SFDPH CHEP: OPT-IN Project
Summary of Findings from Phase 3, and Draft Model Prototypes

BACKGROUND

In San Francisco, there were officially an estimated 8,035 individuals who were experiencing homelessness during the January 24, 2019 Point-in-Time count,[1] a 17% increase over the 2017 count – with most housing advocates noting that the true number of people who were unhoused or unstably housed in San Francisco in 2019 is likely much higher. Unhoused individuals are more likely to be from marginalized communities, including communities of color and LGBTQ+ youth, who also are more likely to suffer from chronic and infectious health conditions and mental health and substance use disorders.[1–3] People experiencing homelessness are more likely to be living with HIV and/or hepatitis C virus (HCV), compared with the general population.[4–8] They also experience many challenges related to accessing health care, maintaining relationships, keeping appointments, including logistical barriers, stigma, and discrimination.[1,3,9] Substance use is one driver of HIV and HCV infection among people experiencing homelessness, with an estimated 65% reporting recent substance use.[1] In addition, there are an estimated 22,500 people who inject drugs (PWID) in San Francisco, with 31% residing in the Tenderloin district and nearly 70% experiencing homelessness at any given time.[10,11]

The San Francisco Department of Public Health (SFDPH) contracted with Facente Consulting to work with the Community Health Equity & Promotion (CHEP) branch to develop and evaluate a model for effective provision of HIV pre-exposure prophylaxis (PrEP) and anti-retroviral therapy (ART), as well as curative HCV treatment, among people experiencing homelessness, including PWID. This report summarizes the findings from Phase 3 (provider interviews) from this project and proposes three prototype models for HIV and HCV medication service delivery, which arose from these interviews.

METHODS

Six one-on-one interviews were conducted in fall and winter of 2019 with key service providers who provide public health or housing support to people who are unhoused or housing insecure in San Francisco. Interviews typically lasted around 60 minutes, utilizing a loose interview guide tailored to the expertise of the interviewee. The providers interviewed included:

- **Dr. Deborah Borne**, Medical Director of the Transitions Division of the SF Health Network.
- **Pierre Cedric-Crouch**, former Director of Nursing at the San Francisco AIDS Foundation
- **Dr. Andy Desruisseau**, former Medical Director of Tenderloin Health Services (HealthRIGHT 360)
- **Adam Leonard**, Nurse Practitioner at CHPY, Cole Street Youth Clinic, and Larkin Street Youth Services
- **Rachel Cabugao**, Phlebotomist and Outreach Specialist at SFDPH
- **Mecca Cannariato**, Outreach Manager, SF Department of Homelessness and Supportive Housing

Interview transcripts were analyzed for recurring themes (especially as they related to findings from project phases 1 and 2), and were also used to develop prototype models for service delivery that incorporated their suggestions about possible solutions to existing challenges in providing HIV and HCV medication to this population.

FINDINGS

Themes from the one-on-one interviews fell into three overarching categories: 1) the critical need for building relationships and a sense of community, 2) the requirement for services to be mobile and/or flexible, and 3) the necessity of interdisciplinary teams and services that are not disease-based, but rather holistic in nature. Specific points were raised related to meeting the needs of youth, utilizing incentives, and preparing for the availability of long-acting injectable ART or PrEP. And finally, when asked about optimal models for service provision, interviewees noted that to successfully provide HIV ART, PrEP, and/or HCV treatment to people who are unhoused or housing insecure, service delivery models must address three things: the prescribers, pickup or delivery, and medication storage.

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Building Relationships

Almost all the providers interviewed spoke about the fact that many efforts to provide services to this population fail because the providers have failed to build trust. This requires patience, and willingness to demonstrate respect and interest in helping over time, rather than just coming onto a scene once and advocating for people to start taking pills or agreeing to injections. "Convince people through actions that you are reliable, that they can count on you, that you know them by their first name!" explained one. One way to do this is to recognize that when approaching people during street or venue-based outreach, providers should offer coffee, snacks, and most importantly approach people like they're coming into their homes. "Imagine how you would act if you were going to visit the home of someone you respect and care about. How would you act? You wouldn't run up to the door, knock loudly, invite yourself in, and start asking the person inside to do things right away, would you? No. So why do we think that's OK with someone living in a tent?" said another.

