Linkage to Care Programs

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Philadelphia Department of Public Health

Overview

I. Summary of community programs

II. Overview of LEAP

III. Summary of LEAP data

Summary of community programs

- Alternative Response Unit 2 (AR-2)
- Viral Hepatitis Surveillance Program (HEP)
- Neonatal Abstinence Syndrome Program (NAS)
- Police Assisted Diversion (PAD)
- Linkage and Engagement After Prison (LEAP)

Linkage and Engagement After Prison Program

Department of Public Health
CITY OF PHILADELPHIA

What is LEAP?

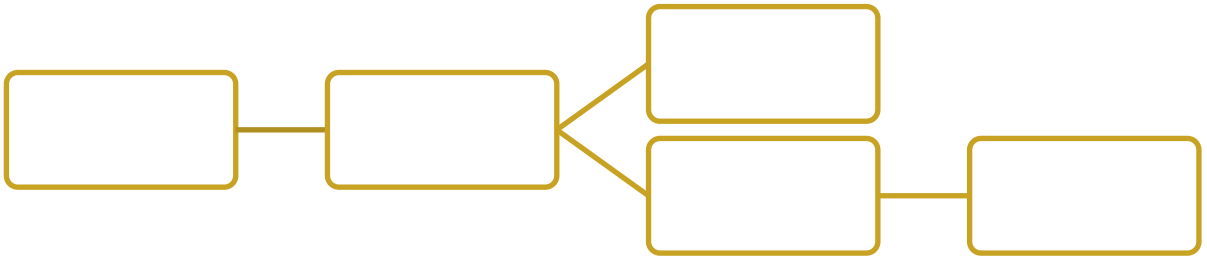
LEAP is a partnership between PDPH and Action Wellness to provide case management to individuals incarcerated at the Philadelphia Department of Prisons who are at risk of overdose upon release.

It was modeled after Action Wellness's successful PLP program, which works with incarcerated people living with HIV.

Case management continues 3-6 months post incarceration, depending on the level of need.

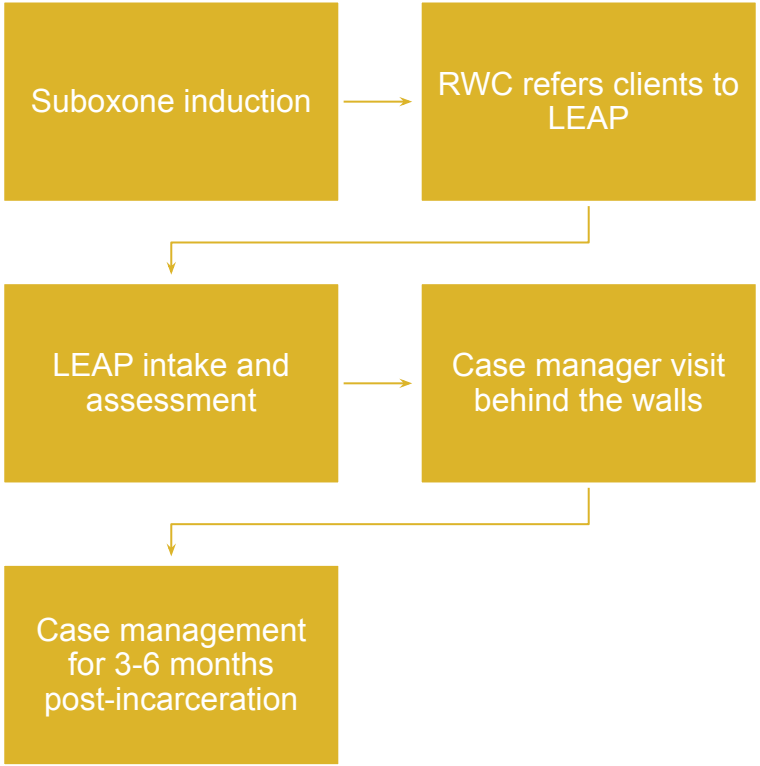
ACTION WELLNESS
Putting good health into motion

LEAP Structure



Total client capacity=140

LEAP Protocol



Other referral mechanisms

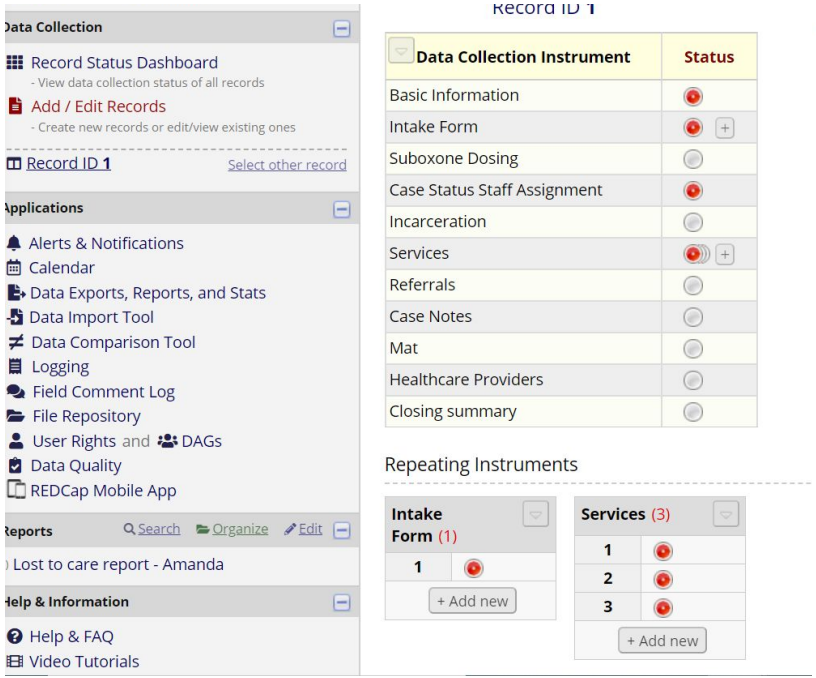
- Defenders' Association
- Community drop-in site (Summer 2020)
- Outreach team

