Strategies for engaging and retaining vulnerable patients in OUD treatment programs

Ranjani Paradise, PhD
Institute for Community Health
Allyson Pinkhover, MPH, CPhT
Brockton Neighborhood Health Center
Gargi Cooper, FNP
Lynn Community Health Center
Joe Wright, MD
Boston Health Care for the Homeless Program
Anthony Lundi, LCSW
Community HealthLink

MassLeague of Community Health Centers: Community Health Institute

June 10, 2021

Background

- In 2018, RIZE Massachusetts Foundation funded four organizations through the *Saving Lives, Improving Health: Redesigning Opioid Use Disorder Care*
  - Three community health centers received 3-year grants
  - One community-based behavioral health care center received a 2-year grant
- Goal: Improve access to **low-threshold, evidence-based treatment** for populations at high risk of opioid overdose and death
  - Focus on medication for opioid use disorder (MOUD)

rize massachusetts

UMass Memorial Health COMMUNITY HEALTHLINK

Brockton Neighborhood Health Center

Lynn COMMUNITY health CENTER

BOSTON HEALTH CARE for the HOMELESS PROGRAM SINCE 1985

INSTITUTE FOR COMMUNITY HEALTH

Overview of programs

- Target population(s)
- Major initiatives/activities implemented and their goals
- Pivots or changes during COVID-19

rize massachusetts

UMass Memorial Health COMMUNITY HEALTHLINK

Brockton Neighborhood Health Center

Lynn COMMUNITY health CENTER

BOSTON HEALTH CARE for the HOMELESS PROGRAM SINCE 1985

INSTITUTE FOR COMMUNITY HEALTH

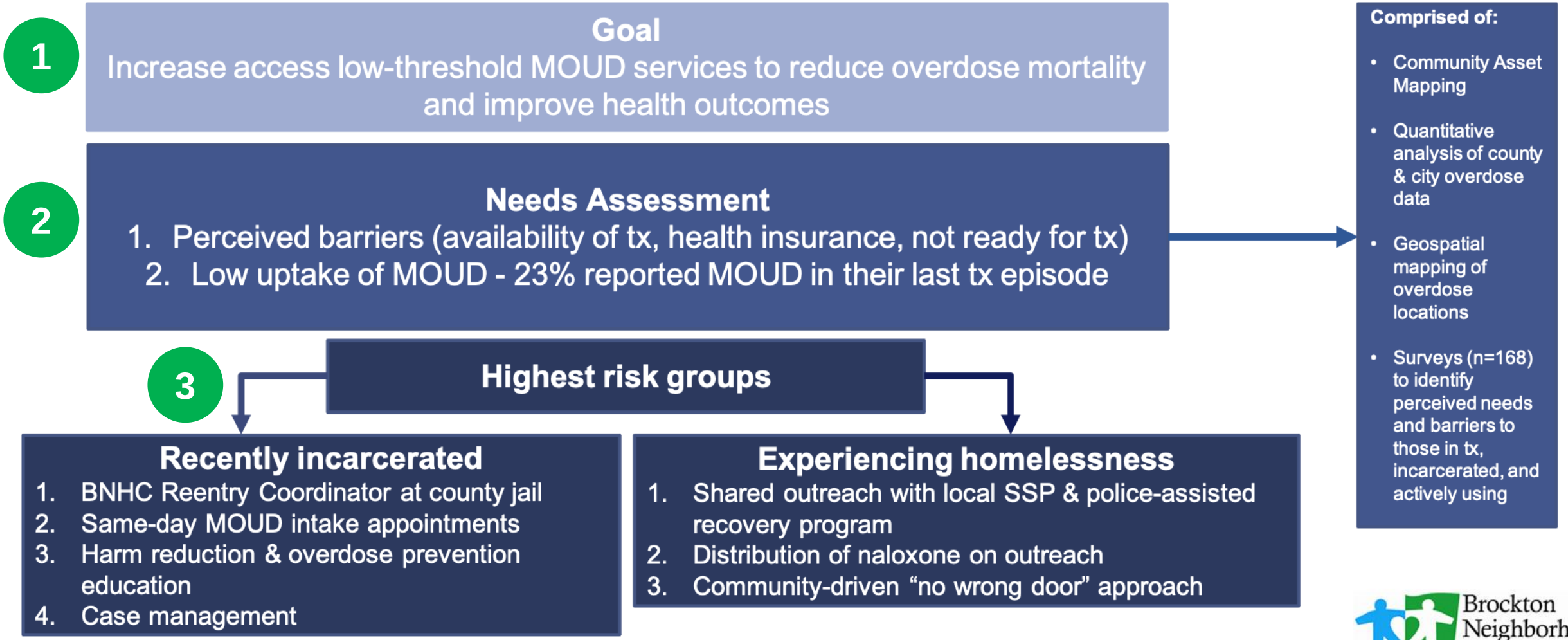
Engaging reentering and unhoused individuals in low-threshold MOUD and other health services in Brockton, MA

