Incorporating a Co-Located Infectious Disease Clinic within Syringe Access Services

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PREVENTION POINT PHILADELPHIA

Background

WHO WE ARE

PPP is a non-profit, public health organization committed to protecting the health and welfare of drug users and sex workers. PPP works to reduce the harm associated with substance use and sex work by offering a safe and humane alternative to the war on drugs

WHO OUR PARTNER IS

Philadelphia Fight is a comprehensive AIDS service organization providing primary care, consumer education, advocacy, and research on potential treatments and vaccines

NEED & OPPORTUNITY FOR CO-LOCATED CARE

- Nearly 90% of HIV positive participants identified in free clinics are out of care for a year or more
- 20% of newly identified HIV positive participants coming through testing program at PPP do not make it to care in first year
- PPP located in neighborhood with highest percentage of Latinos
- Latinos most affected by HIV, HCV, particularly in North Philadelphia
- Only two clinics in neighborhood culturally sensitive to Latinos
- No clinics culturally appropriate for active users

STREET-SIDE HEALTH PROJECT (SSHP)

SSHP provides free triage-style medical care for the community, free of charge and without identification or insurance requirements. Services include vaccinations, benefits enrollments, and wound care, among others. It is staffed by volunteer residents and medical students from the 4 major hospitals in the area and saw >720 individuals in 2014. The Infectious Disease clinic, Clinica Bienestar, is embedded in the SSHP.

Objectives

1. To provide HIV care that is culturally sensitive for people, especially Latinos, who are actively using substances.
2. To decrease viral load and increase CD-4 count in identified lost-to-care and newly diagnosed HIV positive clients.
3. To determine medication adherence readiness and start ARV regiments for people identified as being lost-to-care or newly diagnosed HIV positive.
4. To reduce the number of identified lost-to-care and newly diagnosed HIV positive clients who are homeless or housing insecure.

Identified Co-Location Challenges

1) How do we start a new clinic in a space that we have outgrown?
2) How do we provide low threshold harm reduction focused ID care?
3) How do we use active drug use as a strength?
4) How do we help everyone as they come, every-time they come, when the doctor has a schedule?
5) How do we work with an agency that has a different view of harm reduction?
6) How do we cope with more people going on ARVs?

Identified Client Barriers to Care

Lack of transportation	Language barrier
Lack of stable housing	Fear of being "outed"
Active addiction	Untreated mental health
Incarceration	

Methods

IDENTIFYING POTENTIAL CLINIC PATIENTTS

Outreach
- Already existing care outreach program – Identified 6 participants
- Street outreach – on the "tracks"

In –reach
- Testing, especially social networks testing
- Syringe Exchange Program; mobile sites

Focus on finding people who have "failed" at other clinics

HOW THE CLINIC WORKS

- Clinic takes place once at week in PPP office and is embedded into the long-existing street-side health clinic. Patient registration for both clinics done at reception desk in similar manner to preserve confidentiality.
- Patient navigator directs patient through clinic. Patient meets with HIV specialist, lab technician, behavioral health specialist, housing coordinator, and case manager.
- Client provided harm reduction medical care and case management, including discussions of safer injection methods, overdose prevention and naloxone administration training, safer sex kits, and medication adherence and troubleshooting.
- All specialty medical and social service appointments coordinated for client and transportation/escort provided.

Results

Figure 1: OUTCOMES FLOWSHEET FOR CLINICA BIENESTAR
Enrollment Criteria: New to care or out-of-care for 6 months or more