"The most challenging folks to treat are the people who don't trust us. And there's a reason for that! You have to build trust."

Part of the reason this is so important is that, especially these days in San Francisco, many city policies are actively destroying relationships and a sense of community. Time-limited services, shelter beds where you're in but you've got to get out…there's no continuous sense of anything anymore," said one interviewee. "[City workers] actively destroy community everywhere we go, even if that's not our intention."

To begin to overcome this, we must be thoughtful about building community, and building trust. This involves small but important things like asking people who inject drugs where the best place is to draw their blood – and maybe letting them help – not assuming and poking and

then shrugging off failure as their being "a hard stick." It also means thoughtfully employing people with lived experience similar to the priority populations, and/or having clinical providers and outreach workers who visibly reflect the demographics of the population being served. Regardless of who the providers are, sometimes building trust requires providing basic needs, and getting to know the human being – connecting over music, sports, or some other common interest, without this being tied to an ultimate agenda. "If you share a meal with someone and you're not asking for anything in return, that builds trust and it builds a sense of community," one provider explained. This takes intentional time and resources built into the service model.

Flexible and/or Mobile Services

As important as it is to build relationships with the people who would benefit from services, the methods through which the services are provided are also critical to success. One of the major components of any service model built for people who are unhoused or housing insecure is flexibility, both in timing and location of services. One provider talked about a new clinic that had opened and used an appointment system where "if you're five minutes late, you're rescheduled. That's crazy. That doesn't work for this population," he explained. Another noted that, for everyone but especially for youth, opportunities to drop in, including weekends and evenings, were essential. Related to this, requirements for prior authorizations (which San Francisco cannot control) or a need to go to a different location or otherwise wait before accessing medications become major barriers. Any strategies that employ starter packs of medications – something that the SFDPH is exploring as part of its new Ending the Epidemics efforts for both HIV and HCV – will be important pieces of any new model, requiring identification of funds to support if insurance cannot immediately be billed.

Numerous interviewees suggested that services based in a mobile van might be the strongest format for reaching the members of this population most in need.

"The people we're talking about are constantly being shifted around due to policies, police, DPW… we have to move because *they* are moved!"

Mobile Health Access Points are one strategy already underway by SFDPH to utilize this format, with the understanding that these types of services also often require modifications from traditional mobile services. Leaving the door of a mobile van open so patients don't feel trapped, allowing pets, and encouraging staff to leave the confines of the van and move outside – including to people's tents as necessary – were all noted by interviewees as components of their successful efforts to date.

As one provider said, "Give me a van, have a case manager and a prescriber and medication lockers, and I can change the world." Specifically, this interviewee noted that to be most useful a van needed not just personnel but also laboratory testing technologies, including a CLIA-waived complete blood count (CBC) machine and the ability to test liver enzymes, HCV viral load, and whether hepatitis B surface antigen is present. If medications can't reasonably be made available right from the van (i.e. via starter packs) then vans should be run in partnership with 24/7 pharmacies in the area so patients can immediately be escorted to obtain pills, or worst-case they can be mail-ordered and rapidly sent to nearby medication lockers for next day pick-up.

Interdisciplinary Service Provision and Coordination

Another theme that recurred throughout the provider interviews was the importance of assembling interdisciplinary teams of providers to meet patients as needed, rather than expecting patients to visit numerous locations to see different providers addressing different health needs. Even beyond the "one-stop shop"-style benefits of a multidisciplinary team, interviewees also talked about the synergistic benefits of teams where physicians and nurses and social workers and people with lived experience are working together to learn from each other's approaches and insights.

> **"When you're an outreach worker, they can talk to you and everything, but you're limited if you don't have the flu shot; the ability to give me risks and benefits of medication, the HIV meds, the psych meds. They can talk to you about a doctor. But there's more of a power dynamic with a doctor. [Doctors] can say something that's different… LVN, NP, psych nurses, MDs, you want to put together a multi-disciplinary team – you need a medical provider, not just an outreach worker [to have maximum impact]."**

Bringing together a multidisciplinary team of providers, however, requires different types of providers to be willing to leave the clinic walls and provide medical care (including prescriptions and medical follow-up) in settings that are better suited to people who are unhoused. It also requires a different type of coordination and structure to track patient care, bill for it, and conduct continuous quality improvement. Multiple interviewees talked about the importance of moving away from disease-based linkage, disease-based case management, and disease-focused disease control investigation for this population, and instead thinking about how provider teams and city systems could be used to approach the needs of this population in a more holistic, flexible way.

