Replicating Innovative HIV Care Strategies in the Ryan White HIV/AIDS Program

Innovative HIV Care Strategies for the Unstably Housed

June 23, 2022

Agenda

- *Project Overview*
  - About the Special Projects of National Significance (SPNS) Program & Integrating HIV Innovative Practices (IHIP) Project – presented by: Shelly Kowalczyk (Project Director)
- *Continuing Education Credit Availability*
- *Intervention Overview*
  - KC Life 360 – presented by: Jamie Shank
  - HHOME – presented by: Deborah Borne, Robert Arnold, Martina Travis
- *Q&A*
- *Participant Feedback*

Project Overview: About the Project

- **Funded By**: The U.S. Department of Health and Human Services, Health Resources and Services Administration's HIV/AIDS Bureau through RWHAP Part F: Special Projects of National Significance.
  - HRSA oversight provided by: Melinda Tinsley and Adan Cajina

- **Awarded To:** The MayaTech Corporation
  - Subcontractor: Impact Marketing + Communications
  - Contract Period of Performance: September 27, 2021 – September 26, 2023

- **Purpose:** To support the coordination, dissemination, and replication of innovative HIV care strategies in the Ryan White HIV/AIDS Program (RWHAP) through the development and dissemination of implementation tools and resources.

Framework for RWHAP SPNS

Demonstrate or Implement

- Fund recipients to respond to emerging needs of people with HIV using evidence-based, evidence-informed, and emerging interventions
- Fund special programs to develop a standard electronic client information data system to improve the ability of recipients to report data

Evaluate & Document

- Use an implementation science framework to identify effective interventions to improve HIV outcomes among Ryan White HIV/AIDS Program clients
- Evaluate and document specific strategies for successfully integrating interventions in RWHAP sites

Coordinate, Replicate & Integrate

- Develop guides and manuals, interactive online tools/toolkits, publications, and instructional materials that describe how to coordinate, replicate, and integrate interventions and strategies for RWHAP providers
- Streamline access to materials and promote replication through the Best Practices Compilation

Enhancements to the Integrating HIV Innovative Practices Project

- Focusing on RWHAP innovative strategies in HIV care and treatment (not just SPNS innovations)
- Aligning with the Best Practices Compilation
- Coordinating the delivery of peer-to-peer capacity building technical assistance (TA)
- Delivering one-on-one TA in the development and dissemination of implementation tools and resources
- Providing continuing education (CE) credits for live webinars

Key Support to RWHAP Providers

- Implementation tools and resources
- Capacity building TA webinars
- Peer-to-peer TA on the featured interventions
- Support in the development and dissemination of implementation tools and resources
    - Webinars
    - One-on-one TA
- Helpdesk (ihiphelpdesk@mayatech.com)

Continuing Education Credits

Jointly provided by Postgraduate Institute for Medicine and The MayaTech Corporation

Postgraduate Institute for Medicine

Continuing Education Credits Offered

- Physicians
- Nurses
- Physician Assistants
- Dentists
- Dieticians
- Health Education Specialists
- Social Workers
- Pharmacists

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Jamie Shank	Nothing to Disclose
Deborah Borne	Nothing to Disclose
Robert Arnold	Nothing to Disclose
Martina Travis	Nothing to Disclose

Presentations

KC Life 360

- City of Kansas City, Missouri
- Health Department
- Jamie Shank, MPH

KC Life 360 Disclaimer

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number #H89HA00028 SPNS Engagement and Retention Initiative, awarded at $863,356 over five years, to the City of Kansas City, Missouri, with 0% non-governmental sources used to finance the project. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Presenter, Jamie Shank

Jamie is an experienced public health professional with expertise in federal grant management, quality improvement, HIV care/treatment, and housing-related service provision. She served as the Quality & Housing Program Manager for the City of Kansas City, Missouri Health Department from 2015-2020. Her responsibilities included managing the HIV Housing program portfolio including five federally funded contracts, multiple Special Projects of National Significance, and several IRB approved research projects. She also worked with Ryan White HIV care subrecipients, providing technical assistance and oversight for clinical quality management activities in the KC Metro Area and state of Missouri.

