WOUND CARE IN THE STREETS

Presented for Project ECHO
April 23, 2021
Dr. Christina MB Wang

HAWAIʻI HEALTH
& HARM REDUCTION CENTER
The New Chapter for Life Foundation and The CHOW Project

Reducing Harm, Promoting Health, Creating Wellness and Fighting Stigma in Hawaii and the Pacific

Dr. Christina MB Wang (DNP, MPH, APRN-Rx, AGPCNP-C) is a Nurse Practitioner and Medical Director at the Hawaii Health & Harm Reduction Center. She has focused her efforts on wound care in the community with emphasis on street-based medical practice in Honolulu; delivering care to persons living with HIV/AIDS, Hepatitis, and to support efforts around caring for those with mental illness and substance abuse. She is also passionate about teaching and providing experience for students within the community setting. Christina is also the 2018 recipient of the Healthcare Association of Hawaii - Public Health Award and the 2019 Hawaii Academy of Family Physicians- Advocacy Award.

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SPECIAL THANKS

Courtny Tanigawa, APRN-Rx, FNP, CSAC- Outreach Wound Care Provider/ Mental Health Specialist

Monoiki Ah Nee-Bahn- Tobacco Treatment Specialist, Tester (HIV/HCV)

Alan Cota- Hepatitis coordinator, Tester (HIV/HCV)

Kelly Makino, MD- select slides with permission from her Wound Care Basics Grand Rounds presentation at John A. Burns School of Medicine

Heather Lusk, MSW- Executive Director of H3RC & the entire team at H3RC

Thaddeus Pham- Viral Hepatitis Coordinator Harm Reduction Division of Hawaii Department of Health

Our Street Medicine Partners & Street Outreach Volunteers

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DISCLOSURE

Gilead Sciences- Speakers Bureau

AGENDA

- **Introduction to Hawaii Health & Harm Reduction Center (HHHRC)**
- **Objectives**
- **Public Health Perspectives**
- **Wound Care Program**
  - Assessing the wound
  - Selecting products for the houseless community
  - Treating the whole patient
  - Recommendations

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OBJECTIVES

1. Assessing wounds in a street-based medicine clinic
2. Working with the houseless population- selecting wound care products that work well in this setting
3. Utilizing an acute need- like wound care, to engage in the health care system and address other concerns (i.e. HCV, substance use disorder/ behavioral health)

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H3RC HEPATITIS, WOUND AND SYRINGE SERVICES

- Statewide syringe exchange since 1989
  - All SEP is street or vehicle based
  - Naloxone training and distribution
- H3RC is fiscal sponsor of Hep Free Hawaii
  - Coalition of 80 partners fighting to ending Hep in HI
  - Hepatitis C testing (antibody and RNA)
  - Hepatitis Care Coordination
- Wound care
  - Two days a week street-based wound care
  - In-house clinic

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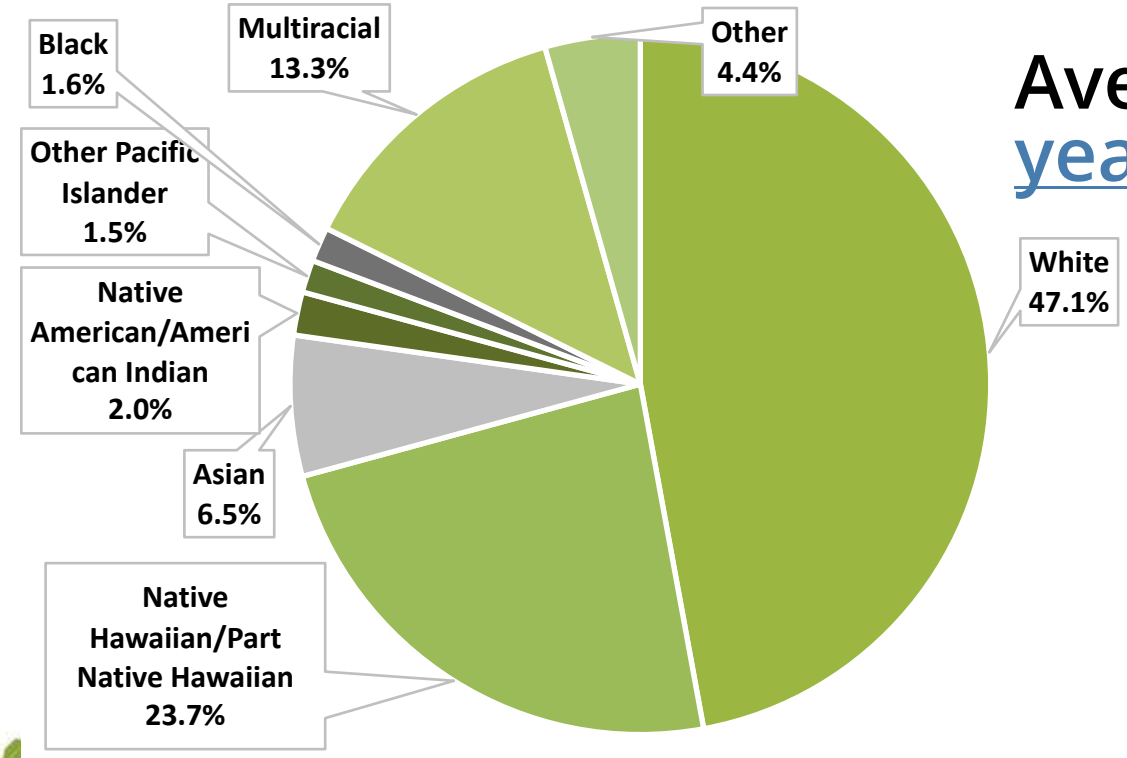
SEP Demographics



Average age: 41 years

2 in 3

identify as male

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Syringes Exchanged in Hawai'i

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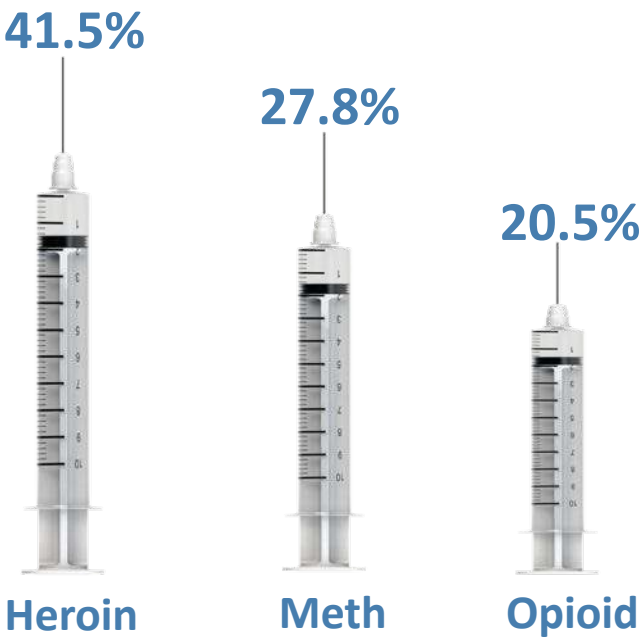
Injection Drug Usage

A high proportion of SEP clients report polydrug use



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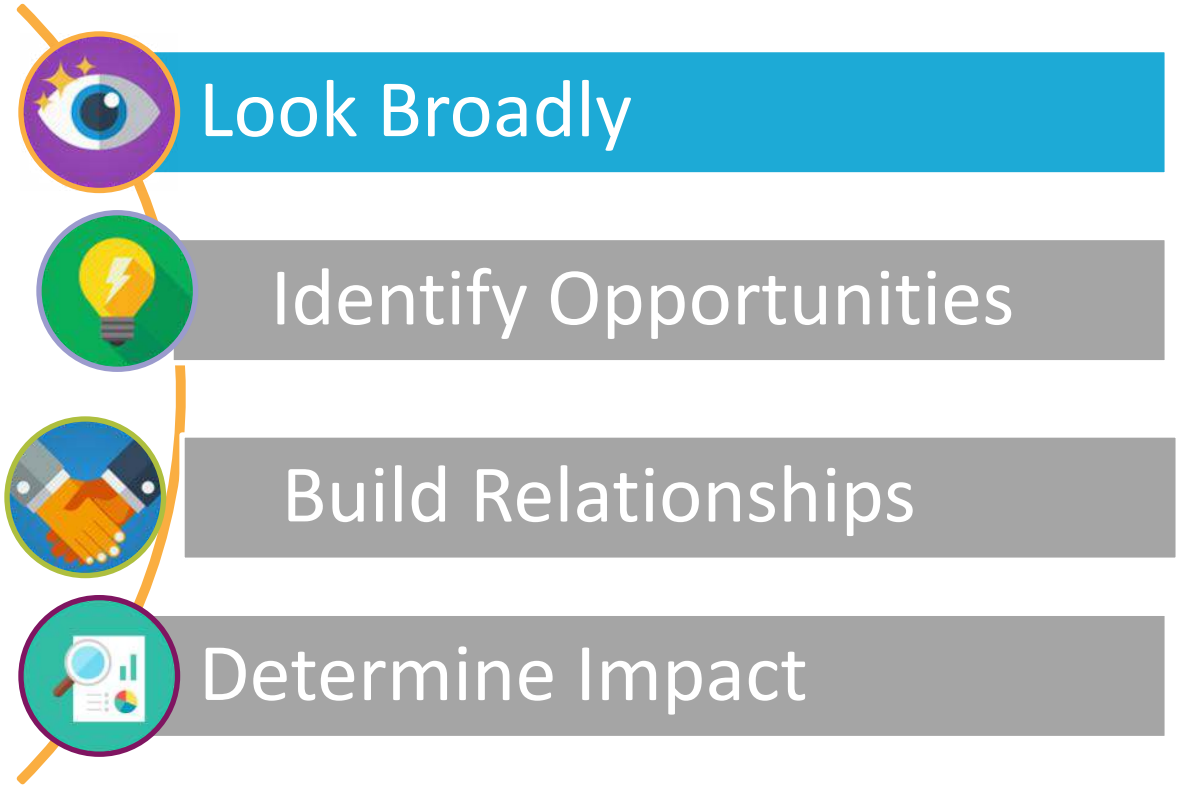
PUBLIC HEALTH IS... SOCIAL JUSTICE



