Ensuring access to MOUD for People Experiencing Homelessness

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Disclosure Information (Required)

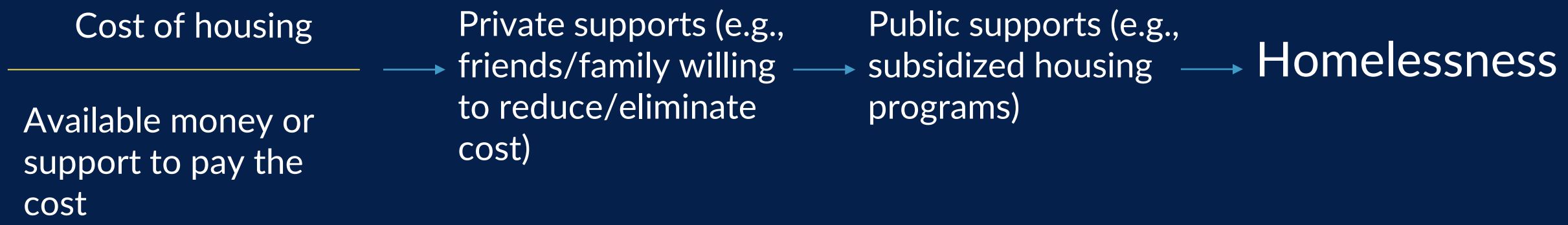
- Samantha Ciarocco, MSW, LICSW, LADC
  - No Disclosures

- Joe Wright, MD
  - No Disclosures

Learning Objectives

- Recognize how societal contributors to homelessness, and individual trajectories of opioid use disorder, interact to multiply risk of adverse events including death.
- Identify at least five strategies to overcome structural barriers to care, for people experiencing homelessness.
- Use a systematic approach to identifying transitions of care and gaps in care that require special support for people experiencing homelessness.

Homelessness and substance use: not the same problem



With enough money or support, you can do lots of drugs, and still not be homeless.

Without enough money or support, you can never do drugs, and still be homeless.

Adverse childhood experiences

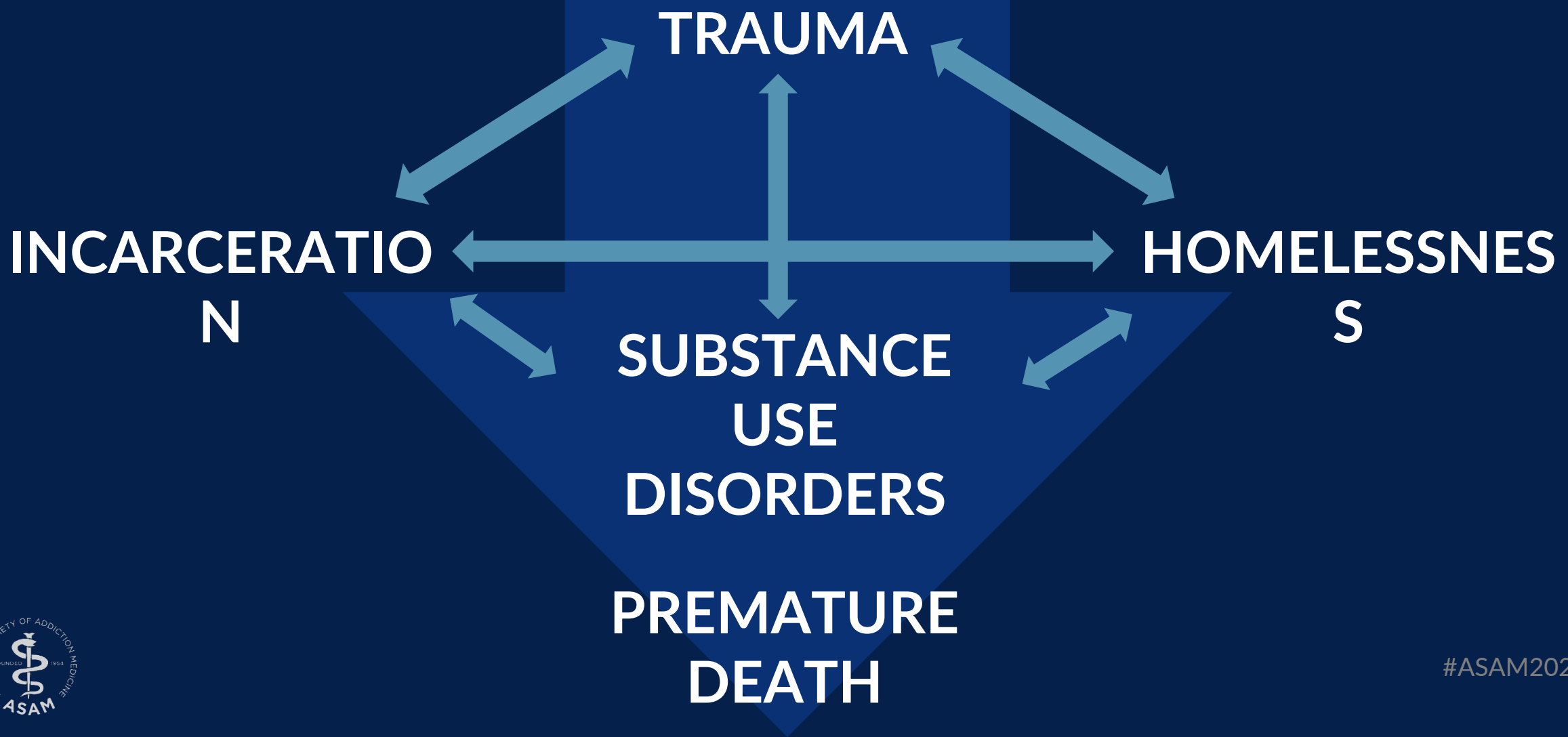
In a commercially-insured sample, the ACES Study showed that the likelihood of early initiation of drugs is strongly associated with adverse childhood events

Adverse childhood experiences account for 2/3rds of the attributable risk fraction of later use of injected drugs

This association with substance use outcomes is also strong when considering community-level adversity like violence and economic deprivation, not measured by the original ACES work