One example of this, according to one provider, would be to examine the use of technology for health record tracking and administration. If interdisciplinary teams had iPads with access to medical records from various entities, then clients who consented to electronic information sharing could have their interaction recorded directly, and clinicians in various settings could flag patients who had been lost to follow-up or had pending test results to disclose. Tackling the huge issues of firewalls between health department clinics, community-based organizations, and large health systems – while still respecting HIPAA rules – is a daunting but important piece of moving forward comprehensive care provision for people who are unhoused or unstably housed. The Telebupe pilot that Behavioral Health Services is about to launch will be one example of how the use of technology can enable provision of services more directly suited to this population.

Another example of moving toward more holistic service provision is to assemble teams that can provide care for many diseases or conditions at once. Almost every provider interviewed in

this phase described a list of services they wished were offered to everyone, though the exact services to be provided differed among the interviewees, with comments like these:

- "It would be awesome to carry suboxone, methadone, and large quantities of PrEP and hep C treatment [on a van], so [patients] can get the treatment the same day [as their first encounter with a service provider]."
- "We should pick 5 things that everyone who's homeless in our city should get, no matter where they go. For example, IDs, insurance, acuity level screening, advance directive/emergency contact, and screening for women of reproductive age."
- "Any place offering psych pills, methadone, or suboxone should be dispensing PrEP with their other DOT, to anyone who wants it."
- "Every site serving people experiencing homelessness should provide bupe, rapid ART and PrEP, family planning, low barrier STI/HIV/HCV/pregnancy testing and care, and immunizations."

Regardless of the exact services offered, the mandate from these service providers was for a citywide discussion and cross-agency commitment to offering a slate of options to everyone experiencing homelessness, not a piecemeal or agency-specific approach to the issue. This will reduce confusion on the part of patients, and improve efficiency for the system overall.

Youth

One of the interviewees, Adam Leonard, was included specifically to gain his insights about the unique needs of unhoused or unstably housed youth in San Francisco. Many of his recommendations were the same as other providers who focused on adult populations; however, he emphatically pointed out that to successfully meet the needs of young people, San Francisco must create youth-friendly and youth-specific spaces. He noted there is no youth-specific Street Medicine team, though currently the Street Medicine team works in partnership with Homeless Youth Alliance to reach this population. Youth-specific spaces create a safer and more welcoming environment from youth, who often feel excluded or unsafe in more adult settings. They also require staff who have a real understanding of the developmental processes of youth, including being willing to serve more familial roles these youth may not have ever experienced, such as explaining what a prescription is, how to get it filled, and that it may require refills on a regular basis. He also noted that youth often feel healthy and won't actively seek out clinical services in typical settings, so some clinical spaces geared for youth should be located in other non-clinical venues, such as laundromats, food pantries, or social spaces.

Injectables

Each of the providers interviewed were asked about their thoughts and suggestions regarding the forthcoming opportunity to provide long-acting injectable HIV ART or PrEP, similar to existing injectables for psychiatric medications or buprenorphine. Overall, most providers were skeptical about how successful these programs would be for this population; as one said, "We're always working with people to help them think about injectable psych meds or bupe, and sometimes it takes motivational interviewing for years to get someone to agree to this."

Providers specifically noted challenges around trust of providers and willingness to accept injections, which are not easily reversed if someone changes their mind. This is especially true for populations that have a long history of mistreatment by the medical community – which applies to many people who are seen as most likely to benefit from a monthly injection instead of a daily pill for PrEP or ART. Other providers had practical concerns, such as low reimbursement rates for injections despite requirements for high-level staff to provide them, and clinic flow that is not prepared for large volumes of people coming in routinely for injections. Given that in many cases people would need to pick up prescriptions at a pharmacy, some providers felt that partnerships with pharmacies were most practical, allowing people to get injections at the time of medication pickup. This, however, requires willing pharmacies who are capable of managing the flow of customers who are unhoused or unstably housed. Another alternative would be low-threshold drop-in injection sites, either within 4-walled clinics or via mobile vans, where clinic flow is built to offer quick injections to people during their monthly visit, and provide follow-up and reminders leading up to that calendar milestone.