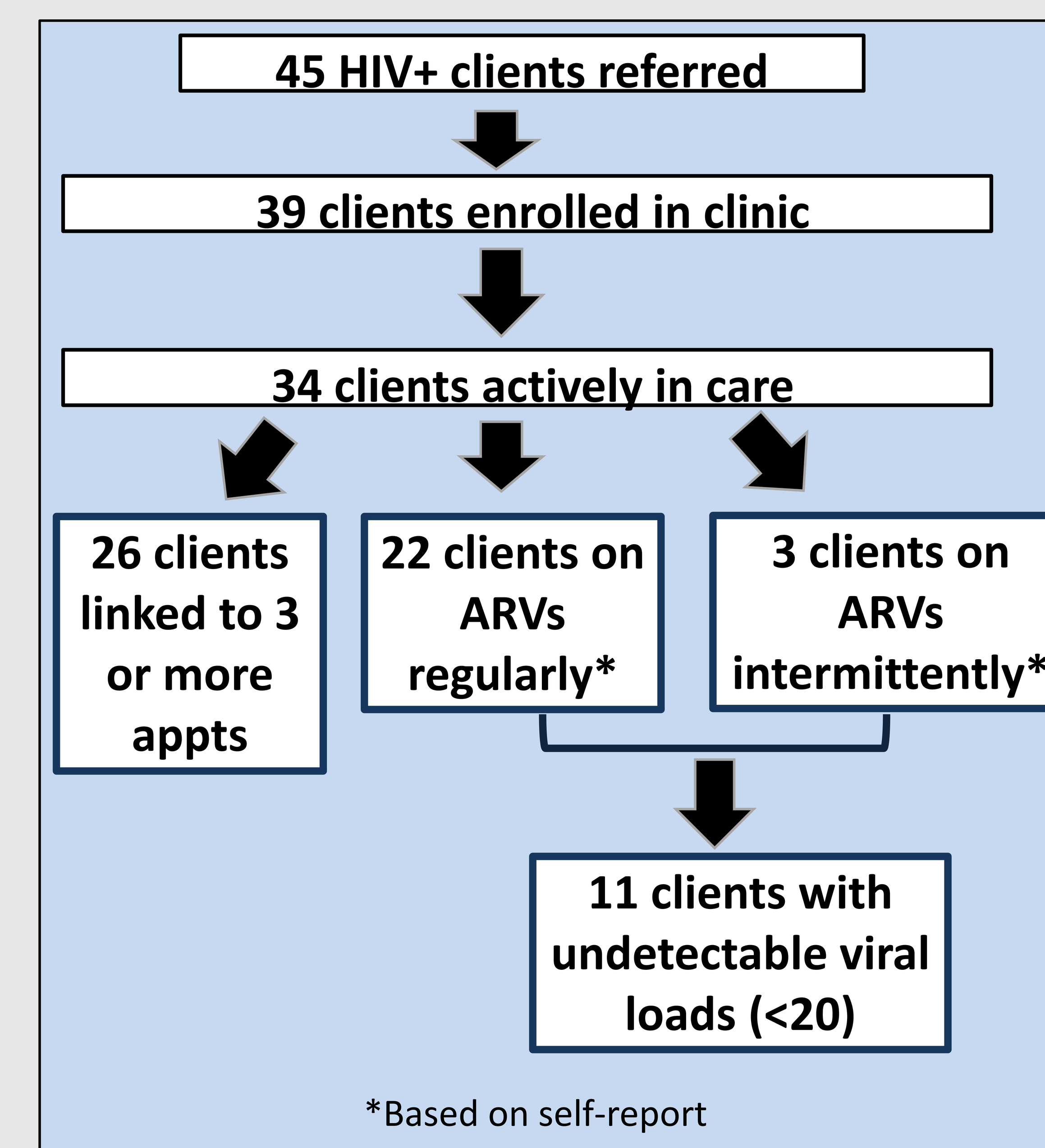
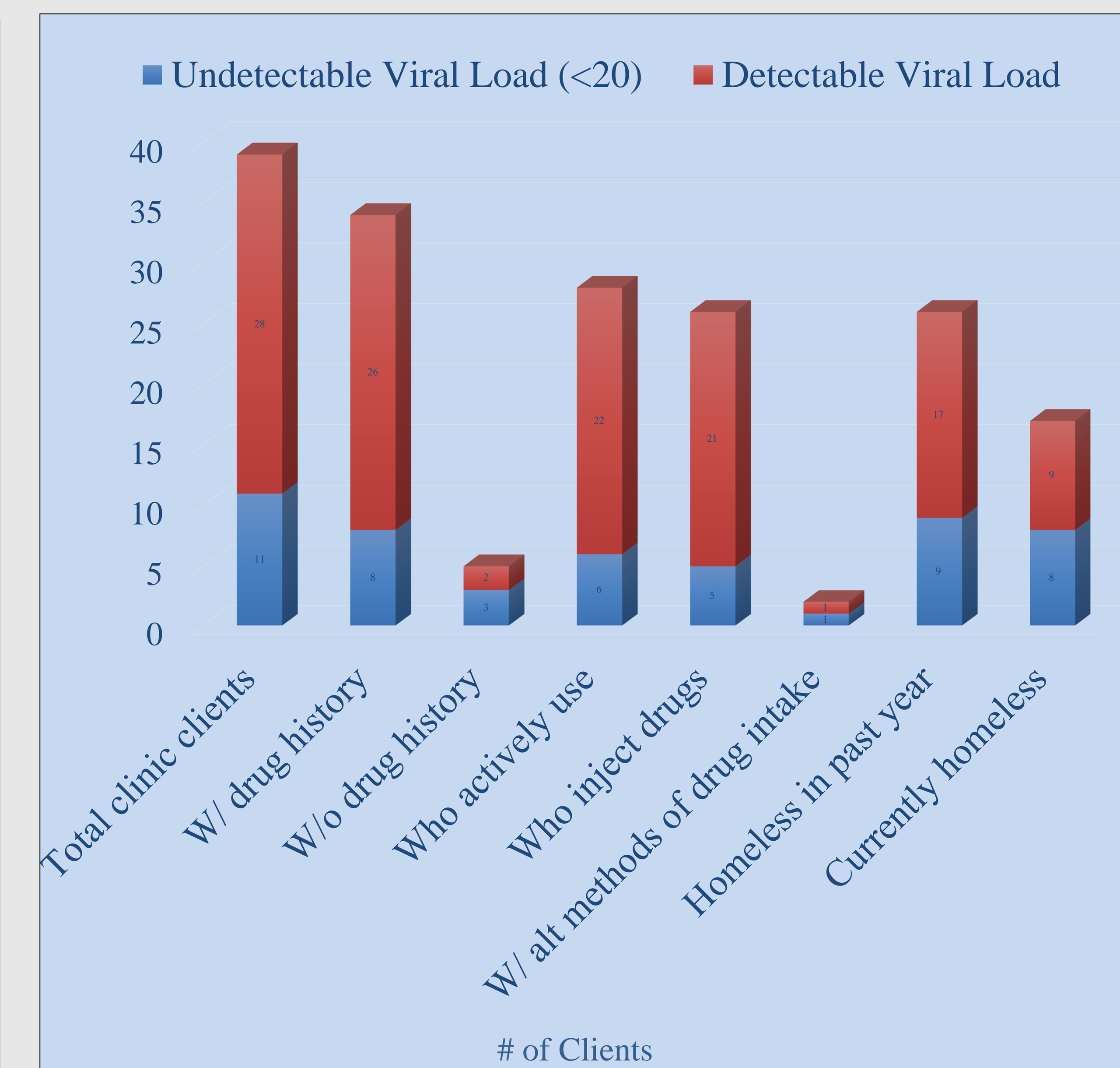