Dube SR et al. *Pediatrics* 2003; 111:564 –572

COLLECTIVE AND INDIVIDUAL VIOLENCE, INSTABILITY, AND DEPRIV



If treatment = housing problems in treatment = eviction

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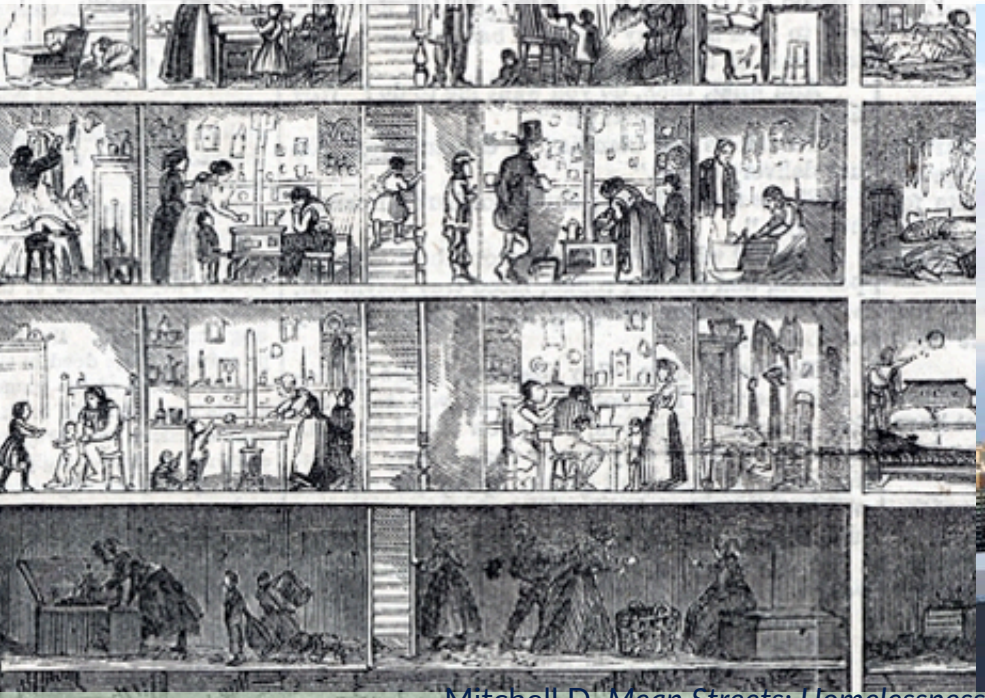
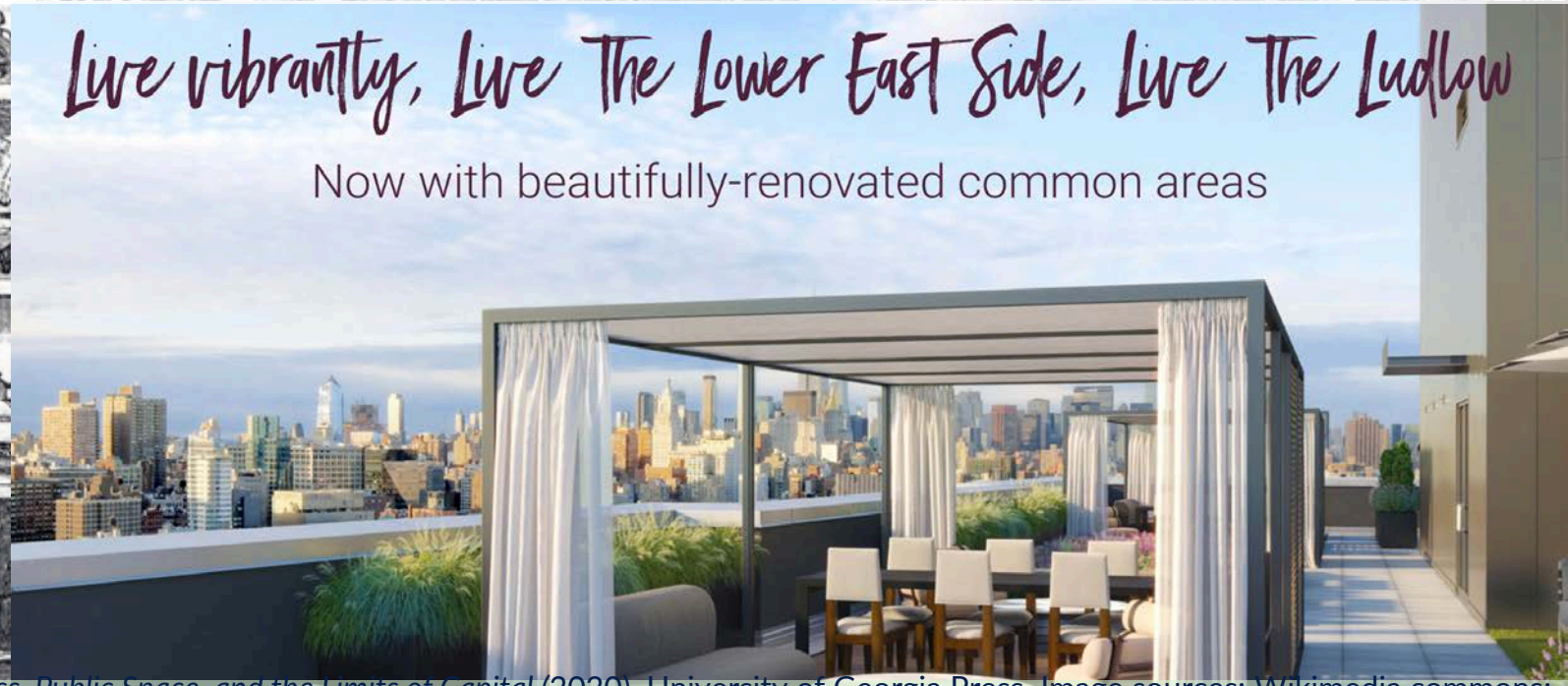
Cook County Sheriff's Office Eviction Unit Challenge Coin https://www.worthpoint.com/worthopedia/cook-county-sheriff-eviction-unit-1863530421 Accessed March 11 2021

