Homeless Health Outreach Mobile Engagement (HHOME)

Intervention Implementation Guide

HRSA
Ryan White HIV/AIDS Program

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Homeless Health Outreach Mobile Engagement (HHOME)

This guide examines the Homeless Health Outreach Mobile Engagement (HHOME) intervention, launched by the San Francisco Department of Public Health. This intervention was first funded through the Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program (RWHAP), Special Projects of National Significance (SPNS) "Building a Medical Home for Multiply Diagnosed HIV-positive Homeless Populations" initiative.

Ending the HIV Epidemic in the U.S. Pillar: Treat & Respond

HIV Care Continuum Stage: Linkage & Treatment

Priority Population: People Experiencing Homelessness

Setting: Mobile Care

HHOME is a robust, mobile care and systems intervention that helps link, engage, and deliver rapid HIV treatment to some of San Francisco's most vulnerable and homeless communities. During the RWHAP SPNS initiative, the intervention was able to stably house and retain in care (at 12-month chart review) 83.6 percent of intervention clients. Post-SPNS funding, the intervention continues to be sustained and is a critical component of San Francisco's efforts to address and end HIV.

This guide includes key components of the HHOME intervention, outlines the capacity required by organizations/clinics to conduct this work, and includes replication steps to support others in their implementation efforts. Finding replicable interventions that meet Ending the HIV Epidemic in the U. S. (EHE) initiative goals and support clients along the stages of the HIV care continuum are key to future programmatic and client success in HIV care.[1]

About SPNS

The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services, is the primary federal agency for improving healthcare to people who are geographically isolated, economically or medically vulnerable. The Ryan White HIV/AIDS Program (RWHAP) Part F: Special Projects of National Significance (SPNS) is administered by the HRSA HIV/AIDS Bureau (HAB). The RWHAP SPNS Program supports the development of innovative models of HIV care and treatment in order to quickly respond to emerging needs of clients served by RWHAP. RWHAP SPNS advances knowledge and skills in the delivery of healthcare and support services to underserved populations with HIV. Through its demonstration projects, RWHAP SPNS evaluates the design, implementation, utilization, cost, and health-related outcomes of treatment models while promoting the dissemination and replication of successful interventions.

About the Building a Medical Home for Multiply Diagnosed HIV-positive Homeless Populations Initiative

The featured intervention was part of the RWHAP Part F: SPNS "Building a Medical Home for Multiply Diagnosed HIV-positive Homeless Populations" initiative. For this initiative, RWHAP SPNS supported nine demonstration sites for five years to design, implement, and evaluate innovative strategies to improve the timely entry, engagement, and retention in HIV care and support services for people with HIV with co-occurring mental illness and/or substance use disorders who are experiencing homelessness or unstable housing. The interventions employed models of care focused on the development of sustainable linkages to mental health, substance use treatment, and HIV primary care services for people with HIV experiencing homelessness or unstable housing. The transient and unstable lives of homeless people with HIV and co-occurring mental health or substance use disorders required coordinated efforts to engage and retain them in care by addressing their complex service needs and to ensure their adherence to treatment.

To learn more about this initiative, visit: **https://ryanwhite.hrsa.gov/about/parts-and-initiatives/part-f-spns/previous-spns-initiatives/spns-initiative-building-medical-home-multiply-diagnosed-hiv-positive-homeless**

Getting Started

This table provides a general overview of the HHOME intervention so readers can assess the necessary steps required for replication. This intervention facilitates linkage and engagement to HIV care and treatment for multiply diagnosed homeless populations with HIV.

INTERVENTION AT-A-GLANCE	
Step 1	**Conduct Community and Resource Assessment** Assess the homeless community, your service offerings and strengths, any local Health Care for the Homeless programs with whom you might be able to partner and identify other key partnerships. Together, key partners should be able to provide clients with the following: community-based drop-in center; mobile case management and outreach; one-stop-shop health center for HIV, primary care, low-barrier adherence program, mental health, substance use treatment, harm reduction; and care coordination for complex clients.
Step 2	**Bring Stakeholders and Partners Together** Coordinate stakeholder meetings to provide details on the intervention and secure buy-in from referral agencies. Include details on how key partners and referral agencies will work together, track, and coordinate activities.
Step 3	**Routinize Assessments/Tools and Clarify Referral Process** Select an acuity scale (to estimate level of intensity of care required) that is easy to follow and correlates with a determined care plan level. Ensure acuity scale is reviewed and approved by all partners and referring agencies so that this can be a truly standardized document and approach.
Step 4	**Conduct Outreach and Receive Client Referrals** Conduct mobile case management outreach in key neighborhoods and areas where the population frequents and reach out to clients referred by partners. If clients are unavailable or refuse services, add them to a "hover list" (priority list) for future engagements and to notify providers if they appear in the hospital or emergency rooms.
Step 5	**Enroll Clients** Explain intervention activities, screen for eligibility, and enlist clients into the intervention.
Step 6	**Conduct Assessments** Conduct acuity assessment and biopsychosocial assessment (to assess the biological, social and psychological factors that influence a person's well-being).

