**GOALS:**

* To decrease community viral load for homeless HIV positive clients in San Francisco
* To establish unified measures for assessing clients acuity and chronicity
* Unify and Standardized procedures and protocols for a coordinated system of care

Two Interlinked Components of Continuum – Protocols are broken into Hospital and Community Based procedure to efficiently address systems issues.

**Section I: Programs Involved:**

**Main Stakeholders:**

**PHAST**- *Located at San Francisco General Hospital, PHAST uses a rapid paced, multidisciplinary care team approach, to link and engage hospitalized or out of care HIV + patients into primary care. This team is comprised of nurses and social workers that provide support with linkage to care and ART initiation.*

**Transitions Division-** *this includes the placement team and care coordination*

**HOT-** *Short-term stabilization support for homeless individuals; Goals are to stabilize individuals by getting them from the street into short-term shelters/SRO’s while working towards securing permanent housing with case management. Other goals include removing personal barriers to attaining permanent housing like attaining benefits, primary care linkage, behavioral health care linkage, IDs, legal aid, etc.*

**HHOME**-*Short term mobile medical care and case management services designed to link and engage clients to a medical home and in treatment. Mobile medical and nursing care is key element to HHOME team service, as well as mobile case management, stabilization room support when deemed appropriate and intensive peer navigation.*

**Prevention- LINCS-** *Targets HIV+ LTFU/out of care patients in SFDPH( pts who have been out of care for 6+ months, or pts who have never been in care).  Offers up to 90 days to help with linkage to care and addressing barriers to care*

**TACE**-(*Tenderloin Area Center of Excellence) - drop in clinic with collocated medical and wrap around case management services located at A&PI Wellness Center*

**Future Stakeholders:**

**Shelter Health –** *Complex Clients presenting in shelter; often not able to be maintained because of ADL or chronic psych/Medical disease*

**Primary Care-** *SF Health network (Primary acre and HIV health services)*

**Jail, Emergency Room, Police dept and Community Based Organizations**

**Section II: Defining support needs for Difficult to Engage Homeless and marginally housed HIV Clients**

**Definitions and Components:**

**Client:** Newly Positive, not in Care, not engaged in care, level of care not sustaining optimal health

**Navigation:** Process by which an individual guides patients through and around barriers in the complex care system to help ensure timely diagnosis and treatment.

**Case Management:** Collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.

**Care Coordination:** the deliberate organization of patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of health care services

**Mobile Medical:**

1. Health Home -Client unable to engage or be maintained in four wall health center. Transitional medical care/health Home
2. Urgent Care- short term acute medical treatment for clients engaged in four wall PC
3. Medicine Adherence

**Behavioral Health:** Full range of mental and emotional well-being – from the basics of how we cope with day-to-day challenges of life, to the treatment of mental illnesses, such as depression or personality disorder, as well as substance use disorder and other addictive behaviors.

**Housing:**

1. Shelter
2. Support Room
3. Respite or ACF
4. Permanent Housing

**The Domains:**

**Section III: Identifying the Appropriate Level of Outpatient integrated Care**

Entry

Engage in Health Home

VL

< 40

PHAST and Clinic Based Social Work

PHAST and Clinic Based Social Work

Assessment Tool:

Modified Massachusetts HIV Acuity Scale

**Mutual Support For Gaps in Service/Care – Sharing of resources and clinical strengths**

**IV. Hospital Referral Client Flow Chart: New Positive, Not engaged or no Primary Care. HUMS, Placement**



**Narrative to Support Flow**

Step 1- evaluation acuity, chronicity and function: Done by referral source and placement

Step 2: Homeless or Not Homeless

Step 3: contact Home/Hot or LINCs representative via: \_\_\_\_\_\_\_Phone/Email. Additionally, contact placement for further assessment

Step 4: Representatives will assess Housing, case management, behavioral health, conserved, HUMS or Placement

Step 5: Representative will coordinate with placement

Step 6. Representative will contact medical assessor if needed

Step 7. Decision confirmed and referral called; email sent; LCR updated: see documentation below.

**V. Continuum of Care for Difficult to Engage Homeless and Marginally Housed HIV Clients**

**Community**

**Main Stake Holders:**

Part A COE:

TACE – COE

Ward 86 COE- CCHAMP and Women’s COE

Primary Care- Social Service and Providers

* Tom Waddell
* Ward 86
* SEHC
* Castro

Care Coordination- Liz Davis Medical Director of Care Coordination Primary Care

LINCS-*Targets HIV+ LTFU/out of care patients in SFDPH (pts who have been out of care for 6+ months, or pts who have never been in care).  Offers up to 90 days to help with linkage to care and addressing barriers to care*

HOT- *Short-term stabilization support for homeless individuals; Goals are to stabilize individuals by getting them from the street into short-term shelters/SRO’s while working towards securing permanent housing with case management. Other goals include removing personal barriers to attaining permanent housing like attaining benefits, primary care linkage, behavioral health care linkage, IDs, legal aid, etc.*

HHOME- *Short term mobile medical care and case management services designed to link and engage clients to a medical home and in treatment. Mobile medical and nursing care is key element to HHOME team service, as well as mobile case management, stabilization room support when deemed appropriate and intensive peer navigation.*

Transitions –*Placement and Care Coordination*

FHC and TWUHC Urgent Care

**Future Projects:**

CBO social service and behavioral health

Jail and Police (through HOT)

Shelter (HOT)

**The Model:**

**Community Referral Client Flow Chart**

**Step 1**

**Step 2**

**Step 3**

**Step 4**

**Steps 5-7**

Mobile

Medical?