Massachusetts League of Community Health Centers
Community Health Institute – June 10, 2021

Allyson Pinkhover, MPH, CPhT
Director of Substance Use Services
Brockton Neighborhood Health Center

Brockton Neighborhood Health Center

Project Overview



Brockton Neighborhood Health Center

Results

Reentry

298
unique encounters

242
referrals for MOUD

90
MOUD initiations

25
MOUD patients retained

As of March 14, 2020

Shared Outreach

938
unique encounters

294
individuals connected to services

269
nasal naloxone distributed

Cumulative since Baseline:
Baseline Jan. 1 2017 –Dec. 30, 2020

Patient Population

915 → 1002
patients with OUD

9.5% increase

303 → 426
patients starting MOUD

40.6% increase

Patient Population Measures:
Baseline Jan. 1 2017 – Jun. 30, 2018
versus
Period 5 Jul. 1 2020 – Dec. 30, 2020

Brockton Neighborhood Health Center

Modifications during COVID-19 Pandemic

1. Could no longer provide reentry services in Plymouth County Correctional
    1. Continued to coordinate referrals for MOUD if we received them from the jail
    2. Recorded various trainings that we usually offered in the jail and provided them to PCCF (including overdose prevention and harm reduction basics)

    1. Coordinated 2nd dose appointments for people who received Dose 1 of their COVID vaccination while incarcerated
2. Stopped street outreach for a period of time
    1. Began outreach again in later Summer 2020
    2. Put together PPE and overdose prevention kits to “drop & go” to people

3. Continued to provide MOUD throughout the pandemic, primarily via telehealth
4. Helped to provide harm reduction education and supplies to Lexington isolation hotel

Brockton Neighborhood Health Center

MEDICAL OUTREACH PROGRAM

Gargi Cooper
FNP

Medical Director

Medical Outreach Program
Recuperative Care Center

Medical Outreach Team/ RCC TEAM

Carolyn Matheson NP	Esther Mackenzie NP	Patrick Bonville Case manager	Yanira Concepcion Patient Care coordinator
Jodi Amor RN	Reina G. PRACTICE MANAGER	Ryan Griffin PMHNP-B.C.	Daenor Linton Direct support

MEDICAL OUTREACH
PROGRAM

CONTACT US!
781-691-9486 RCC CLINIC

- Providing Compassionate and consistent care to patients residing on the streets or in shelter.
- Low barrier BUP program (suboxone, vivatrol, sublocade) High touch program that starts patients immediately, stabilizes and transitions to orange or PCP teams
- Onsite Behavioral health psycho-pharm care weekly clinic appointments
- On demand episodic and primary care services
- Distribution of Narcan, needle exchange
- Assistance with referrals to Detox
- Case management services including housing referrals, obtaining ID, insurance and benefits
- Locations: My Brothers Table, streets of Lynn, Lynn shelter, home visits

- Pandemic caused our organization to shift due to PPE constraints and safe staffing levels.
- The soup kitchen we run our clinic out of became a grab and go model which limited access to our clinic space.
- The city closed the doors to the main site which limited clients from seeking care.
- We are proud that our clinic remained open for in person care, and allowed us to assist clients with telemed services, including specialty care, BH and IOP programs.
- Consulted and set up a Quarantine site at a local school to help support Covid quarantine in the homeless population
- Became a mobile testing site and now mobile vaccinate site for homeless individuals
- Continued outreach to encampments, street and later a motel site (that was temporary shelter in Saugus for Lynn shelter association)
- Began a shower encampment program out of our outpatient clinic to provide wellness services to folks living outside as all public access to showers, bathrooms were closed.

Saving Lives, Improving Health: Redesigning Opioid Use Disorder Care grant program

Who We Aim to Serve

A collaborative initiative with Boston Health Care for the Homeless Program (BHCHP), St. Francis House (SFH), and Pine Street Inn (PSI) focused on people experiencing homeless and opioid use disorder (OUD) in the City of Boston and providing new and multiple pathways to on-demand treatment and harm reduction services (HRS).

Since 2015, one out of every three deaths at BHCHP has been caused by a drug overdose, which is the leading cause of death among the people we serve. More than half of BHCHP's patient population has a documented diagnosis of substance use disorder (SUD), including OUD.