INTERVENTION AT-A-GLANCE	
Step 7	**Develop Care Plan** Based on acuity score, assign a care plan level and work with the client to identify goals and tailor the care plan.
Step 8	**Provide Case Management** Provide case management services; help reduce barriers to care; and support access to applicable HIV primary healthcare, substance use treatment, mental health treatment, adherence counseling, benefits programs, and identification (e.g., license or other photo ID, birth certificates).
Step 9	**Secure Housing and Provide Life Skills Training** Identify appropriate housing for clients and work with both clients and systems to secure housing and help support clients in the transition by providing life skills training.
Step 10	**Step Down Clients as They Move to Lower Levels of Acuity** As clients progress through their care, plan and develop increased autonomy, support their "step down" to a lower-intensity level program.

RESOURCE ASSESSMENT CHECKLIST

Prior to implementing HHOME, organizations should walk through the following Resource Assessment (or Readiness) Checklist to assess their ability to conduct this work. If organizations do not have the recommended readiness, they are encouraged to develop their capacity so that they can successfully implement this intervention. Questions to consider include:

- ❑ Does your organization have experience working with people with HIV and helping support their medical and social service needs?
- ❑ Is staff culturally responsive, compassionate, and interested in working with those experiencing homelessness?
- ❑ Is your organization able to either offer or partner in such a way to provide clients with wraparound services in a medical home model (including HIV primary care, mental health services, substance use services, and housing)?
- ❑ Does your organization offer housing services and, if not, are you able to partner with an organization who does?
- ❑ Does your organization have a mobile outreach van and clinical staff who can devote time on the mobile van to ensure care is brought to clients? If not, is there a local healthcare for the homeless organization or similar organization serving homeless populations with mobile access with whom you could partner?
- ❑ Does your organization or a partner organization have a low-barrier adherence program or activities that support drop-in visits and/or directly observed therapy (DOT)?
- ❑ Does your organization have peer navigators with lived experience on staff or are you able to hire individuals to perform outreach, care plan development, and navigation support services?
- ❑ Is staff trained in HIV, mental health, substance use, trauma-informed care, and benefits/insurance programs and, if not, are you able to provide trainings on these topics?

Setting the Stage

15,707 people with HIV

8,035 people experiencing homelessness

SAN FRANCISCO
CALIFORNIA

San Francisco has some of the highest rates of HIV and homelessness in the country with 15,707 people with HIV[2] and 8,035 people experiencing homelessness.[3] Among San Francisco's homeless population:

- The average age of death is 51 years old.[4]
- Approximately 74 percent reported living with one or more health conditions, including chronic physical illnesses, physical disabilities, chronic substance use, and severe mental health conditions.[3]
- Among those with HIV, only 20 percent were virally suppressed.[5]
- Among the chronically homeless, 53 percent reported a mental health condition, 52 percent reported post-traumatic stress disorder (PTSD), and 63 percent have alcohol and substance use disorders.[3]

Studies have demonstrated the strong association between access to stable, secure, and adequate housing and improved engagement and retention in HIV prevention, treatment, and care; viral suppression; and long-term survival.[6,7,8,9] Despite this evidence, approximately one-half of the estimated 1.18 million people with HIV nationwide[10] are expected to experience homelessness at one point in their lifetime.[11,12]

Homelessness is an independent risk factor for elevated viral load[13] while housing is linked to reductions in individual morbidity and mortality and is an important factor in achieving long-term health.[14]

Like most healthcare infrastructures, San Francisco relies on the traditional clinic and is not equipped to serve those most affected by homelessness, substance use, mental illness, and HIV. Many people with HIV experiencing homelessness in San Francisco either avoid medical care altogether despite suffering from serious chronic conditions or they are high utilizers of medical services in the most expensive and inefficient manner possible (e.g., ER visits).[14]

To prevent homelessness in San Francisco, San Francisco Health Care for the Homeless has a great model that brings services directly to clients, while the San Francisco Homeless Outreach Team (SF HOT) (within the Department of Homelessness and Supportive Housing) is able to successfully find and link hard-to-reach clients experiencing homelessness into housing. That said, some clients still fail or are denied services even at safety net clinics. At the onset of the RWHAP SPNS initiative, the project leads from the San Francisco Department of Public Health started traveling with the SF HOT team on their outreach in the community. What they found were critically ill individuals who, with the right engagement, could be connected to and supported by wraparound healthcare services, but not always willing to receive the care offered. Some clients were not ready to receive care at a traditional, four-walled clinic as it did not suit their needs or comfort; however, they were willing to receive mobile care.

That's when the power of what would become the Homeless Health Outreach Mobile Engagement (HHOME) Project became clear. The San Francisco Department of Public Health (SFDPH) in partnership with SF Community Health Center (formerly API Wellness Center), Tom Waddell Health Clinic, and Healthcare for the Homeless formalized their collaborative approach and applied for and received grant funding under the RWHAP SPNS "Building a Medical Home for Multiply Diagnosed HIV-positive Homeless Populations" initiative and set out to engage with one of the city's most challenging populations and build a city-wide referral process and HIV care continuum.

Achievements

The HHOME intervention served 106 clients. Of the 106 clients, 84 percent were retained in care at 12-months; 84 percent were stably housed; and 60 percent were virally suppressed.