In 2020, Jamie relocated to Atlanta, GA, and launched Organizational Empowerment, LLC. She believes people working in the fields of public health and social services are the best people! Tackling intersectoral issues and empowering diverse teams to address complex problems motivate her work.

Learn more and connect with Jamie at https://orgempower.com/

KCHD HIV Services Team

Travis Barnhart, BSW

Housing Support Specialist

Debbie Adams, LMSW

Employment Support Specialist

Joey Lightner, PhD MPH

Evaluator

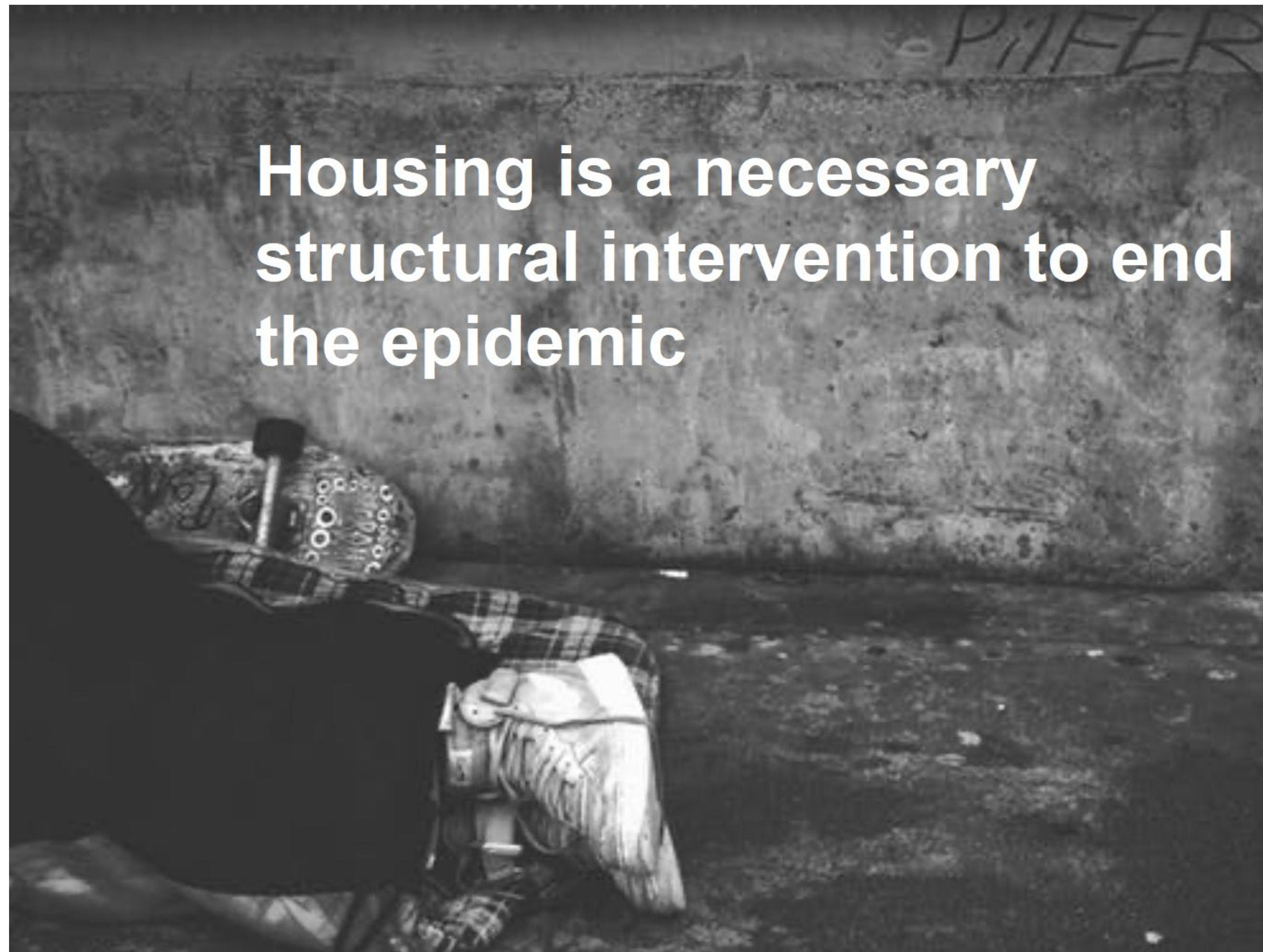
Mary Jo Hoyt, BSN

Clinical Evaluator

Coordinated System of Care - Keys to Success

- 11-County bi-state geographical region
- KCMO Health Department is the Ryan White Part A recipient and HOPWA grantee (formula and competitive HOPWA awards)
- Approximately 2,700 Ryan White clients annually
- Approximately 500 served in RW and Non-RW Housing Program
- Intensive efforts to expand HIV Housing Program in the past 4 years

Housing



KC Life 360: Overview

- HRSA funded SPNS grant
- Addresses intersection of living with HIV, experiencing housing instability, and unemployment/underemployment
- Partnered with Catholic Charities for employment support services
- Partnered with reStart for transitional housing services
- Multi-site research component

KC Life 360: Purpose

- Address the desires of PWH related to employment and earned income
- Improve housing stability
- Improve engagement in care
- Improve viral load suppression

KC Life 360: Reaching Our Goals

Climbing the Mountain

1. Vocationalizing & Addressing Housing Needs
2. Dedicated Staff
3. Assessment of Clients at Intake & Knowledge of Benefits
4. Interagency Collaboration

Intervention Model

KC Health Department

- Program Manager
- Data Manager
- Employment Support Specialist
- Clinical Evaluator
- Evaluator

Catholic Charities

- Employment Program Manager
- Employment Specialist

reStart Inc.

- Program Manager
- Housing Case Managers

Challenges & Solutions (Macro View)

Challenge

- New Program
- Need Employment Expertise
- Lack of Short-term, Immediate Housing
- Need for Database to Capture Programmatic Info
- Holistic Care

Solution

- Extensive Planning
