TREATING OPIOID ADDICTION IN HOMELESS POPULATIONS

Challenges and Opportunities Providing Medication Assisted Treatment (Buprenorphine)

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SPEAKERS TODAY

• **Nilesh Kalyanaraman, MD**, Chief Health Officer, Health Care for the Homeless (Baltimore, MD)

• **Terry Clark**, Addictions Counselor, Health Care for the Homeless (Baltimore, MD)

• **Brianna Sustersic, MD**, Senior Medical Director of Primary Care, Central City Concern (Portland, OR)

• **Brian Barnes**, Clinical Supervisor, Central City Concern (Portland, OR)

• **Barbara DiPietro** (Moderator), Senior Director of Policy, National HCH Council
WHY THIS ISSUE?

- Growing problem of addiction in U.S. now recognized as epidemic
- Long-term issue among vulnerable populations; causes and prolongs homelessness
- Homeless adults age 25-44 9x more likely to die from opioid overdose than housed peers (Boston study)
- HCH providers well-versed in integrated, harm reduction model of care to address opioid addiction

Source: Centers for Disease Control and Prevention, 2014
### WHY THIS ISSUE?

**Heroin Use Has INCREASED Among Most Demographic Groups**

<table>
<thead>
<tr>
<th></th>
<th>2002-2004*</th>
<th>2011-2013*</th>
<th>% CHANGE</th>
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<tbody>
<tr>
<td><strong>SEX</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Male</td>
<td>2.4</td>
<td>3.6</td>
<td>50%</td>
</tr>
<tr>
<td>Female</td>
<td>0.8</td>
<td>1.6</td>
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<td><strong>AGE, YEARS</strong></td>
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<tr>
<td>12-17</td>
<td>1.8</td>
<td>1.6</td>
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<tr>
<td>18-25</td>
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<td>7.3</td>
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<tr>
<td>26 or older</td>
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<td>1.9</td>
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<td><strong>RACE/ETHNICITY</strong></td>
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<tr>
<td>Non-Hispanic white</td>
<td>1.4</td>
<td>3</td>
<td>114%</td>
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<tr>
<td>Other</td>
<td>2</td>
<td>1.7</td>
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<tr>
<td><strong>ANNUAL HOUSEHOLD INCOME</strong></td>
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<tr>
<td>Less than $20,000</td>
<td>3.4</td>
<td>5.5</td>
<td>62%</td>
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<td>$20,000-$49,999</td>
<td>1.3</td>
<td>2.3</td>
<td>77%</td>
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<td>$50,000 or more</td>
<td>1</td>
<td>1.6</td>
<td>60%</td>
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<tr>
<td><strong>HEALTH INSURANCE COVERAGE</strong></td>
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<td></td>
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<tr>
<td>None</td>
<td>4.2</td>
<td>6.7</td>
<td>60%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>4.3</td>
<td>4.7</td>
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<tr>
<td>Private or other</td>
<td>0.8</td>
<td>1.3</td>
<td>63%</td>
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</table>

### Heroin Addiction and Overdose Deaths are Climbing

**Heroin-Related Overdose Deaths (per 100,000 people)**

286% increase

**Heroin Addiction (per 1,000 people)**

Source: Centers for Disease Control and Prevention, 2014
UNDERSTANDING MAT

• Use of medications in combination with counseling and behavioral therapies

• Three MATs: methadone, naltrexone, **buprenorphine**

• Buprenorphine first medication permitted to be prescribed and/or dispensed in physicians office
  → Suppresses withdrawal, decreases cravings, lowers risk of overdose
  → Increases access to treatment in primary care setting
  → Highly regulated: physician-only prescribing rights, required trainings & record-keeping, patient limits, waiver authorizations, health insurance regulations
FEDERAL LEVEL CHANGES

• **Congress:** Comprehensive Addiction and Recovery Act
  → Grants to expand access to overdose reversal drugs (Naloxone/Narcan)
  → Grants to expand treatment alternatives to incarceration
  → Expands buprenorphine prescribing rights to NPs and PAs
  → Furthers movement towards treating addiction as a disease, not a criminal activity

• **Administration:** Dept of Health & Human Services (HHS)
  → Raising the MAT patient cap to 275
  → HRSA grants to health centers
  → SAMHSA grants to increase SUD training and expand MAT
  → Reduce over prescribing with updated training and prescriber guidelines
CHALLENGES PROVIDING MAT