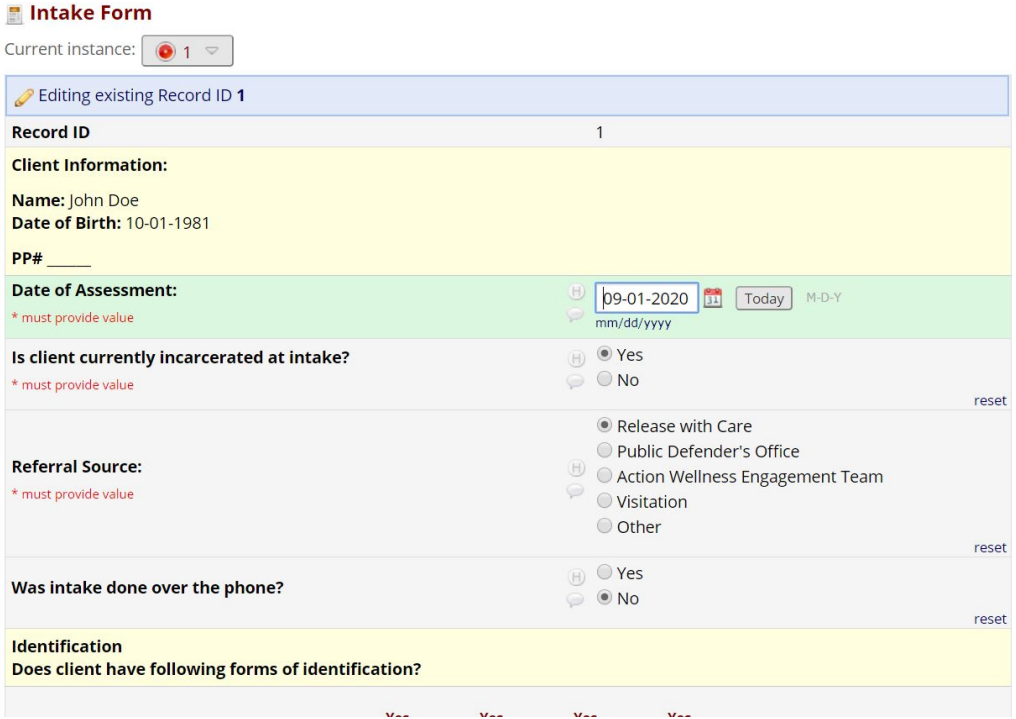
LEAP Hurdles

- COVID—PDP closed to official visits April-July, November-present
- Number of Suboxone providers post-incarceration
- Barriers to telehealth
- Number of referrals

LEAP Data Overview

Overview of data collection





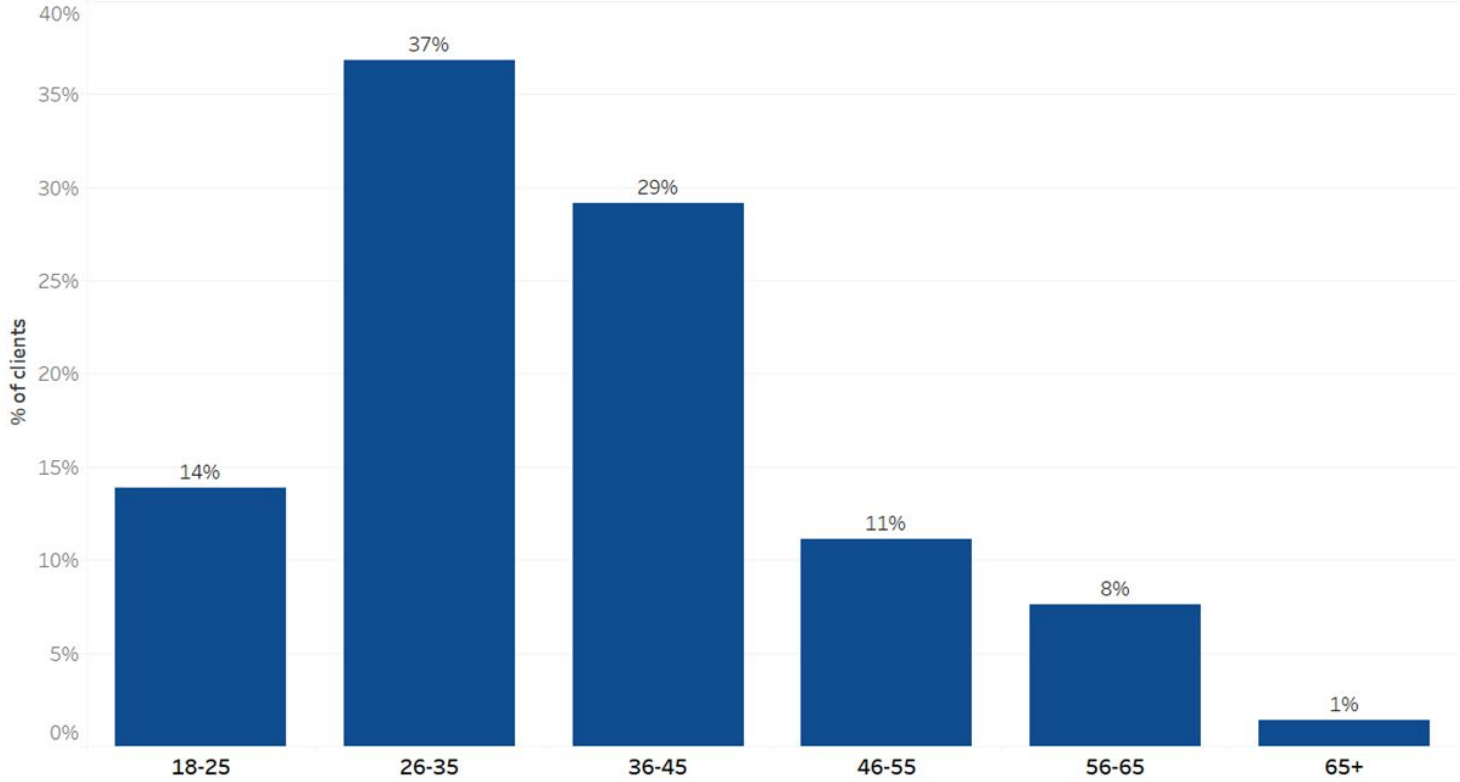
Key indicators

- Client demographics: Age, race and ethnicity, gender
- Characteristics: Referral source, medical comorbidities, recent substance use history, substance use treatment history
- Barriers: Perceived barriers at intake for effective case management, reasons for refusing linkage (ex. MAT)
- Successes: Number of clients with successful linkage, *amount of time engaged in LEAP program*, *where clients are being linked (MAT providers, shelters, housing resources, etc.)*