- Employment Partner
- Emergency Hotel Lodging
- Customization & Training
- Co-Location

Challenges *in Depth*

- Time/effort of program launch
- Client motivation
- Insufficient stock of permanent, safe, decent and affordable housing
- Transportation
- Importance of cell phones
- Legal name change/new IDs for transgender clients
- Client follow-up made difficult

Facilitators of Success *in Depth*

- Communication mechanisms
- Dedicated staff for evaluation activities
- Hotel gap lodging
- Coordinated system of care
- Strong employment partnerships

Adding Emergency Hotel Gap Lodging

Problem: Kansas City struggled to provide immediate shelter for clients

- Chronically Homeless
- Street Homeless
- Those fleeing Intimate Partner Violence
- Waiting for lease-up
- And more…

Solution Step 1: Kansas City learned from Family Health Centers of San Diego & Positive Impact Health Centers of Atlanta about their programs

Step 2: Working with Fiscal & Contract Staff

Emergency Hotel Gap Lodging

Step 3: Building Relationships with Area Hotels

- Utilized extended stay type room options

Step 4: Promoting the New Program Component

- Presentations to service providers
- Updates to electronic database

Step 5: Care Coordination

- Weekly renewals
- Client Housing Plan
- Weekly housing case management + employment support services & linkage to care

Step 6: Sustainability

- Integrating into HOPWA Formula Funds

Outcomes

93.9%	67%	78.3%	96.7%
Achieved or maintained viral load suppression	Increasing earned income through employment	Receiving permanent housing assistance	Engaged in medical care

39-year-old transgender female

"I'm thankful for the support of the employment staff assisting me with finding out the process for the name change in another state; this is important for me to get done so that I feel better about myself."

– KC Life 360 client

Single mother of three children

“We are stable, safe and together. We are in a good spot.”

— Single mother of three children, fleeing domestic violence & KC Life 360 Client

18-year-old Latino arriving in the US diagnosed with HIV

" The peer educators and staff helped me and my family understand how to handle my HIV better."