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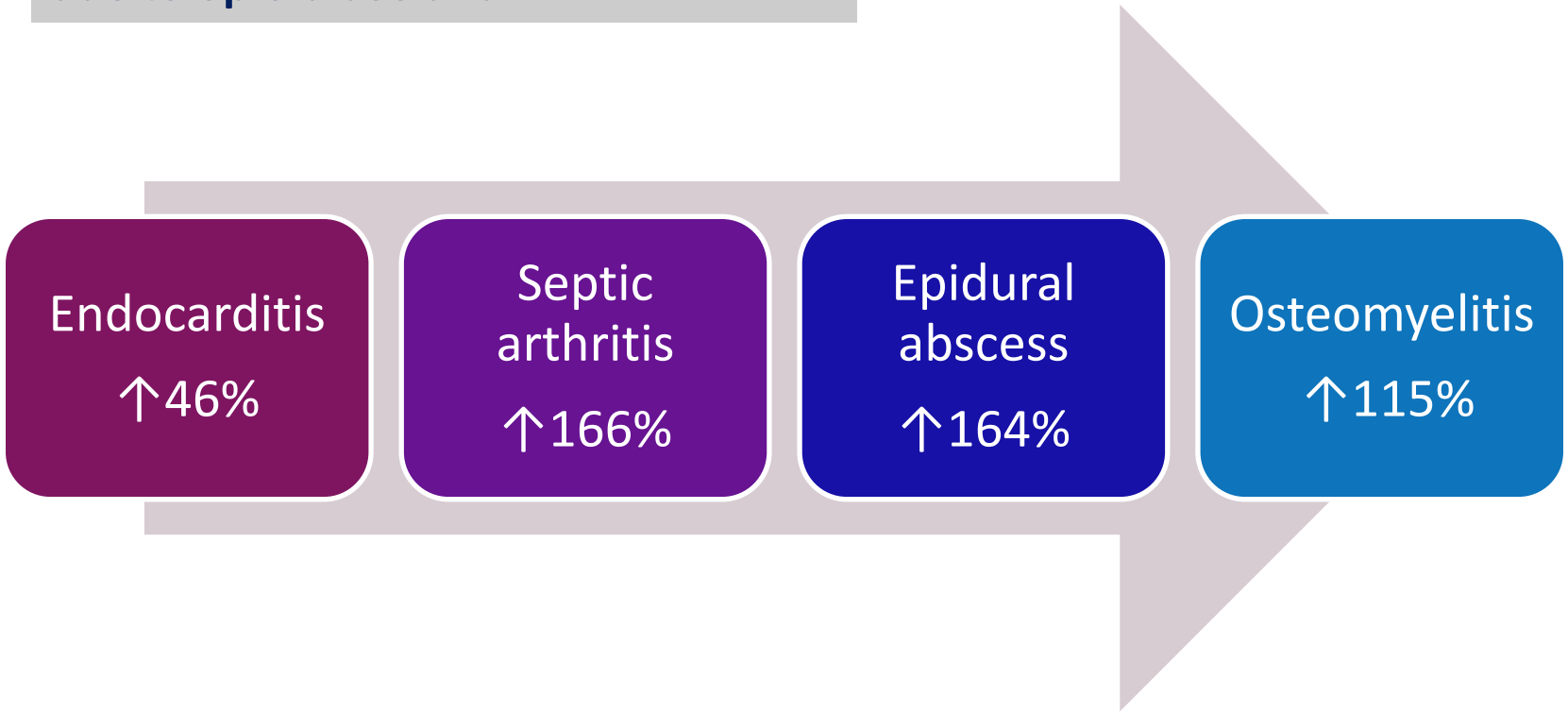
OPIOID USE AND WOUNDS

Hospitalizations (2002-2012)
due to opioid use and…



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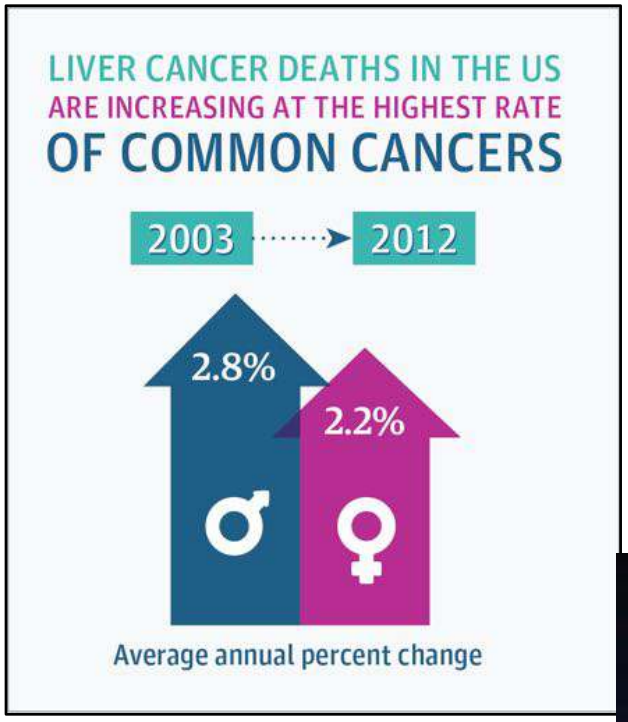
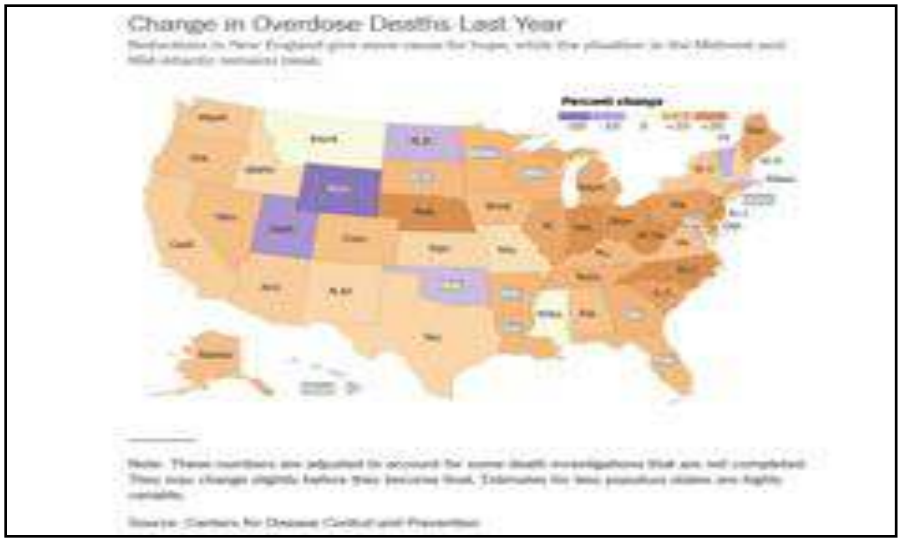
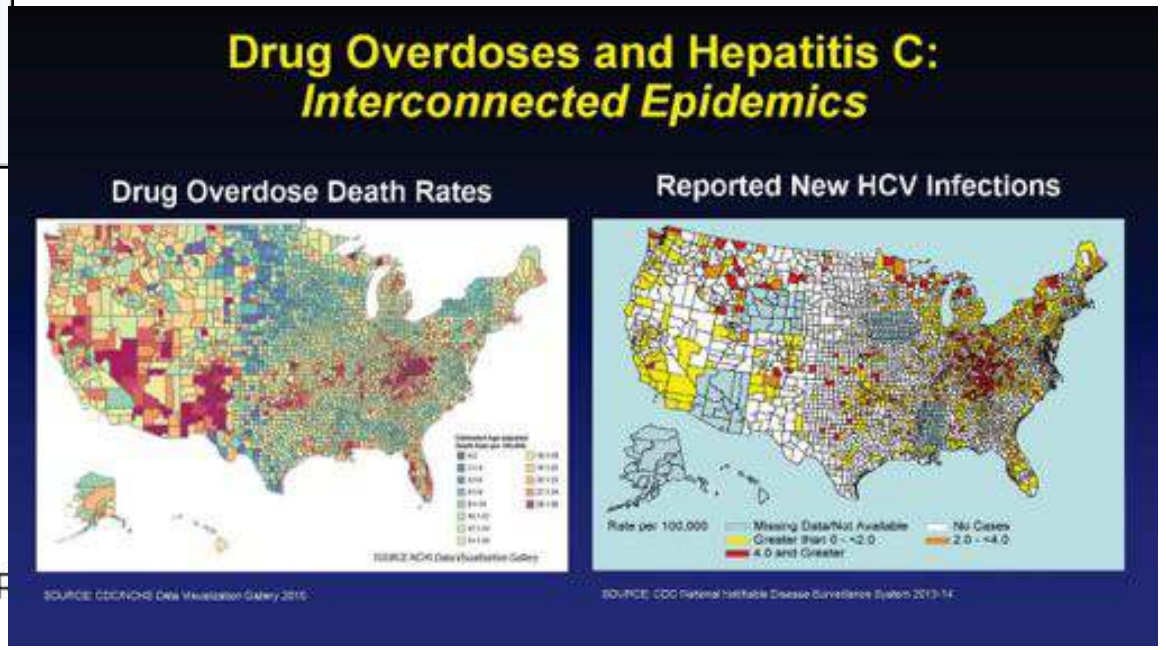
RELATED HARMS