Incentives

Interviewees were not specifically asked about incentives during this phase, but multiple providers mentioned them anyway. Incentives might be monetary, but can also be snacks, hygiene products, etc. The goal of incentives is two-fold: to recognize the economic realities of being unhoused and help make space for some attention to health issues, and to show respect for the time and energy it takes to prioritize one's health when there are so many competing, urgent priorities. At least one provider strongly suggested that tokenizing gift cards should be abandoned in favor of regular cash, something that is more helpful (and less paternalistic) for people living in unstable housing situations. Providers described incentives as playing an important role for encouraging people to visit medication lockers to pick up medications on days they would not otherwise see a service provider, as well as for starting medications and/or getting an injection of a long-acting injectable medication – or more realistically, having a 15-minute conversation about long-acting injectables for 2-3 times *before* getting the injection, which builds trust and demonstrates respect and not just a self-serving provider agenda.

PROPOSED PROTOTYPE MODELS

Given the suggestions and feedback from the providers interviewed in this phase, below are three draft prototypes of models for HIV or HCV medication provision that are tailored to the needs of people who are unhoused or unstably housed in San Francisco.

MODEL 1: On-Call Mobile Clinicians within the SFHN.

What does this look like?
Most clinicians in the SFHN already have assignments to work "in clinic" during certain times within the walls of their home clinic. With this model, some clinicians could elect to serve some of their clinic hours "on call" for street response; they could provide in-clinic services during their shift but if a call comes in, they will rapidly deploy to the street location and provide services (including prescribing HIV ART, PrEP, or HCV treatment medications, with starter packs if possible).

How does it work?
A hotline or message system with an unpublished number would be used by outreach teams when they encounter someone who needs a prescription or other non-emergency medical care. Service as an on-call mobile clinician would be voluntary for SFHN providers, but would come with a pay differential to encourage participation in the program by those who would feel comfortable. It could potentially also become a required rotation for UCSF medical students or interns. The focus of this service would be on providing rapid ART, HCV treatment initiation, PrEP, or long-acting injectables that an outreach worker can't provide, when it appears someone won't (or can't) go to a nearby clinic for these medications. Outreach teams would be responsible for tracking people to ensure they received indicated follow-up care, i.e. on February 1, the team who originally identified Person X will know to look for them and assist in connecting him to a mobile clinician or clinic for medication refill. While this tracking would likely be best as an outreach-team specific effort, the overall care of multiple teams could be coordinated at a higher level.

Why is this important?
Existing SFHN clinic times require patients to physically come to the clinic to seek service, and multiple providers interviewed for this project noted that SFHN physicians typically will not respond to requests for health support on the street, citing "being in clinic" as a reason they can not respond to help someone in need who is unwilling to leave their belongings, or physically unable to get up and wait in line at the 4-wall clinic. This would encourage clinicians to provide critical HIV and HCV-related services in the settings that work best for people who are unhoused or unstably housed, without requiring them to serve as a regular part of a multidisciplinary outreach team, which might be prohibitively expensive and not always necessary.

How scalable is this?
Initially, all clinics could have a single on-call mobile clinician at all times; however, once more data is available this could become more centralized or scaled up or down at specific clinics as needed. After being piloted at SFHN clinics, this model could potentially be expanded to other clinics as well, including community clinic consortium members and other large health systems.

How could this be sustainable?
A pilot of this model would not require the hiring of additional staff, though it would potentially entail additional resources if clinicians are frequently called away from indoor clinic in order to respond to a mobile need. Over time, a robust mobile clinician program may lessen the impact of higher-acuity clients on indoor clinic flow; regardless, the balance between standard clinic service and on-call mobile response could be fine-tuned for sustainability.

MODEL 2: A Trio of Well-Stocked Mobile Vans

What does this look like?
Three well-stocked mobile vans would move together in San Francisco, showing up on a weekly basis in various locations at the same time, with the same staff where possible. One van would provide harm reduction and syringe access services, one would provide HIV/HCV/STI testing (including technology for CBC, liver enzymes, viral load, and hepatitis B testing), and one would provide HIV and HCV medication prescription and adherence support along with chronic disease management. It may be worthwhile considering a partnership with a van that

would also offer hot food, and/or the LavaMae shower van, regardless of whether people took advantage of the health services.

