Strategies to improve systems for successful delivery of HIV ART, PrEP, and HCV treatment to people experiencing homelessness in San Francisco

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Phase 1: Literature Review

Goal: Identify evidence-based strategies for delivering care and outreach for people experiencing homelessness who are living with or at risk for HIV or HCV.

Outreach and recruitment	Incentivized peer-network or snowball recruitment, location-based outreach in areas frequented by people experiencing homelessness, and information sharing with emergency departments and jails.
Contingency management	Providing reinforcements, specifically monetary or voucher incentives for achieving care goals (e.g., clinic visits, blood draws, and viral suppression).
Medication-assisted treatment	Medical treatment to combat physical addiction to opioids improves ART adherence, therapy completion, and other health outcomes for people with substance use disorders. There are some data that it can be effectively combined with daily directly-observed therapy for ART.
Harm reduction	Harm reduction approaches improve health outcomes for people with substance use disorders.
Cultural competency and stigma	Proactively monitoring for experiences of stigma among clients using standardized tools can help to continually ensure that services offered are culturally sensitive and accessible.
Housing	Permanent supportive housing using a Housing First model has been shown to successfully address chronic homelessness among people with serious mental illness and/or substance use, especially when harm reduction is integrated into service provision.
“Peer” provider programs	Interventions that use peer support services among people experiencing homelessness and people with severe mental health conditions show positive impacts on quality of life, substance use-related harms, and physical and mental health. Appropriate compensation for expertise is a must!
Integrated and tailored care	The most effective care models for people experiencing homelessness offer an integrated physical site that is specifically tailored to this population where they can access medical care, mental health care, social services, and related services.

Phase 2: Client Interviews and Observations

What did people like about the encampment health fairs?

"I care about my health but getting to a clinic is too hard. Here someone came by last night and told me I could stop by. That's something I could do."

- One-stop hub for all their medical, social, and behavioral needs
- Can visit medical providers and receive HCV testing, and also receive free food and coffee
- Community hub as well as a place to get services
- Open space, where people can socially interact, play music, eat, chat, and bring their personal belongings and pets
- Only rule to follow was to be respectful of others
- They were treated like it was care providers in *their* domain, not a requirement for them to go to care providers' domains, following their rules and codes of behavior.

Phase 3: Provider Interviews and Prototype Development

Six one-on-one interviews were conducted in late 2019:

- **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

Themes 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.

Building Relationships

"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."

What does this mean in real life?

- Demonstrating respect and interest in helping over time, rather than insisting on action in the first interaction
- 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
- Offer coffee, snacks, and approach people like you're coming into their home

> *"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?"*

- Thoughtfully employing people with lived experience
- Having clinical providers and outreach workers visibly reflect the demographics of the people being served

Flexible and/or Mobile Services

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

What does this mean in real life?

- No more late policies where if you're 5 minutes late you're rescheduled
- Opportunities to drop in, including weekends and evenings
- Wherever possible, prevent the need to go to another location or otherwise wait before accessing medications
- Employ starter packs of medications when possible
- Be more creative about the use of mobile vans, where the door is left open (so people don't feel trapped), pets are allowed, and staff leave the confines of the van and move outside wherever possible
- Including lab and testing technologies on the van, not just outreach and vital signs