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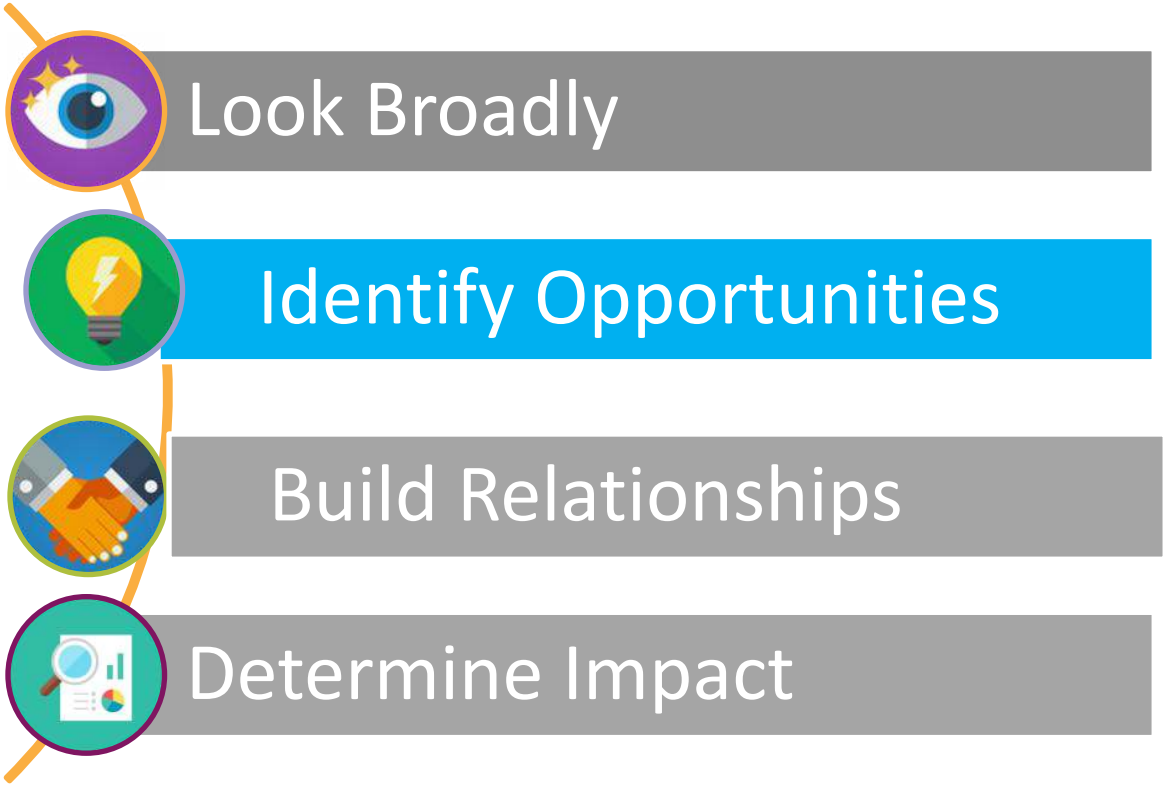
"Yvonne Christie, 63, was cited on Oct. 23 for sitting on the River Street wall with a shopping cart of belongings. Christie says she is trying to get help to get into housing, but in the meantime, she is waiting for her COVID-19 test results to gain access to sleep in a nearby shelter."

PUBLIC HEALTH IS... SOCIAL JUSTICE



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NEEDS ASSESSMENT

Annual Evaluation Survey: ED Use

- 86/100 participants reported visiting the ED in the two years prior to interview
  - 14 people reported 10 or more ED visits in the last two years
  - 4 people reported 20 or more ED visits in the last two years
- 42/86 people reported abscesses/wounds or infections as one of the reasons they visited the ED
  - 29 people reported having a wound or open sore that did not heal within a month in the year prior to interview
  - 23/29 visited the ED for these wounds
  - 8/29 had been hospitalized for these wounds

CHOW Wound Care Needs Assessment

- 46/55 participated in survey
  - 85% sought wound care 0-5 times in the past 3 months
  - 13% sought wound care over 20 times in the past 3 months
  - 96% reported they needed help with wound care

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HepFree HAWAI'I

BIG CONCEPT

- ~13,000+ ED visits in 2015
- ~1200+ EMS runs in 2016
- $20-25 Million Dollars of unpaid costs NOT including provider salaries for Hawaii 2015
- 70 % of our super utilizers are homeless
- Hawaii has ranked #1 homeless per capita 49.3/10,000
- Behavioral health and Substance abuse make up the majority of acute care diagnosis
- 1 in 10 used illicit drugs in the past month; Hawaii has #1 total admissions for methamphetamine related Diagnosis

(Cheng, D., 2017)

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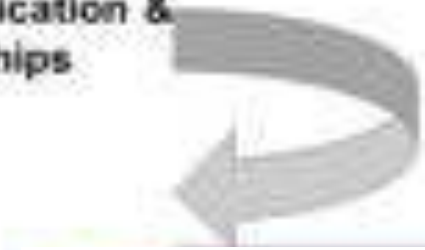
DEVELOPING WOUND CARE AT H3C

The Process

Previously no community-based wound care program in collaboration with the Hawaii State Syringe Exchange Program (SEP)

Developed community-based wound care program in collaboration with The CHOW Project

- Survey Results (Annual Survey & Needs Assessments)
- Utilized Johns Hopkins nursing Evidence-Based Practice Model
- Literature Review
- Established community-based wound care clinics as models
- **Communication & Partnerships**



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Model Programs

Maryland Program: Wounds on Wheels

Joint collaboration with Johns Hopkins Wound Care Healing Center & Baltimore Needle Exchange program (BNEP)

- Wound assessment, wound cleansing, incision & drainage, sharp debridement, compression treatment, antibiotic prescriptions, specialty wound dressings.
- Demonstrated effective care through mobile outreach (2012)

([illegible], et al., 2018, p. 205-7)

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Model Programs

California Programs:

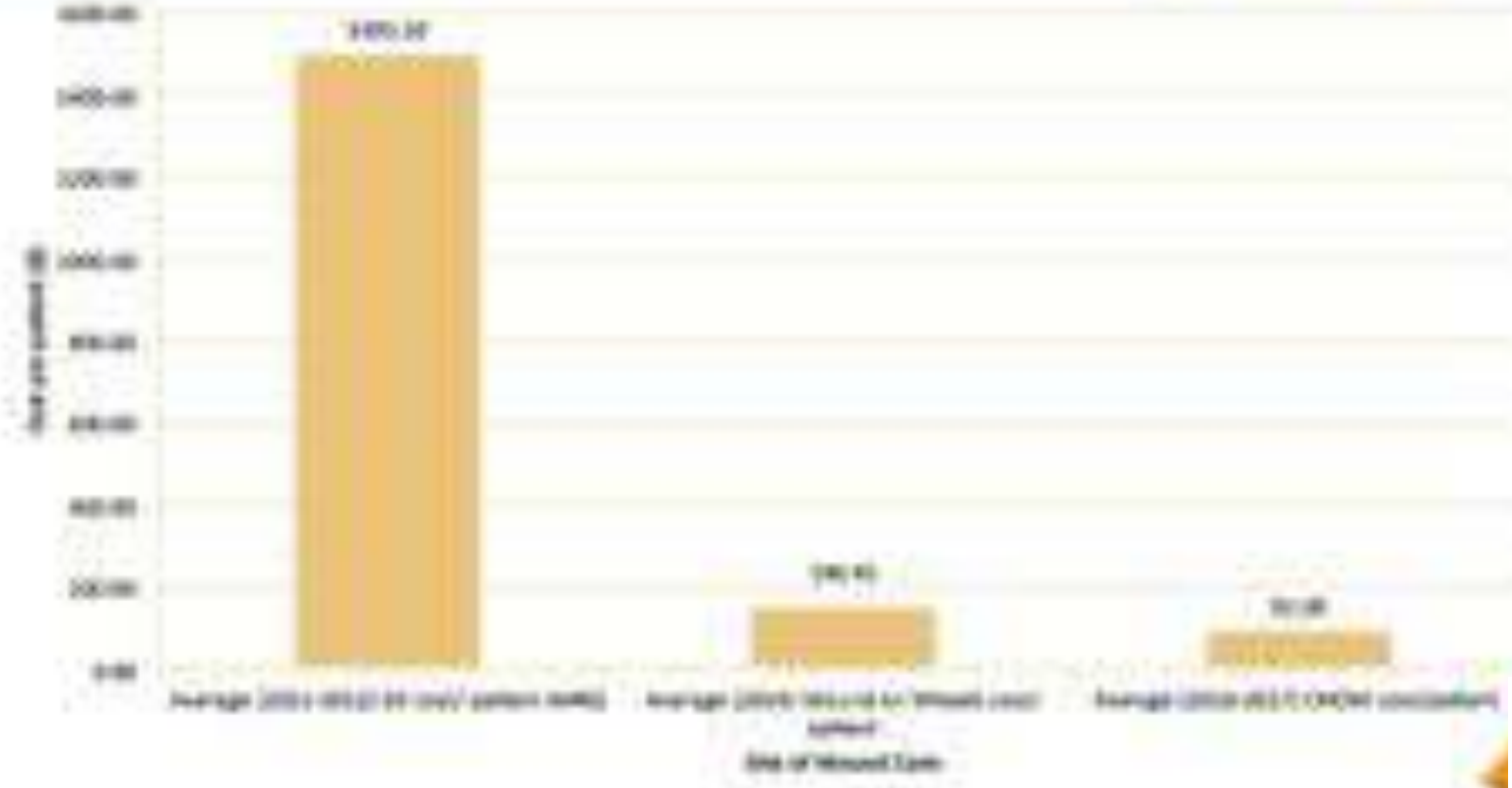
Integrated Soft Tissue Infection Services (San Francisco)

- Reduced ED, surgical service admissions, & inpatient days
- $8,765,200 in savings in the first year of the clinic's operations as of 2002 (Harris & Young, 2002).

