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

CHIPTS
Center for HIV Identification, Prevention and Treatment Services

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

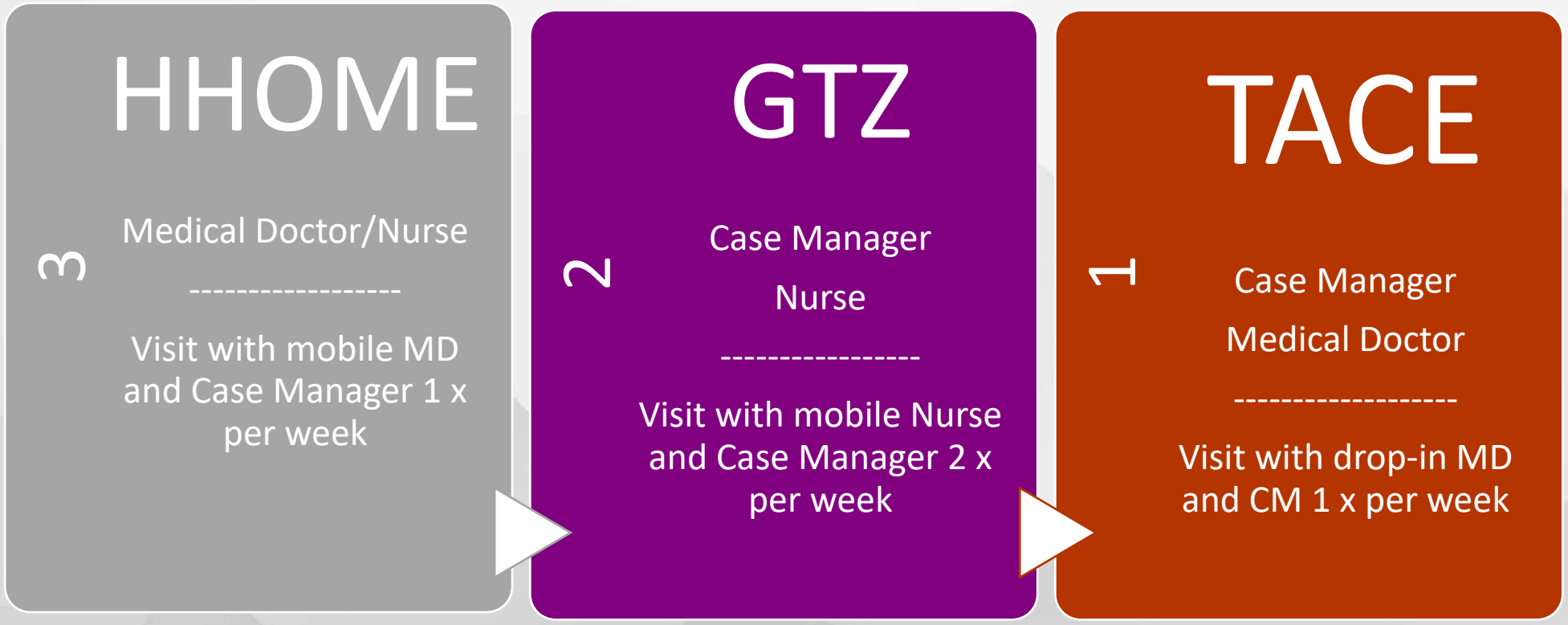
Client Services- GTZ- ICM

- **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 asses:**
  - 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