This project specifically aims to increase access to medication for opioid use disorder (MOUD) and HRS with a specific focus on creating new pathways to culturally-appropriate care and enhancing our existing partnerships with SFH and PSI to better meet the needs of our shared community members.

MAJOR GRANT ACTIVITIES

- Cultivate close community partnerships through a thoughtful planning period to develop a shared philosophy across systems and innovative strategies to prevent overdose deaths and provide high-quality, culturally appropriate, and integrated MOUD and HRS
- Create the infrastructure and added capacity to increase access to on-demand MOUD treatment and harm reduction services in multiple clinic, outreach, and shelter settings
- Provide ongoing trainings on harm reduction, stigma, the chronic disease model of treating SUDs, MOUD, trauma-informed supervision, along with trauma counseling for staff, frequent interagency meetings and communication, and individualized trainings and technical assistance between BHCHP providers and agency staff based on newly identified needs
- Implement two-way data sharing processes around retention, initiation, and engagement of OBAT and HRS Services across partnerships

Goals and COVID-19 Adjustments

BHCHP- By expanding OBAT and Harm Reduction Services in multiple settings, the primary goal of this project is to serve an unmet need for accessible, culturally competent treatment for individuals experiencing homelessness with OUD.

- Increasing the number of DEAX waivered providers (currently at 78 waivered providers!) and DEAX prescribing limits
- Increasing access to MOUD and OBAT model of care (RN, BH, RC) weekend and evening clinic
- Data analysis around engagement and retention
- Increasing the number of patients receiving MOUD at our main clinic site as well as and all shelter-based sites
- Expanding mobile clinic, harm reduction, and outreach services

COVID-19 response *– BHCHP increased access to telehealth (phones, calling cards, IPADS) and buprenorphine initiation, expanding OBAT to new temporary COVID-19 shelters and Boston's COVID-19 field hospital.*

St Francis House – The goal of this partnerships is to expand and integrate MOUD services within SFH Clinic, and develop and expand low-threshold, harm reduction engagement program within SFH (RIZE Room).

- Creating an access point for guest engagement via harm reduction services and recovery coaching to offer a new pathway to receive on-demand access to MOUD.
- Increasing access and capacity at SFH clinic site with the goal to double the census of patients receiving
- Developing and refining a collaborative, cross-system model of care to meet the needs of patients and offer low-barrier, patient-centered care and support for OUD, treatment, and referrals to detox programs

COVID-19 response *–The RIZE Room briefly suspended due to COVID-19 which provided the opportunity to collaborate and create more robust outreach model of care for engagement.*

Pine Street Inn- This original goal of this partnership was to provide housing-based OBAT services in PSI congregate housing to mitigate risks of overdose in during periods of social isolation that occur upon transitioning into housing.

- Early barriers were identified in engaging people in this setting as patients preferred to continue to access OBAT services in clinic settings for a variety of reported reasons.
- Partners pivoted to develop an OBAT model of care at PSI shelter-based clinic site and expand the number of patients accessing MOUD.

COVID-19 response*– The PSI shelters were decongested to mitigate the spread of COVID-19, and many guests were placed in alternative shelter sites. BHCHP provided telehealth infrastructure and harm reduction to prevent disruptions in MOUD and behavioral health care, including access to on-demand MOUD initiations, to lessen risk of fatal overdose in an unfamiliar setting.*

CHI-RIZE Grant Presentation

Community Healthlink- Behavioral Health Addiction Urgent Care

Anthony Lundi LCSW- Urgent Care
Program Director

6/10/2021

Overview of BHAUC

- Only 24-hr Behavioral Health Addiction Urgent Care Center in the state
- Focused Population: Homeless (40%), MH/SUD- Co-Occurring,
- > 66% Opiates 57% ETOH, >80% seeking detox treatment.
- Walk in > 80%,others referred by treatment programs including correctional houses, ER, Police & community members.
- > 70% male, <1% transgender and about 30% female.70% Caucasian, 20% Hispanic, 9% African American.
- Individuals Experiencing sexual exploitation, DV.

