TAKING THE NEXT STEP: HIV TESTING AND TREATMENT WITHIN MARGINALIZED POPULATIONS

Joel Boivin, Mark Forsythe, Camille Lavoie (not present)

Thinking Outside the Box: Engaging People in Testing and Care
November 19th, 2013 – 3:10pm

Summary

- It is a constant challenge to provide HIV testing and treatment to highly marginalized individuals due to several factors:
  - Drug and alcohol dependency
  - Homelessness
  - Stigma and previous experiences in the health care system
  - Mental health issues
  - Other psychosocial needs which often take priority to HIV status
- The following pilot project was developed to increase accessibility of HIV and primary care services through low-threshold services that takes clients as they are

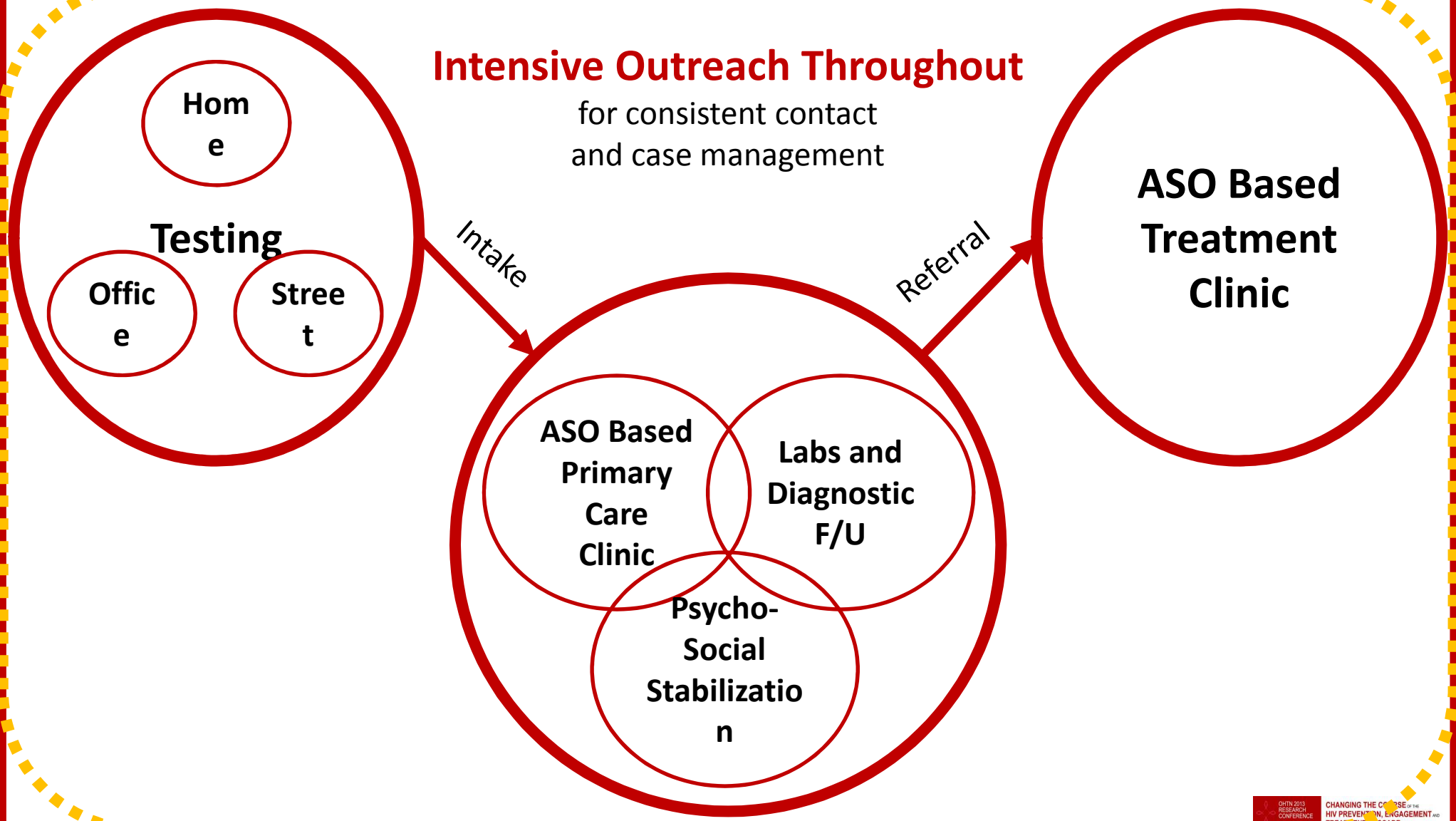
Issues Leading to the Described Project

- Lack of access to care among marginalized populations
  - Stigma
  - Addictions
  - Negative past experiences
  - Health as low priority
  - Lack of transportation
  - Emergency room wait times
  - Fear
  - Lack of health education
  - Lack of address or contact information
- Began to notice a trend of many individuals, who know they are likely HIV positive, but never sought HIV treatment