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

Keck School of Medicine of USC
Street Medicine

street medicine institute

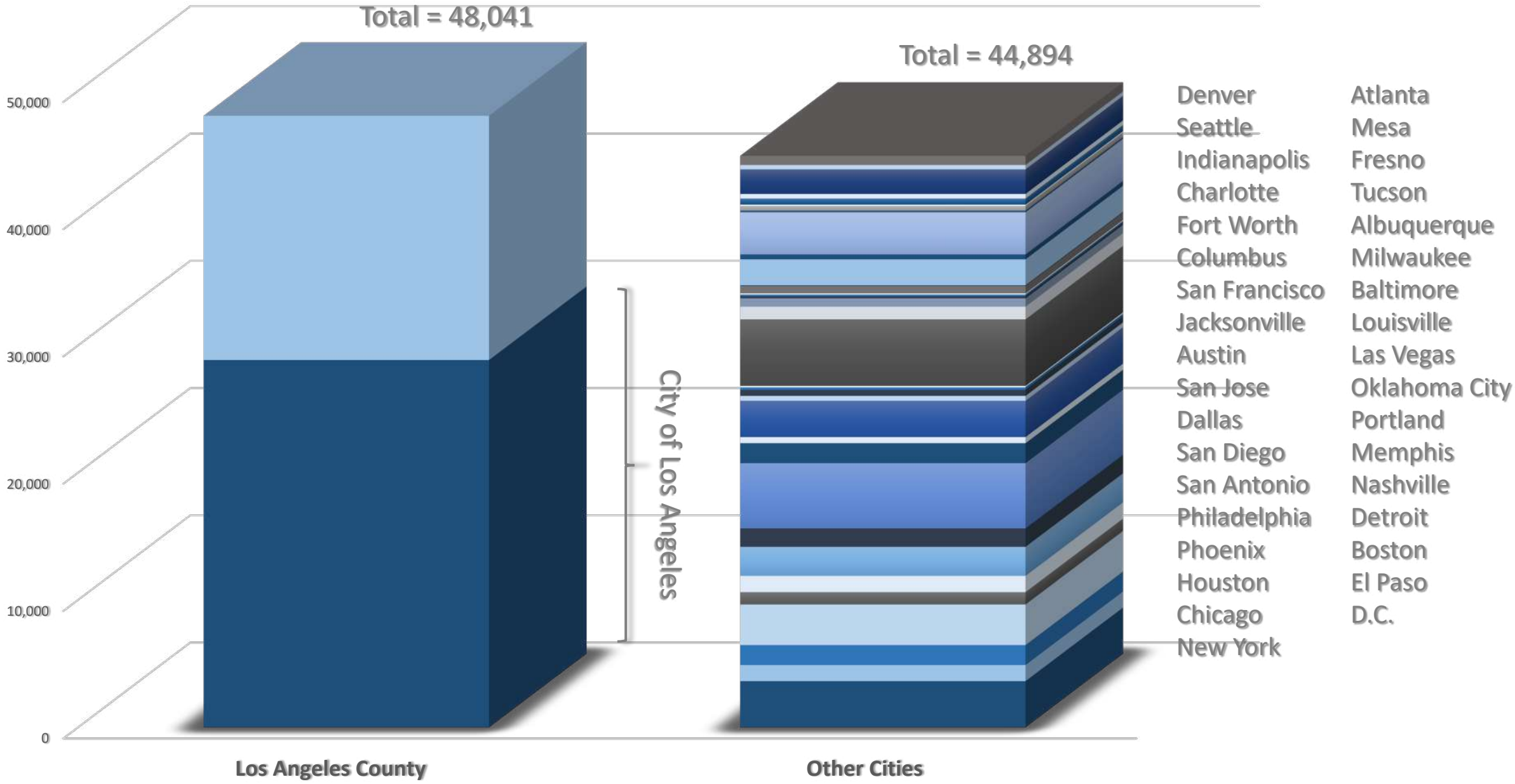

osprey


LAC + USC
Keck School of
Medicine of USC
Street Medicine

Values and Philosophy

- Patient led
- Reality based
- Unconditional respect
- Medicine as an instrument of peace
- Medicine as tool of advocacy