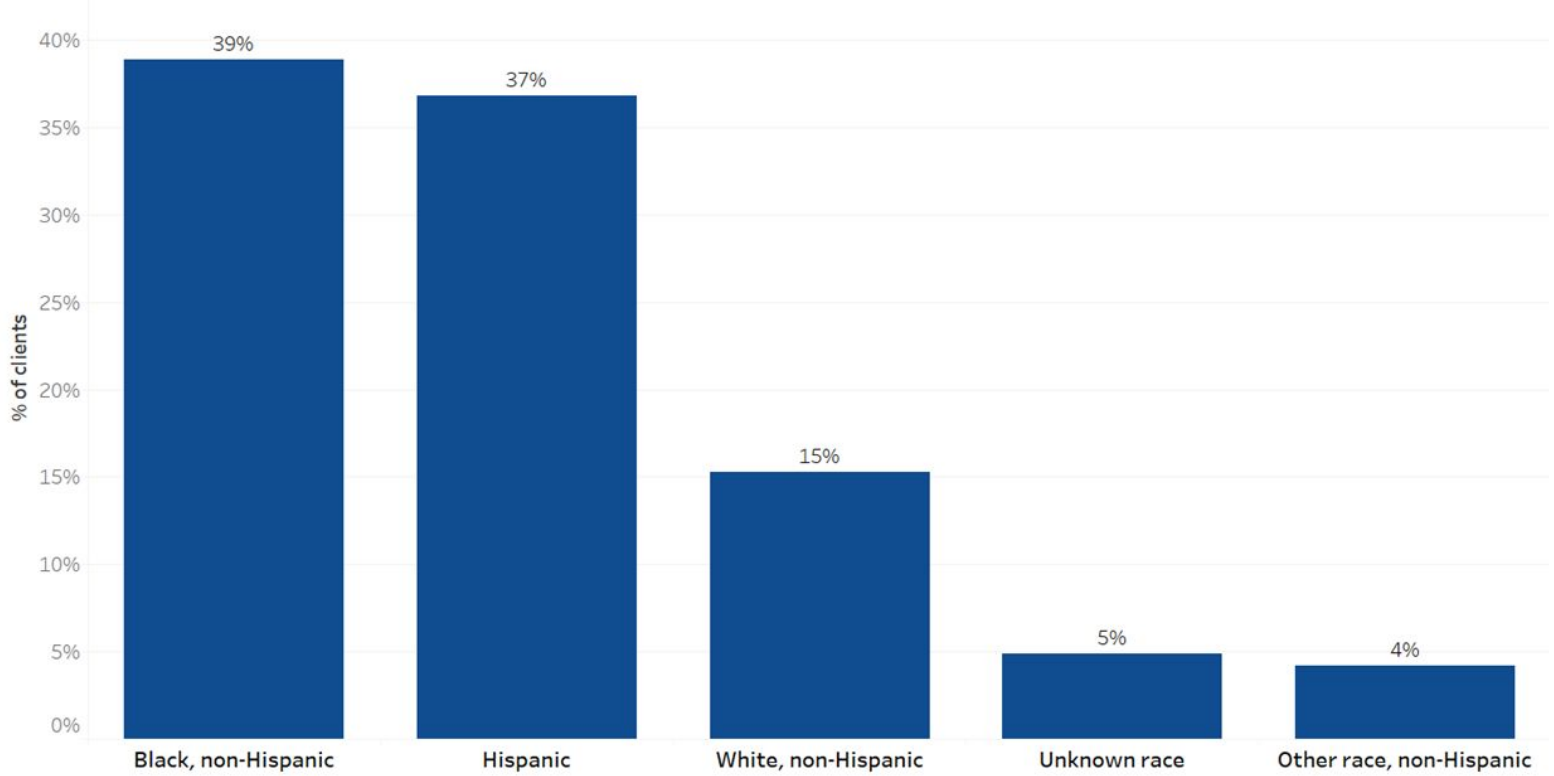
Overview of data

- 144 clients (Jan 2020 – Jan 22, 2021)
- Most were referred by Release with Care (60%), followed by Visitation (33%) and Defenders' Association (4%)
- Most were currently incarcerated at the time of intake (63%)

