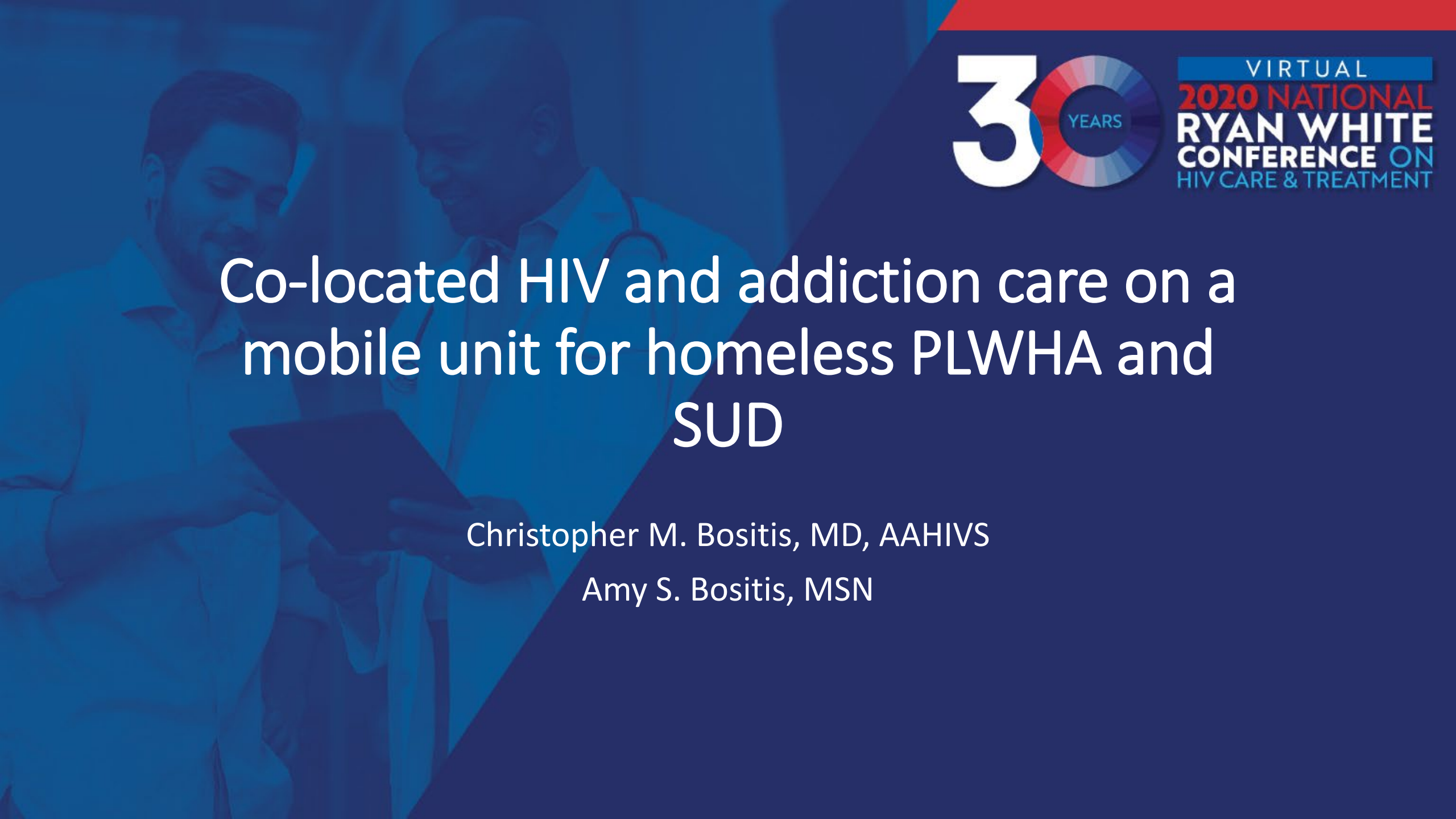

VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Co-located HIV and addiction care on a mobile unit for homeless PLWHA and SUD