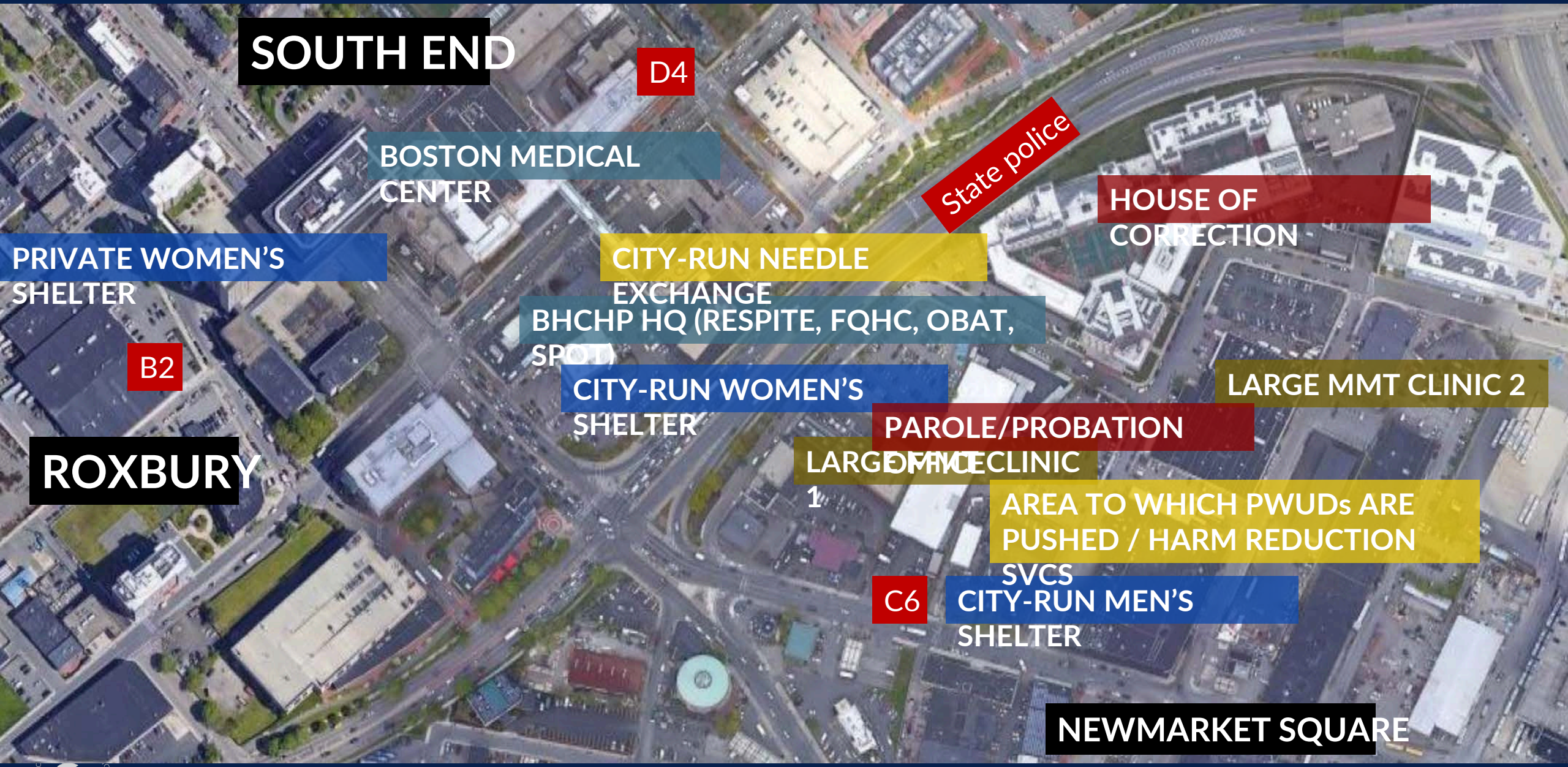
Urban land use trends aren't helping

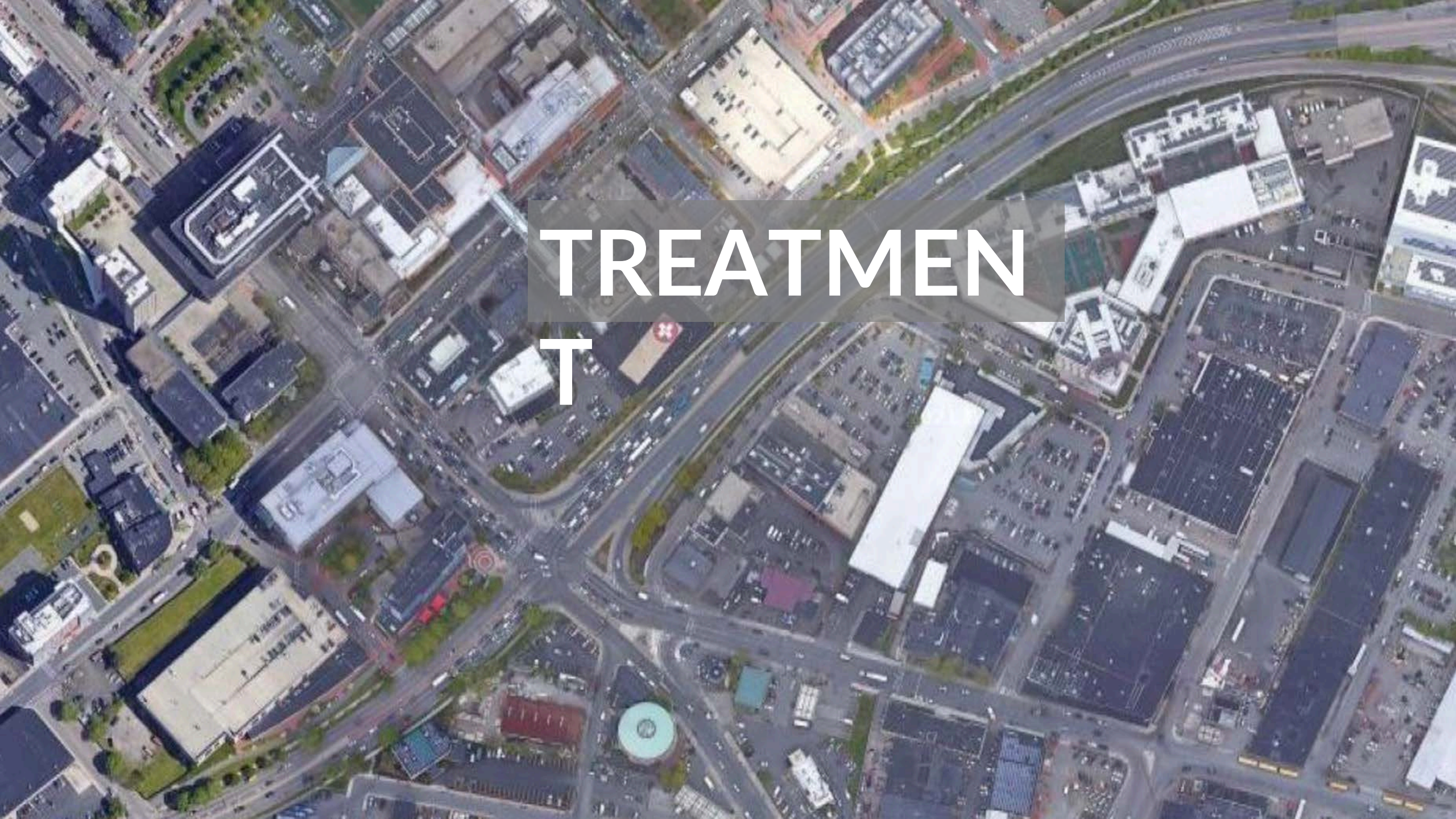
In cities, housing is not just housing but also a site of investment and an activity of capital, with the expectation by those who own it that it should increase in value, and that those who impede its increase are harming the investment. Less and less public or "interstitial" space exists in cities, so that people without homes are concentrated.





Mitchell D. *Mean Streets: Homelessness, Public Space, and the Limits of Capital* (2020), University of Georgia Press. Image sources: Wikimedia commons;


SOUTH END
D4
BOSTON MEDICAL CENTER
State police
HOUSE OF CORRECTION
PRIVATE WOMEN'S SHELTER
CITY-RUN NEEDLE EXCHANGE
BHCHP HQ (RESPITE, FQHC, OBAT, SPOT)
B2
CITY-RUN WOMEN'S SHELTER
LARGE MMT CLINIC 2
PAROLE/PROBATION
ROXBURY
LARGE MMT CLINIC 1
AREA TO WHICH PWUDs ARE PUSHED / HARM REDUCTION SVCS
C6
CITY-RUN MEN'S SHELTER
NEWMARKET SQUARE