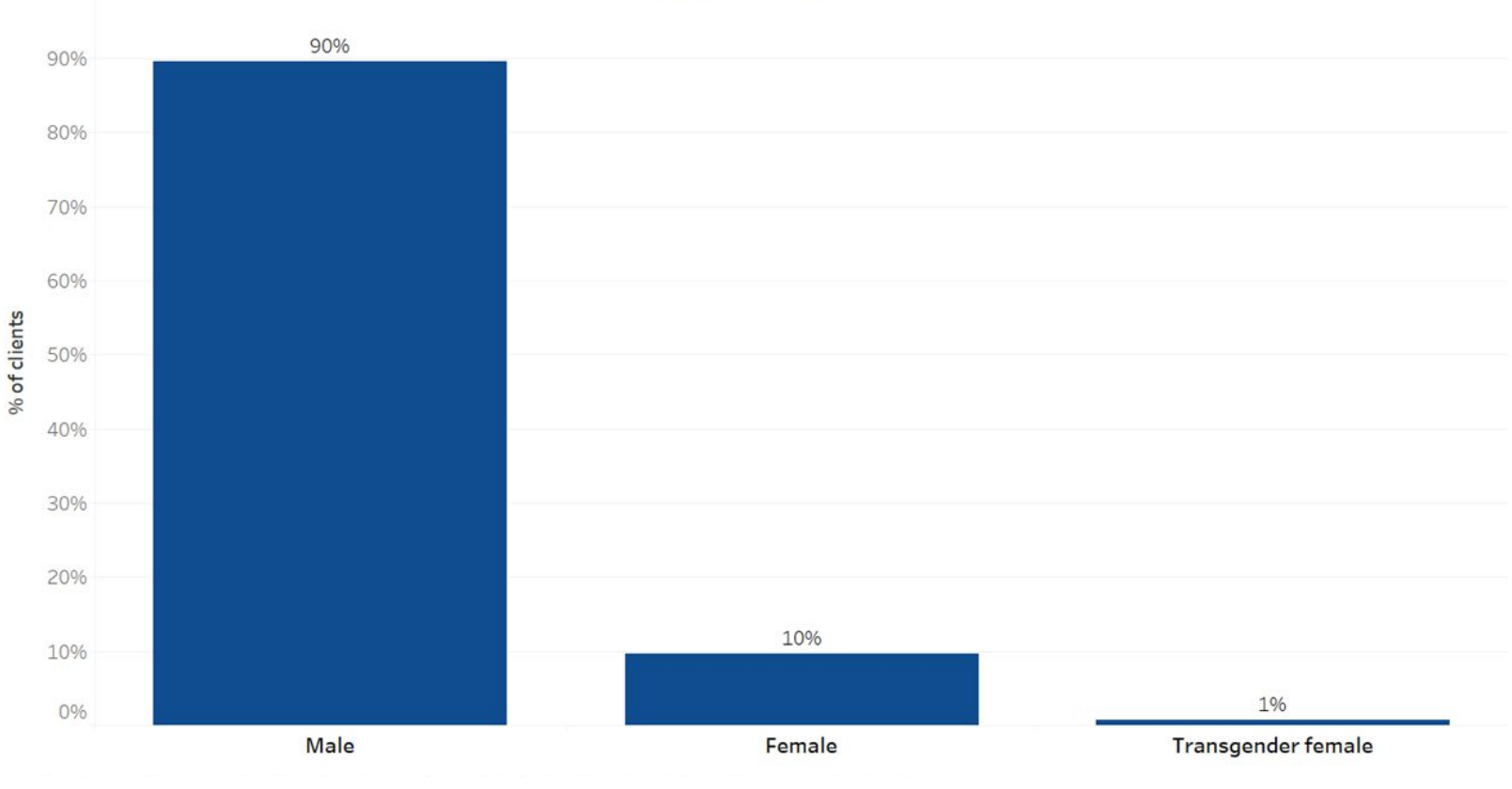
Age of clients



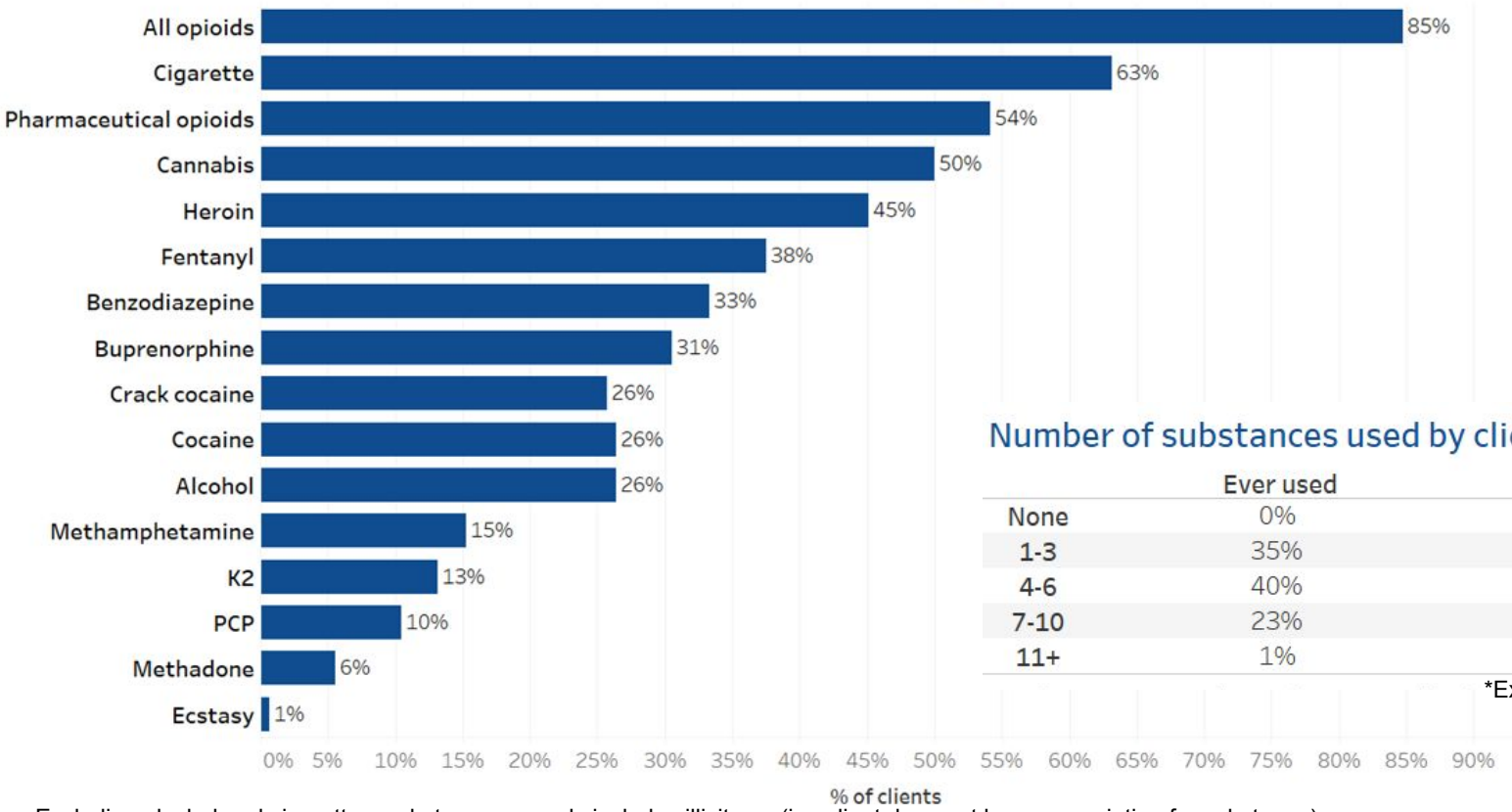
Race and ethnicity of clients



Gender of clients



Past three month substance use among clients*