Interdisciplinary Service Provision and Coordination

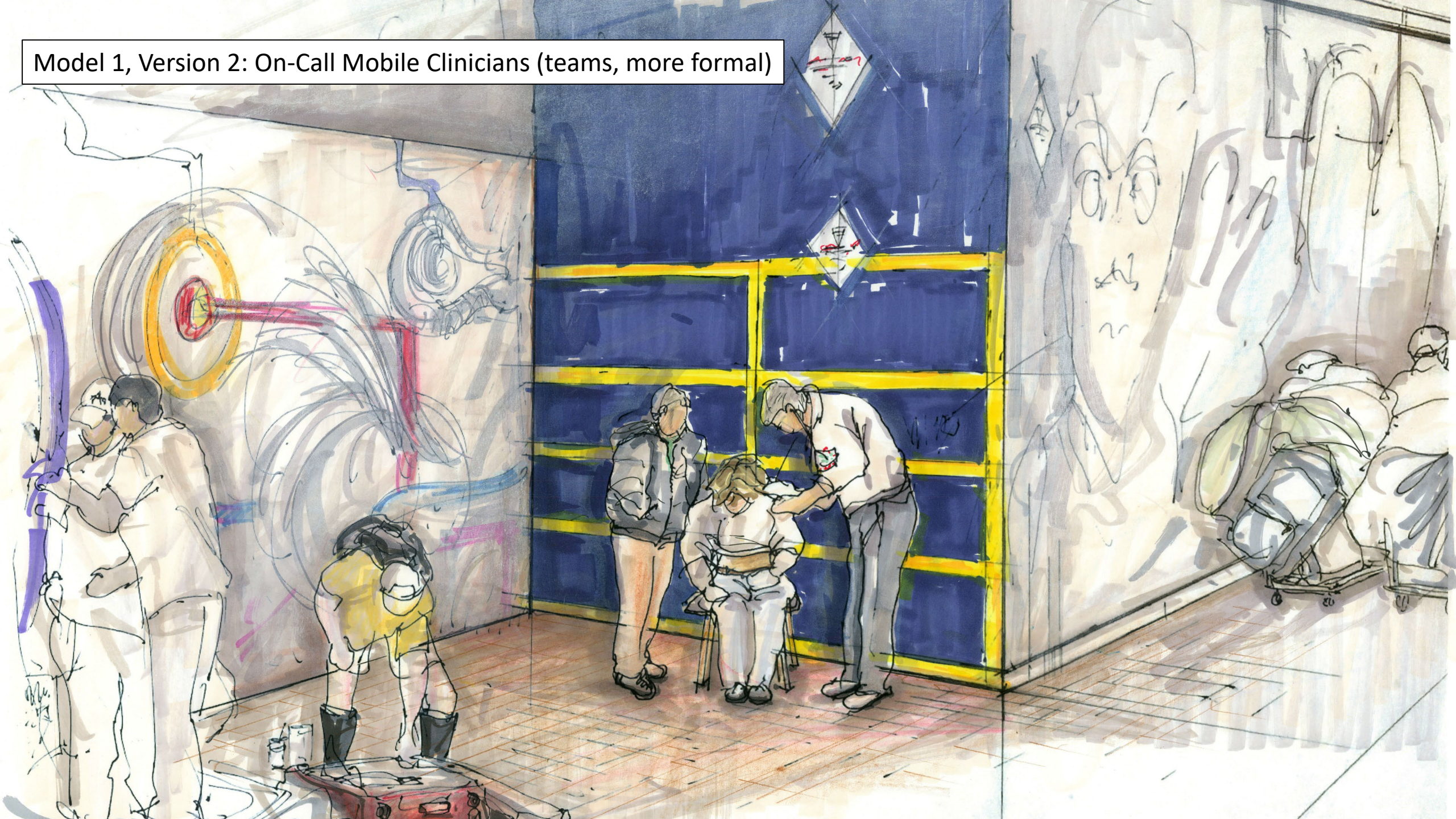
"When you're an outreach worker, they can talk to you and everything, but you're limited if you don't have the flu shot; the ability to give me risks and benefits of medication, the HIV meds, the psych meds. They can talk to you about a doctor. But there's more of a power dynamic with a doctor. [Doctors] 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]."

What does this mean in real life?

- Different types of providers being willing to leave the clinical walls and provide care
- Examine the use of technology for health record tracking and administration (interdisciplinary teams with iPads that can access medical records from various entities).
- Breaking down the firewalls between health department clinics, CBOs, and large health systems
- Assemble teams that can provide care for many diseases or conditions at once

Model 1, Version 1: On-Call Mobile Clinicians (informal)