Figure 2: VIRAL LOAD OUTCOMES BASED ON DRUG-USE AND HOMELESSNESS



Discussion

WHAT WORKS

- Clients being accepted as they are
- Clients' time being valued: accepting when they come, when they have to go
- Personal relationships with staff, both in and out of setting
- Honest discussions about what clients want and are motivated by
- Conversations based on harm reduction rather than behavior reduction/abstinence
- Continuum of care that accepts who is not ready for scheduled visits or meds
- Assessing for and addressing chronic conditions, mental health, social needs according to client priorities
- Everything is a strength, including trauma, lifestyle, self-medication habits
- Not referring to drug & alcohol treatment until client expresses desire to

REPLICATION CHALLENGES

- PPP/ provider issues
- After the patient, who drives the care?
- Conducting in-reach and outreach sensitively
- Stabilizing existing patients
- Making space to enroll patients for next program year
- Addressing HCV care

SURPRISING FINDINGS

- # of people on ARVs and actively using
- # people who are street homeless and on ARVs
- People show up too often
- People's medication adherence routines
- People's methods of safe medication storage

FUTURE CHALLENGES

Housing

Mental health

Criminal Justice Involvement

Pharmacies, HMOs, Medicaid, SPBP

Reduced ability to prevent, clean, or heal from wounds

Co-infection

Documentation

Lack of residency

Lack of basic ID

Coming soon! Patient education series