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- Disclosures
  - During the last 12 months, Dr. Chris Bositis has served on a medical advisory board for Gilead Pharmaceuticals

Objectives

- Describe 3 components to low-barrier, integrated HIV/SUD in a mobile setting
- Identify 3 key staffing roles necessary for providing integrated HIV and SUD care in a mobile setting
- Describe 2 patient experiences accessing HIV and SUD treatment in this setting
- Describe how low barrier, mobile, integrated SUD and HIV care has impacted engagement and viral suppression in this population

Background - the problem

Lawrence, Massachusetts

- Population: 79,497
  - Land area: 7 square miles
  - 79.1 % Latinx
  - 29% live below federal poverty level
  - Median household income ~$35K, per capita income ~ $17K

The Bread and Roses Mural

David Fichter, 1986

Depicts historical and contemporary scenes in Lawrence, as seen on the side of GLFHC's Park Street clinic.

Data sources:
https://datausa.io/profile/geo/lawrence-ma/, accessed 6/25/19
https://www.metro.us/boston/these-are-the-10-poorest-cities-in-massachusetts/zsJpbc---0EJUIZlerciBo, accessed 6/25/19

Greater Lawrence Family Health Center

- **Established in 1980**
- **Over 600 employees** serving nearly 60,000 patients (250,000+ visits) annually
- **Six primary care sites**, 2 school based health centers, 14 Healthcare for the Homeless sites
  - Family medicine model
  - "Special programs"
    - HIV
    - Viral hepatitis
    - Addiction medicine
    - Behavioral health
- **Home to the Lawrence Family Medicine Residency,** the nation's first community health center based residency program
  - 4 year training
  - Areas of Concentration

Experience of 2016-2018

Summer 2016: Noticed 5 new HIV diagnoses in two months among PWID, including 2 acute infections – a dramatic increase from previous years