Major Goals of the Grant

- Education & training activities with the police, Partnerships with the City of Worcester Quality of Life and Reentry Taskforces
- Expanding the capacity of Urgent Care to dispense comfort medications and referring of patients to OSUT for MAT – *Med room established onsite,* comfort med dispensed. - *Onsite (Genoa) Pharmacy. – Workflows established for patient referral to OBOT clinic warm handoff and telehealth sessions by on call providers afterhours, - NP during busy hours for med clearance, prescribing MAT*
- *Clinicians grant paid for 1 clinician, currently 4.5 FTE & 7 PerDiem; 2000 assessments conducted*
- *Recovery Support Navigators 3.0 FTE; > 1300 bailable encounters*

COVID-19 Response Plan

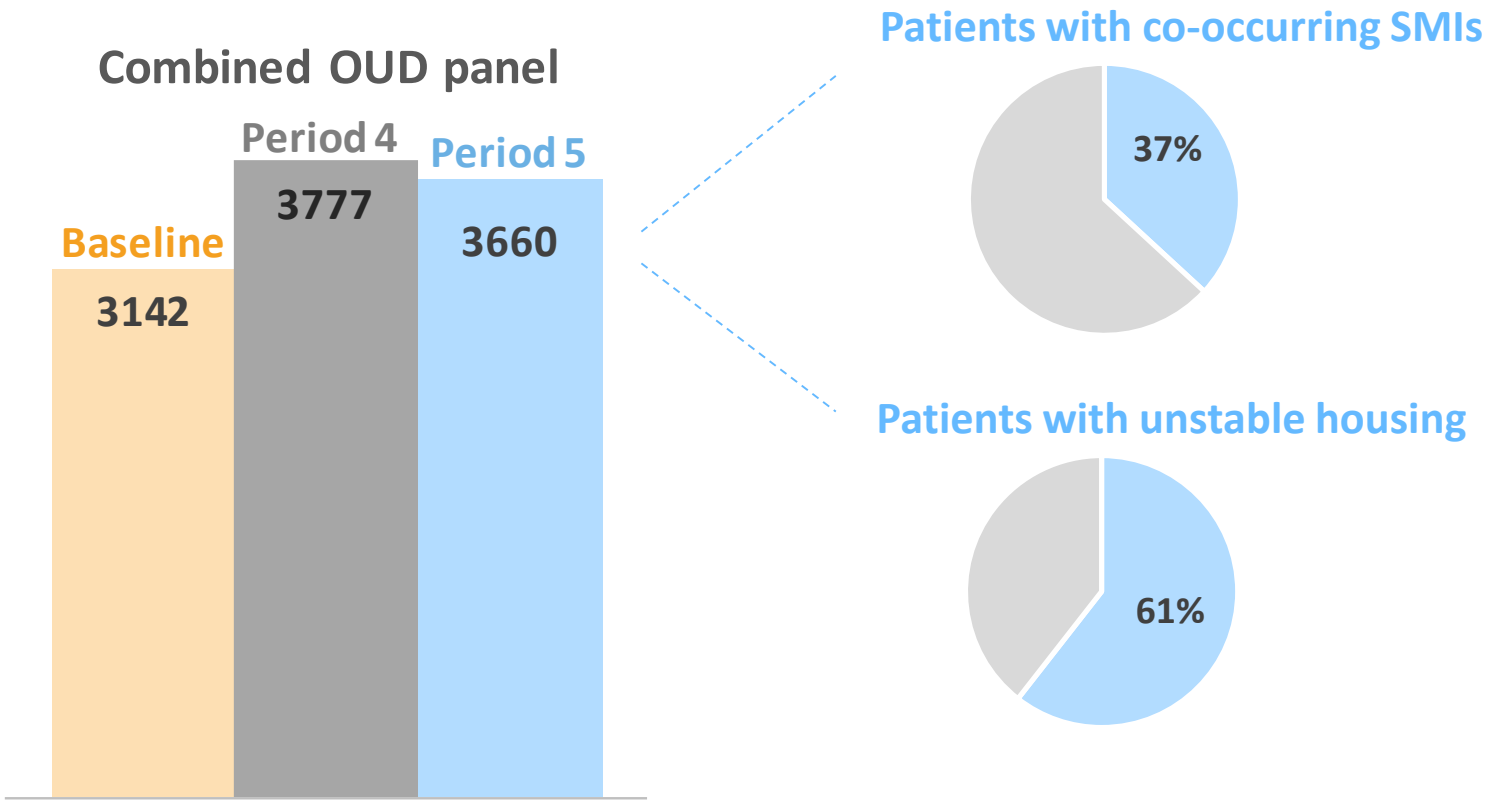
- Tent Screening for entire site location- 24-hr results
- COVID Testing for all clients
- Isolation rooms
- Lobby Area- Protective Screens for each client waiting area
- Increased cleaning for all shifts
- On-site Vaccinations
- Additional Nurse Practitioner Hours to Divert from ED