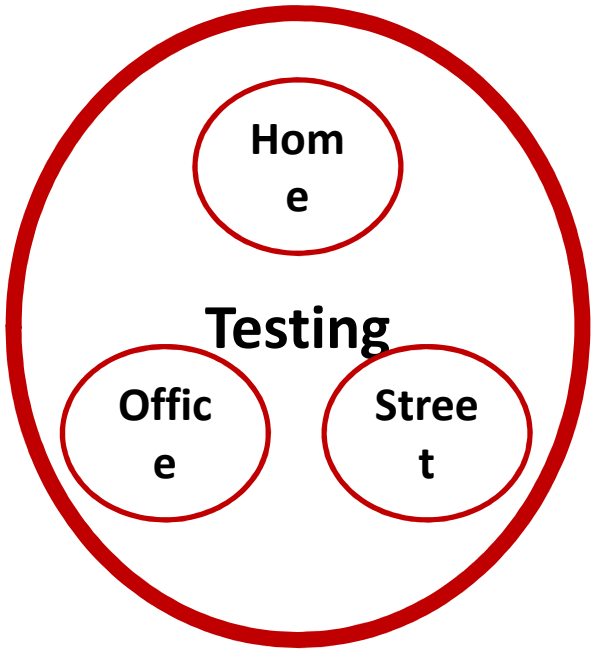
Relevance of these issues

- Unnecessary HIV related deaths
- Significantly high resistance in Northern Ontario (55% resistant to NRTI, 49% to NNRTI, 48% to both) (Sullivan, et al., 2012)
- Poor rate of follow-up among highly marginalized groups
- Limited ability to address these issues with presently available services

Model of Care: Summary

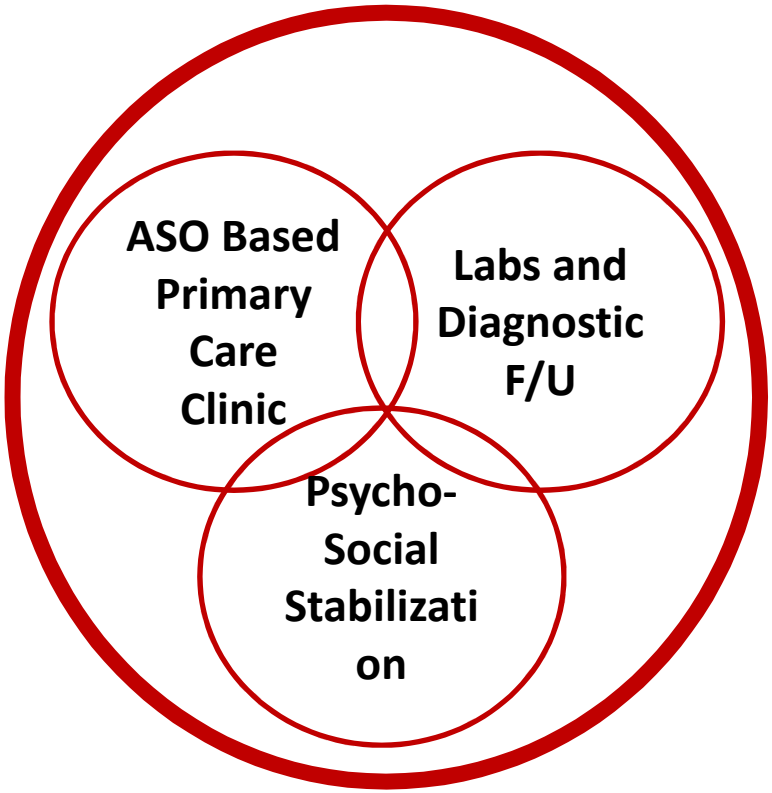


Model of Care: Testing



- Testing offered in office and through home visits by direct blood draws
- POC testing available through direct referral to PHU
- Street level "Testing Under the Tent" events
  - 3-4hr events held where high-risk individuals frequent
  - Food served to attract individuals
  - 5$ Gift Cards given as incentive for testing/receiving education
  - PHNs available for pre/post test counseling and POC testing
  - Outreach workers and HIV nurse walk downtown promoting event