Abscess Clinic at Casa Segura/Safehouse (Oakland)

- One of the oldest clinics in US (est. 1997)
- "...soft tissue infection clinics held in conjunction with syringe exchanges can be economical and can make more appropriate use of emergency departments, in that clinic staff refer patients only as needed" (Grau, et al., 2002, p.1917).

COST



WOUND CARE AT H3RC

IDUs are at, "significant risk for numerous serious, high morbidity and mortality infections, [and] disproportionately use the emergency department (ED) for health care needs" **(Kievlan, Gukasyan, Gesch, & Rodrigues, 2015).**

- Street-based Tues/Fri 9-12 Chinatown- Oahu, HI
- Partnerships with students/volunteers
- Costs are $0.05 for every $1 spent at Queens Medical Center
- Utilizing dressing changes for other healthcare needs/ engagement

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STREET-BASED WOUND CARE- PROGRAM SNAPSHOT

- **Operating 5 years**
- **Recent 6 month look back: 595 encounters in the street; 198 unique patients**
- **Primary referrals: Queens Medical Center, Castle Medical Center, Straub Hospital / Kapiolani Hospital for Women & Children & Kuakini Medical Center**
- **Collaboration & Referral from I.H.S- largest homeless service organization**
- **Wound care as the engagement for**
  - Primary Care
  - Birth Control and Women's Preventative Services
  - Housing
  - Care coordination- i.e. Hepatitis Management/ HIV case management
- **Enhanced partnerships, fighting stigma**

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HepFree HAWAI'I

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ASSESSING WOUNDS

- Start with initial interview of patient (CC, PMHx, PSxHx, medications, allergies, Social Hx etc.)

- Key to consider past medical history
  - PMHx: Chronic diseases (T2DM, HTN, Cardiac Diseases, Vascular insufficiency (venous, arterial, mixed), smoking status, injection drug use (IDU).
  - History of previous ulceration/ amputation- mobility status
  - History of osteomyelitis/ other SSTI infections
  - Medications

- Specific wound assessment: "OLDCARTS" *

- Other S/S of infection: erythema, edema, tender to touch, odor, drainage
- Additional Assessment: imaging (x-ray/ vascular studies), Diabetic foot exam (tuning fork, monofilament), skin integrity/ callosities, edema
- Plan: wound care modality, medications,

address pressure, friction, biomechanics & manage mc

WOUND ASSESSMENT, CONT.

- **OLDCARTS:**
  - O: onset
  - L: Location
  - D: Duration
  - C: Characteristics of *wound bed/ stage + SIZE (including: depth, tunneling, undermining)
  - A: Aggravating/ alleviating factors (treatments tried)
  - R: Radiating (pain) / Risks (biomechanics)
  - T: Temperature
  - S: Severity of pain/ wound (type & quality)
- ***Note if the wound bed is too wet, to dry**

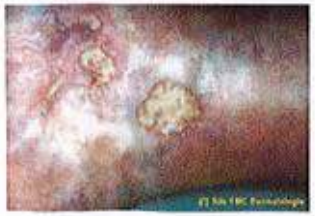
WOUND TYPES

- **Acute Wounds**
  - Surgical incision*
    - Examples: S/P I & D for abscess ; Fractures requiring surgical intervention
  - Trauma
    - Skin tears
    - Lacerations
    - Puncture wounds*
    - Crush injuries
    - Burns*
- **Chronic Wounds**
  - Venous ulcers*
  - Arterial*
  - Diabetic foot ulcers*
  - Pressure ulcers
  - Non-healing surgical wounds
    - Esp. with persistent copious drainage.

VENOUS ULCERS

Mechanism	Venous valve failure -> congestion, HTN
Location	Ankle to mid-calf; often medial malleolus
Wound margin, bed & size	Irregular shape Usually shallow bed, viable or necrotic Usually large
Exudate, edema & wound staining	Exudate varies (none, heavy, weeping) Generalized edema Often hyperpigmented
ABI & pulses	ABI >0.8. Pulses normal (or undetectable due to edema)
Pain	Often w/ dependent position (edema)

Venous leg ulcer



Atrophy blanche

hemocidirin staining

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ARTERIAL ULCERS

Mechanism	Arterial occlusion, ischemia
Location	Distal extremity (anywhere)
Wound margin, bed & size	Well-defined margin Pale, little granulation. Necrosis common Starts small; increases in size
Exudate, edema & wound staining	Minimal to no exudate +/- local edema Usually no staining
ABI & pulses	ABI <0.8 (<0.5 → BAD!). Dec pulses
Pain	At rest, night or w/ limb elevation

Arterial ulcers

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DIABETIC FOOT ULCERS

Mechanism	Autonomic / sensory / motor nerve damage Arterial perfusion deficit
Location	Usually foot, can be anywhere
Wound margin, bed & size	Well-defined margin, calloused edge Pale, little granulation. Necrosis common. Usually small
Exudate, edema & wound staining	Minimal to no exudate +/- localized edema Usually no staining
ABI & pulses	ABI and pulses unreliable (calcification)
Pain	Variable (absent or severe; neuropathy)

Figure 2: **Neuropathic ulcer in typical position under second metatarsal head and surrounded by callus**

Figure 3: **Digital gangrene**

Diabetic/Neuropathic Ul

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Type	Arterial ("ischemic")	Neuropathic / Diabetic	Venous
Mechanism	Arterial occlusive disease causes ischemia	Damage to autonomic, sensory, or motor nerves; arterial perfusion deficit	Venous valve failure, causes venous congestion and hypertension
Location	Distal extremity (anywhere)	Usually **foot**, but can be anywhere	Ankle to mid-calf, often medial malleolus, can be circumferential
Wound margin, bed, and size	Well-defined margin. Pale, little granulation, necrosis is common. Starts **small, then increases** in size.	Well-defined margin with **calloused edge.** Pale, little granulation tissue, necrosis is common. Usually **small size**.	**Irregular shaped.** Usually shallow, can have viable or necrotic tissue. Usually **large size**.
Exudate, edema & limb staining	Minimal to no exudate. +/- localized edema. Usually no staining.	Minimal to no exudate. +/- localized edema. Usually no staining.	Exudate varies (none, heavy, generalized weeping). Generalized **edema**. Usually **hyperpigmented**.
ABI and pulses	**ABI <0.8** (<0.5 bad!). Reduced / no pulses.	ABI and pulses not reliable (calcification).	**ABI >0.8**. Pulses usually normal, or undetectable due to edema.
Pain	**At rest, at night, or when limb is elevated**	**Variable**: absent or severe (neuropathy)	Often in **dependent position** (edema)

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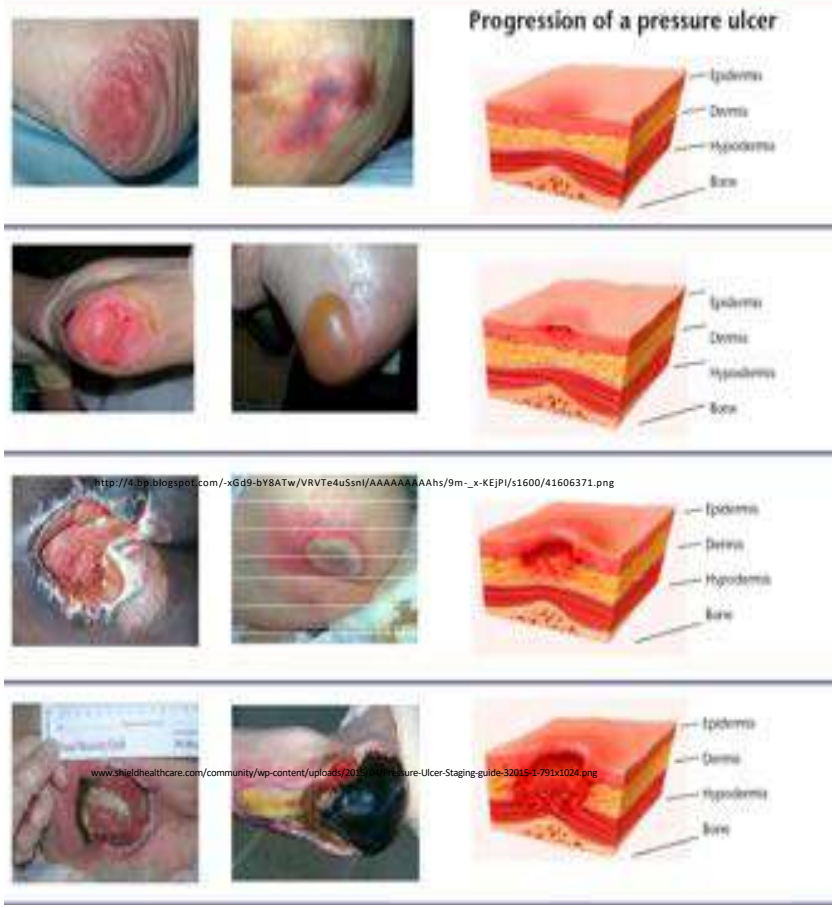
PRESSURE ULCERS



- **AKA: decubitus ulcers, bed sores**
- **Localized tissue necrosis due to compression, diminished blood flow**
- **Staged based on depth of necrosis**
  - Stage 1: Non-blanchable erythema, intact skin
  - Stage 2: Partial thickness, involves epidermis, abrasion or blister
  - Stage 3: Full thickness, damage to subcutaneous tissue, may extend to fascia
  - Stage 4: Deep destruction, necrosis, extends to bone / muscle
  - Unstageable: slough or eschar obscures wound bed

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Wound Type: Does it matter?