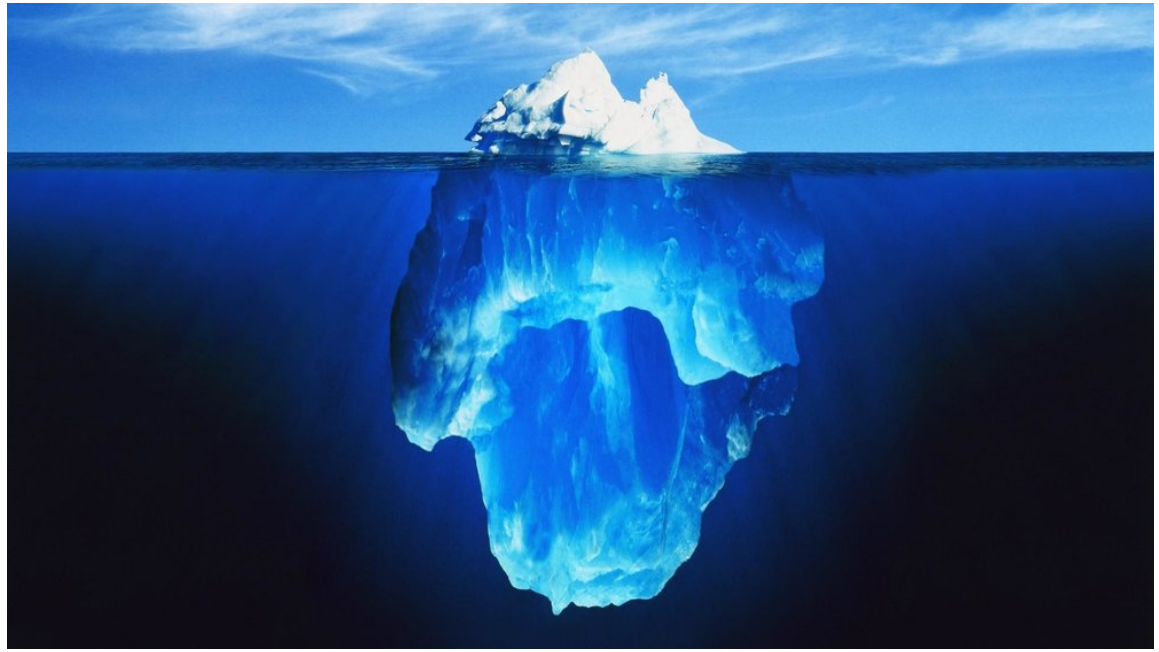
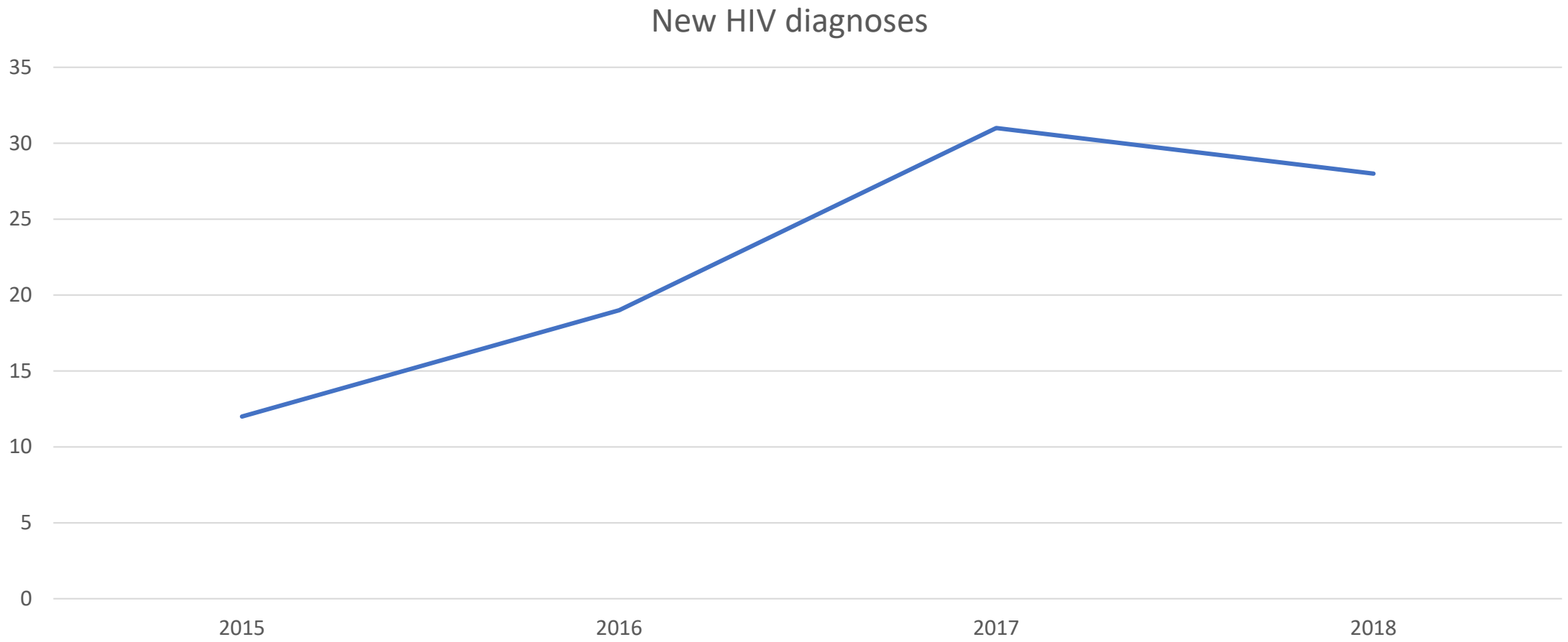