Model of Care: Preparation for Treatment



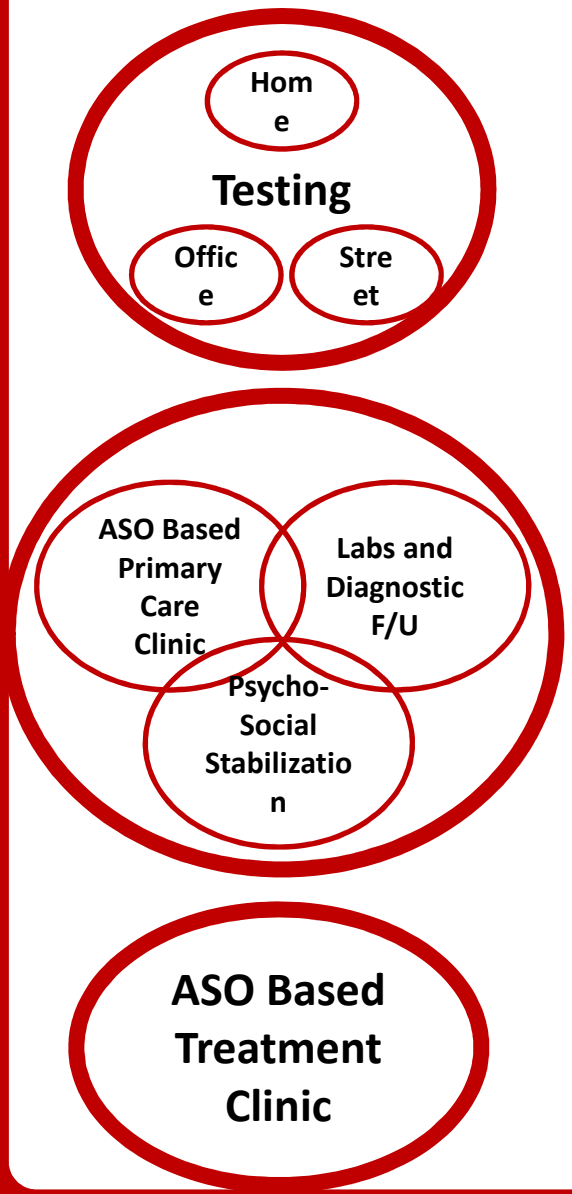
- Primary Care Clinic led by Dr. T. Mirka held bi-weekly to address ongoing medical concerns, and refer to HIV clinic
- Assisting clients in finding stable housing, financial support, mental health and addiction services, nutritional support, etc.
- Ongoing nursing case management through intensive outreach, searching for clients several times a week at street level
- RAN Outreach workers assisted in maintaining continued contact, delivering messages and appointment reminders, keeping staff updated on individuals

Model of Care: Treatment

ASO Based Treatment Clinic

- Led by Infectious Disease Specialist Dr. R. Sandre, held every 2-3 months
- Outreach utilized before clinic for reminders
- Independent attendance was mostly unsuccessful, but clients were easily found through outreach and accompanied to clinic
- Getting clients to stay is also an issue
  - Food provided at clinics to encourage clients to stay long enough until seen by the doctor
- Outreach utilized to provide
  - ongoing education
  - Side effect tracking
  - Compliance tracking
  - Ongoing support

Results as of September 30, 2013:



- 2 “Testing Under the Tent” events held
- Total of 23 High risk individuals tested for HIV
- Education performed with 68 high risk individuals
- Primary Care services acted as important link in attracting and retaining clients
- Roughly 15 clients expressed interest in pursuing the program
- 10 currently at some stage of the treatment process
- 4 HIV positive individuals placed on treatment
  - 3 currently undetectable Viral Load
  - Most recent treatment client under 200 copies/mL
- One individual with severe mental health issues currently undergoing Directly Observed ART and just recently, psychiatric medications
  - Compliance showing ongoing improvement

What comes next?

Limitations	Recommendations
Testing events: Overwhelming response	• Longer testing events • More testing events throughout the year
Target population requires extensive and ongoing case management. Requires many hours to get a few into clinic.	• More nursing hours to increase intake, follow-up, attendance at clinics, etc. • Less frequent HIV clinics (overkill)
External referrals for POC testing were often not followed up. Blood draws often used when follow-up at PHU unlikely, but sometimes challenging depending on setting.	• Exploring ways to increase access to POC testing • Continued collaboration with local PHU
Ability to do needle-exchange outreach in evenings limited by available hours. Missed opportunity for forming initial rapport with potential clients	• Increased nursing hours to accommodate this • An interagency "Nursing Outreach Team" would be useful in attracting new clients and providing education

References

Sullivan, A., Harrigan, P. R., Swantee, C., Wu, K., Rank, C., Halverson, J., et al. (2012, February). Increase in HIV drug resistance among treatment-naive patients in Ontario, 2005–2011: Grounds for concern. *Twenty-first Annual Canadian Conference on HIV/AIDS Research*. Montréal, Québec, Canada.