• Lack of training in identifying and treating SUD among primary care providers
• Limited capacity in health centers to meet demand
• Diversion and misuse of medication
• High costs, differing insurance plans & Medicaid state policies
  → Non-Medicaid expansion states: greater difficulty accessing SUD care
• Difficulties specific to homelessness
  → Lack of stability, social supports, transportation, income
  → Negative experiences in health care systems
  → Difficulty adhering to daily care plan
  → High rate of comorbidities
  → Focus on basic daily needs
OVERCOMING CHALLENGES: PROVIDER PRACTICES

• Establish stability in housing
• Address comorbidities using integrated care
• Treat the whole person
• Take a low-barrier, harm reduction approach
• Use evidence-based best practices
• Be patient centered
• Be flexible
OVERCOMING CHALLENGES: POLICY RECOMMENDATIONS

- Remove patient caps & treat as any other medication
- Expand prescribing rights to all clinicians eligible to prescribe Class III, IV and V CDS drugs
- Require training to prescribe all opioids
- Enforce parity laws (especially re: prior authorizations)
- Reduce stigma and treat addiction as a disease
- Train all health care providers on addiction
- Expand prevention and treatment programs
- Reduce incarceration in response to addiction behaviors
Health Care for the Homeless: Baltimore, MD

• FQHC serving over 10,000 people experiencing homelessness a year
• 3 primary care clinics
  – Downtown Baltimore
  – West Baltimore
  – Baltimore County
• Services offered: medical, behavioral health, dental, nursing, case management, outreach, supportive housing
• Treatment philosophy
  – Person centered
  – Trauma informed
  – Harm reduction
  – Multidisciplinary care teams
• Patients served
  – Current MAT initiation: 60
  – MAT in the past year: 500
Entering Care

• No wrong door: addictions counselors and medical providers conduct warm hand offs

• Comprehensive multidisciplinary care with
  – Mental health
  – Case management
  – Nursing
  – Dental
  – Supportive Housing

• On-site pharmacy

• Naloxone training
Initiating MAT

• Treatment agreement
• PDMP review
• Most clients have taken buprenorphine in the past
• Client managed induction once in withdrawal
• Daily group meetings
• Weekly individual counselor sessions
• Weekly MAT group for buprenorphine adjustment
• Weekly urine screens
Maintenance

- Transition to primary care provider or psychiatrist
- 4 physicians
- 5 NPs who co-manage with MDs
- 4 psychiatrists
- Continue individual therapy/counseling
- Dual diagnosis group
Central City Concern: Portland, OR

- **Old Town Clinic** is a Healthcare for the Homeless FQHC primary care medical home, housed within the larger social services agency of CCC.
  - We strive to provide low barrier, patient centered, and holistic care.
- **Our MAT philosophy:** MAT is most effective when offered as part of a comprehensive and individualized treatment program, which includes medication, counseling and community support.
- **SUD treatment is fully integrated into primary care:**
  - Warm hand-offs to addictions counselors
  - Range of SUD treatment groups on-site: dual diagnosis, pain management, understanding addiction
  - Weekly case consultation with provider champions
- **Number of patients being treated with buprenorphine:**
  - 167 in the last year; 45 currently active patients
Central City Concern: Portland, OR

- Started MAT program in 2013 with 1 counselor and a couple of prescribers → we now have 3 counselors, 1 clinical supervisor, 1 admin assistant, and 8 prescribers
- Our response to the challenges:
  - **Addressing stigma** - changing language and culture around addiction
  - **Monitoring practices**: pill counts, urine drug screens, bubble-packing of meds, treatment agreement, twice weekly group attendance required
  - 5 beds available in supportive housing
  - **Onsite pharmacy** - ongoing collaboration, multiple dispensing options including: bubble packing, daily dispense, weekly dispense
  - **Provider education** – addiction-trained physicians and nurse practitioners, frequent education sessions on substance use disorder topics
  - **Other wraparound services**: specialty mental health, case management, benefits/employment assistance, housing
  - **Naloxone training, prescribing**
QUESTION: APPROACH TO CARE

• MAT implies that medication is coupled with counseling and therapy. Do you find that counseling is necessary for all patients, or do some patients do well on medication alone?

• What does being “patient-centered” and “flexible” mean when crafting treatment plans for people who are homeless?

• Under what conditions would you stop treatment?
QUESTION: DIVERSION

Diversion of buprenorphine is a topic of concern. From a public health perspective, how concerned are you about diversion and what steps do you take to mitigate it?

→ Self treatment

→ Possible risk v. other opiates

→ Prescriber caps and other limits
QUESTION: BENEFITS TO MAT

What are some of the benefits patients engaged in MAT have experienced?

→ Increased stability
→ Ability to address other health issues
→ Ability to reconnect with family & social supports
→ Ability to maintain housing, engage in work
OTHER QUESTIONS?

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