HHOME

This fact sheet contains highlights from the Homeless Health Outreach Mobile Engagement (HHOME) intervention, designed to link, engage and deliver rapid HIV treatment to those experiencing homelessness in San Francisco, California.

INTERVENTION OVERVIEW: A robust 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 into HIV primary care, behavioral healthcare, and housing.

PRIORITY POPULATION: People experiencing homelessness

ORGANIZATIONAL SETTING: City public health department (San Francisco, California)

FUNDING SOURCE(S): HRSA RWHAP Part F: SPNS "Building a Medical Home for Multiply Diagnosed HIV-positive Homeless Populations" initiative

INTERVENTION PURPOSE/GOAL: This intervention aims to 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.

INTERVENTION SUCCESSES: HHOME served a total of 106 clients. Of the 106 intervention participants:

- 84% were retained in care at 12-month chart review
- 84% were stably housed at 12-month chart review
- 79% achieved viral load suppression at least once during the previous 12 months
- 74% acquired permanent housing at 12-month chart review
- 60% were virally suppressed at 12-month chart review

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 quality improvement and data tracking component, and sharing information about the need among this population and the success of the model.

INTERVENTION CORE ELEMENTS:

Conduct community and resource assessment. Assess your community of those experiencing homelessness, 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.

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.

Routinize assessments/tools and clarify referral process. Select an acuity scale 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.

Conduct outreach, receive client referrals, and enroll clients. Conduct mobile case management outreach in areas where the population frequents and use peer navigators to reach those referred by partners. Enroll clients, screen for eligibility, and enlist clients in the intervention.

Conduct assessments and develop care plan. Conduct acuity assessment and biopsychosocial assessment. Based on acuity score, assign a care plan level and work with the client to identify goals and tailor the care plan.

Provide case management. Provide case management services; 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., photo ID).

Secure housing and provide LifeSkills Training. Identify and secure appropriate housing for clients and work with both clients and systems to support clients in the transition by providing LifeSkills training.

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.

INTERVENTION STAFFING:

- ***Project Manager:*** Provides day-to-day oversight of HHOME program and supervises the direct service team members. Oversees quality improvement efforts and convenes clinical, administrative, and community stakeholder meetings.
- ***Medical Doctor (MD):*** Provides co-located onsite and mobile primary medical care to clients and works closely with the RN. Trains the team on all aspects of medical and behavioral health/addiction medicine and provides medical advocacy.
- ***Registered Nurse (RN):*** Provides co-located onsite and mobile nursing care and complex care management. Provides referrals to clients for additional care services. Provides health literacy education to clients. Works with housing case manager, providing at-home care to clients.
- ***Peer Navigator:*** Oversees outreach and engagement efforts. Accompanies clients to appointments, advocates for clients with other providers, supports clients in building support networks, provides risk reduction counseling to high-risk clients, and provides life skills training.
- ***Housing Case Manager:*** Provides housing case management and housing-related counseling. Referrals to emergency shelter, stabilization rooms, permanent housing, benefits acquisition, and treatment residencies. Connects clients to psychosocial services and primary care.
- ***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 barriers to care.
- ***Clinical Supervisor:*** Plans, coordinates, supervises, and evaluates the integrated program of HHOME. Coaches HIV service providers with informed referrals and provides training to the HHOME team on housing, mental health, substance use, and benefits issues.

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.

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 is challenging to apply QI principles when the environment and clients are so frequently changing and different organizations throughout the city use different data systems.

Lack of trauma-informed care. There are a lack of trauma-informed programs and providers throughout most cities.

Limited transitional care assistance. 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.

RESOURCES:

HHOME Intervention Implementation Guide: **https://targethiv.org/ihip/hhome**

HHOME Program Manual: **http://ciswh.org/wp-content/uploads/2017/07/HHOME-SFDPH.pdf**

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