Description of Intervention Model

CHALLENGE ACCEPTED

The Challenge: Create a coordinated medical home—including standardization of service utilization, acuity testing, and treatment—for people with HIV experiencing homelessness, mental illness, and substance use, and who have been unable to engage in housing, HIV medical care, and behavioral healthcare.

HHOME is a mobile, team-based and systems-level intervention that addresses the limitations of a traditional healthcare system and four-wall clinic in order to engage and retain the most severely impacted people with HIV in San Francisco into HIV primary care, behavioral healthcare, and housing. Eligibility criteria initially included all of the following (although this has expanded more broadly post-SPNS initiative):

- People with HIV not currently engaged in HIV treatment or failing at the current level of care with a detectable viral load and a CD4<200;
- Active substance use disorder;
- Diagnosed severe mental illness or mental health condition that impairs functioning; and
- Experiencing homelessness or with an imminent risk of eviction.

HHOME spurred the development of a citywide San Francisco HIV Care Continuum Task Force. This Task Force reviewed the eligibility criteria and recommended some additional

"The amount of courage it takes to trust all of these people at HHOME, the amount of courage that each of our patients has to have to make the kind of changes they did in their lives—it's like watching someone climb Mount Everest."

– Deborah Borne, MSW, MD
San Francisco Department of Public Health
& Former HHOME Principal Investigator

populations who fell through gaps in care and for whom HHOME should also prioritize. These communities do not need to meet all aforementioned criteria, but individuals do need to be experiencing homelessness or unstable housing, and can benefit from: mobile medical services, low-barrier HIV medication adherence, mental health, behavioral health, and navigation support services. These special populations include:

- Pregnant people with HIV
- Serodiscordant partners who meet HHOME criteria and need pre-exposure prophylaxis (PrEP)
- Youth and young adults aged 18–30 who are aging out of Transitional Age Youth Care programs
- Newly diagnosed individuals

Mobile care minimizes the trauma on and from the system, which is critically important as clients experiencing homelessness often have significant trauma in their lives, including at the hands of providers and healthcare systems who are supposed to help them. The HHOME model was built around the idea that for particular priority populations, systems fail, not clients.

HHOME seeks to teach the broader healthcare community about:

- Effectiveness of mobile care
- Significance of incorporating social determinants of health into treatment planning
- Benefit of standardizing provider communication and referrals[15]

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.[14]

HHOME is grounded in the following values and strategies:

- *Client-centered.* HHOME prioritizes client preferences and goals while respecting client rights and values. It empowers clients and helps address not just clinical but psychosocial, spiritual, familial, and emotional matters in order to positively affect linkage, engagement, and retention in care.

- *Mindful medicine.* Work is grounded in a psychosocial and holistic approach. HHOME recognizes that the provider-client relationship is both dynamic and always evolving and seeks to heal past client-level and system-level trauma.
- *Self-affirming, appropriate care that is coordinated and continuous.* HHOME assigns an appropriate level of care based on client acuity and identified needs; and provides consistent, continuous, trauma-informed, and holistic wraparound care that is destigmatizing and self-affirming. This includes decreasing systems barriers and creating an HIV care continuum among providers across the city and ensuring clients feel welcomed and safe where they are accessing care.
- *Harm reduction.* HHOME provides nonjudgmental and non-coercive services to assist clients in minimizing the risk in their environment and activities.
- *Team-based.* HHOME has a non-hierarchical team dynamic that values all team and partner voices and experiences and prioritizes cross-training.

Although HHOME collaborates with and receives referrals from entities across the city, the intervention is run by four key agencies. Each agency is doing complementary work to one another. Under HHOME, they come together and share their culture, resources, staff, as well as coach individuals and referral organizations throughout the city on the model and on trauma-informed care in order to create an HIV care continuum responsive to the needs of the population. The key partners and their respective roles include:

1. **SF Community Health Center:** a community-based drop-in model
2. **San Francisco Homeless Outreach Team (SF HOT):** citywide mobile case management
3. **Healthcare for the Homeless:** one-stop-shop health center for primary care, mental health, and addiction medicine, utilizing a harm-reduction approach
4. **San Francisco Department of Health, HIV Health Services, Transitions Division and Primary Care:** care coordination for complex clients; placement of clients into least restrictive most cost-effective level of care

Although not a formal partner, the development of relationships with local pharmacies was particularly important in executing this work as well.

HHOME devotes a substantial amount of time searching the community for missing clients. As such, the role of the Peer Navigator is critical. Clients of HHOME have underscored the importance of the Peer Navigator's shared life experience as follows: "I won't listen to anyone who hasn't been out there…some people know policies; some people know *the life.*"[16]

The HHOME mobile care clinic provides: HIV primary care, addiction and psychiatric medicine, nursing, case management, medical social work, and peer navigation in a mobile and drop-in clinic-based setting capable of providing intensive care unit (ICU)-level care and stepping clients down when their care stabilizes.

The HHOME mobile team—consisting of a Medical Doctor, Registered Nurse, Medical Social Worker, Peer Navigator, and Housing Case Manager—need to be able to continuously coordinate care and participate in case conferencing.