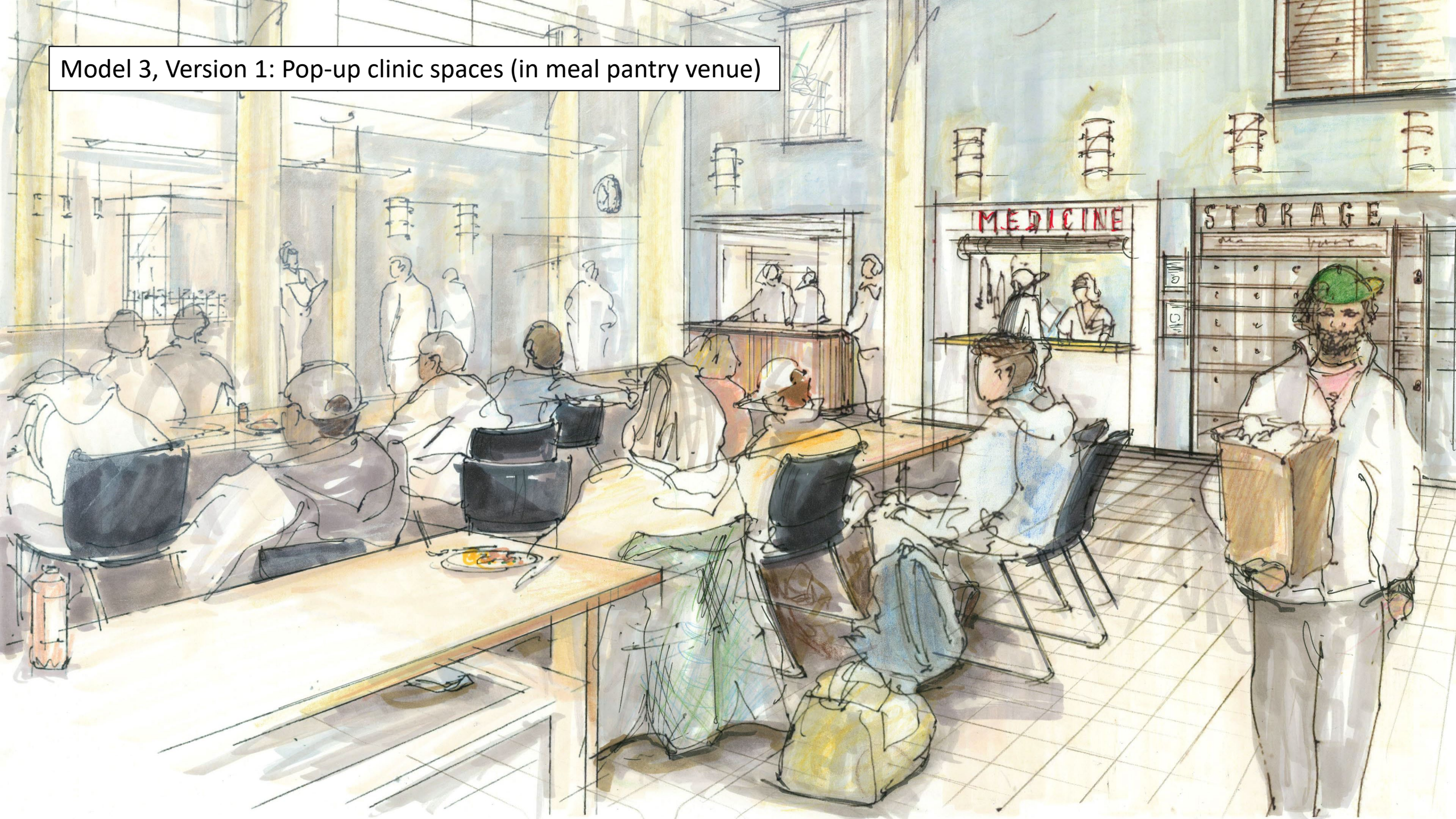
Model 1, Version 2: On-Call Mobile Clinicians (teams, more formal)



Model 2, Version 1: Mobile Van Collaborative (food truck style)

Model 2, Version 2: Mobile Van Collaborative (discreet style)

Model 3, Version 1: Pop-up clinic spaces (in meal pantry venue)



Model 3, Version 2: Pop-up clinic spaces (outdoor/park venue)