Common Features

- Address underlying barriers to healing
- Support healthy wound bed
- Compression* (except arterial)
- Offload weight
- Address moisture balance
- Address bioburden (i.e. bacteria)

Unique Features

- Venous: Compression therapy for life
- Arterial: *Compression can make it worse. Surgical referral is often necessary (revascularization, amputation)
- Diabetic: Supportive footwear for life
- Pressure ulcers: Surface support
- Hyperbaric oxygen: Arterial & diabetic

NORMAL WOUND HEALING PROCESS

Coagulation

Days 0 - 3

Cellular: Vasoconstriction, platelet plug / aggregation

Facilitated by cytokines (thromboxane, serotonin, adrenaline, coagulation cascade)

Inflammation

Days 1 – 3

Cellular: Leukocytes (PMNs, monocytes, macrophages, lymphocytes)

Facilitated by growth factors (PDGF, VEGF, TGF-alpha / beta, TNF-alpha, MMPs, IL-1, IL-6

Proliferation

Days 4 – weeks

Cellular: Fibroblasts, ECM deposition, reepithelialization, angiogenesis

Facilitated by collagen (type 1 & 3), VEGF, PDGF

Remodeling

Weeks – months (sometimes years)

Cellular: wound maturation

Facilitated by collagen (type 3 → type 1), cross-linkage of collagen to increase tensile strength

SUPPORTS OR IMPEDANCES FOR WOUND HEALING

Factors that may delay wound healing

- **Nutrition / Macronutrients**
  - Adequate protein, fluid intake, amino acids
  - Glucose control
- **Vitamins (especially A, C, and D)**
- **Minerals (especially zinc, copper, iron, selenium)**
- **Optimization of wound bed / moisture**

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Factors that may delay wound healing

- **Tissue necrosis, devitalization**
- **Infection / inflammation**
- **Moisture imbalance**
- **Edges (stalling in advancement of edges / closure)**

Table 3 TIME*† – the principles of wound bed preparation

Clinical observations	Proposed pathophysiology	WBP clinical actions	Effect of WBP actions	Clinical outcomes
Tissue non-viable or deficient	Defective matrix and cell debris impair healing	Debridement (episodic or continuous) • autolytic, sharp surgical, enzymatic, mechanical or biological • biological agents	Restoration of wound base and functional extra-cellular matrix proteins	Viable wound bed
Infection or inflammation	High bacterial counts or prolonged inflammation ↑inflammatory cytokines ↑protease activity ↓growth factor activity	• Remove infected foci topical/systemic • antimicrobials • antiinflammatories • protease inhibition	Low bacterial counts or controlled inflammation: ↓inflammatory cytokines ↓protease activity ↑growth factor activity	Bacterial balance and reduced inflammation
Moisture imbalance	Desiccation slows epithelial cell migration Excessive fluid causes maceration of wound margin	Apply moisture-balancing dressings Compression, negative pressure or other methods of removing fluid	Restored epithelial cell migration, desiccation avoided oedema, excessive fluid controlled, maceration avoided	Moisture balance
Edge of wound – non advancing or undermined	Non migrating keratinocytes. Non responsive wound cells and abnormalities in extracellular matrix or abnormal protease activity	Re-assess cause or consider corrective therapies • debridement • skin grafts • biological agents • adjunctive therapies	Migrating keratinocytes and responsive wound cells. Restoration of appropriate protease profile	Advancing edge of wound

*Courtesy of International Advisory Board on Wound Bed Preparation 2003.
Adapted from table 6 – #Schultz GS, Sibbald RG, Falanga V et al, Wound Rep Reg (2003) 11:1–28.
Wound Bed Preparation and TIME are clinical concepts supported by Smith & Nephew Medical Ltd.

Ref: Schultz 2004: Wound bed preparation and a brief history of TIME

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TISSUE

- Remove all devitalized or necrotic tissue by sharp, enzymatic, biological, mechanical or autolytic debridement.
- Larval therapy is a real option for pressure ulcers (debrides & antibacterial!)

Tissue - Remove non viable or deficient tissue - may be episodic or continuous

Dry necrosis

After debridement

Necrotic Tissue
Sharp surgical debridement
if adequate arterial supply -
alternatively autolytic methods

Slough

After debridement

Sloughy Tissue
Autolytic, enzymatic, mechanical or
biological debridement

Ref: Schultz 2004: Wound bed preparation and a brief history of TIME

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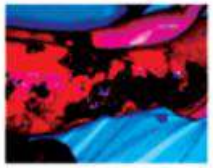
INFECTION / INFLAMMATION

Infection or inflammation - diagnose and treat infection or inflammatory diseases

Infection

Pyoderma gangrenosum



Vasculitis

Infection - Diagnosis of infection can be difficult. The interpretation of swab results needs to be done with care and always consider clinical features. Management of infection may require intravenous or oral therapy. Consider the use of modern topical anti-microbials. If infection is not resolving after 2 weeks of therapy, consider referral or seek advice.

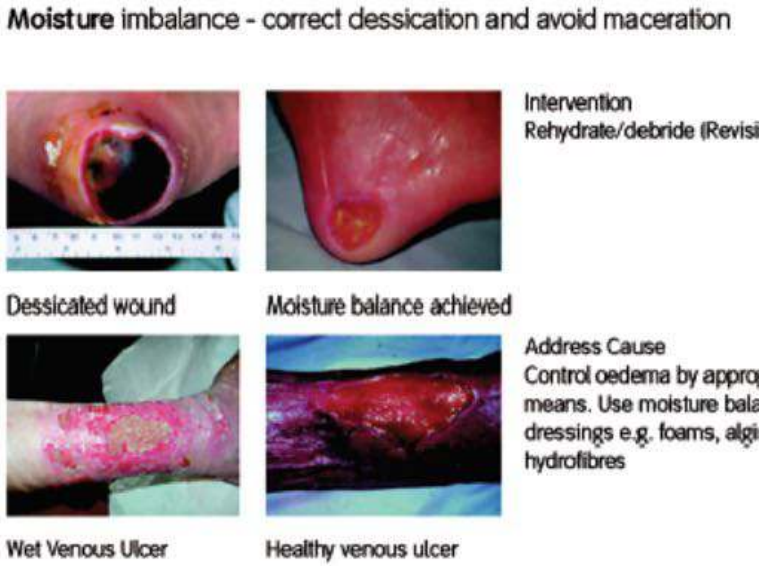
Inflammation - Consider inflammatory diseases in ulcers that have unusual presentations/appearances and are not responding to first line treatment. Confirmation of diagnosis may require specific blood tests, biopsy or if in doubt, consider referral

- **Infection:**
  - Diagnosis with swab / biopsy culture
  - If not resolved after 2 weeks, seek advice!
- **Inflammation:**
  - i.e. Pyoderma gangrenosum
  - Consider anti-inflammatory trial vs referral to dermatology

Ref: Schultz 2004: Wound bed preparation and a brief history of TIME

MOISTURE

- If it's wet – make it dry
- If it's dry – make it wet



Ref: Schultz 2004: Wound bed preparation and a brief history of TIME

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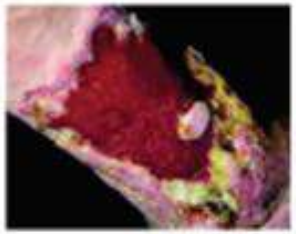
EDGE

Edge - consider surgical intervention or advanced therapies if edge is not advancing and T, I & M have been addressed

Undermining edge

Healthy edge

Intervention
Surgical debridement



Non migrating edge

Migrating edge

Intervention
Reassessment. Consider biological agents, advanced therapies or skin grafting.

Ref: Schultz 2004: Wound bed preparation and a brief history of TIME

FEATURES OF CHRONIC WOUND INFECTION

Often do not see “the usual” (tumor, rubor, calor)

Signs/symptoms of chronic wound infections;

- Increased pain
- Delayed healing (no improvement in 2 weeks)
- Discoloration of granulation tissue (pale, dusky)
- Friable granulation tissues, bleeds easily
- Foul odor
- Wound breakdown (increased size, loss of epithelium, bone exposure)
- Pocketing at base or in recessed areas

TO CULTURE OR NOT TO CULTURE?