All HHOME team members seek to build trust among clients and offer a trauma-informed approach, address social determinants of health (including housing, food access, benefits, as well as mental health and substance use needs), and harm-reduction palliative care (particularly in cases of impaired cognitive function).[15]

HHOME Referrals

Referrals to HHOME come from the following:

Community

- Primary care
- Urgent care
- Police
- Shelters
- Community members
- Homeless outreach workers
- Jail

Hospital

- Medical
- Psychiatric
- Emergency room
- Long- and short-term care facilities

Intervention Steps:

1. *Mobile outreach.* When a referral comes in, HHOME staff gather client information from available databases and begin the process of locating the client.

   - HHOME staff arrange to meet the client immediately, particularly if the referral is from an area hospital. HHOME staff bring food and bracelets. (See text box.)
   - In the event that the client is unable to be reached or refuses services, he/she is added to a "hover list," which the Peer Navigator uses to prioritize clients for future engagement. These clients are flagged in the system so that an alert notifies primary care providers if these clients appear in a city hospital or emergency room.

2. *Case management, assessment, and planning.* Once a client is located, the HHOME team conducts an initial assessment, seeks to build rapport, and has the client sign an acceptance form to receive services. The team works with the client to identify goals related to medical care and housing. Part of this process includes educating the client about available resources.

   The Housing Case Manager writes the client assessments, oversees the integrated care plan, and works with the client to secure benefits and referrals. Over time, other HHOME members add to the assessment.

The HHOME Bracelet

The HHOME bracelet is made of soft plastic and bears the program's name. Like many components of HHOME, this evolved from client interactions and now serves as a positive reminder of the program.

As HHOME Medical Doctor explains, "We have a client who finally agreed to go to our skilled nursing facility after five hospitalizations, was hit by a car several times, and I said, 'I've chased you all around the city; my whole team's chased you all around the city, what changed?' He said, 'I just couldn't believe that anyone loved me and that what you were saying was true. I wish there was a way that even when I wasn't with you, that I could have a reminder.' He had this bracelet on and that's where the idea of the bracelet came from."

The care plan is developed by the case manager and client together and seeks to:

- Identify and prioritize short- and long-term goals related to 1) medical care and treatment, 2) psychosocial and behavioral health, and 3) associated timeframes for each goal.
- Assign a level of care that promotes continuity and improves health outcomes.

- Clearly defines the role of the client and HHOME team members.
- Identify necessary services, identify agencies with the capacity to provide these services, and determine how the services will be accessed and coordinated.[14]

The level of the care plan is based on an acuity scale that was borrowed from the RWHAP SPNS "Minority AIDS Initiative Retention and Re-engagement in HIV Care" Project. The acuity scale has a simple number system (0 to 3) making it easy to follow and readily adopted by HHOME staff and community partners. A shorter version is used for referrals and a longer version is used for clinical assessments. The acuity assessment has very specific domains and subdomains. This is particularly useful in maintaining a standard of care and ensuring that staff roles are clearly outlined despite providing care in a chaotic, rapidly paced environment. Another innovation that supports quick decision making is the development of a panel that tracks clinical variables as well as psychosocial, adherence, and navigation measures. HHOME staff also use group text messaging to communicate in real time regarding any decisions that require immediate input.[14] (To view the acuity assessment, visit: **https://ciswh.org/wp-content/uploads/2017/12/SF-Acuity-and-Chronicity-Assessment-Tool.pdf**.)

Because all staff and partners use the acuity scale and any edits are made together, it functions as a shared clinical language and living tool to adapt to client and system needs. For higher acuity clients, a significant part of the care plan might include care coordination.

3 *Housing.* Close collaborations exist with housing resource programs in order to provide medical respite care, emergency housing, short-term housing, permanent housing, and single-room occupancy housing. HHOME also has access to stabilization rooms through SF HOT.[14] HHOME helps clients obtain the following in order to support entrance into housing: birth certificate, identification, social security card, general assistance or social security income.

4 *Stepping down clients.* Clients are discharged from case management when HHOME no longer serves client needs. This can occur if a client: 1) advances to a more severe disease state and requires more intensive case management, 2) has progressed to a stage of self-sufficiency, 3) moves out of the service area, 4) refuses further involvement in the program or is no longer eligible, or 5) exhibits threatening or dangerous behavior.[14] It is particularly important that transfer and discharge is carefully planned and executed to avoid disrupting services. Additionally, clients

often feel "pushed away" when being discharged or transferred, especially after having developed trust and relationships with providers. This can be traumatic so providers need to be cognizant of the human experience when making plans and executing them and clearly communicate with clients about any transitions early and often.

Meetings

There are a series of meetings to help keep HHOME team members and partners coordinated. This includes social service morning huddles three times a week, a referral huddle, a weekly team case conference, as well as quarterly meetings with hospital and community partners. In addition to clinical care meetings, which are important. It is equally important to hold strategy/administrative meetings.

