HHOME - Homeless HIV Health, Outreach and Mobile Engagement

A System, Program, and Client-Level SPNS Intervention

SYSTEMS FAIL, Not People

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Disclaimer

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System Wrangler

Improving HIV Care Outcomes Requires Care Coordination and System Cooperation

System Change: Partners who created HHOME and HIV Care Continuum Task Force

- What are the GAPS in care?
- How can we stop blaming the consumer and other programs for system failures?

  - SFDPH Primary Care Clinics
  - Housing and Urban Health Direct Access to Housing & Respite
  - SF General Hospital, PHAST*, & Social Service
  - SF Homeless Outreach Team and Homeless Services
  - Project Homeless Connect
  - SFDPH HIV Prevention: LINCS, Testing-Linkage-Engagement
  - SF Community Health, Social Service & Drop In Center
  - Forensic AIDS Project, (Jail Health)

** PHAST: Positive Health Access to Services and Treatment; UCSF Positive Health*

One size fits all

One size fits all is NOT trauma-informed, and increases stigma

Is this a good location for a health center for people with lung disease on oxygen?

4-Wall health centers are not accessible for people who use substances and/or have experienced medical and sanctuary trauma

Areas of ‘Out of Clinic’ Care Need for all PLWHA

Safe Place to Live	Navigation	Case Management	Behavioral Health	Medical Care
• Emergency Stabilization • Permanent housing • Placement to fit functional need	• Knowledge of Resources • Social support • Health literacy	• Benefits • Legal • Coordinate services • Food access	• Mental Health • Addiction treatment • Address service utilization – ‘right door’	• Adherence Support • Acute and chronic disease care • Low-barrier HIV care

SYSTEM CHANGE: Defining Acuity and Chronicity

Acuity scale is used to assess:

- Current severity of the client in 6 Domains
- Current needs and predicted chronicity of each client
- What program will match client needs

Domains assess ability to:

- Engage in primary care
- Adhere to medication regimen
- Achieve, adjust to, and maintain housing
- Identify and obtain basic needs
- Navigate health and supportive services
- Engage in mental health treatment
- Impact of substance use and level of recovery

Client

- Medical
- Medication Adherence
- Navigation
- Case Management
- Substance Use
- Mental Health

Client Need Form (Short Referral Version)

Please complete to the best of your ability, based on your experience with the client Ct Name: _____ DOB: _____