Image downloaded from https://www.insites-consulting.com/diving-beneath-the-surface-the-psychology-of-online-qualitative-research/tip-of-the-iceberg-2/, accessed 6/21/19

New HIV infections over time



Preliminary Data – CDC Epi-Aid

- 129 HIV+ were diagnosed during 2015–2018 who met case definition criteria
  - Transmission risk category was predominately injection-drug use (88%)
  - 90% had laboratory evidence of HCV (either HCV antibody or RNA positive)

MMWR Morb Mortal Wkly Rep. 2019 Mar 15;68(10):253-254

Other key take homes from Epi-Aid

- **Fentanyl**
  - Different pattern of use
  - Cost differential may explain some of observed findings
- **Sexual risk**
  - 54% of women, 14% of men reported history of exchange sex in the prior year
  - Partner trust
- **Homelessness**
  - 100% experienced homelessness within the previous 12 mos

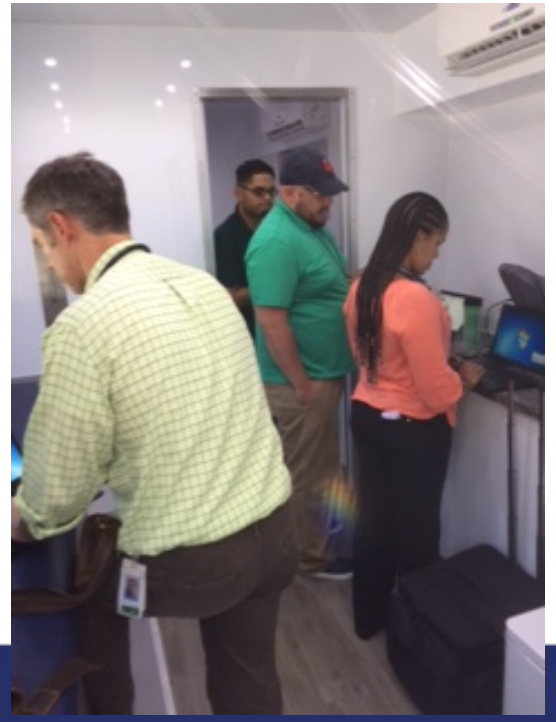
CDC Community Meeting, July 24, 2018

Where are they all?

- Prior to July 2018, 11/29 (38%) PLWH with SUD and housing instability engaged in HIV care
  - 12/29 (41%) Rx'ed ART
  - 8/29 (28%) Viral suppression
- Possible reasons
  - Transient nature of populations
  - Changes in local policies and practices around homelessness
  - Untreated SUD