STAFFING REQUIREMENTS & CONSIDERATIONS FOR REPLICATION

Staffing/Organizational Capacity

The minimum staff requirements and competencies needed to successfully implement HHOME include the following:

- *Project Manager:* Provides day-to-day oversight of HHOME program. Supervises direct service team members and evaluation staff. Coordinates referrals and discharges and 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.
- *Medical Doctor (MD):* Provides co-located 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.
- *Registered Nurse (RN):* Provides co-located onsite and mobile nursing care and complex care management. Oversees medication adherence program within HHOME, medicine reconciliation, and medical treatment plans. Oversees clinical care for less acute clients; coordinates client 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, providing at-home care to clients.
- *Peer Navigator:* Innovative position and role within the team. Oversees team's outreach and engagement efforts. Familiarity with local neighborhoods, businesses, residents, and community leaders as well as how to navigate the unique challenges within local communities. Accompanies clients to appointments (e.g., Medicaid, medical appointments, department of motor vehicles), advocates for clients with other service providers; supports clients to build their own support networks; and provides risk reduction counseling to affected clients. Provides life skills training for clients. Works with MD and RN to promote medication and care adherence.
- *Housing Case Manager:* Provides housing case management and housing-related counseling to clients throughout the intervention. Connects clients to 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 as well as provides informal, field-based, short-term psychosocial counseling to address immediate client barriers to care (including mental health and substance use issues). Oversees social security income application and transition of clients 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; coaches HIV service providers with informed referrals; and provides training and guidance to the HHOME team on housing, mental health, substance use, and benefits issues.

*Note: While not a formal position necessary to replicate this model, HHOME does recommend integrating quality improvement efforts into this work as checklists and standards help ensure high quality care and referrals in a fast-paced, chaotic environment.

Staff Characteristics

Core competencies include:

- Cultural responsiveness and compassion
- Willingness to work with this population
- Familiarity with homelessness, HIV, mental health, harm-reduction, trauma-informed care, and substance use disorders
- Communication skills, humility, and teamwork

Source: Adapted from: Tryon J, Borne D, Franza K, et al. The Homeless HIV Outreach and Mobile Engagement (HHOME) Program. [Manual.] 2017. Available at: **https://ciswh.org/wp-content/uploads/2017/07/HHOME-SFDPH.pdf**

Replication Tips for Intervention Procedures and Client Engagement

This section provides tips for readers interested in replicating the intervention and, where applicable, examples for further context.

Successful replication of the HHOME intervention involves the following:

Assessment. Organizations should assess 1) current availability of levels of care, 2) availability of services your organization or community partners can offer (being honest about strengths), 3) needs of the multiply diagnosed homeless community, and 4) whether a new level of care for clients who are not thriving in a traditional clinic setting is needed.

Collaborate. No one organization can do it alone. A particularly useful replication step is to contact your local Health Care for the Homeless program. The National Health Care for the Homeless organization can help you locate the nearest program and also offer technical assistance. Health Care for the Homeless program staff are the experts on populations experiencing homelessness and what it takes to help these clients into housing services.

Part of the collaborative process of HHOME is developing referral relationships. Consider all the places, people, and entities who come in contact with the priority population and bring them to the table to discuss the intervention. It is important to recognize states of transition that clients experience and leverage these opportunities to intervene. This is particularly true as clients leave jail or hospitals and are at points of transition where they may be more ready and willing to engage and receive help. Organizations want to connect with these individuals before they disconnect with the system.

Trauma-informed approach. The impact and enormity of trauma on the lives of homeless, multiply diagnosed people with HIV cannot be overstated. As such, an important piece of replicating this intervention is ensuring that leadership is devoted to trauma-informed management both at the system and client level and that team members are trained in a trauma-informed approach.

Routinize assessments and tools. Use acuity tools to assign levels of care. Replicating organizations can pick up the existing HHOME acuity assessment and screening tools (found in the appendices here: **https://ciswh.org/wp-content/uploads/2017/12/SF-Acuity-and-Chronicity-Assessment-Tool.pdf**) or they can access any number of other available acuity scales that may work for their organization. Doing so enables everyone to know where a client is at with respect to their care readiness and can more quickly identify those with complex needs. This work does necessitate someone to play the role of "air traffic controller" to ensure activities and referrals are proceeding as planned.

Hire the right staff. Hire a navigator with good instincts who knows the community, its resources, businesses, and people. Recognize that one navigator cannot do this work alone and that this work necessitates a team approach. HHOME team members need to have a high degree of efficiency because they are providing services outside of the office but still needing to maintain some sense of structure. All HHOME team members should have interpersonal skills and the ability to connect with clients in real and meaningful ways.

Share resources and information. Regularly scheduled meetings are important to discuss intervention logistics, protocols, as well as case conferencing for more complex clients. It is also useful to have a shared resource guide outlining available resources in the city and that clearly outlines organizational roles and services. This should be a living document to which all stakeholders have access.

Have the right attitude. Humility is required to do this work. Providers need to thank clients, really listen to them, and value their input in developing the care plan and goal setting. Staff also need to be humble enough to work selflessly as a team without a true hierarchical structure and willing to cross-train and cross-learn. Perseverance and self-care are also critical as this is hard work.

