Ending the HIV Epidemic (EHE)
Regional Learning Collaborative

Alameda, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, and San Francisco Counties

Session 5:
Strategies and Best Practices for Mobile Service Delivery

Tuesday, February 16, 2021
10-11:30 a.m. PST
Session Agenda

Bienestar Human Services’ Mobile HIV Services
• Jorge A. Diaz, MSW, Director of Prevention Programs

San Francisco Community Health Center’s GTZ/HHOME Programs
• Charilyn Quarto, LVN, GTZ/HHOME Program Manager
• Robert Arnold, LVN, Associate Director of HIV Services
• Doston Ganiyev, Medical Case Manager

Keck School of Medicine of USC’s Street Medicine Program
• Brett J. Feldman, MSPAS, PA-C, Director of Street Medicine

Panel Discussion/Q&A
HIV Homeless Mobile Engagement (HHOME) and Getting To Zero Intense Case Management (GTZ-ICM)

San Francisco, CA
HIV Homeless Mobile Engagement (HHOME)

- Homeless HIV+ clients in the County of San Francisco
- CD4 < 200
- Psychiatric Diagnoses
- Substance Use
- Mobile Medical and Case Management Services
  - 1 Mobile MD
  - 2 HHOME Case Managers
  - 1 RN
  - 1 Housing Case Manager

Getting To Zero Intense Case Management (GTZ-ICM)

- Homeless or marginally housed HIV+ clients in the County of San Francisco
- CD4 > 200
- Psychiatric Diagnoses
- Substance Use
- Mobile Medical and Case Management Services
  - 1 MD
  - 2 Case Managers
  - 1 LVN
Client Services- HHOME

• Medical
  • 1 RN and 1 MD
    • Mobile outreach, medical assessments, wound treatment, medication delivery, blood draws
    • Drop in 4 wall medical clinic

• Case Management
  • 2 HHOME Case Managers and 1 Housing SF HOT Case Manager.
    • Mobile outreach, navigation, connection to shelter, obtaining ID, Social Security card, food services, connection to medical insurance and income.
    • Referral to psychiatric services
Client Services- GTZ- ICM

• Medical: 1 LVN and 1 MD.
  • LVN: Medication adherence, medication delivery, medical assessment, wound treatment, blood draws, mobile outreach, psychiatric assessments
  • 4 wall drop in clinic

• Case Management: 2 Case Managers.
  • Assists clients with any intense Case Management needs; connection to lawyers, possible evictions, referral to psychiatric services
  • Mobile outreach, navigation, counsels clients
  • In contact with clients supportive housing Case Managers
  • Connection to food services
  • Assists clients in maintaining housing and income
  • Assists clients in obtaining lost ID, lost SS Card
Acuity Assessments

- **Acuity scale is used to assess:**
  - severity of the client
  - needs and chronicity of each client

- **Domains**
  - Ability to:
    - Engage in primary care
    - Adhere to medication regimen
    - Adjust to and maintain housing
    - Engage in mental health treatment
    - Manage life while using substances
    - Identify basic needs
    - Navigate health and supportive services
Program Recipe

HHOME

Medical Doctor/Nurse

Visit with mobile MD and Case Manager 1 x per week

GTZ

Case Manager Nurse

Visit with mobile Nurse and Case Manager 2 x per week

TACE

Case Manager Medical Doctor

Visit with drop-in MD and CM 1 x per week
Client and Care Team Connection- HHOME

• Referrals from other community services.
• Meets with initial referring person for a warm hand off
• Consistently outreaches and builds rapport with client.
• Gift Cards are given to client on an as needed basis- Intake process or meeting with MD
• Team outreaches client to bring them to clinic to meet MD.
• Assistance and escort to specialty medical appointments
• De-escalate situations, counsel clients and assess for psychiatric services if needed; Mobile Crisis or contacting in house Social Worker for 5150.
Client and Care Team Connection- GTZ

• Referrals from other community services or clients who have graduated HHOME

• Case Manager
  • Meets with initial referring person for a warm hand off.
  • Frequent check in’s with clients and their housing case managers or social workers.
  • Assists clients with connection to lawyers if needed
  • Case Manager and LVN work together to connect clients to PCP and for client to attend medical appointments at a 4 wall clinic.
  • Any other intense case management needs

• LVN creates a medication adherence plan with client

• LVN and/or Case Manager refers client to Psychiatric services if needed
Unable To Find a Client

• If a client goes MIA:
  • Case Manager contacts hospitals in the county, morgue and may file for a missing person; if needed.
  • Program Manager sends a “Be On the Look Out” email to clients DPH care team; SF HOT.
Best Practices

• Bring snacks when meeting with client
• Be consistent with clients
• Meet clients where they're at in their care
Thank you!
Exploring the Value(s) of Street Medicine in Care of the Unsheltered Homeless

Brett J. Feldman, MSPAS, PA-C
Director of Street Medicine Keck School of Medicine of USC
Assistant Professor of Family Medicine

February 16, 2021 | Zoom, CA
Values and Philosophy

• Patient led

• Reality based

• Unconditional respect

• Medicine as an instrument of peace

• Medicine as tool of advocacy
Targeted interventions address social risk factors

**Vision**: all unsheltered homeless in LA have access to basic healthcare

- Hospital-based consult service
- Street-based care
- Workforce development
  - Education
- Research
Depths of Outreach with Solidarity

- **Level 1: Outreach**
  - Surface level interaction
  - Offering of services

- **Level 2: Engagement**
  - Genuine intent to deliver services
  - Informed by population level trends and beliefs

- **Level 3: Solidarity**
  - Seeks deeper level of understanding without agenda
  - Shared responsibility of goals and outcomes
Acceptable (patient centered): patient preferences and aspirations

Recognizing system vs patient centered thinking