- **Culture if:**
  - Suspected infection in debrided ulcer
  - No progress in 2 weeks after debridement
- **How to culture**
  - Wound tissue biopsy (curette)
  - Validated quantitative swab technique
    - Levine method superior to Z-method
  - Obtain both aerobic and anaerobic Cxs
  - Consider fungal if no response to Abx

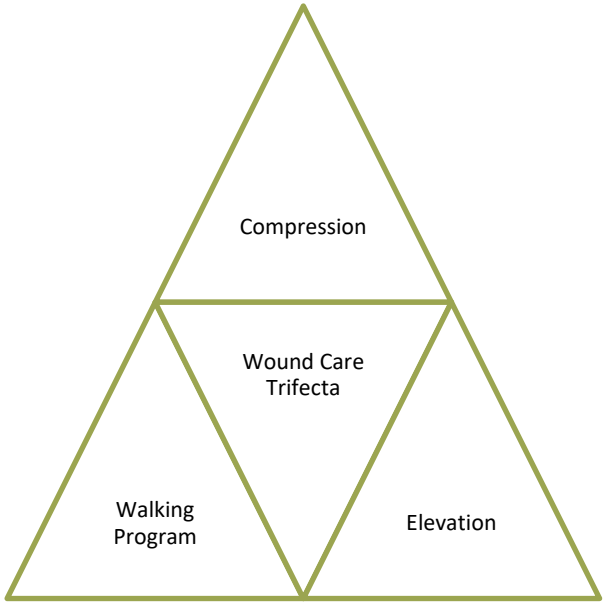
- **Levine Method for Wound Swab**
  - 1) Thoroughly cleanse with NS, blot dry with sterile gauze
  - 2) If wound is very dry, pre-moisten swab (NS)
  - 3) Don't swab pus / exudate / eschar / necrosis!
  - 4) Rotate swab tip in 1cm square area of clean granulation tissue. Apply gentle pressure 5 seconds to release exudate
  - 5) Insert swab into culture medium

TREATING CHRONIC WOUND INFECTIONS

- **Topical and/or systemic antibiotics**
  - Cellulitis – tx with systemic gram-positive bactericidal antibiotic
- **Discontinue antibiotics once back in bacterial balance (< 1 x 10^6 CFU/g)**
  - Antimicrobial agents can be cytotoxic to granulation tissue
  - Continued antibiotic use leads to increased bacterial resistance
- **Consider bone biopsy (gold standard for osteomyelitis)**
- **Dressings that decrease bioburden**
  - Silver (Ag; i.e. silver alginate, silver carboxymethylcellulose, silver gel)
  - Manuka honey
  - Iodosorb cadexomer
  - Others; resin salve, polyhexamethyl biguanide, lactoferrin / xylitol wound hydrogel with silver)

CHRONIC WOUND CARE TRIFECTA:

- **Compression:**
  - Only if adequate pulses and ABI >0.8
  - Multi-system wrap (2-layer or 4-layer) has best evidence
- **Walking program:**
  - Calf muscles are the heart of the legs
- **Elevation:**
  - Raise extremity above heart when not walking



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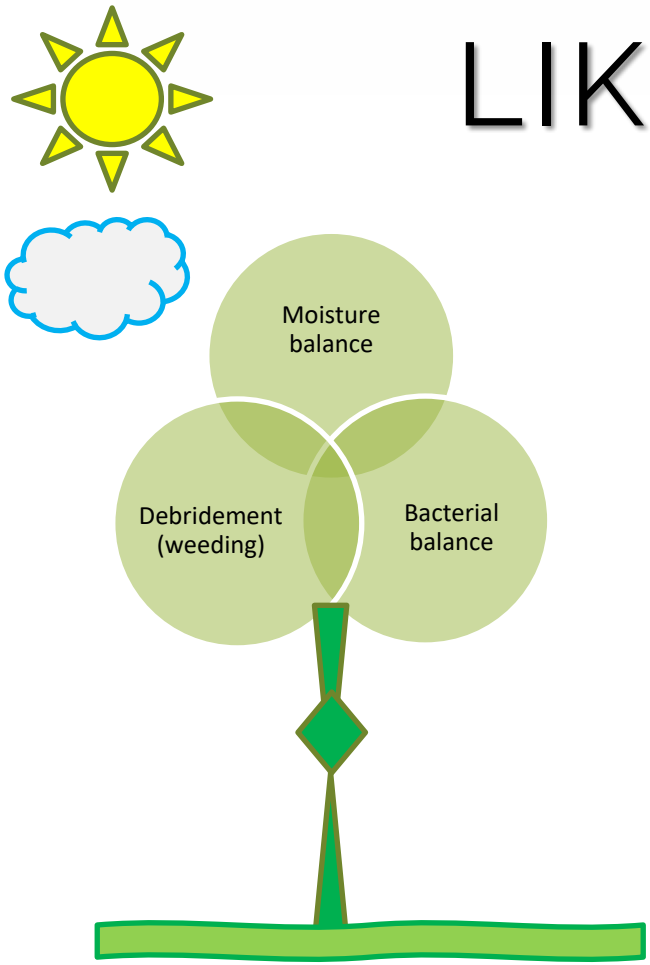
WOUND BEDS: THEY'RE LIKE A GARDEN



- **Moisture balance:**
  - Choose the right dressing (see separate slide)
- **Bacterial balance:**
  - Cleanse wound with dressing changes
    - Tap water (if clean), sterile saline, acetic acid solution (pseudomonas), commercial wound cleanser (surfactant)
  - Treat infections if needed
- **Debridement**
  - Scrubbing (pre-treat with 4% topical lidocaine)
  - Sharps debridement
  - Surgical debridement
  - Enzymatic (i.e. collagenase)
  - Autolysis (phagocytes, leukocytes, need moisture balance)

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Films	•Pros: Comfort, ease, less pain to remove •Cons: Retains moisture → maceration; skin tear with removal •Examples: Tegaderm, Mepore	Minimal exudate; STSG donor sites Duration: days if dry
Hydro-colloid	•Pros: Less maceration; stay in place for couple/few days •Cons: Contact dermatitis; dressing turns yellow •Examples: Tegaderm hydrocolloid, DuoDERM	Small / superficial wounds; STSG donor sites Duration: 2 – 7 days
Alginate	•Pros: Maintain for days; absorbs exudate •Cons: Increased moisture in peri-wound → more maceration •Examples: Algisite M, Melgisorb	Moderate – high exudate; hemostatic dressing Duration 1 – 3 days (sometimes up to 7)
Hydro-fibers	•Pros: More absorbent and less wicking than alginate; leave on for days •Cons: Fibrinous residue on wound bed → need saline to remove •Examples: Aquacel	Moderate to high exudate Duration: 2 – 7 days
Foam	•Pros: Absorption, cushions wounds •Cons: Frequent dressing changes (vs alginate, hydrofiber) •Examples: Mepilex, Allevyn foam)	Mild to moderate exudate; provides padding Duration: up to 1 week
Hydro-gels	•Pros: Maintains moisture; soothes wound base; helps reduce necrosis •Cons: Frequent changes; increased moisture peri-wound, not anti-infective •Examples: Flexigel, Skintegrity	Dry wounds with eschars Duration: 24- 72 hours

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COMMON WOUNDS WITH IVDU

Bilateral forearm

Hand wound

Typical infected lower extremity ulcerations- often circumferential

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COMMON WOUNDS

Arterial wound to the left lateral LE

Infected hardware s/p multiple revisions- surgical debridement/ washout, VAC and external fixator

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DIFFERENTIALS

Venous

VS Pyoderma Gangrenosum

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ABSCESS PROGRESSION

2 days s/p I & D in the ED; oral antibiotics at time of discharge

2 weeks with oral antibiotics completed

1 month with subsequent good closure

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CLEANING & DEBRIDING

- Utilization of Hibiclense and Normal Saline (often both)
- Wash less/ Waterless wipes
- Debride with cleaning- manually versus with sharps (i.e. 15’ blade)
- Debride with product selection


4X4 GAUZE

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CHOOSING A PRODUCT

Factors to consider:

- Houseless v. marginally housed
  - Living in a shelter?
  - Couch surfing?
  - Living in a park?
  - Living on the sidewalk?
  - Living under a bridge- in the water?
  - Living in the tree line along the roadway/ highway?
  - Living in a car?
- Ability to access water?
- Ability to stay dry?
- Ability to store extra dry dressings/ supplies/ medications?
- Using a wheelchair?
- Using other assistive devices? (crutches, cane, etc.)
- Insurance?
  - Cost of dressing/ product/ medication
- How frequently need to change the dressing

Alginates (Calcium/ Silver)

Xeroform

COST CONSIDERATION

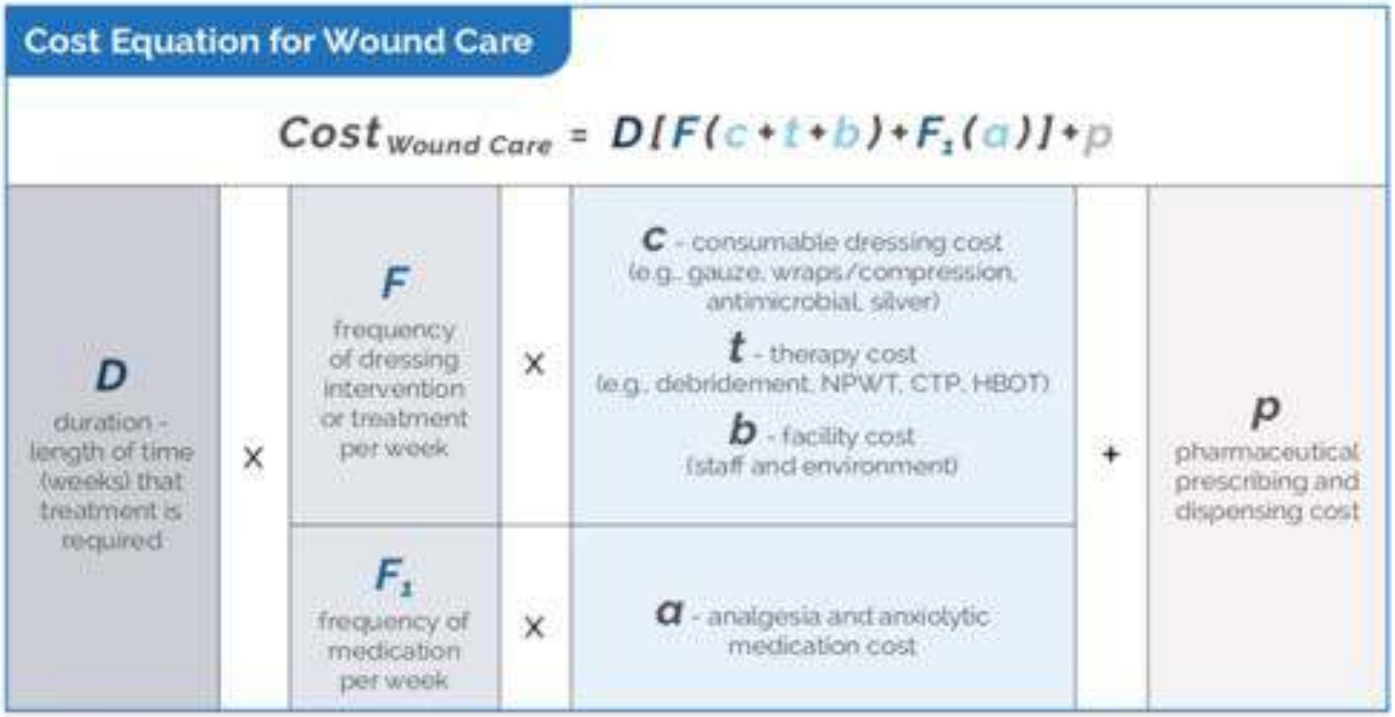

Figure 3: The cost of wound care is modeled in the above equation (adapted from Butcher and White 2014)[26]

The biggest driver of wound care costs is the duration (D) of wounds[26].