Provide incentives. If possible, provide client incentives. HHOME found that bringing food goes far when meeting a client for the first time and even when meeting with community and referral partners. Food is a great way to create a friendly and welcoming atmosphere. Also, if resources permit, provide tarps when conducting outreach to clients experiencing homelessness and encampments. For many clients, nothing is as useful and valuable as a tarp.

Have a good QI foundation. This helps organizations stay trauma-informed, maintain high quality, and standardize activities. Track data as much as possible to keep all partners abreast of information as well as illustrate the powerful effectiveness of this intervention.

Be mobile. Ideally, replicating organizations would have a mobile care van or be working in partnership with an organization who does; however, HHOME staff underscore that important components of this intervention can still be utilized and impactful, even without a mobile van, particularly the work to create a city-wide HIV care continuum and standardize tools to better connect and serve clients. Mobile also means delivering care where the clients are. Individuals experiencing homelessness may not want to leave their belongings for fear they may be stolen.

Provide trainings. Offer trauma-informed care and harm-reduction trainings to providers and life skills trainings to clients.

Securing Buy-in

Securing the support of leadership, staff, and other relevant stakeholders is an important step when implementing a novel intervention. The following strategies may help to secure buy-in for the HHOME intervention:

- Highlight the need the intervention seeks to address. HHOME is treating clients who are not thriving elsewhere or who drain system resources and provider time through frequent utilization of costly healthcare access (e.g., ER visits); therefore, it fills a gap that other entities are failing to meet or are ill-equipped to meet.
- Ensure all key players are at the table; this includes not only formal partners but also community stakeholders, hospital representatives, jail health and re-entry programs, any city linkage programs, all referral agencies, and consumers, and discuss how referrals will be handled and tracked.
- Employ a collaborative approach to intervention planning and implementation and schedule regular meetings to keep partners informed and involved.
    - Invite stakeholders to review acuity tools and discuss how they align with proposed care planning.

Overcoming Implementation Challenges

Lack of basic life skills

Clients experiencing homelessness often struggle with being indoors and being organized. Many lack basic living skills and it can take many weeks to many months before they adjust and thrive indoors. To address this, HHOME provides clients with life skills education. Life skills interventions are found to significantly improve housing outcomes among homeless and mentally ill individuals. HHOME looked to the literature which demonstrates four key life skills categories to help improve housing maintenance: 1) food and nutrition, 2) money management, 3) safe community participation, and 4) home and self-care.[17] To assess client needs, HHOME also surveys clients on interpersonal conflict resolution (e.g., ability to resolve conflicts with neighbors, ability to navigate housing rules, how they would cope or seek out services if feeling isolated living inside, likelihood in forming relationships with new neighbors, and eviction prevention skills).[16] Life skills topics requested by clients include: navigating building rules/laws, safety, sobriety, resource access, culture shock, and empowerment.[16]

HHOME also uses a Life Skills Assessment Checklist. To complement the life skills trainings, HHOME offers peer mentorship and provides clients with a Skills Resource Handbook (with community resources), a House Warming Kit, and vocational training.

Limited staff resources

As with many intensive interventions, key staff are always spread thin on time. This is particularly true for the Peer Navigator and Registered Nurse and underscores the importance of cross-training as it enables other staff to step in and provide support when needed.

Ensuring quality improvement (QI) in a changing environment

QI is an incredibly important piece of doing this work; however, it's challenging to apply QI principles when the environment and clients are so frequently changing and different organizations throughout the city use different data systems. This is where the panel developed by HHOME to track clinical variables as well as psychosocial, adherence, and navigation measures has been particularly useful.

Lack of trauma-informed care

Even in a city like San Francisco, there are a lack of trauma-informed programs and providers. To address this, HHOME's Medical Doctor provides increased trainings across the city and enables some shadowing of the HHOME intervention.

Limited transitional care assistance

Additionally, there are not enough medical case management programs with "step down" components to help clients transition out of or to a different type of care; however, a new HHOME spin-off program is being developed to address this challenge.

Promoting Sustainability

The HHOME work has been sustained, expanded, and is now being replicated under additional spin-off programs. Important components of sustainability include developing partnerships, routinizing the acuity assessment and care/referral planning, implementing a QI and data tracking component, and sharing information about the need among this population and the success of the model.

Outcomes related to sustainability and expansion have included:

- System-wide coordination, including the creation of a San Francisco HIV Care Continuum Task Force.
- Integrated, team-based navigation.
- Adapted RWHAP SPNS Peers Initiative acuity scale, now being used across divisions of the San Francisco health system to support coordinated, standardized care.
- HHOME has transformed the city in how it is assessing clients and understanding levels of care and is recognized as a leader in trauma-informed care in San Francisco and is helping train the next generation of providers. This includes HHOME's physician training medical students, residents, and fellows in San Francisco, including San Francisco General Hospital, on trauma-informed care and mentoring infectious disease residents on HHOME model.
- The launch of spin-off programs, including:
  - Intensive care management program
  - Transitional program to help people "step down" to the next care level
  - HHOME Life Skills, a peer-led program designed to retain people with HIV in housing
  - Social determinants of health consult

