Harm Reduction Street Outreach Clinical Services: Case Studies

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SPARC A CENTER FOR WOMEN

Background

People who use drugs (PWUD) face many barriers accessing and remaining connected to traditional healthcare systems, which negatively affects retention in care[1,2]

Harm Reduction, as a social justice and anti-oppressive framework, helps break down individual/systemic barriers[3]

Harm Reduction principles for understanding drug use [3,4,5] :

- Complex, stigmatized behavior
- Spectrum of use from abstinence ↔ disordered
- Some methods of use inherently more risky
- Individual/community health improvement is better metric of intervention success than cessation of all drug use
- Goal: Meet patients where they are, but don't leave them there

Methods

CRNP on Outreach

Urine Drug Screen During Outreach Visit

Harm Reduction Supplies

Very low barrier (related to status, time, location, readiness)

- OK if no ID, insurance, fixed address, transportation, phone
- Toxicology as informational tool only, focus on patient-centered metrics of success
- Patient-driven: many opportunities to succeed and no involuntary discharge
- Recognition that medication for opioid use disorder (MOUD) treats OUD only, and total abstinence may not be patient's goal.

Street medicine / "home" visit model

- Contracted clinicians must partner with local Harm Reduction organization
- Patients determine safe location for visit: home, alley, abandoned house, park, tent, train station, bus stop, etc.
- Utilize interprofessional flexible team, based on patient needs: case managers, peers, prescribers, community health workers, etc.
- Model should center voices of those with lived experience

Population: Mostly female-identifying persons who sell sex and/or use drugs

- Clinician does MOUD outreach one day/week, 8-12 patients seen per outreach day, additional telemedicine support available rest of week
- 40 patients currently on MOUD, 58 on waiting list; 83% 90-day retention rate

MOUD integrated with other services

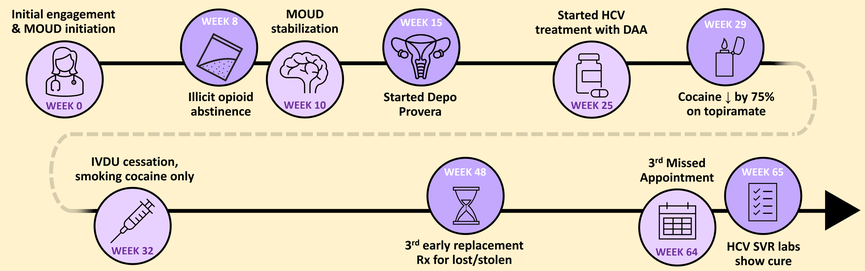
- **Harm Reduction supplies**: naloxone, drug supply testing, safer smoking/snorting/injecting supplies, safer sex kits, etc.
- **Medical**: STI testing and treatment, HCV and HIV testing and treatment, PrEP, reproductive care, wound care, substance use disorders treatment
- **Case management**: Connection to primary/mental health/specialist care, vital documents, connection to social services and legal aid, peer services

Case Studies

Patient "A" 34-Year-Old Female

- **Unhoused, no transportation, phone, vital documents, or any financial resources**
- **PMH:**
  - Long polysubstance use disorder history: drugs of choice include snorting fentanyl and injecting cocaine into her neck and/or groin multiple times per day
  - Chronic HCV, severe anxiety disorder
  - Not otherwise engaged in healthcare ("failed" multiple OBAT and OTP programs), not taking any medications
- **Clinical visits usually conducted at train station**

Continues to be positively retained in program for over 18 months:



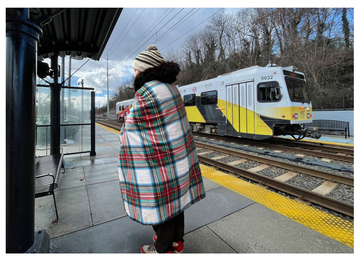


Image of Clinical Visit – used with patient's permission

January 2023	
HCV RT-PCR:	
Hepatitis C Quant	830 IU/mL
HCV Fibrosure:	
Fibrosis Score	0.03
Fibrosis Stage	F0
December 2023	
HCV RT-PCR:	
Hepatitis C Quant	HCV Not Detected

HCV Labs Jan 2023-Dec 2023

Broken Glass Replaced with Sterile Supplies – used with patient's permission

Patient "B" 33-Year-Old Female

- **PMH:**
  - Long polysubstance use disorder history, snorting/injecting cocaine and using illicit buprenorphine
  - History of syphilis, history of trading sex
  - HIV+ and was out of care at time of engagement
- **Unstably housed, seen at partner's home for clinical visits**
- **"Failed" out of mobile truck-based MOUD clinic due to difficulty with appointment adherence**
  - Initially presented for safer drug use supplies and testing and treatment of syphilis - after trust and rapport was established, began MOUD
  - Taking MOUD appropriately and intentional-illicit-opioid abstinent, cocaine laced with fentanyl complicating treatment

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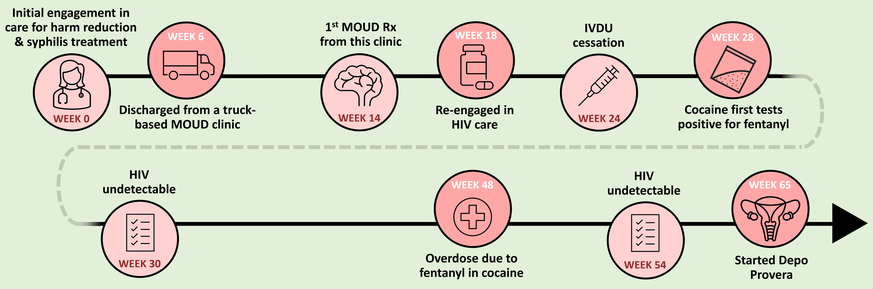

Case Studies (Cont.)

> I like this because **you guys come to me where I'm at.** I'm homeless, no transportation. My previous program…I had to [sneak onto] 2 buses and a train to get there – and there's cops. It wasn't worth it, so I left. Before that was inpatient and I was so close to graduating but they kicked me out for a bad urine – that really got to me. Took awhile to get over**. I wish other doctors treated us like people** – you guys at SPARC always have what I need."
>
> **-Patient A**

Patient B Self Portrait – used with patient's permission

Discussion & Conclusions

Increased access to healthcare for "hard to reach" patients

- Engages patients otherwise marginalized from other low barrier settings
- Measurable improvement in patient centered and public health outcomes over 18 months

Keys to establishing trust and rapport:

- Partnering with Harm Reduction agency, known and trusted by community = community goodwill extended to clinicians
- Clinicians that are willing to operate within the Harm Reduction lens
- Patient-directed/trauma-informed approach
- Many touchpoints over long period of time, celebrate small wins

Challenges:

- Staffing: difficult to predict needs, fund
- Logistical: outreach is time-intensive, unstable phone access
- Phlebotomy: difficult veinous access, limited laboratory access
- Policy: racist war on drugs, paraphernalia laws, insurance coverage, pharmacy stock, access to long-acting buprenorphine

Implications

Linking clinical outreach with trusted community-based Harm Reduction agencies can help the most marginalized patients engage in treatment, initiate MOUD, address infectious disease and promote reproductive autonomy in a patient centered framework

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