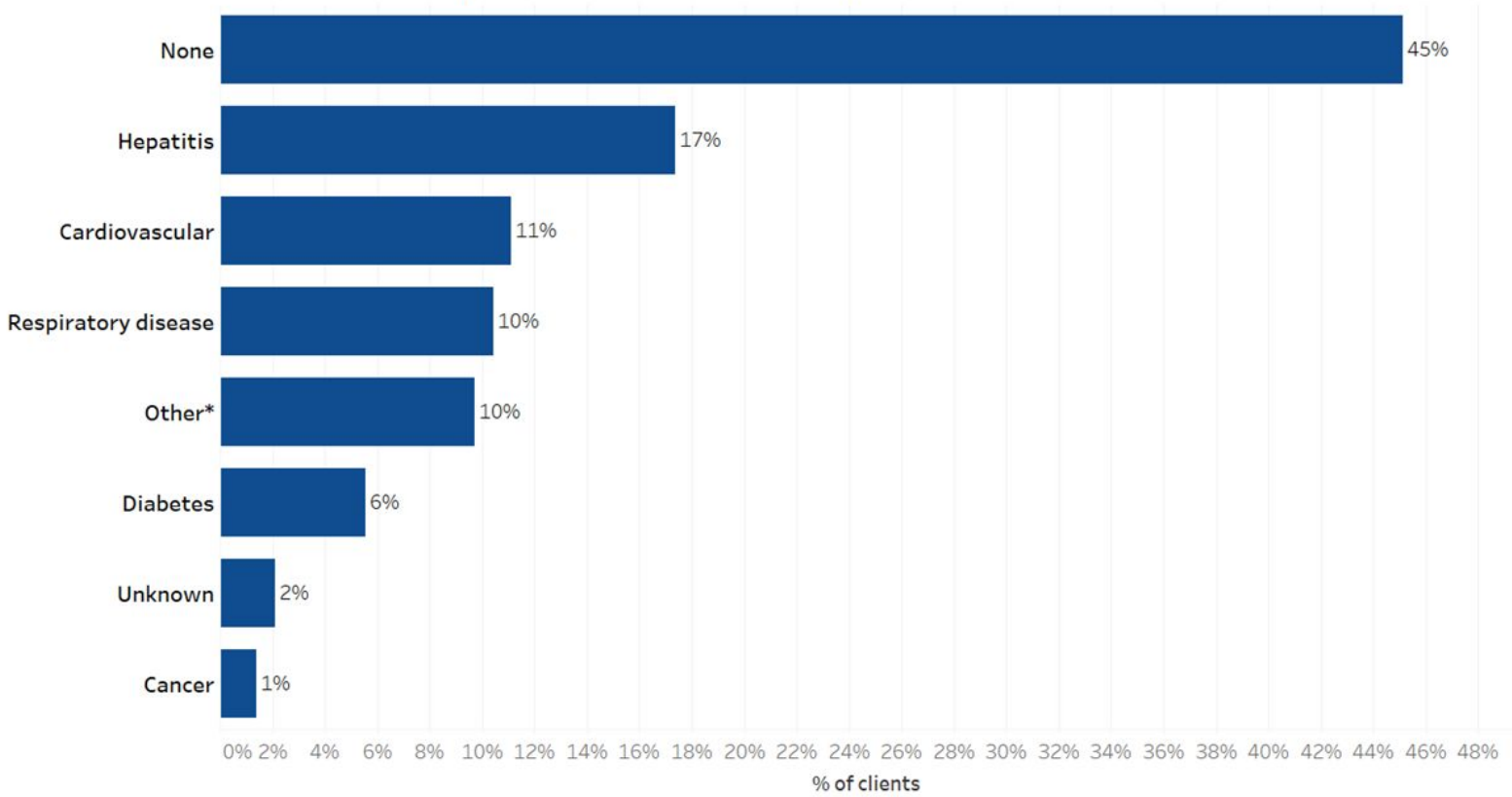
Number of substances used by clients*

	Ever used	Used in past 3 months
None	0%	13%
1-3	35%	47%
4-6	40%	33%
7-10	23%	6%
11+	1%	0%