Unsheltered Homeless in US, 2019/2020

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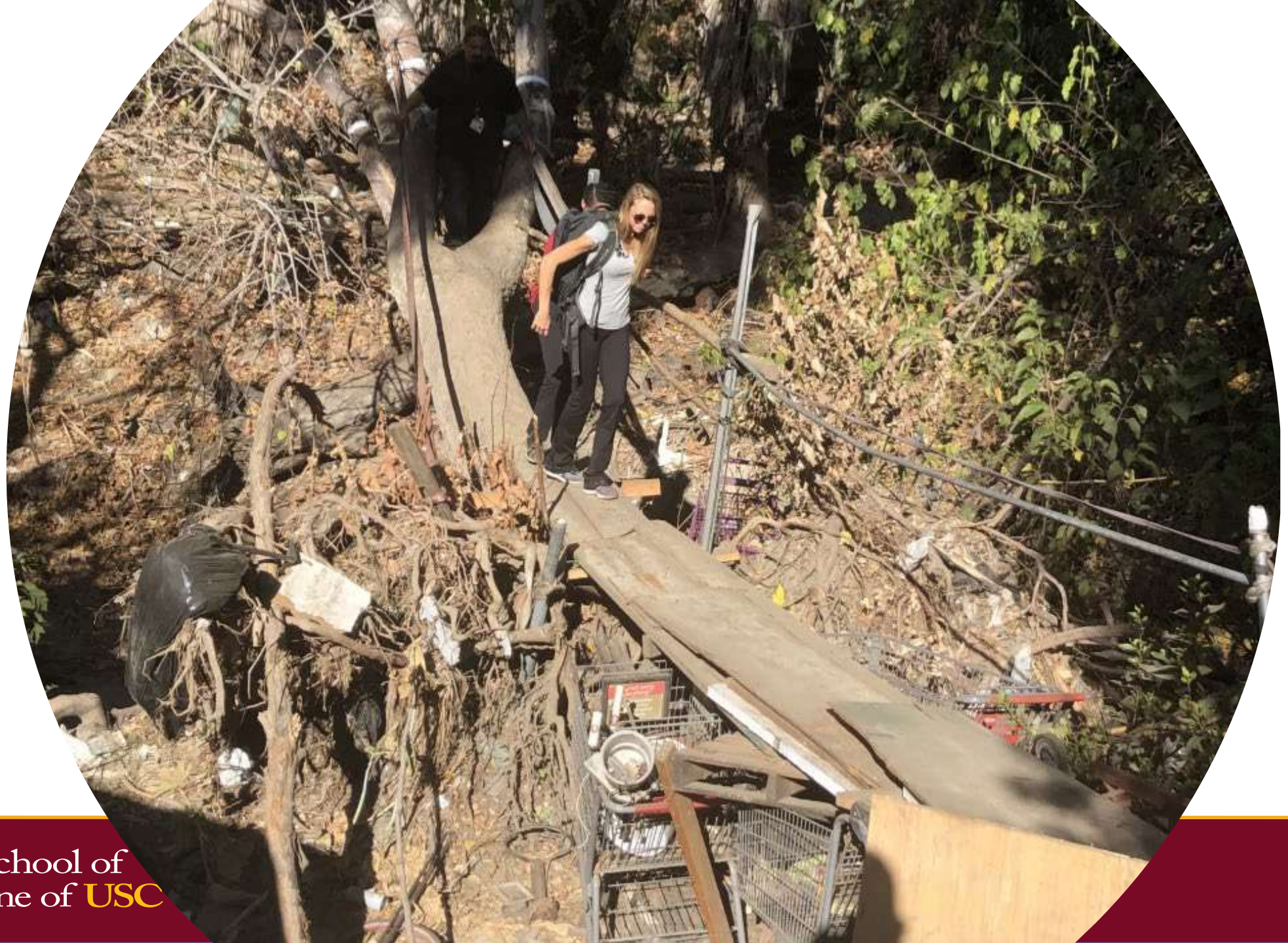
Skid Row
CITY LIMIT
POP Too Many
ELEV 2008
© AFP



Keck School of
Medicine of USC

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