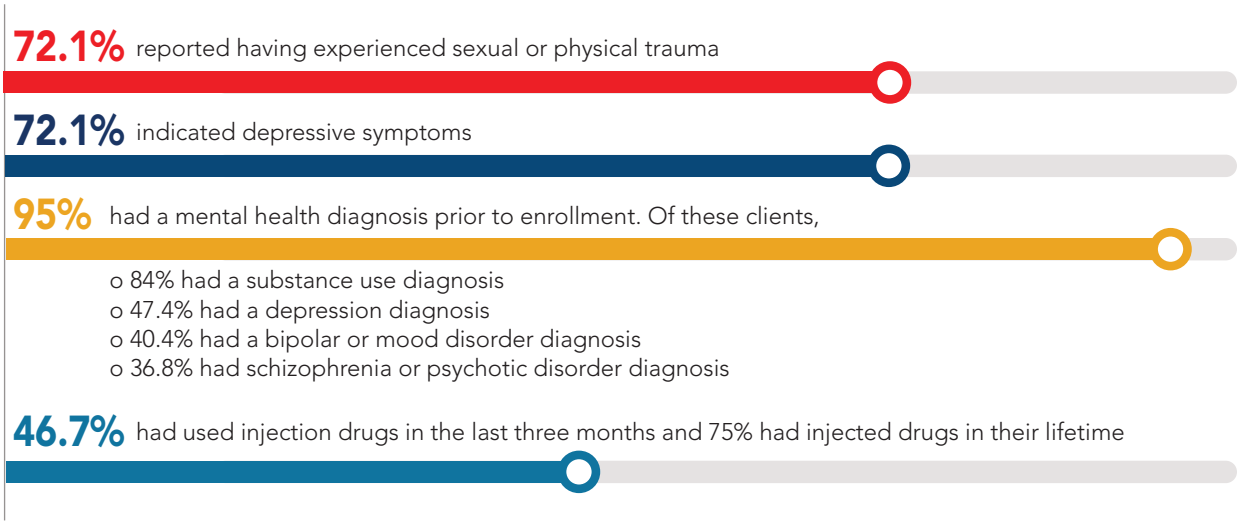
"I've been doing this for almost 30 years now, and this has been the most rewarding and humbling work of my career."

– Deborah Borne, MSW, MD
San Francisco Department of Public Health
& Former HHOME Principal Investigator

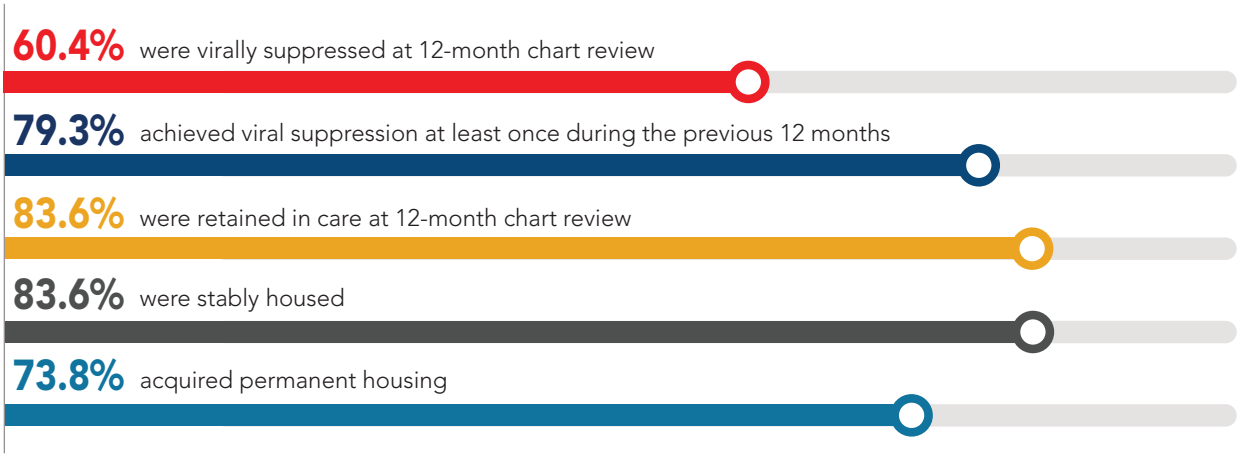
  - Encampment Health, a program providing low-barrier PrEP, sexually transmitted infection (STI) testing, and rapid treatment to encampments in San Francisco *This work is particularly important given the incredibly high rates of not only HIV but gonorrhea, chlamydia, and syphilis seen in these encampments.
  - Drop-in centers for care and directly observed treatment (DOT) or HIV medication pickup
  - Safe and welcoming spaces with drop-in hours—and with soon-to-come additional bathrooms and showers
  - Expansion of mobile care to unaccompanied pregnant people, individuals with opioid addiction, and high utilizers of emergency rooms
- Examining health homes in California and 1115 waivers to try and pay for increased care coordination.
- Development of new partnerships, including:
  - Larkin Street Youth Services (a local homeless youth organization)
  - HIVE (a sexual and reproductive wellness organization)
  - Project Open Hand (a nutritional services and meal delivery organization serving people with HIV and others with chronic diseases who are disabled)
  - Safety net medical clinics
  - Medical and psychiatric emergency rooms and inpatient hospitals
  - Surveillance and linkage organizations
  - San Francisco county jail health program