		Level 3 - Intensive Need *Mobile Medical; HHOME; Health at Home*	Level 2 - Moderate Need *Intensive Case Management; HOT*	Level 1 - Basic Need *Centers of Excellence*	Level 0 Self-Management *Panel Management*	Comments
Medical Care and Treatment Adherence	Care Engagement	☐ Unable to tolerate 4-walls clinic or has received Denial of Service from >1 clinic ☐ Severe physical illnesses w/o capacity for Tx engagement	☐ Rarely able to tolerate 4-walls clinic w/o an escort and/or redirection ☐ Multiple physical conditions w/ low Tx engagement ☐ May self-direct to drop-in clinic	☐ Engages in 4-walls clinic w/ intensive appt. reminders (multiple calls, texts, emails) ☐ Engages w/ clinic to address physical conditions	☐ Engages in clinic w/ standard appt reminders only (phone, text, email) ☐ Engages independently to address physical conditions	
	Current Health Status	☐ VL>40 and CD4<200 ☐ ART: refuses or not taking ☐ OI's w/i last month ☐ Hospitalized w/i last 30-days ☐ High Risk Pregnancy	☐ VL>40 and/or CD4<350 ☐ ART: Refuses, not taking, or needs strong adherence support (eg: DOT) ☐ OI w/i last 6-mo ☐ Hospital w/i last 6-mo ☐ Pregnant	☐ VL>40 or Hx of detectable VL since ART first initiated ☐ ART: taking, may need adherence support ☐ No Hx of OIs w/i last 6-mo ☐ No acute medical issue w/i last 6- mo	☐ Virally suppressed ☐ ART: taking consistently ☐ No Hx of OIs w/i last 12-mo ☐ No acute medical issues w/i last 12-mo or greater	
	Chronic Illness	☐ > 2 visits to ED w/i 30-days ☐ Palliative care or Hospice ☐ 1-2% high utilizer	☐ > 2 visits to ED w/i 60-days ☐ Not flourishing medically in current level of care ☐ 3-5 % high utilizer	☐ 1 visit to ED w/i 90-days ☐ Stable medically with support of wrap-around care ☐ Past 1-5 % high utilizer	☐ 0 visit to ED w/i 180-days ☐ Empowered for self-care of chronic illness ☐ No Hx of high utilizer	
	Function: Physical & Cognitive	☐ Despite accommodations persistent inability to follow through d/t cognitive or physical impairment ☐ Impulse control or decision-making impairing health and multiple life Fx ☐ Dementia ☐ MoCA < 17	☐ Frequent inability to follow through d/t cognitive or physical impairment ☐ Impulse control or decision-making impairing 1 or more life Fx ☐ MoCA 18-22	☐ Occasional inability to follow through d/t cognitive or physical impairment ☐ MoCA 22-26	☐ No Impairment ☐ MoCA >26	
	Rx Adherence	☐ Misses doses daily ☐ Requires DOT ☐ <30% med adherent ☐ Not taking ART	☐ Misses doses weekly ☐ New to ART or lifesaving regimen ☐ 30% to 60% med adherent	☐ Misses doses monthly ☐ Missed treatment or Rx refill w/i last 90 days ☐ 60% to 90% med adherent	☐ Rarely misses a dose	
Housing	Housing Status and Housing Readiness	☐ Lives in a place not meant for human habitation (street, car, park, etc.) AND is unable to negotiate for self in that environment ☐ Critical unmet ADL/IADL needs; major health or safety hazards in current housing ☐ Expected to be released from incarceration, placement, or long term care facility w/i next 3-mo ☐ Faces imminent eviction	☐ Lives in a place not meant for human habitation AND able to negotiate for self in that environment ☐ Requires assistance managing ADLs and/or IADLs ☐ Lives in a shelter, transitional/ temporary housing or is doubled-up ☐ Released from incarceration or long term care facility w/i last 6-mo ☐ Chronic challenges maintaining housing ☐ At risk of eviction	☐ Lives in permanent or stable/safe housing but needs wrap-around assistance to remain housed ☐ May require minor assistance managing ADLs or IADLs ☐ Couch surfing or hotel hopping	☐ Resides in stable, affordable and appropriate housing with no issues that impact housing retention in the last 365-days ☐ Does not require help managing ADLs or IADLs	

Client Need Form (Short Referral Version) (cont)

Please complete to the best of your ability, based on your experience with the client Ct Name: _____ DOB: _____