TREATMEN
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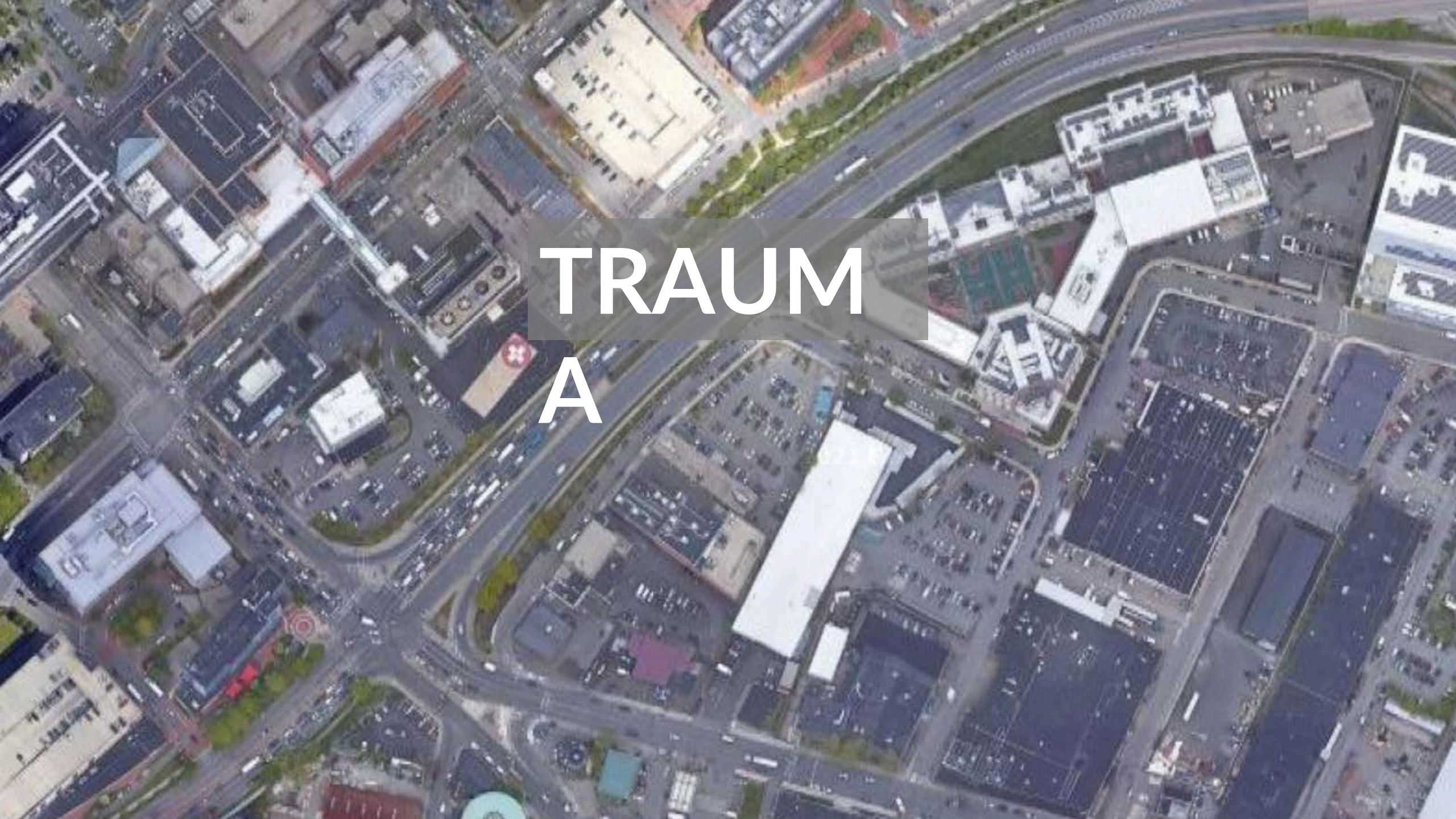
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TRIGGER
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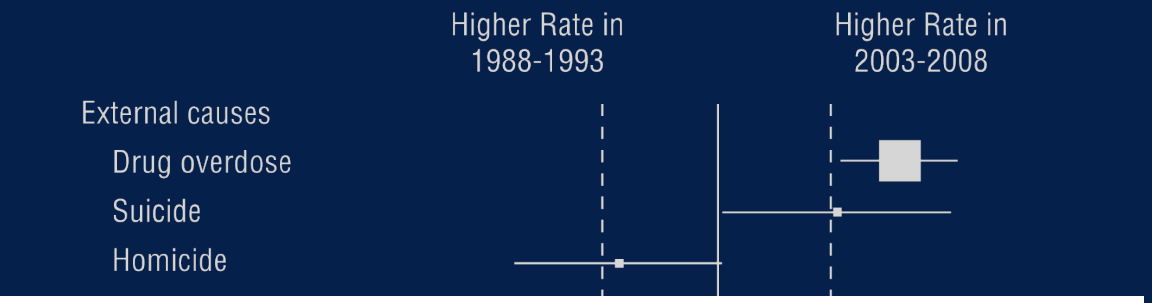
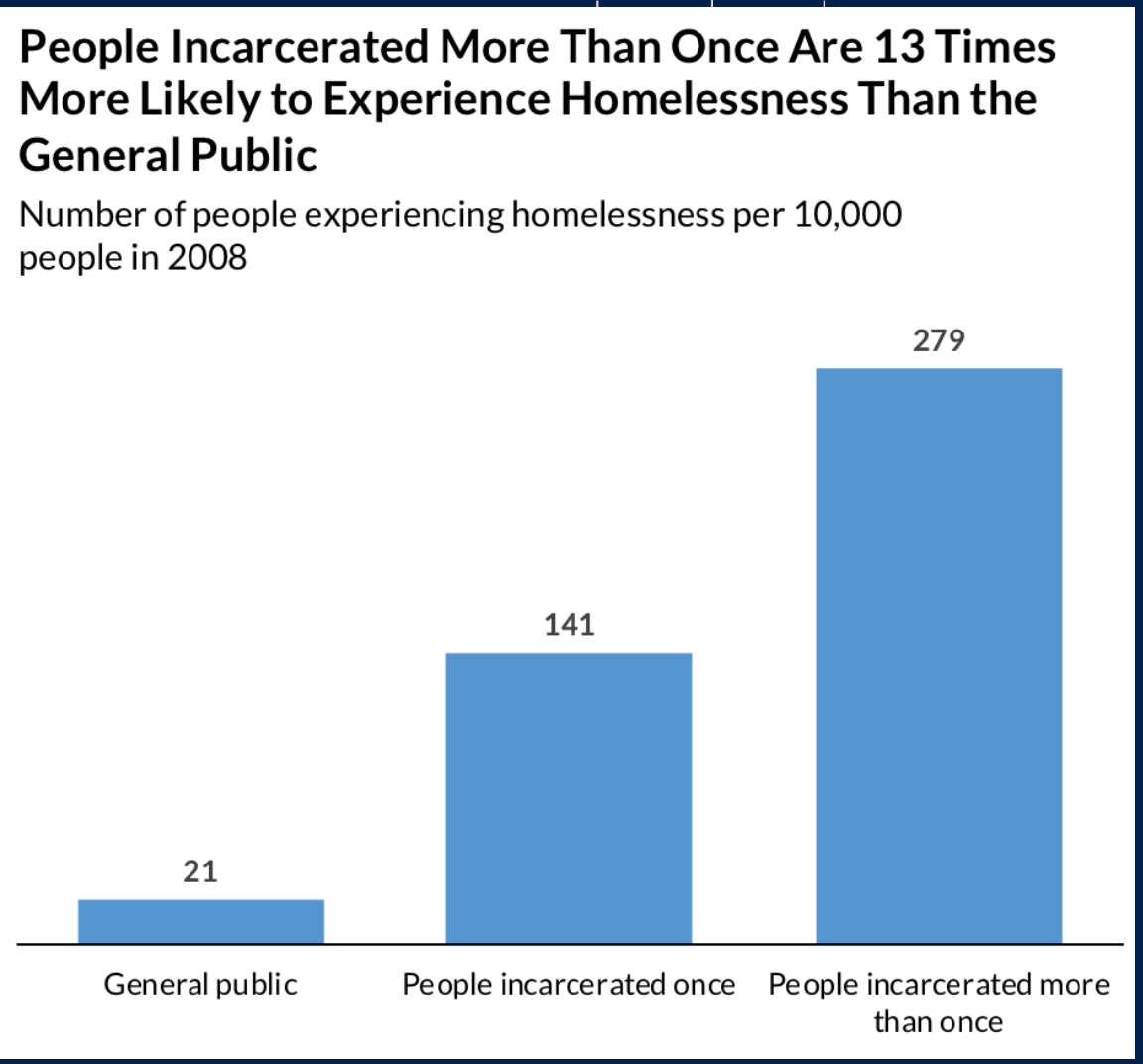