HHOME: BY THE NUMBERS

During the RWHAP SPNS initiative, HHOME treated 106 significantly high-need clients. **At baseline**, psychosocial factors included:



At the end of the **RWHAP SPNS initiative**, outcomes among study participants included:



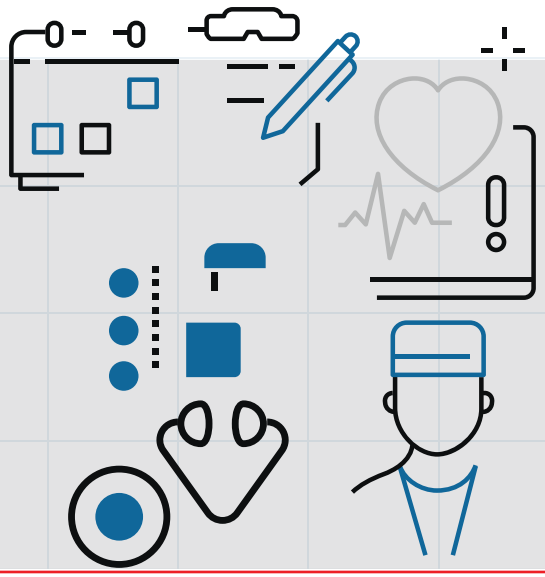
Source: Tyron J, Borne D, Fox J, et al. HHOME: Mobile Multidisciplinary Care for Hard-to-Reach Homeless in San Francisco.

Conclusion

HHOME represents an innovative, comprehensive, and promising intervention to find, engage, and retain medically acute, complex, multiply diagnosed clients experiencing homelessness who have been unsuccessful in traditional healthcare settings. The intervention helps fill gaps in care and housing to facilitate viral suppression and stability for clients and, once stable, positions them to be transitioned to a more traditional outpatient model of care.

Clients who have never been in care, refused ambulatory care even when critically ill, have left in the middle of hospital stays, and who suffer from chronic homelessness and severe mental health and substance use issues, have thrived under this model—many of whom now have undetectable HIV, cured hepatitis C virus, and in some cases, are now doing volunteer work in the city or working as the next generation of navigators. Although the work requires perseverance to develop trust and work with this challenging population in an often-chaotic environment, it is possible to make real and meaningful change.

The ability to move nimbly through the community and reach otherwise hard-to-reach populations also positioned HHOME to support San Francisco's COVID-19 response. Robert C. Arnold, LVN, San Francisco Community Health Center and current director of HHOME and his team applied their community knowledge, holistic approach, and mobile outreach and were able to support neighborhoods, such as the Tenderloin, in moving from a 40 percent vaccination rate to upwards of 89 percent.



OTHER AVAILABLE RESOURCES

HHOME & Initiative Resources

The Homeless HIV Outreach and Mobile Engagement (HHOME) Program Manual:
https://ciswh.org/wp-content/uploads/2017/07/HHOME-SFDPH.pdf

HHOME Adopted Acuity Scale:
https://ciswh.org/wp-content/uploads/2017/12/SF-Acuity-and-Chronicity-Assessment-Tool.pdf

HHOME Poster Presentation:
https://ciswh.org/wp-content/uploads/2017/06/HHOME-SFDPH-poster.pdf

HHOME One-page Handout:
https://ciswh.org/wp-content/uploads/2018/01/HHOME-SFDPH-one-page.pdf

Website: **https://ciswh.org/project/medheart/**

HHOME Presentation:
https://targethiv.org/sites/default/files/supporting-files/4012SFDPH.pdf

Finding Home: Tips and Tools for Guiding People Living with HIV Toward Stable Housing Toolkit:
https://ciswh.org/wp-content/uploads/2017/09/Housing-Toolkit.pdf

About the Building a Medical Home for Multiply Diagnosed HIV-positive Homeless Populations Initiative:
https://hab.hrsa.gov/about-ryan-white-hivaids-program/spns-homeless-populations

Building a Medical Home for Multiply Diagnosed HIV-positive Homeless Populations Multisite Evaluation Overview:
https://ciswh.org/wp-content/uploads/2018/01/med-home-multisite-overview.pdf

Additional Replication Resources

Best Practices Compilation:
https://targethiv.org/bestpractices/search

Integrating HIV Innovative Practices (IHIP):
https://targethiv.org/ihip

HIV Care Innovations:
https://targethiv.org/library/hiv-care-innovations-replication-resources

Need Help Getting Started?

If you are interested in learning more about this intervention or other interventions featured through the Integrating HIV Innovative Practices project and want to see if you qualify for technical assistance, please email: **ihiphelpdesk@mayatech.com**

Subscribe to our Listserv

Subscribe to our listserv to receive news about the latest resources and TA trainings from Integrating HIV Innovative Practices: **https://targethiv.org/ihip**

Tell Us Your Replication Story!

Are you planning to implement this intervention? Have you already started or know someone who has? We want to hear from you. Please reach out to **SPNS@hrsa.gov** and let us know about your replication story.

Endnotes

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