		Level 3 - Intensive Need *Mobile Medical; HHOME; Health at Home*	Level 2 - Moderate Need *Intensive Case Management; HOT*	Level 1 - Basic Need *Centers of Excellence*	Level 0 Self-Management *Panel Management*	Comments
Behavioral Health	MH Care Engagement	☐ Unable to tolerate 4-walls clinic ☐ Severe Mental Illness with no provider or tx engagement ☐ Denial of Service at mental health center	☐ Unable to tolerate 4-walls clinic w/o an escort and redirection ☐ MH diagnosis with no current health provider or inconsistent tx engagement	☐ Needs face to face appt reminders or navigation ☐ MH diagnosis w/ consistent treatment engagement	☐ Attends MH appointments w/ standard reminders ☐ No indication of need for MH care or need for help engaging in Tx	
	Acute Psych Issues	☐ Psych hospitalized w/i last 30-days ☐ Imminent danger to self or others or grave disability ☐ Psychosis with high risk of decompensation ☐ Presence of psychosis w/ command auditory hallucinations	☐ Presented to PES or psych hospitalized w/i last 90-days ☐ Reports thoughts of harm to self/others but contracts for safety ☐ Exhibits erratic behavior ☐ Limited insight into negative impact of MH Sx on other areas of functioning	☐ Severe Mental Illness, no psych hospitalizations w/i 6-months ☐ Need for additional mental health support or regular check-in with mental health clinician	☐ No PES contact or psych hospitalizations w/i 1-year or more ☐ No current acute psych issues	
	Chronic Illness	☐ > 2 visits PES in the past 30-days or 1-2% HUMS ☐ MH has severe impact on health care engagement ☐ No insight into negative impact of personality d/o on life functioning	☐ > 2 visits to PES in the past 60-days or 3-5 % HUMS ☐ MH has major impact on health care engagement ☐ Limited insight into negative impact of personality d/o on life functioning	☐ 1 visit to PES 90 days or past 1-5 % HUMS prior year ☐ Seeks MH Recovery	☐ Empowered for self-care ☐ Regularly engages in MH care	
	Alcohol & Drug Use	☐ Abuse or dependence that has severe impact on health ☐ Not engaged in Sub Use Tx ☐ >2 ED visits for drugs/ETOH w/i 30 days ☐ IVDU with health consequences	☐ Current or recent use that sometimes interferes with health ☐ Loosely engaged in Sub Use Tx ☐ >2 ED visits for drugs/ETOH w/i 6-mo ☐ IVDU and uses clean needles	☐ Current or recent use that does not interfere with health ☐ Engaged in Sub Use Tx and need for additional support ☐ SU d/o in full remission	☐ No current or past issues with substance use ☐ Engaged in recovery with no indication of need for additional support	
Case Mgmt.	Case Mgmt. Needs	☐ Acute support needed w/ financial, legal, nutritional, and/or life skills ☐ No income or benefits ☐ IPV, declines support ☐ Complex coordination between multiple providers and agencies	☐ Substantial support needed w/ financial, legal, nutritional, and/or life skills ☐ Income/benefits are inadequate ☐ IPV, accepts support ☐ Active coordination between multiple care providers	☐ Would benefit from linkage to services to address basic needs ☐ Income/benefits occasionally inadequate ☐ Occasional coordination between providers	☐ No current or recent legal issues ☐ Has steady income; manages all financial obligations ☐ Rarely needs coordination between providers	
Navigation	System Surfing and health literacy	☐ No access to safety net programs which impacts health ☐ Cognitively impaired or severe system trauma ☐ Demonstrates no understanding of illness, treatment, or risk reduction	☐ Inconsistent follow-up and routinely needs assistance to stay engaged in care ☐ Challenges that limit ability to follow-up with appointments ☐ Demonstrates minimal understanding of illness, treatment or risk reduction	☐ Occasionally needs assistance to stay engaged in care ☐ Can make their own appointments ☐ Demonstrates basic understanding of health issues	☐ Consistent and reliable access to and engagement in care ☐ Demonstrates solid understanding of health issues	

Five Levels of Programming Harm Reduction: Health Care Engagement

Level 0	Level 1	Level 2	Level 3	Level 4
Health Care for the Homeless and Safety Net Clinics Appointment reminders/ missed visit follow up/ routine review of panel to ensure visits	**CCHAMP, TACE, POP-UP** Address mental health, substance use barriers, stigma	**GTZ Case management** Address long-term barriers	**HHOME** Bringing medicine and care to people	**TRANSITIONS Complex Care management** High utilizer of multiple systems

Referral and Gate Keeper: PHAST (Hospital) & LINCS (Community and Clinic, Glide (community)) Navigation

SERVICES PRIMARILY WITHIN 4-WALL CLINIC

SERVICES PRIMARILY MOBILE

Level 3: HHOME Come as you are, wherever you are

HHOME Target Population: The Highest Level Acuity and 'Hardest' to Serve

- PLWHA not currently engaged in HIV treatment or not succeeding in the current level of care, with:
  - Detectable Viral Load
  - CD4 < 200
- Active substance abuse disorder severely affecting health
- Diagnosed with severe mental illness or mental health condition impairing functioning
- Experiencing homelessness
- Special Populations:
  - HIV-positive pregnant women
  - HIV-negative partner of HIV-positive individual, partner meets HHOME criteria and needs PrEP
  - Transitional Age Youth (TAY), ages 18-25 and young adults ages 25–30 aging out of TAY
  - Newly diagnosed with HIV
  - Eminent risk of eviction

HHOME - Combines Three Programs: Staff, Resources and Culture

PROGRAM	Street Medicine *(SF DPH Safety Net Health Center)*	SF Homeless Outreach Team (SF *Homeless and Supportive Housing Division)*	SF Community Health Center *(community-based non-profit FQHC)*
STAFF	• RN • MD • Phlebotomy	• Housing CM • Clinical Supervision	• Program Manager • Social Work • Navigation • Evaluation
RESOURCES	• Medical Clinic • Medicine/Supplies • Insurance Support	• Shelter Beds • Stabilization Rooms • Permanent Housing	• Open Access Clinic • Drop in Center • Medical Clinic
CULTURE Expertise and Change Support	**Health Care for the Homeless:** Mobile, trauma-Informed, one stop for medical, addiction medicine, mental health treatment	**Mobile Care Culture & Crisis Care Management:** Outreach, stabilization and engagement.	**Community-Based Culture:** Community-based, consumer driven care; peer support and workforce development

