INCORPORATING A CO-LOCATED INFECTIOUS DISEASE CLINIC WITHIN SYRINGE ACCESS SERVICES

2015 National Summit on HCV and HIV Diagnosis, Prevention and Access to Care

June 5. 2015

Prevention Point Philadelphia

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

PPP SERVICES

- **Syringe Exchange**
  - **In 2014: 2,000,000+ syringes to ~4300 participants**
  - **Distribution 6 days/week; 5 mobile exchange sites**
- Drop-In Center
- **Mail**
- Suboxone clinic
- Case Management
  - Outreach
  - Chronic condition care coordination
- Referrals
  - Clothing
  - Food
  - Shelter
  - legal aide
  - behavioral/mental health
- Harm reduction education
  - OD prevention
  - safer injection
  - safer sex
- **Homeless outreach: Punto de Refugio**

Street-Side Health Project

- Insured or not
- Services
  - Triage to mental and medical
  - **Wound care**
  - **Vaccinations**
  - **Benefits enrollment**
  - Opt-out testing & linkage
  - Routinized Naloxone
- Staff
  - Volunteer residents & med students
  - 4 hospitals
- Outcomes
  - ~720 total patients seen 2014

COMMON HEALTH ISSUES FOR OUR PARTICIPANTS

- **HIV: > 20% self report**
- **HCV: > 60% self report**
- Abscesses and Cellulitis
- Wounds
- Upper respiratory infections
- Overdose
- Malnutrition
- Chronic pain/pain management
- Endocarditis
- **Depression**
- **Homelessness**

NEED AND OPPORTUNITY FOR ADDITONAL 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

CLINIC BEGINNINGS

- Sessions
  - 1st pilot Dec 2013
  - 2nd pilot Jan 2014
  - Clinic starts Feb 2014
- Outreach
  - Already existing care outreach program – Identified 6 participants
  - Street outreach
- In –reach
  - Testing
  - SEP
- Emphasis: find people that have “failed” elsewhere

WHAT PATIENTS GET: THE WORKS!

- Confidentiality
  - Intake with SHP
  - Embedded in street-side clinic
- No insurance; no problem
- Education
  - OD prevention & Naloxone distribution
  - Safe injection
  - Safe sex
  - Adherence counseling
- Care for other chronic conditions
  - HCV testing and linkage
  - Patient navigator
- Housing assistance

INITIAL OUTCOMES DATA

Enrollment criteria: previously never had care or lost to HIV care 6 months or more

- At least 1/3 of patients out of care for several years
- 45 HIV positive patients referred
- 39 patients enrolled; 34 actively in care
- 34 have drug histories, 28 actively using, majority actively injecting opiates
- 26 patients successfully linked to 3 or more medical visits!
- 25 patients on ARVs
- 11 patients have undetectable viral loads!
- 26 patients street homeless in past year
- 17 patients currently street homeless

CHALLENGES & HOW WE OVERCAME THEM

- 1) How do we start a new clinic in a space that we have outgrown?
  - Creative shared space - marked rooms
  - Not an issue anymore!
- 2) How do we provide low threshold harm reduction focused ID care?
  - Tailor education to patient needs (ex: diabetes 101, wound care)
- 3) How do we use active drug use as a strength?
  - Exchange = health care

CHALLENGES & HOW WE OVERCAME THEM (cont.)

- 4) How do we help everyone as they come, every-time they come, when the doctor has a schedule?
  - Flexible appointment scheduling; coming soon: walk-in and block scheduling
- 5) How do we work with an agency that has a different view of harm reduction?
  - Regular goal-setting meetings; focus on patient needs and expectations
- 6) How do we cope with more people going on ARVs?
  - Medication drop-off on-site; medication adherence counseling; only start meds when ready

PATIENT BARRIERS & HOW WE OVERCAME THEM

- Active addiction
  - Highlighted it as a strength; education on safer practices (OD prevention, wound care)
- Lack of transportation
  - Convenient location; tokens & passes for external appointments
- Lack of stable housing
  - Housed in our shelter; still working on it…
- Incarceration
  - Built collaborations with prison linkage programs to identify when released
- Language barrier
  - All bi-lingual staff
- Fear of being “outed”
  - Embedded clinic in already-existing street-side health clinic
- Untreated mental health
  - Behavioral specialist on staff; still working on it…

WHAT WORKS

- Acceptance of who people are, when they come, when they need to go, who is ready for scheduled visits, meds
- Personal relationships & honest discussions
- Escorts to appointments – the company
- Prioritizing with the patient – comprehensive care
- Money talks – incentivizing adherence
- Sex talks – adherence
- ID copies – staff introductions
- Everything is a strength, including trauma, lifestyle, self-medication habits

FUTURE CHALLENGES FOR PATIENTS & CARE

- Housing!
- Mental health
- Criminal Justice Involvement
- Pharmacies, HMOs, Medicaid, SPBP
- Reduced ability to prevent, clean, or heal from wounds

CHALLEGES FOR EXPANSION & REPLICATION

- After the patient, who drives the care?
- Conducting in-reach and outreach sensitively
- Documentation
  - Lack of residency
  - Lack of basic ID
- Stabilizing existing patients
- Co-infection

Questions?

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