How does it work?
For this to be successful, it would require City buy-in to support parking permits and related logistics – something that has been an ongoing challenge for encampment health fairs run by SFDPH. If one of the vans doesn't include pharmacy services on board, there must be a partnership with pharmacies near the sites so pills can be picked up nearby 24/7, or mail-ordered and sent to medication lockers the next day. Some services should be offered outside the regular 9-5 weekday timeframe, depending on the neighborhood for a particular site. Providers suggested that this would be a good opportunity to be proactive about hiring more people from the community, giving them access and opportunity for training and supported work in this area; people could be hired for internships, externships, full employment, or volunteer positions, but should be appropriately compensated and not simply offered small stipends or gift cards in exchange for their labor.[1] Regardless, it is important that staff are not all English-speaking white city employees, even if they are strong harm reductionists. If these services are intended to serve unhoused youth, it would be useful to consider ways to make the vans especially youth-friendly or youth-specific during one of the regular weekly sites.

Why is this important?
This model would formalize and systematize the original encampment health fair model, minimizing the need for set-up and tear-down and containing the participation of various ad hoc partners (which has historically been unwieldy). Providers felt that mobile vans offered a stability that could allow for medication dispensing and other routine services that are less practical during backpack-style street outreach, and stressed the importance of consistent service days and times when people would know they could head over to "Alley X" and receive numerous types of services all at once, in a safe and friendly environment where pets, shopping carts, music, and friends would be welcome.

How scalable is this?
If this model were very successful, there could potentially be morning, afternoon, and evening shifts seven days a week, with different staff on regular shifts. The main expense is the up-front purchase and outfitting of vans, as well as the logistics of parking the vehicles together in an alley during the pre-planned shift.

How could this be sustainable?
The model is one of the most expensive to initiate, as it requires considerable up-front cost. However, over time the maintenance of mobile van clinics is not really more expensive than standard clinical settings within 4 walls (in fact, some providers through it was likely cheaper).

MODEL 3: Pop-Up Clinical Spaces located in Non-Clinical Venues

What does this look like?
Small clinical spaces would be located in non-clinical venues such as laundromats, meal programs, drop-in centers or other social spaces, or SROs. Modeled after the concept of a bank

[1] The San Francisco Drug User's Union was noted as an organization that excels in this area, and could offer technical assistance in developing and maintaining such a program.

in a supermarket, these clinical spaces would be open at limited regular times, when trained staff would be present and able to provide clinical services to patrons of the non-clinical venue. At least one youth-specific site would be available.

How does it work?
These sites would allow for an assortment of services beyond simple prescribing and maintenance of HIV and HCV medications. Depending on the site, medication storage could also be made available (i.e. even when the clinical site itself is not open, patrons of the non-clinical venue could return daily to discreetly access their medications). Medi-Cal enrollment could also be offered at these locations. These spaces would be ideal settings out of which to run peer-led programs, including testing and treatment programs where social network recruitment is incentivized. Existing SFDPH vaccine pop-up protocols could provide a template for this type of service.

Why is this important?
Rather than expecting people to visit a specific mobile van parked in an alleyway, this model brings services right into the locations already frequented by the priority population(s). It also provides more anonymity to people who may not want to be seen entering the "HIV van" but could instead plausibly say they were entering the building to seek other services. In short, it is a convenient way for people to access health services even when that is not their primary reason for visiting the space.

How scalable is this?
The only limiting factor for this model is the identification of suitable venues, with willing hosts who will support and encourage their patrons to access the clinical services when offered. If services are offered in ways that drive traffic into the space for non-clinical reasons without creating substantial burden on the venue, people may find this to be a mutually beneficial relationship, allowing for rapid scale-up.

How could this be sustainable?
If non-clinical venues were willing and able to provide (small) physical space at no cost where providers could work and medication or equipment could be securely stored, these sites would have the potential to be very low-cost to maintain, with staffing being the largest expense to be sustained.

NEXT STEPS

The final phase of this project involves working with CHEP to make any necessary modifications to the prototype models laid out here, then working with an architectural graphic designer to create illustrations of the prototypes and conducting a series of market-research-style focus groups with members of the priority community to determine whether one of more of these models (or a hybrid) is worthwhile turning into a pilot initiative.

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