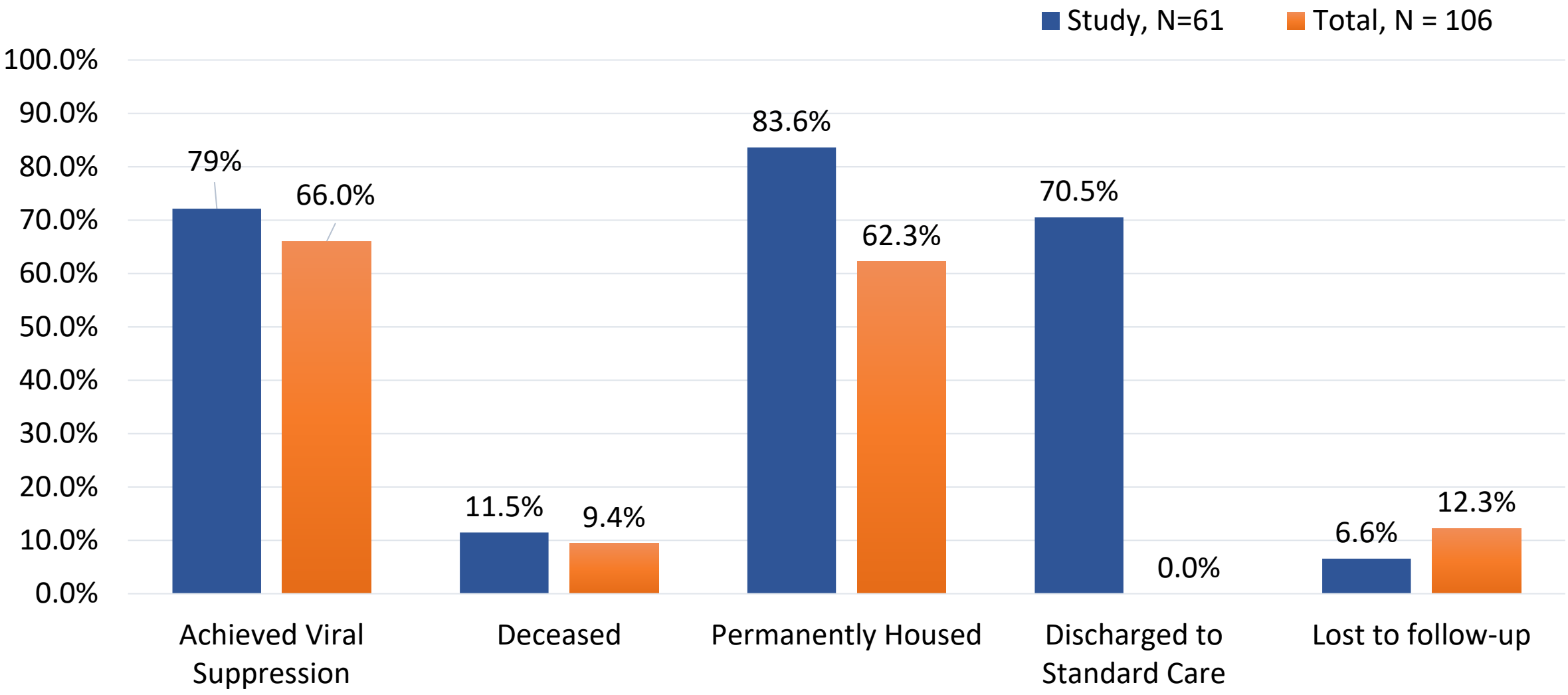
HHome Client Intervention: Philosophy

- Interdisciplinary, consumer centered, trauma-informed, harm reduction-based care.
- Care based on the consumer's health goals with respect to their stage of change. If not, we can cause more trauma.
- Consumer is "captain" of the team, and their goals drive the treatment plan.
- Love and affection are a part of the "treatment." Stigma is the disease.
- Focus on resiliency and coping strengths while learning new life skills.
- Humor and always come "bringing chocolate."