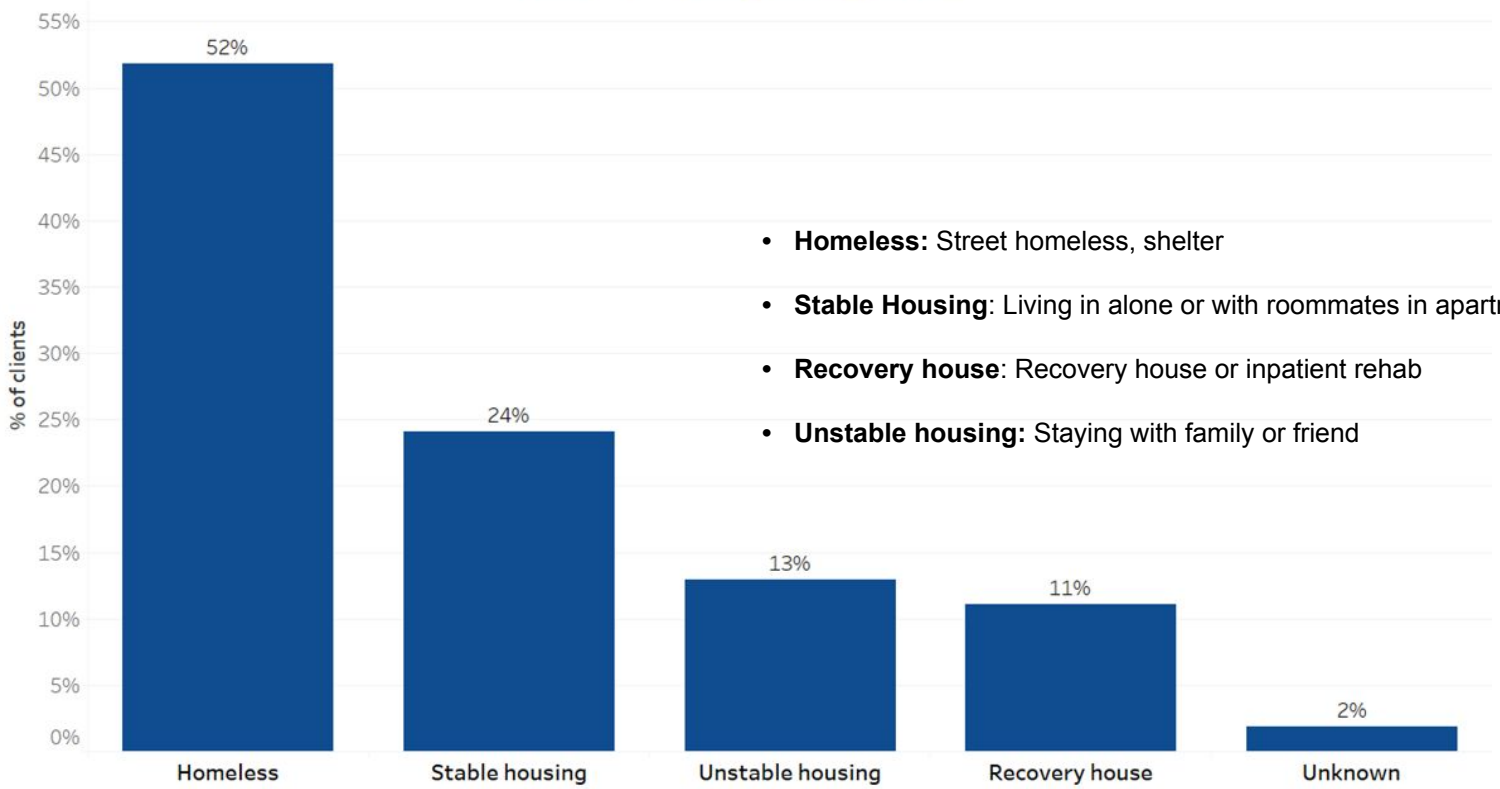
*Excluding alcohol and cigarettes

Excluding alcohol and cigarettes, substance use only includes illicit use (i.e. client does not have prescription for substance)
*Past 3 months for clients not currently incarcerated or 3 months prior to incarceration

