The Homeless HIV Outreach and Mobile Engagement (HHOME) Program

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Model Description

Target Population: People living with HIV/AIDS (PLWHA) in San Francisco, who are experiencing homelessness, facing complex co-morbidities including mental illness and substance use, and who have been unable to engage in housing, HIV medical treatment, or behavioral health care.

Special Populations: P2PR/RC participants, young adults (18-30) at risk for eminent eviction, denied services at more than one medical clinic, experiencing end-of-life, pregnant, and zero-discordant pregnant couples.

HHOME Program Staff:
Administrative Team: Medical Director/Project Director, Medical Director, Medical Social Worker, Nurse
HHOME Program Staff: Medical Director, Registered Nurse, Peer Navigator, Housing Case Manager, and Social Worker.

Description of the Model: Mobile, team-based intervention designed to engage and retain the most severely impacted and hardest-to-serve PLWHA in HIV primary care, behavioral health services, and housing.

HHOME aims to stabilize and transition individuals into a four-wall primary care clinic with less intensive support services.

HHOME Partners:
- API Wellness: Community-based drop-in case management, navigation, substance use services, mental health and counseling services, art therapy, nutritional services, and acupuncture.
- SF Homeless Outreach Team: Outreach, case management, and housing for people experiencing homelessness in encampments, streets, parks, and shelters.
- Team Waddell Urban Health Center, SFDPH: Health Care for the Homeless Clinic providing urgent and primary care, mental health and addiction medicine.
- Transitions Care Coordination, SFDPH: Complex care management and coordination for high utilizers of urgent and emergent services and underserved populations.

Patient Demographics

(study participants, N = 61)

- **RACE**
  - 42.6% White
  - 29.5% Black/African American
  - 11.5% Multiracial
  - 4.9% Alaskan Native/Native American
  - 1.6% Asian/Pacific Islander
  - 9.8% Other

- **GENDER**
  - 72.1% Male
  - 16.4% Female
  - 3.3% Transgender male-to-female
  - 8.2% Other/Other/Something else

- **HOUSING** (at study entry)
  - 100% homeless or unstably housed

**Metric:**

- **Achieved viral load suppression at least once during intervention**
- **Deceased**
- **Permanently housed or linked to the appropriate level of supportive-living**
- **Successfully discharged to standard level of medical care and less intensive support services.**
- **Lost to follow-up**

**Metrics**

- **HOMME Metrics**
  - Achieved viral suppression
  - Deceased
  - Permanently housed
  - Successfully discharged
  - Lost to follow-up

**Sustainability**

This HHOME program will be sustained through the city of San Francisco as originally designed.

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