Client Intervention: The Basics and Techniques

- All services are mobile or in open access
  - Drop-in social service programs
- Outreach, engagement, and treatment wherever consumers are located: street, jail, hospital, treatment center, social service program and shelter/stabilization room
- Contingency management and incentives
- Harm reduction, low barrier treatment on demand
- Palliative care approach, end of life planning
- Creative and flexible medication adherence, crisis management, and treatment plans

HHOME Study Results 2017



45 Clients where unable to complete research consent and baseline evaluation

Policies that Improve Outcomes for People Experiencing Homelessness

- Open access clinics and a no “late policy”
- Transportation support
- Medi-sets and med adherence support at social service, shelters and drop-in site, with community pharmacy partnerships
- Incentives: Food, clothing, and gift cards
- In-clinic housing support: Housing – Health Partnerships
- Navigation
- Mobile teams - nurse adherence programs, labs in the field
- Creative communication: phones, Facebook, bracelets

Challenges

- Staff retention and turn-over: Cost of living and keeping focus on trauma-informed leadership when client demands are heavy.
- Lack of support available for newly housed individuals. “Getting housed is a slow walk to the starting line.”
- Data Issues: Referral process is not centralized nor computerized and 5 different data systems.
- Applying “QI” principles to a moving target is tricky.
- Maintaining calm focus in the midst of chaos: “If we weren’t meditating before this, we certainly meditate now.”

Challenges (cont)

- City-wide reorganization, affecting homeless health care and service access—political environment constantly changing.
- Lack of resources: Not enough emergency stabilization or supportive housing.
- Discharging clients from program is difficult:
  - No permanent/long-term care equivalent
  - No palliative care for substance users
  - High risk of eviction & disengagement
  - Lack of trauma-informed programs and providers

Unexpected Successes and Sustainability

‘SPIN-OFFS’

- New Getting to Zero intensive case management programs
- HHOME Life Skills
  - Peer led program designed to retain PLWHA in housing
- Encampment Health
  - Low barrier PrEP, STI testing, and HIV/HEP C testing and rapid treatment for encampment communities in SF
- Pregnant women mobile care
- Social determinants of health consult service in safety net hospital - social medicine

SUCCESSES

- City is supporting the ongoing funding for the program
  - Using Ryan White and general fund dollars
- System-Wide Coordination
  - Acuity Assessment and Intervention Framework
  - Creation of the SF HIV Care Coordination Task Force.
  - System-wide referrals and linkages for PLWHA that are timely and appropriate
- Championing palliative care and advanced care planning
- Recognized as a leader in trauma-informed medical care!
  - Training faculty, medical students, residents, and fellows

The HHOME model proves that systems fail, not ‘the patient’

- A HHOME clients’ success comes from their resiliency coupled with a Trauma-Informed System, Leadership, and Program
- Consumer driven treatment plans and interventions decrease stigma and increase resiliency and recovery
- Trauma-informed leadership and team support requires the same attention as the care we give to our clients. Healthy multi-disciplinary teams create space for clients and staff to thrive
- System success comes from working together to define and address system gaps, align goals and outcomes, pool resources, and integrate care between agencies

Resources

- National Healthcare for the Homeless: https://www.nhchc.org/
- SAMHSA: Homeless Programs Resources
- Matthew Bennet: https://connectingparadigms.org/
- San Francisco HIV Epidemiology Report
- San Francisco Point in Time Homeless Count: Report
- Getting to Zero Initiative: https://www.gettingtozerosf.org/
- SFDPH Population Health-Disease Prevention and Control: https://www.sfcdcp.org/
- San Francisco Community Health Center: https://sfcommunityhealth.org/

Additional Resources

- National Healthcare for the Homeless: https://www.nhchc.org/
- SAMHSA: Homeless Programs Resources
- Matthew Bennet: https://connectingparadigms.org/
- San Francisco HIV Epidemiology Report:
- San Francisco Point in Time Homeless Count: Report
- Getting to Zero Initiative: https://www.gettingtozerosf.org/
- SFDPH Population Health-Disease Prevention and Control: https://www.sfcdcp.org/
- San Francisco Community Health Center: https://sfcommunityhealth.org/

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