Self-reported medical conditions present at intake



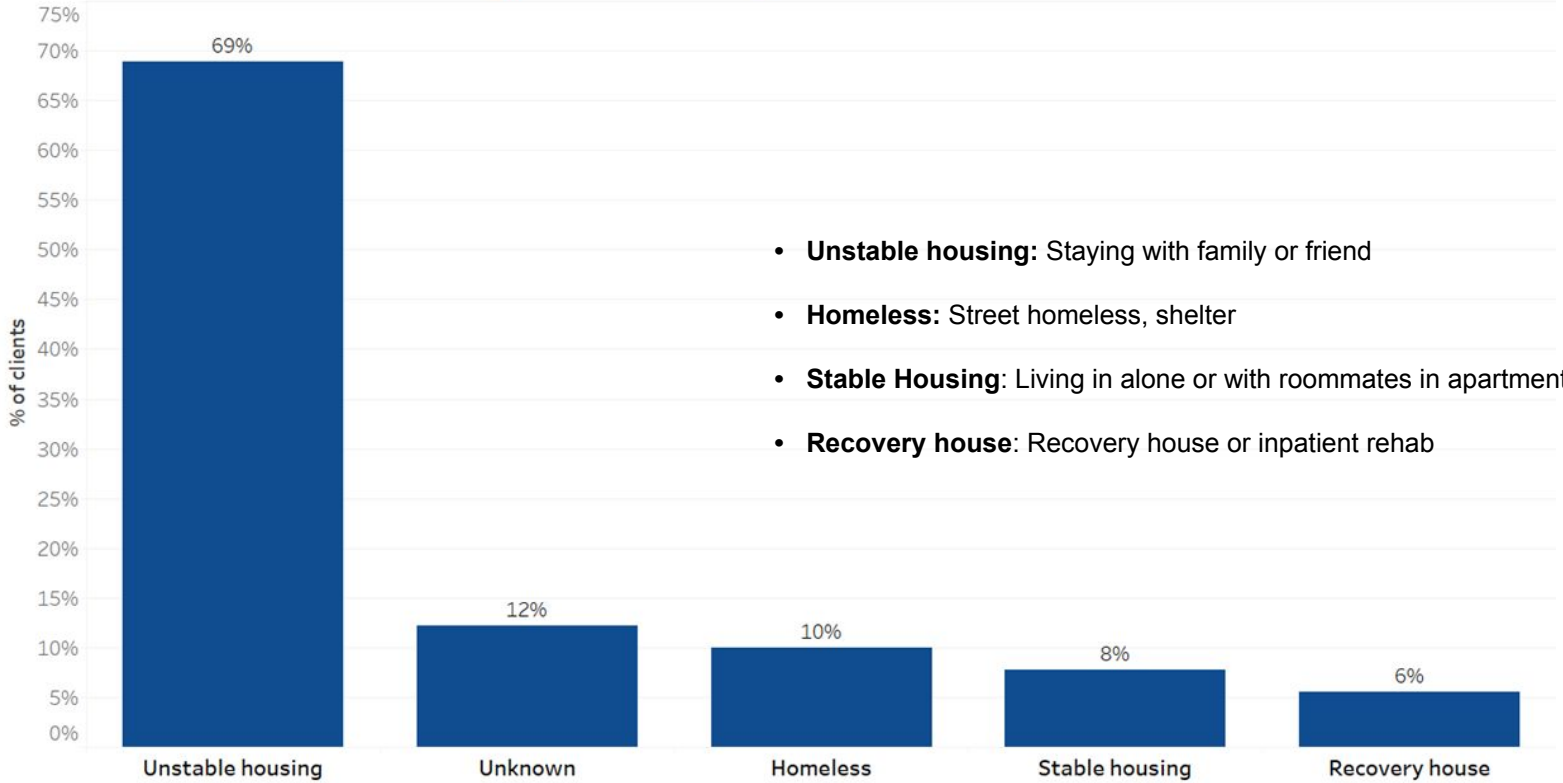
Current housing among clients



- **Homeless:** Street homeless, shelter
- **Stable Housing**: Living in alone or with roommates in apartment or home
- **Recovery house**: Recovery house or inpatient rehab
- **Unstable housing:** Staying with family or friend

* Includes only clients who are no longer incarcerated (n = 90), 1 client listed multiple housing options (unstable housing and homeless)

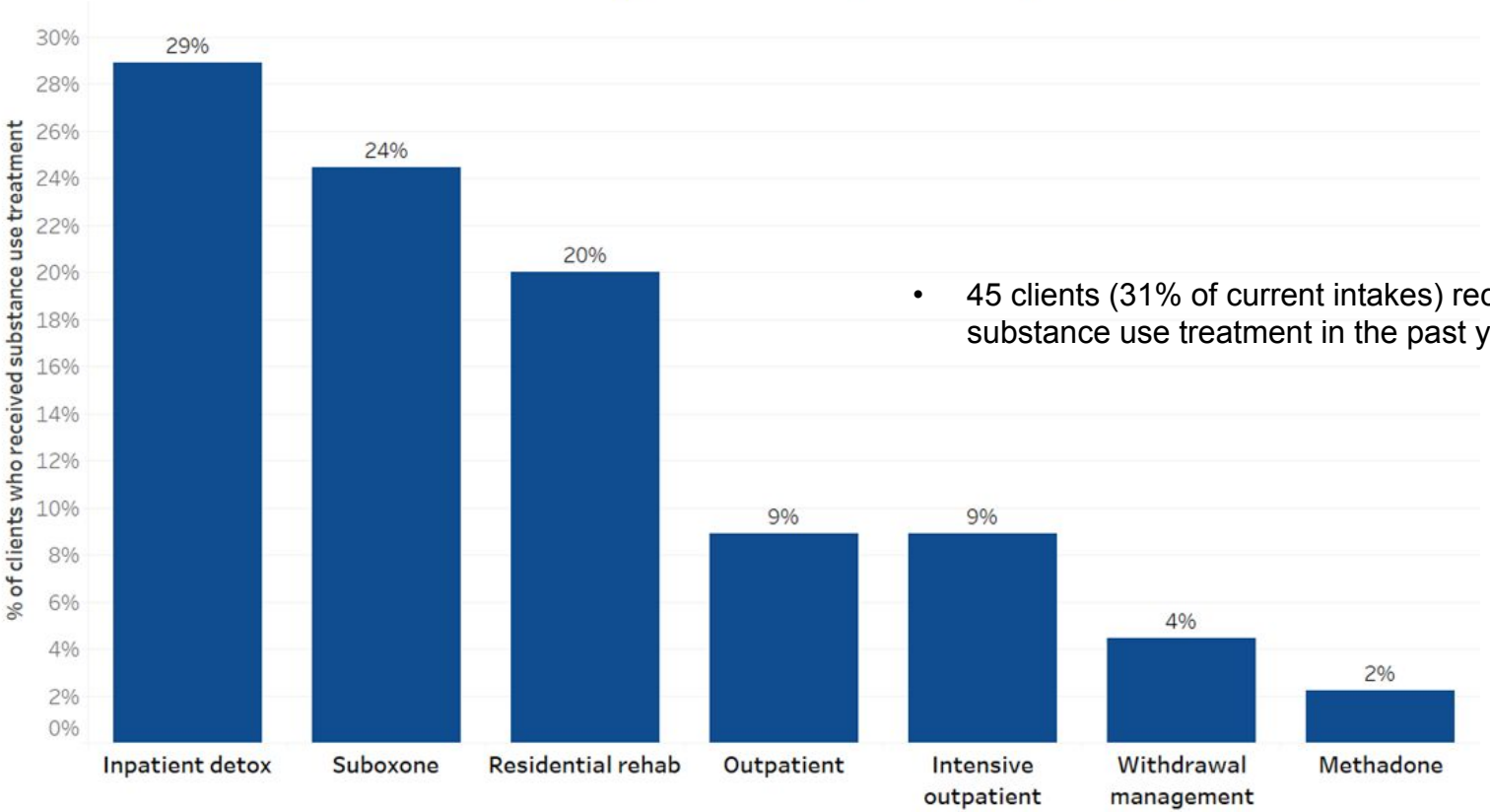
Housing planned following release from incarceration



- **Unstable housing:** Staying with family or friend
- **Homeless:** Street homeless, shelter
- **Stable Housing**: Living in alone or with roommates in apartment or home
- **Recovery house**: Recovery house or inpatient rehab

* Includes only clients who are currently incarcerated (n =54), 4 clients listed multiple housing options (recovery house, shelter, homeless)