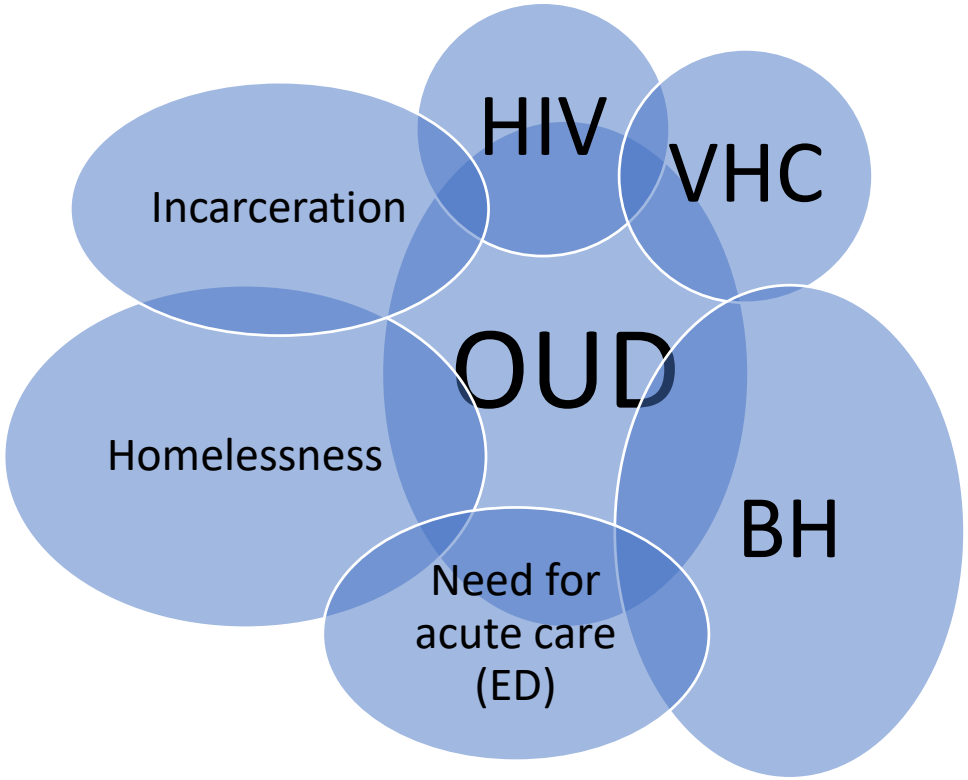
The intervention

Mobile HIV/OUD care



Our response: the 20,000 foot view

- Enhanced development and integration of:
  - Programs
  - Personnel
  - Patient Care



Programs

- All special population grants were brought under one leadership leading to integrated programming
  - Ryan White A and C, E2i (SPNS)
  - DPH prevention (SSP, OEND, HIV/HC/STI testing, linkage to care, Corrections)
  - DPH BSAS Office Based Addiction Treatment, Post Overdose Response Team
  - Homeless care funding
- Patients and programs were reviewed in combined team meetings
- Adopted a common vision: low barrier, harm reduction, integrated care for people with SUD, ID and housing instability

Personnel

- Community Health Worker / Medical Assistant
  - Outreach worker, Insurance, Driver/Mechanic, SSP staff, MA
- Nursing
  - Trained in HIV, VHC, and SUD
- Clinicians
  - Family Practice MD's, Adult NP: all trained in SUD, 1 trained in HIV, VHC

Patient Care – MHU

- Bring care to the patients
- Densely Layered Care/Services
- Addiction care shifted to a harm reduction model
- All patients offered/counseled re:
  - Overdose prevention (naloxone)
  - HIV treatment/prevention
    - If HIV negative, PrEP or PEP to PrEP
  - Infection prevention: SSP, proper injection technique (“Getting Off Right”)

Adapting

- Logistical challenges
  - Printing the prescription
    - Printer at community-based
    - E-prescribing
  - Getting medications to patients
    - Courier for observed inductions
    - Home inductions
  - MHU location – tried several
    - Lawrence unique because of its small size
- Service expansion
  - Viral hep treatment
    - Fibroscan

“MHU Magic”

- MHU parked at/near our SSP
  - CHW’s who know the people best bring/encourage clients to seek treatment; outreach
- Providers and team available for any/all needs
  - Primary care (contraception, vaccines, chronic disease management)
  - SUD – buprenorphine
  - HIV, VHC
  - PrEP, SSP, OEND
  - Skin infections
  - Insurance help, detox, shelter/housing
- HIV Case Management team (CHW, RN) co-located at SSP for on-demand help

Patient 1

- 43 yo M with severe SUD, chronic homelessness, HIV
  - Primarily opiates, injects
  - Also h/o cocaine, BZD use
  - Several overdoses 2-3 years prior to engaging on MHU
  - PMH notable for:
    - HIV
      - Toxoplasmosis encephalitis
    - Seizure disorder
    - HCV (untreated)
    - Past CVA
    - Depression
    - Cognitive impairment

Patient 1 (cont)

- First started buprenorphine/naloxone July 2018
  - Has stopped/re-started OUD treatment multiple times
  - Majority of toxicology screens positive for both buprenorphine and non-prescribed substances
- Overdoses during 2019: 0
- HIV VL Jan 2020: < 200
- Currently: engaged in care