- KC Life 360 Client

Sustaining the Gains

- Incorporating Hotel Gap Lodging into HOPWA Formula award annually
- Maintaining Employment Support Specialist Position
- Maintaining database employment log
- Maintaining partnerships (formal and informal) with Catholic Charities and reStart

“I’m so thankful for the opportunity to be out of the winter weather and in a safe place.” —KC Life 360 client

Lessons Learned & Recommendations

1. Housing is the prime need/interest
2. Budget for cell phones
3. Explore alternative transportation
4. Co-location benefits
5. Client motivation
6. Employment fluidity
7. Leveraging care related data systems (e.g. EMRs)
8. Trans specific barriers

KC Life 360 Resources

On Target HIV:

Manual

One Pager

Tip Sheet

Poster

Spotlight

HUD's Getting to Work

Curriculum & Training

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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

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number #H97HA24957 SPNS Systems Linkages and Access to Care Initiative, awarded at $750,000 over five years, with 0% non-governmental sources used to finance the project. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

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: _____

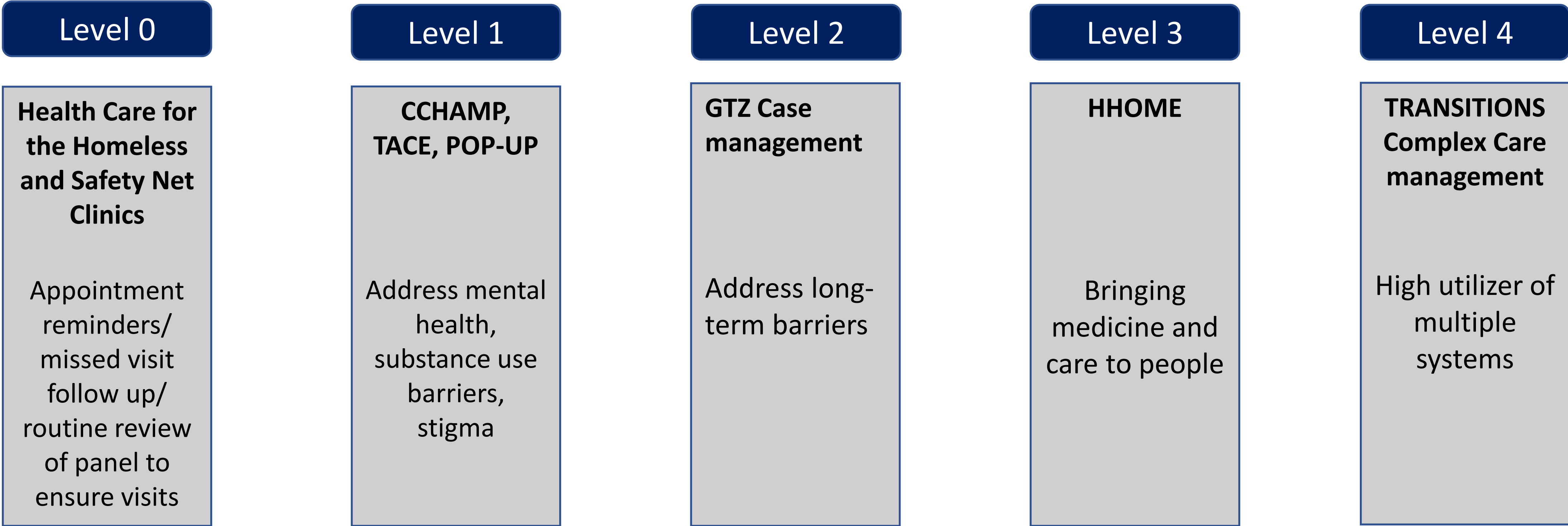
		Level 3 - Intensive Need *Mobile Medical; HHOME; Health at Home*	**Level 2 - Moderate Need** *Intensive Case Management; HOT*	**Level 1 - Basic Need** *Centers of Excellence*	**Level 0** **Self-Management** *Panel Management*	**Comments**
Medical Care and Treatment Adherence	**Care Engagement**	☐ Unable 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 ☐ <u>Past</u> 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 <u>unable</u> 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 <u>able</u> 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: _____

Domain	Area	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	
Behavioral Health	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	
Behavioral Health	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	
Behavioral Health	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