Overdoses were the drivers of death rates in our population *before* heroin's rise in 2012, and *before* fentanyl's appearance in Boston in 2014-15; death rates have worsened. (Detailed analyses are in progress.)

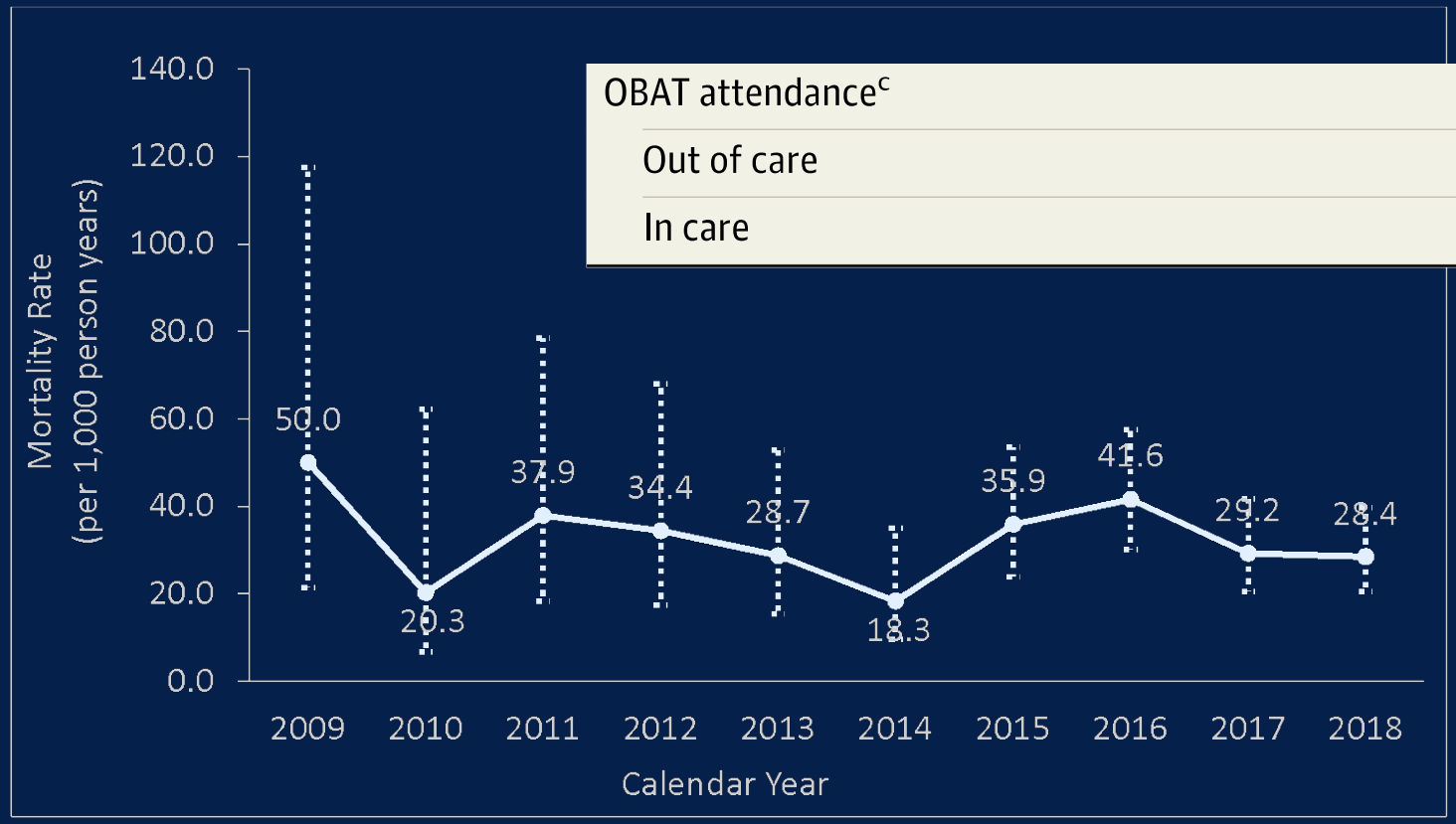
Massachusetts state data showed people with history of recent incarceration have rates of fatal overdose 120 times greater (with most of this risk in the first four weeks after release), and people with history of homelessness have rates of fatal overdose 16-30 times greater, than the general population.

2. Baggett T et al. *JAMA Intern Med*. 2013 Feb 11; 173(3): 189–195.
3. Massachusetts Dept of Public Health. An Assessment of Fatal and Nonfatal Opioid Overdoses in Massachusetts (2011 – 2015). Aug 2017
4. Graphic: Urban Institute, from Coulute L, "Nowhere to go: homelessness among formerly incarcerated people", Prison Policy Initiative August 2018. Https://prisonpolicy.org/reports/housing.html

“HITTING BOTTOM” =
HIGH RISK OF IMMEDIATE DEATH

HOMELESSNESS IS NOT A THERAPEUTIC TOOL

Mortality



OBAT attendance[c]		
Out of care	1 [Reference]	[Reference]
In care	0.34 (0.21-0.55)	<.001

eFigure 1. Mortality rates among people experiencing homelessness who engaged in an office-based addiction treatment program. Point estimates represent deaths per 1,000 person-years and vertical blue dashed-lines represent 95% confidence intervals.

Fine D et al. *JAMA Netw Open*. 2021;4(3):e210477.