Substance use treatment types received by clients in past 12 months*



- 45 clients (31% of current intakes) received substance use treatment in the past year

Observed potential barriers to effective case management at intake

38% lacked apparent social support

31% mentioned issues with securing adequate housing

14% had insufficient access to employment

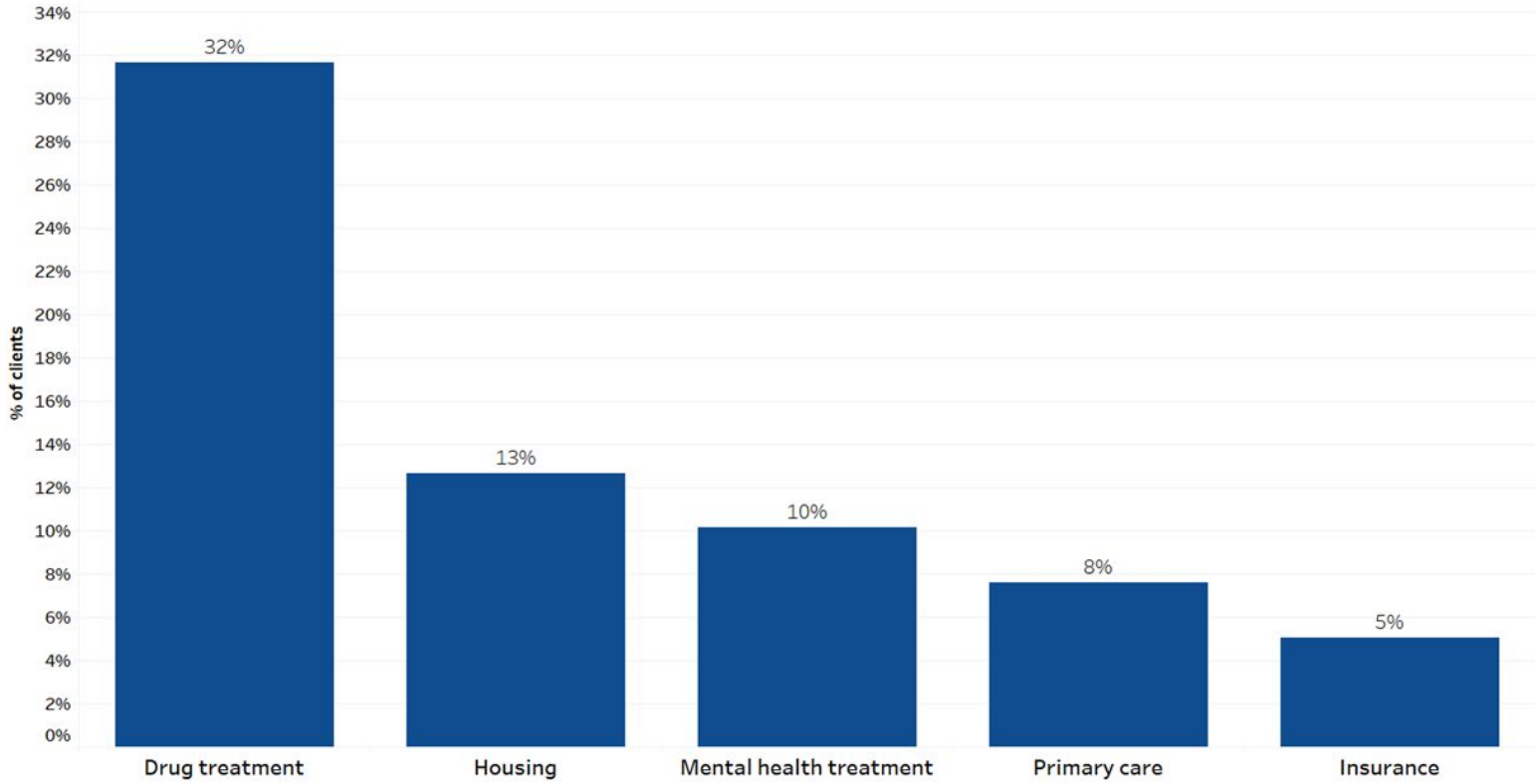
6% expressed issues with MAT, including hesitation and adherence

2% mentioned concerns regarding money and finances

Tracking service linkage barriers

- 36% of clients were referred to MAT
- 16% refused linkage, 5 stated that they did not feel that they needed MAT, 2 were already receiving MAT from another provider

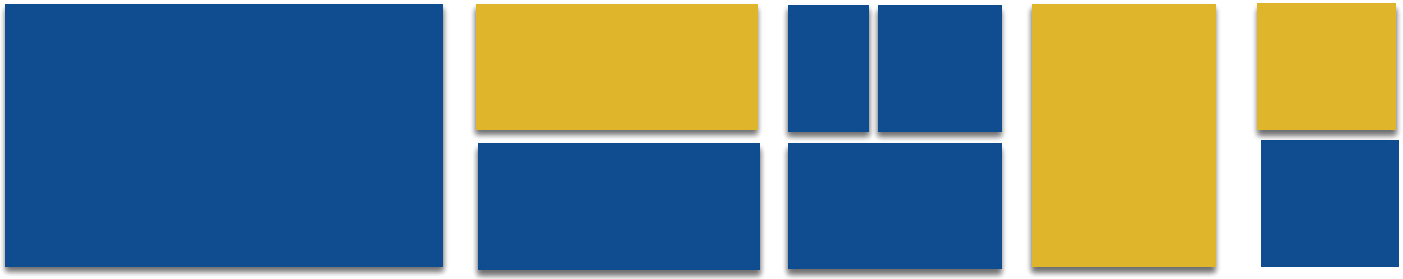
Referral to services among clients no longer incarcerated



Questions for discussion

- What are other key indicators that could be tracked?
- How might these indicators be similar to other community linkage to care programs?
- What are potential barriers to linkage not discussed and how could we track them with this data?

THANK YOU



Questions?

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