Patient 2

- 26 yo F w OUD, HIV diagnosed as part of outbreak
  - Tested at our community based site
  - HIV positive August 2017
  - History notable for homelessness, exchange sex
    - Currently housed BUT ? emotional abuse
  - Multiple attempts at outreach made over next 2 years
    - At least 1 documented overdose
  - Engaged in care: Sept 2019
    - Initially started HIV care, did not want to start OUD treatment
    - Eventually agreed to try buprenorphine/naloxone
    - Off and on OUD treatment
  - HIV VL Jan 2020: ND
  - Last visit: March 2020 (pre-COVID)

Patient 3

- 35 yo M with OUD, HCV, housing instability
  - First presented May 2019
    - Couch surfing at mom's
    - Drug use first started at 18
    - Previously on methadone and buprenorphine with long periods of recovery
    - Actively using again for 5 months (since release from jail)
    - + nonfatal overdoses
  - Started on buprenorphine and TDF/FTC for PrEP at first visit
    - "Fits and starts" with both
    - By October, going to gym, stable on buprenorphine, tox screens with buprenorphine only x 2 months
    - Transitioned off PrEP
    - November – started treatment for HCV

Patient 3

- During treatment for HCV, had multiple tox screens positive for illicit substances including fentanyl
  - Reported severe GI side effects from HCV treatment
  - Side effects improved after treating constipation
- Finished HCV treatment end January (on time)
- Currently:
  - Remains engaged in OUD care via telehealth
  - SVR12 labs pending (deferred due to COVID)

Is it working?

- N =29 (PLWHA with SUD and housing instability)
  - Prior to July 2018: 11 (38%) engaged in care
  - 12 additional HIV+ patients engaged through MHU
  - As of 12/2019:
    - 22/27 (81%) engaged in care, excludes 2 who have died)
    - MHU patients:
      - 12/12 prescribed ART
      - 8/12 (66%) virally suppressed
      - 9/12 (83%) started MOUD with buprenorphine/naloxone
      - 3 linked to or continued on methadone maintenance treatment

Challenges

- Major barriers to success
  - Goal was 20 patients, fell short of that
    - Double stigma of HIV and SUD?
    - Hierarchy of needs
    - Individual readiness
  - Ongoing challenges
    - Staff buy-in
    - Tension b/w desire for recovery and low-barrier/harm-reduction model of care
    - Limited behavioral health
  - COVID!!

COVID modifications

- Initially all visits done via telehealth
  - No tox screens
  - Longer prescriptions for buprenorphine even for patients who had been struggling prior to transition (e.g., 1 week w 3 refills, 2 weeks w 1 refill)
- Currently: mix of telehealth and “in person”
  - Only 1 provider (NP) all the time
  - “In person” is actually outside the van
  - Fewer patients accessing MHU
    - NB: Clinic-wide, we starting doing new starts via telehealth
    - Lack of privacy, minimal person-to-person contact

Next Steps

- Plan to resume pre-COVID schedule in September
- Anticipated service expansion:
  - Integrative Medicine
  - Behavioral health
  - LTBI
- Drug user input

Summary

- Low barrier, mobile, integrated SUD and HIV care has significantly improved care engagement for this vulnerable population
  - Key components for success:
    - Meeting patients where they're at
    - Setting up systems that enable care integration
    - Cross-training of support staff
    - Clinicians who can provide "one-stop shopping"
    - Diverse funding streams
    - Programmatic flexibility/adaptability

Summary

- Patient stories reflect both challenges and successes
- Big picture:
  - HIV care engagement increased from 38% to 81%
  - Of those newly engaged through MHU
    - 100% prescribed ART
    - 66% virologically suppressed
    - All on or linked to OUD treatment

- Acknowledgments
  - Sandra Silva, MA
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  - HIV Ryan White case management team
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Questions?