PREVENTING OVERDOSE DEATH IS OUR PRIMARY MEDICAL G

ACTIVELY USING, NOT CURRENTLY INTERESTED IN STOPPING		SUBSTANCE USE DISORDER IN LONG TERM REMISSION
Sedation monitoring, harm reduction supplies, abscess and skin care, PrEP, HIV/HCV testing, general medical care, naloxone, other overdose death prevention education	Buprenorphine prescribed in a harm reduction mode to reduce injection frequency and frequency of use	Buprenorphine as maintenance therapy and long-term mu-receptor blockade, in a flexible, patient-centered model

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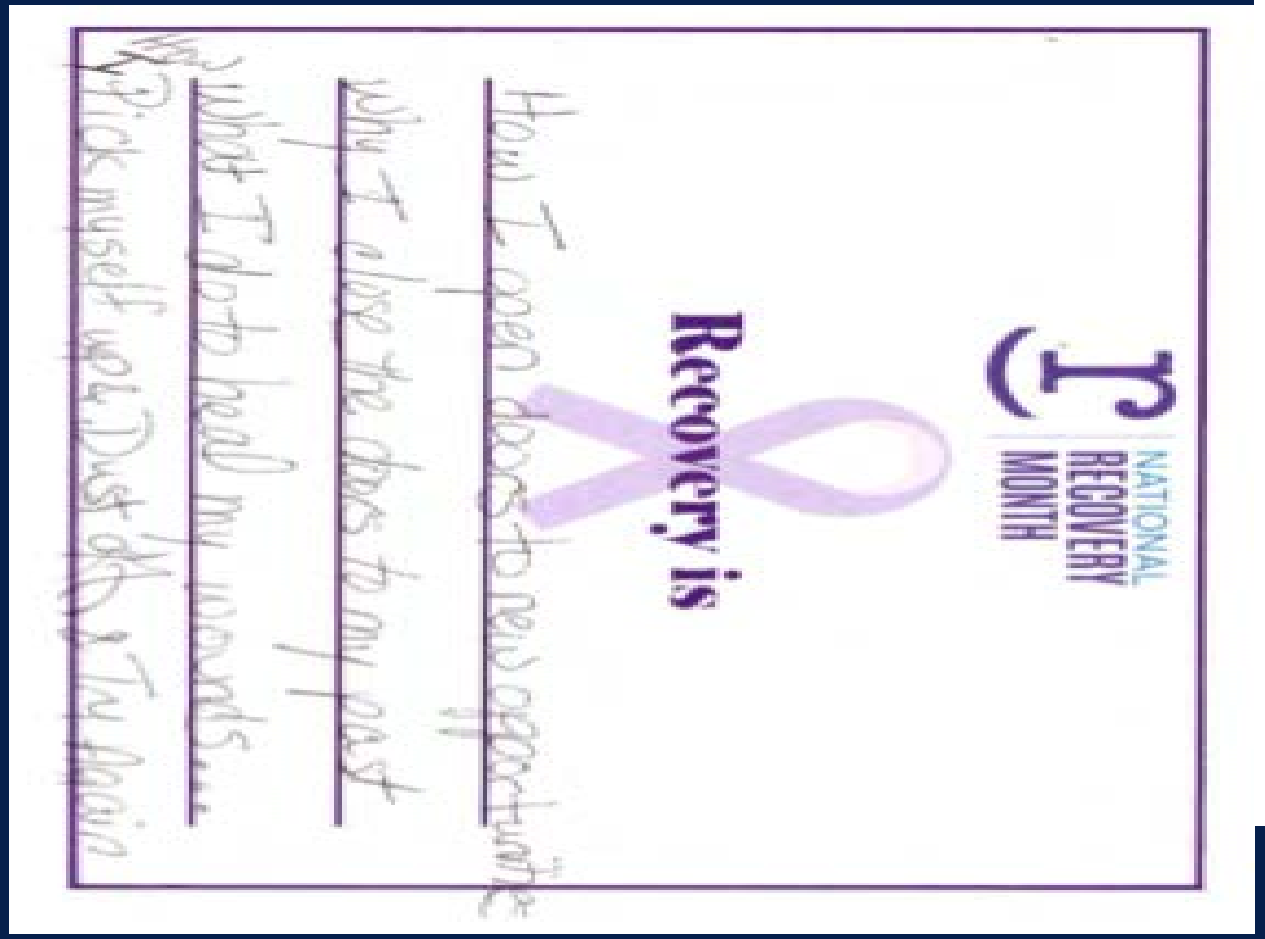
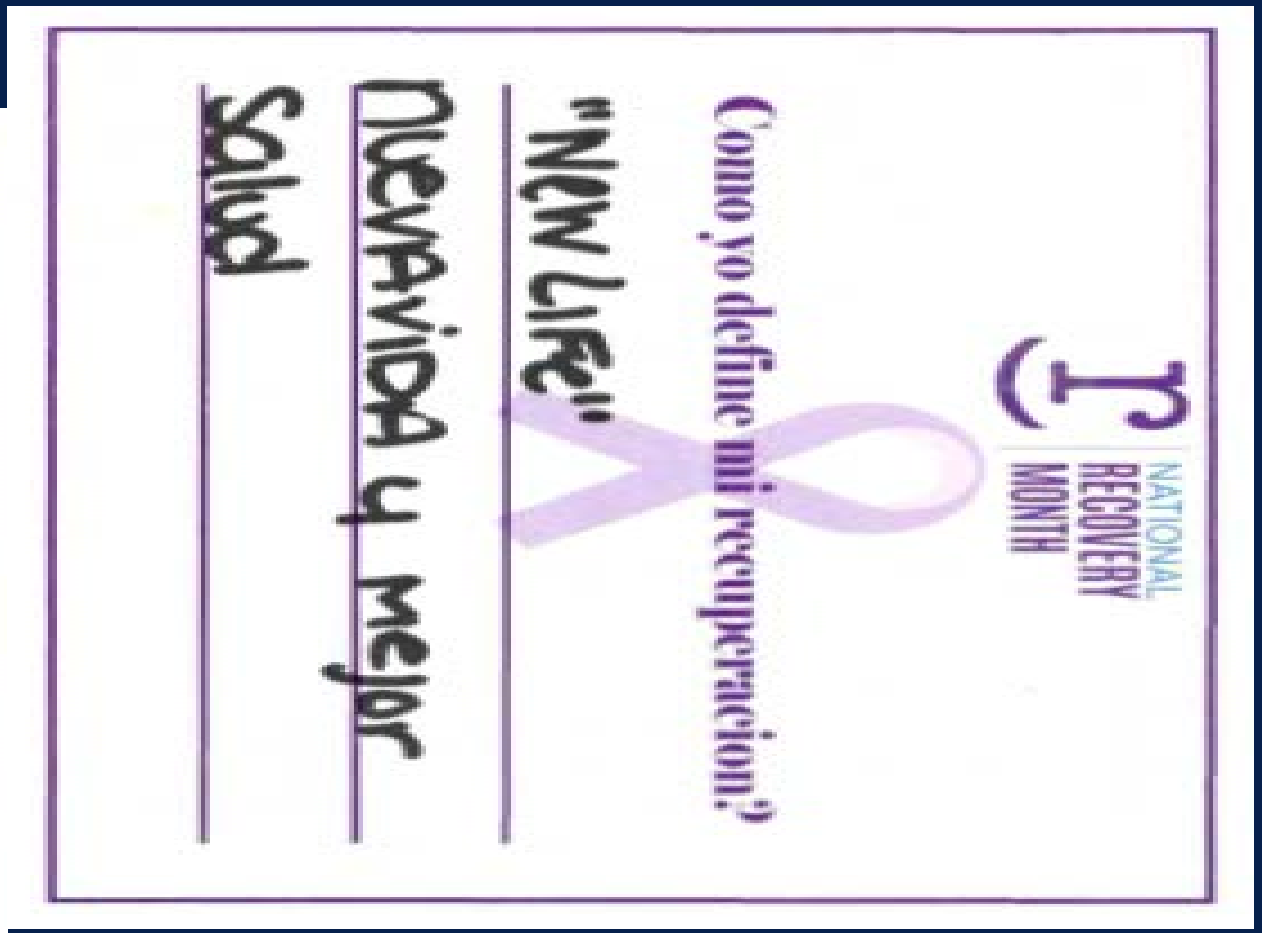
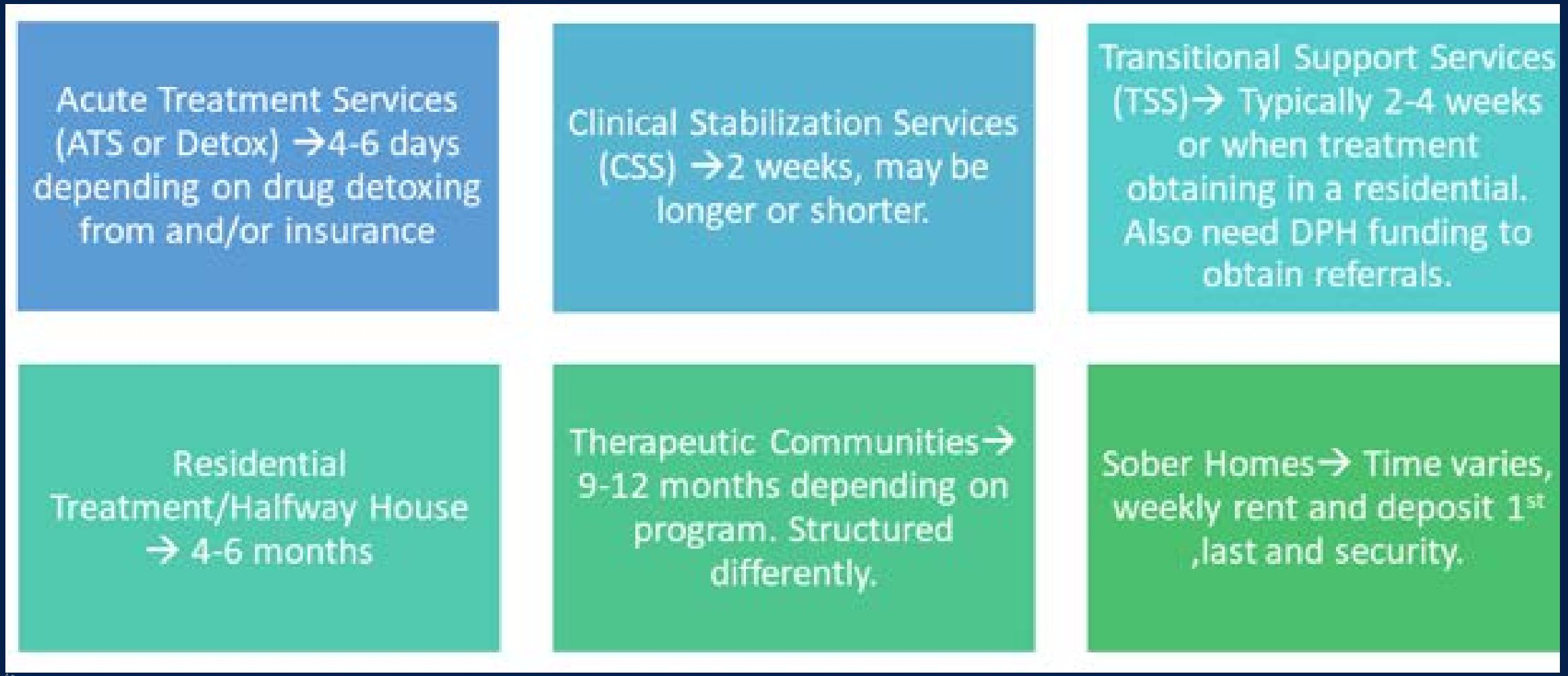
Martin SA, et al. *Ann Intern Med.* 2018;169:628-635