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	<u>Street Medicine</u> *(SF DPH Safety Net Health Center)*	<u>SF Homeless Outreach Team</u> (SF *Homeless and Supportive Housing Division)*	<u>SF Community Health Center</u> *(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	**<u>Health Care for the Homeless:</u>** Mobile, trauma-Informed, one stop for medical, addiction medicine, mental health treatment	**<u>Mobile Care Culture & Crisis Care Management:</u>** Outreach, stabilization and engagement.	**<u>Community-Based Culture:</u>** Community-based, consumer driven care; peer support and workforce development

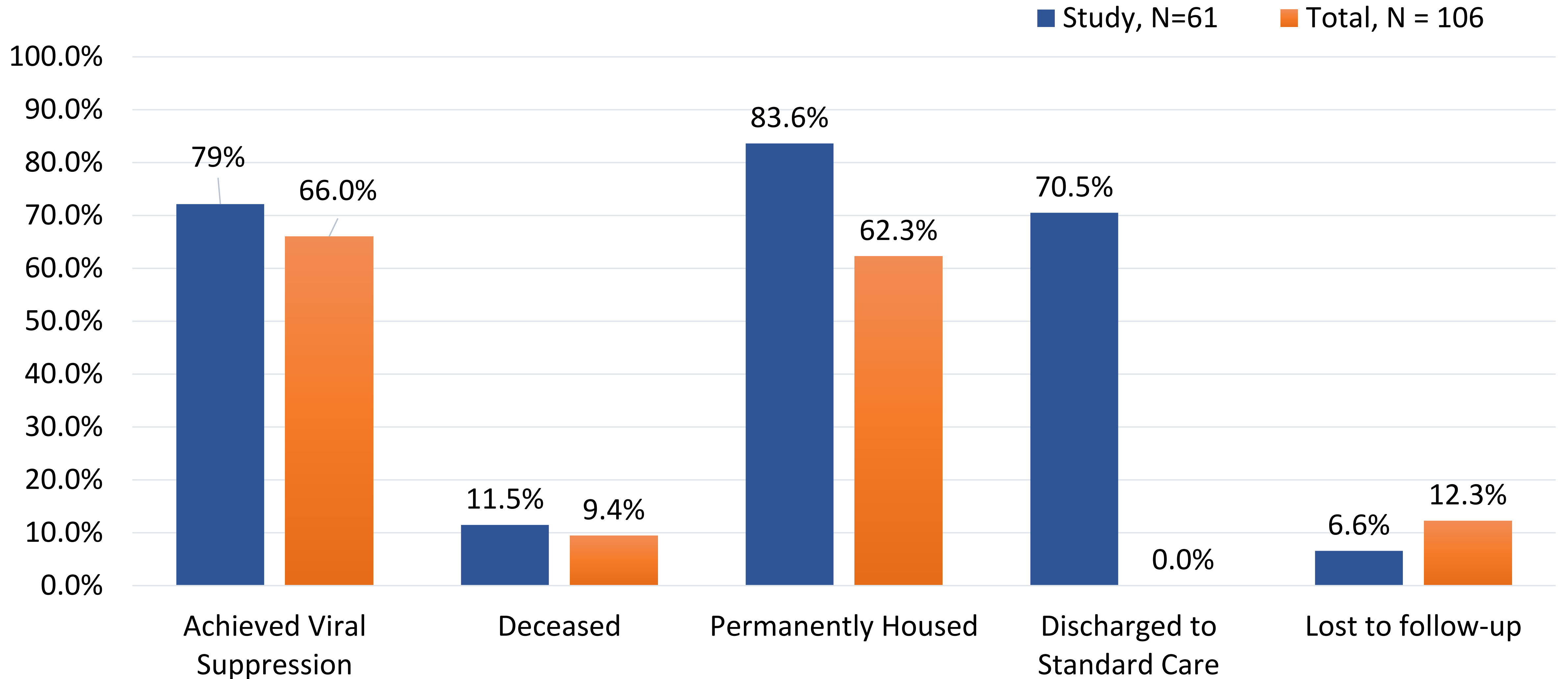
HHome Client Intervention: Philosophy

- 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
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Participant Feedback

Please use the following link to give your feedback

https://www.surveymonkey.com/r/TZ9M5VM

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Sharing Information & Strategies

CBTA questions, email:

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To access IHIP tools/resources and join the IHIP Listserv:

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