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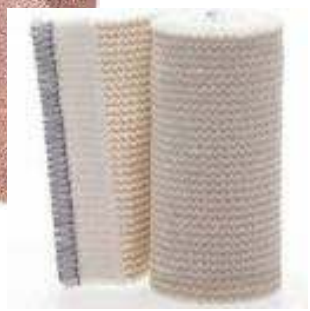
WRAPPING IT UP

Consider Zinc barrier cream for the periwound

Select an appropriate wound care product for the wound bed



Consider non-stick pads, ABD pads to cover the sit roll (open weave v closed weave) as a wrap; consider the final dressing layer- ability to compress? Self-adherent Cohesive bandage (Coban) v. Elastic wrap (ACE); 4 –layer?, just needs a Band-Aid*? Which tape- transpore v. retention

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WOUND CARE AS ENGAGEMENT

- **Rapid HIV/ HCV Testing**
  - Confirmatory results also drawn in the field
- **Referral to CSAC/ BH services**
  - Buprenorphine clinic
  - Referrals to outpatient and residential treatment programs
- **Smoking Cessation**
- **Vaccines**
  - Hep A/B and Influenza
- **Engagement with housing and case management**

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Street-Based Testing integrated with wound care

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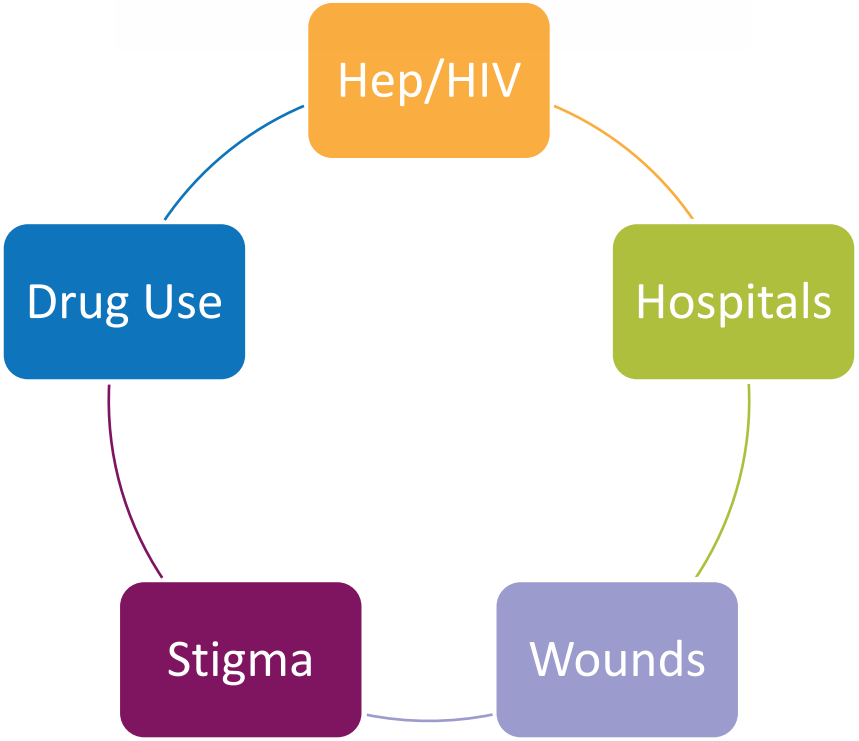
THINGS ARE RELATED TO THINGS



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Hawaii's Homeless - in the news

Hawaii's largest hospital cracking under strain of homeless crisis

Published Friday, February 10th 2017, 8:29 am HST
Updated Wednesday, February 15th 2017, 12:24 am HST

By Allyson Blair, Reporter

CIVIL BEAT

Hawaii Homelessness

Homeless emergency declared in Hawaii

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HOW WE CARE FOR OUR PATIENTS

- Assess readiness to change
- Utilizing motivational interviewing (MI)
- Using the tenants of harm reduction
- Utilizing the teach back method
- Goal setting- but not mistaking goals for tasks
- Recognize and reward that relapse is part of recovery and is expected- again non linear but cyclical

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MATCHING STAGE OF CHANGE AND TYPES OF INTERVENTIONS

Pre-Contemplation: Engagement

Outreach, practical health, crisis intervention, relationship building, assessment

Contemplation & Preparation: Resolve Ambivalence

Education, goal setting, increase awareness of problems practical skills training, family support, peer support

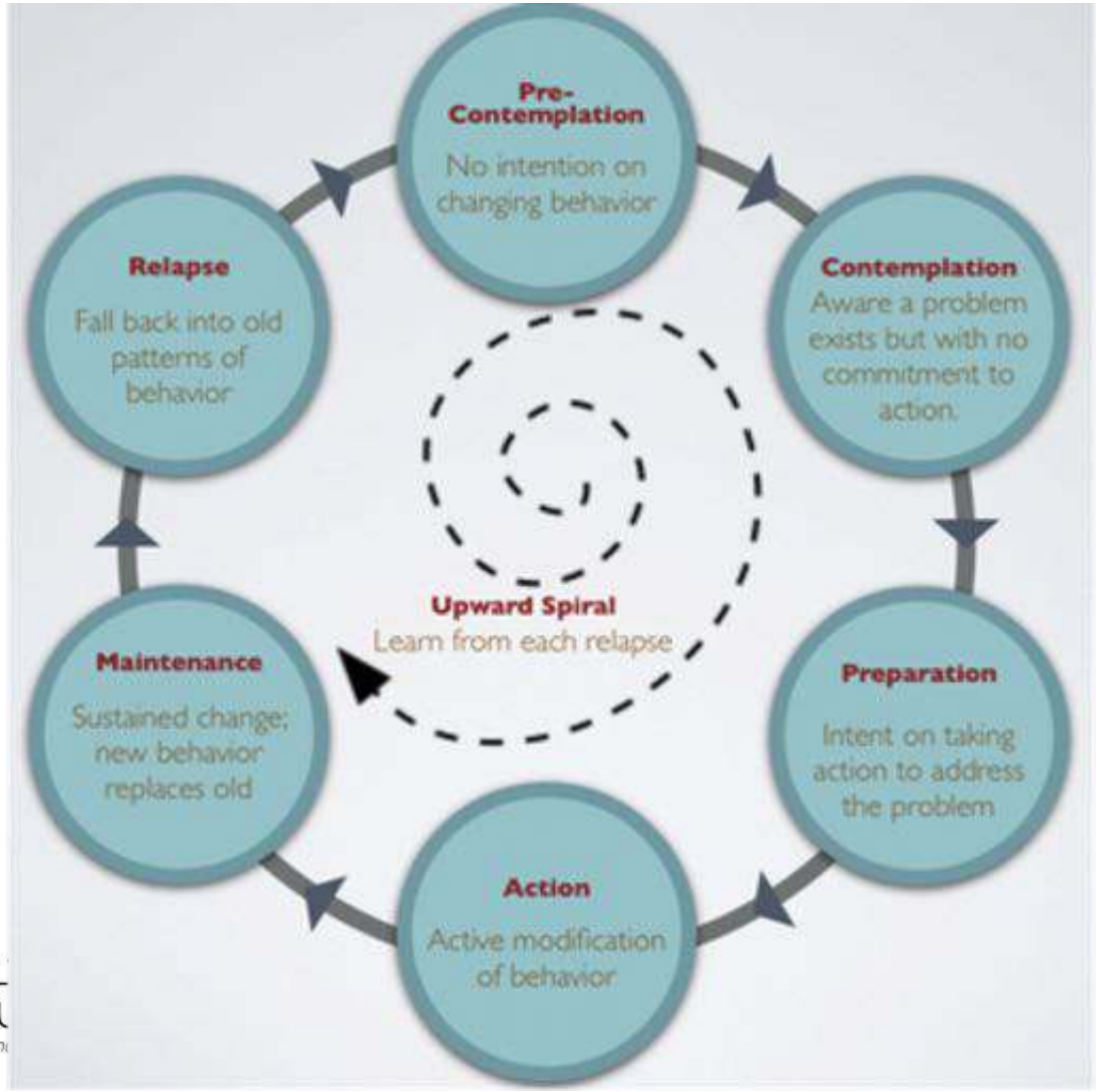
Action: Active

Substance abuse counseling, medications treatment, skills training, self-help, groups, family therapy

Maintenance: Relapse prevention

Relapse prevention plan, continuing skill training, expanding recovery to other areas