…BUT RECOVERY, AS EACH PERSON DEFINES IT, IS THE LARGER GOAL





SUD Continuum of Care



**MOUD can be used at any point along this continuum

Polling Question #1

How does your program or clinic approach people without homes whose drug use leads to them having to leave their residential treatment?

a) No specific steps; ”come back when you’re ready” +/- list of shelters
b) Refer to detox
c) Active efforts to find people beds in shelters or other options
d) “Step-down” options within the program
e) Case management referral

No tenancy protection

For people who were experiencing homelessness when they entered the treatment continuum,

the cost of relapse,

or of behavioral manifestations of trauma or mental illness, is a

return to homelessness

The structure of the treatment continuum produces and reinforces risk for homelessness at every return to drug use, but:

HOMELESSNESS IS NOT A THERAPEUTIC TOOL

Homelessness makes every step of the SUD Continuum of Care

Barriers to accessing SUD Care Continuum

- Bed availability lessens as the patient progresses through the continuum
- Location of programs
- Language barriers
- Complex acute or chronic medical needs
- Legal considerations
- Employment
- Financial
- Dept. of Children and Families
- Insurance
- Psychopharmacology and Mental Health needs
- Isolation from existing social supports/community
- Behavioral challenges, changing “program rules”
- Transitioning through the continuum
- Any relapse results in d/c and requires the Patient to start at the beginning creating “program fatigue”
- Inability to move to next stage results in returning to previous environment

Polling Question #2

With all other factors being equal in terms of MOUD suitability, would homelessness lead you to be more likely to recommend:

Buprenorphine

Methadone

Naltrexone

Doesn't influence my recommendation

Barriers MOUD creates in accessing care:

Detoxification Programs

- MOUD availability varies by program
  - MOUD detox protocol vs ongoing treatment
  - Guest dosing of methadone clinics
  - Confirmation of outpatient bupe provider will continue to provide MOUD during and post-discharge of program

Barriers MOUD creates in accessing care:

Clinical Stabilization Services (CSS)
Transitional Support Services (TSS)

- Limited ability to get to outpatient medical appointments or meet psychosocial needs
- MOUD availability is independent of these programs
- Challenges with MMTP and pharmacy availability

Barriers MOUD creates in accessing care:

Residential Treatment Programs

- Limited availability = minimal choice of location= barriers to existing MOUD providers
- Requires attendance of house meetings, mutual help meetings
- Requires members to find employment or have income to contribute to monthly costs
- Relapse = Eviction

Buprenorphine vs Methadone

Psychosocial challenges and barriers to MOUD

- **Buprenorphine**
  - Requires a safe place to store medications
  - State ID to pick up meds from most pharmacies
  - Requires abstinence from opioids prior to initiation*
  - Ability to manage time for medications, follow-up appointments
  - Ability to travel to pharmacies and providers
  - Stigma
  - Ability to adhere to program “rules”
  - Insurance

- **Methadone**
  - State ID required for intake appointment
  - Initiated at a suboptimal dose- titration process may be more difficult if not stably housed
  - Must present daily for medication
    - Funds for transportation
    - Employment
    - Changes in housing status/location
  - Must engage in MH treatment
  - No ability for telehealth
  - Not able to travel outside the immediate area
  - Stigma
  - Insurance
  - Psychopharmacology

Case discussion: what problems will homelessness cause for a patient's recovery

Julia is a 28 yo woman with a history of opioid use disorder and cocaine use disorder, and has tried both methadone and buprenorphine MOUD treatment in the past. She engages in survival sex work at night which limits her ability to stay in shelter settings, and doubles up or sleeps outside during the day. She presents today to restart suboxone at your clinic after being assaulted the night before; she is not yet in withdrawal.