Determine

Score and

Refer



Contact Outreach Team

for

support



SF HOT

**1**

**-**

**2**

Assess

Acuity & Chronicity

2

-

3

Yes

**No**



LINCS /COE



Transitions Division

SF HOT/HHOME



Placement/ Care

-

Coordination



HHOME

Homeless

Homeless



Yes

No



Yes

No

HUMS,

Conserved, LCF

DAH

**Steps to Making a Referral:**

**Step One** Six Steps Should Be Taken Before Making a Referral:

1. Talk to treatment team if anyone has seen them and to **complete acuity scale**
2. Letter to patient to come in(only LTFU)
3. Phone call(LTFU)
4. Phone call emergency contact(LTFU)
5. Utilize Clinic Resources: Outreach worker from program look for client

Care Coordination and Grant staff needs to improve

SEHC has best clinical model

COE referral protocol

a. TACE referral- email Tom, CC Primary Care and Royce Lin

1. CCMS Access- can access through LCR – who is working with person – contact them (supportive housing etc.)

**Step 2:** Review Assessment

Review the completed Acuity and Chronicity Assessment

Include highest level of function

*(Eviction history should be added to the scale).*

**Step 3:** First Decision Tree

(Same as hospital algorithm)

Homeless?-

Yes - Email:

Brenda, Deb, Kate, cc LINCs (Kate will alert Brenda who will triage client for HHOME or HOT services).

No - LINCS-

Email: Erin, Deb, cc Kate (Erin will triage client and report back next steps)

***When making an email referral please include:***

Subject: HIV Homeless (not homeless) client for pilot referral from Health center name (i.e. ward 86)

1. Client name dob and med number, PCP, social work, case manager, care coordinator
2. Acuity in each domain:

Medical

BH

Housing

Case management

Navigation

1. Current issues and concerns
2. What has been tried (see 6 steps from above)
3. Are they HUMS client?
4. Highest level of function

**VI. Ward 86 COE Referral Flow- Pending**

**VII. Special Populations**

1. BAPAC/HIVE and HPP

**GAPS IN CARE:** Post-partum clients would benefit from home visits with a provider

* + Items consistently pending: contraception, med adherence, viral load

**HHOME to accept a lower threshold clients from BAYPAC/HIVE:**

* + - Prenatal HIV + unengaged women
    - Post-Partum Women (DV issues, unengaged, MH issues)
    - Serodiscordant partners can be referred and triaged for HHOME support
  + NEW REFERRALS SHOULD BE TEXTED TO PCP, DEB BORNE for immediate triage
  + HPP services should be initiated early on in the HHOME intervention for added layer of support

1. Pregnant Women
2. Transitional aged youth
3. Newly diagnosed
4. HIV negative partners at risk of HIV infection

**Section VIII: Surveilance of LTFU/Out of Care Clients**

*Reviewing the Registry- How it works:*

Since all HIV labs are reported to Surveillance, they check last CD4 and VL

Identify clients who have moved, become insured, or are in care someplace other than a SFDPH clinic

Surveillance review should be added as a preliminary step before a referral is made

**Section VIIII: Documentation and Tracking of Referral process:**

1. Email sent to stake holders
2. Tracking recorded
3. LCR Clinic alert (see below)
4. Brief Note in LCR about acuity /chronicity domains

Clinic Alert Placed under ‘Scheduling’:

Health Home: (if needed) ‘Transitional Health Home with:

HHOME ICM

SFHOT

Placement/ Care Coordination

Care Coordination:

Case Manager/Care manager:

PCP listed in alert or as contact

*Example:*

*SCHEDULE ALERT   
Patient being seen in Transitional Health Home with HHOME ICM*

*Care coordinator- Luis Calderon tele #*

*Case manager: Siotha King-Thomas tele #*

*Provider Deb Borne tele #*

**Section X: Future Work by Stakeholders:**

Assessment (who and what, where documented):

Acuity: *Modified Massachusetts Department of Public Health Scale*

*LOCUS- Placement- hospital only*

*MoCa – Cognitive Scale*

*Medical Discharge plan*

Communication:

Point if contact

Use of phone email

Time frame: referral time (early in hospitalization), turn around to decision, follow up

Tracking:

Client Referral Tracking List - updated as new referrals come in for triage

From Hospital

From Clinic

Community

Tracking Outcomes

Evaluation:

Outcomes

Process measures

Meetings:

*Monthly Administrative Meetings (LINCs, PHAST, HHOME, Placement-care coordination and HOT)-*

Inpatient

Outpatient

**Section XI: Stakeholders Contact List:**

**Hospital Stakeholders Ward 86 Stakeholders**

Sandra Torres Helen Lin

PHAST Team Ward 86 COE

Social Work Associate Social Work Supervisor

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**Transitions Stakeholders BAPAC/HIVE/HPP Stakeholders**

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*This publication is part of a series of manuals that describe models of care that are included in the HRSA SPNS Initiative* Building a Medical Home for HIV Homeless Populations*. Learn more at* <http://cahpp.org/project/medheart/models-of-care>