PROCHASKA & DICLEMENTE: CYCLE OF CHANGE



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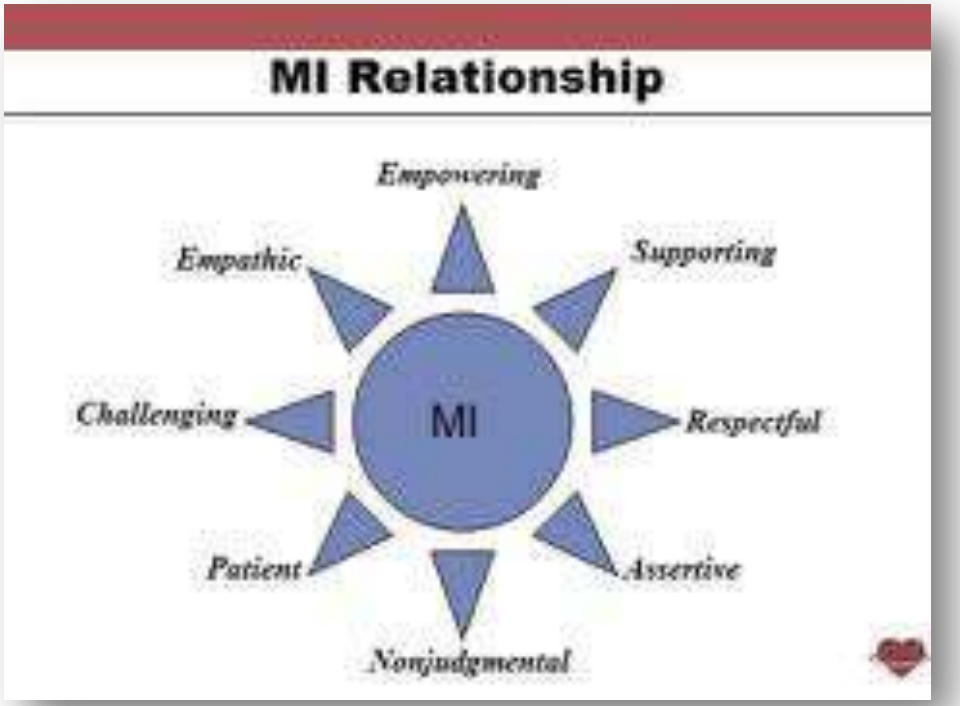
MOTIVATIONAL INTERVIEWING

"a therapeutic style intended to help clinicians work with patients to address the patient's fluctuation between opposing behaviors and thoughts." **(Miller & Rollnick, 1991).**



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DEFINING HARM REDUCTION

Harm reduction is a philosophy and set of strategies for working with individuals engaged in potentially harmful behaviors. The main objective is to reduce the potential dangers and health risks associated with such behaviors, even for those who are not willing or able to completely stop. Harm reduction uses a non-judgmental, holistic and individualized approach to support incremental change and increase the health and well-being of individuals and communities.

- Pupukahi I Holomua, Harm Reduction Conference Planning Committee, Honolulu, HI 2009

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SOME TENANTS OF HARM REDUCTION

- Meet people where they are
- Non-judgment and respect
- Low threshold services
- Participant/client-centered
- Any positive change
- Consumer (or other peer) involvement
- Options, not directives
- Behavior change goals are defined by the person or community
- People are responsible for their behaviors

WHAT IS HARM REDUCTION

- It is about reducing death and disease and increasing health and well-being
- “Nothing for us without us”
- It’s about taking a step away from policies that cause harm
- It’s about using scientific, evidence-based interventions and strategies
- It’s about exploring and addressing why people engage in potentially harmful behaviors
- It is more about the process than outcome
- Addressing the harms of “isms” and stigma

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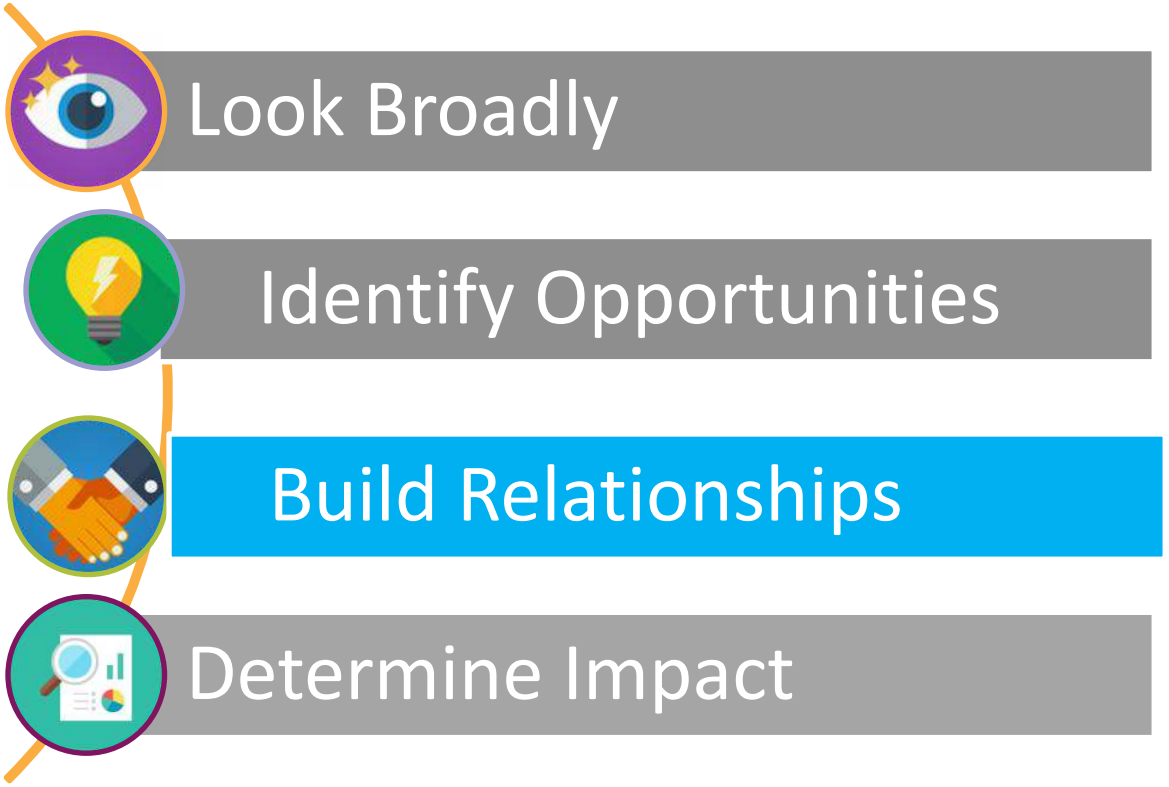
WHAT HARM REDUCTION IS NOT

- Condoning, enabling, or promoting harmful behaviors
- Anti-abstinence
  - Harm reduction is a continuum which includes abstinence
- “Anything goes!”
- Blind to the harms of drug use or other behaviors
- Lack of accountability or responsibility
- Deciding for someone what they should do

PUBLIC HEALTH IS... SOCIAL JUSTICE



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Community Partnerships

THE QUEEN'S MEDICAL CENTER

The Institute for Human Services

Ending the Cycle of Homelessness

Hawaii H.O.M.E. Project

Homeless Outreach & Medical Education

Adventist Health Castle

HAWAII PACIFIC HEALTH

STRAUB MEDICAL CENTER

AMTT

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HepFree HAWAI'I

PUBLIC HEALTH IS...

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LESSONS LEARNED

No Wrong Door

- Acute needs (wound care) as bridge to chronic issue (HCV)
- Match services with client motivations

Opportunities to Heal

- Improved health outcomes and reduce stigma
- Heal PWID relationship to healthcare system
- Cost effectiveness has brought partnerships to table

Non-Healthcare Settings

- Street-based and peer-based interventions
- Street medicine is harm reduction

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TAKE-AWAYS

Nurses and nurse practitioners serve on the frontlines of health care- street based care is an example of this

Wound care is one effective way to engage the homeless, PWID community which is at high risk for HCV and other bloodborne pathogens/ viruses*.

Utilizing harm reduction and motivational interviewing techniques have shown to keep patients engaged in health care

Finally, ensuring that healthcare providers continue to reduce barriers to treatment, particularly among the high-risk community remains an essential next step.

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CASE STUDY & RECOMMENDATIONS

Aurelius Warren, Vietnam Veteran

Met client 2017, by 2018 increased LLE Edema, diabetes- DFU, neuropathy, SOB, HTN= ER utilization 1x/week with EMS called to the park

Homeless 20 years, Aala Park 7+

Cocaine abuse

Tested for HCV in the field→ HCV +

*Pictured above Nicole, outreach worker completing LEAD paperwork with client for substance abuse treatment (Aug 2018)

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CASE STUDY & RECOMMENDATIONS, CONT.

- Spoke on TV 5.15.19 at Partners in Care Point in Time Survey report (Photo Credit: Mahealani Richardson, HNN)
- Reconnected to daughter and 8 grandchildren
- Wounds healed; reconnected to PCP
- Referral to Cardiologist
- Diabetes management/ hypertension management – medication management
- Stopped smoking
- Maintaining sobriety
- MH/ BH support
- VA support→ Treated HCV achieved SVR in 2019
- Surgical candidate 15% EF up to 35%

RECOMMENDATIONS

- Continue to hear about the success, but recognize the challenges
- Decrease barriers to care
- Increase data efforts, reporting
- Lived experience with the treatment team = impactful

MAHALO

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"Danny Honea, 71, who lives on the North Kukui Street sidewalk in Honolulu, said he keeps to himself to avoid contracting COVID-19. He was most worried about catching the virus when public bathrooms were closed earlier in the pandemic."