Case discussion: use the chat!

Where will she manage the induction process?

How will she keep her medications safe?

If she goes to detox, and there's no next level of care available, where will she go?

If she enters residential treatment, does not get evicted for relapses, and succeeds—what does she do next? What support does she have?

If she has open warrants, how might that influence her recovery process?

Addiction Treatment Services at BHCHP

Buprenorphine treatment sites

Office Based Addiction Treatment (OBAT aka The Massachusetts Model)

MD, NPs, RNs, LICSWs, Case Manager, Recovery Coach

CCiR mobile clinic

MD, RN, CM & partnership with AHOPE (BPCH harm reduction services)

House of Corrections

MD, CM, Recovery Coach

Addiction Treatment Services at BHCHP

Access points for buprenorphine treatment

Harm Reduction Services

SPOT, Engagement Center, Comfort Station

BMH- Medical Respite Unit

Shelter based clinics

Outreach Teams

PCPs

Local Hospitals

Community Partners

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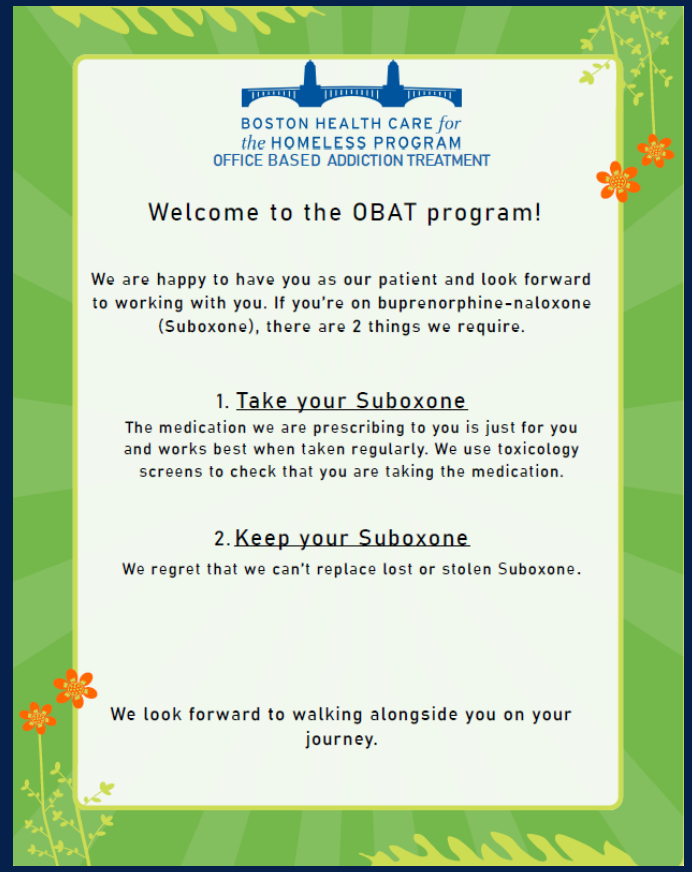
Ancillary Supports Available

- ACO Community Partner Case Managers
  - Ability to follow people in the community
- Primary Care Case Managers
  - Assist with connecting people to needed resources to engage in SUD treatment
- Specialty Treatment Team Providers
  - HIV, HEP C, Psychiatry
- Recovery Support Navigators
  - SUD treatment program referrals

BHCHP OBAT Participant Requirements

How we reduce barriers to accessing MOUD treatment

- Meet diagnostic criteria for OUD
- Connected to BHCHP primary care or psychiatry, or planning on transferring care to BHCHP (OK for OBAT to point of first contact)
- To maintain our DEA-mandated diversion plan, we ask patients to adhere to two rules:
  - Take your suboxone
  - Keep your suboxone


BOSTON HEALTH CARE *for the* HOMELESS PROGRAM
OFFICE BASED ADDICTION TREATMENT

Welcome to the OBAT program!

We are happy to have you as our patient and look forward to working with you. If you're on buprenorphine-naloxone (Suboxone), there are 2 things we require.

1. Take your Suboxone

The medication we are prescribing to you is just for you and works best when taken regularly. We use toxicology screens to check that you are taking the medication.

2. Keep your Suboxone

We regret that we can't replace lost or stolen Suboxone.

We look forward to walking alongside you on your journey.

Strategies in Reducing External Barriers

The importance of Case Management Support

- Specialized OBAT Case Management conducts needs assessment during intake
- Transportation offered via public transportation passes, PT1, lyft/uber for visits
- Nutrition/clothing provided during visits
- Telephones provided to increase access to telehealth
- Housing applications
- Treatment program referrals
- Assistance with obtaining vital documents
- CORI sealing

OBAT @ BHCHP

Reduction of Internal Barriers in Accessing Care

- Multidisciplinary team increases access points of care
- Allows for scheduled and “Open Access” appointments
- Same day inductions for buprenorphine
- “Diversion plan” focuses on adherence rather than call-backs/counts
- No discharge from care for substance use
- Referral point to medical and psychosocial needs
- Embedded in multiple shelter clinic sites and outreach teams (brings care to the patient instead of requiring the patient come to the care)
- Evening hours and telehealth options
- Team is trained in harm reduction, motivational interviewing, and trauma informed care

Goal-setting

- Patients deserve autonomy in identifying personal goals in care
- Goals can be fluid
- Feel better vs remission; food/shelter vs medical appointment adherence
- Goals should be mutually-agreed upon and celebrated when met
- A philosophy of “any positive change”, from harm reduction, is especially helpful when many many barriers to complete change exist

Break out group

Identify 3 strategies in how you might change your own home program (or the program you know best) to increase access and decrease barriers for people experiencing homelessness.

What are challenges in completing this in 3,6,12 months?

What can you simply not imagine accomplishing, because the structural barriers are too great?

Summary

- Homelessness presents many barriers to success with treatment of SUDs
- Homelessness as a form of punishment or moral lesson is not a treatment for substance use disorders
- Homelessness is associated with risk of death from overdose
- Our program does many things to try to address these challenges
- Proactively addressing barriers and possible solutions should improve outcomes
- We regularly fail in part because we can not solve the structural problems, most of all, housing itself

References

1. Dube SR et al. *Pediatrics* 2003; 111:564 –572 (Adverse childhood experiences)
2. Baggett T et al. *JAMA Intern Med.* 2013 Feb 11; 173(3): 189–195. (Mortality in homeless adults)
3. Massachusetts Dept of Public Health. An Assessment of Fatal and Nonfatal Opioid Overdoses in Massachusetts (2011 – 2015). Aug 2017
4. Coulute L, "Nowhere to go: homelessness among formerly incarcerated people", Prison Policy Initiative August 2018. https://prisonpolicy.org/reports/housing.html
5. Fine D et al. *JAMA Netw Open.* 2021;4(3):e210477. (Mortality and retention in our OBAT program)
6. Martin SA, et al. *Ann Intern Med.* 2018;169:628-635 (Buprenorphine guidelines that are similar to ours)

For more information, or questions, email jwright@bhchp.org and sciarocco@bhchp.org