Program evaluation

- Institute for Community Health (ICH) was the evaluator
- Electronic health record data for BNHC, LCHC, and BHCHP
- Measures include overall OUD patient panel, engagement in behavioral health care, MOUD initiation and retention
- Comparing data from baseline to five time periods over the grant period. Data shown for:
  - Baseline: Jan 2017-June 2018 (18 months before the grant started)
  - Period 4: Jan 2019-June 2020 (2 years into the grant period; 3-4 months overlapping with COVID-19)
  - Period 5: July 2019-Dec 2020 (2.5 years into the grant period; 9-10 months overlapping with COVID-19)

INSTITUTE FOR COMMUNITY HEALTH

Patient panel: SMIs and housing



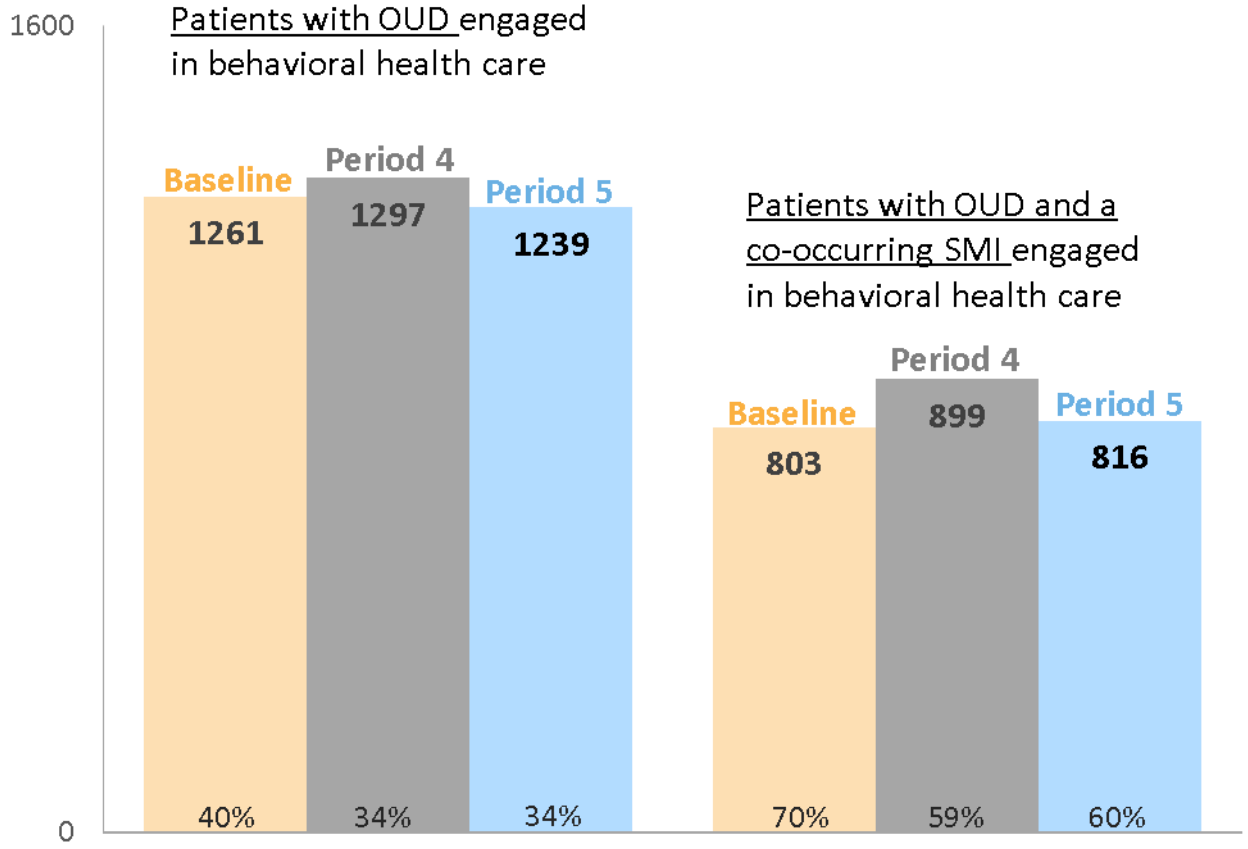
OUD panel has **increased by 518 (16%)** from baseline to Period 5

Panel decreased from Period 4 to Period 5

Panel size data for BHCHP, BNHC, and LCHC comparing baseline (18 months pre-grant), Period 4 (Jan 2019 – Jun 2020), and Period 5 (Jul 2019 – Dec 2020); demographics for Period 5 only

INSTITUTE FOR COMMUNITY HEALTH

Engagement in behavioral health care



Data for BHCHP, BNHC, and LCHC comparing baseline (18 months pre-grant), Period 4 (Jan 2019 – Jun 2020), and Period 5 (July 2019 – December 2020)

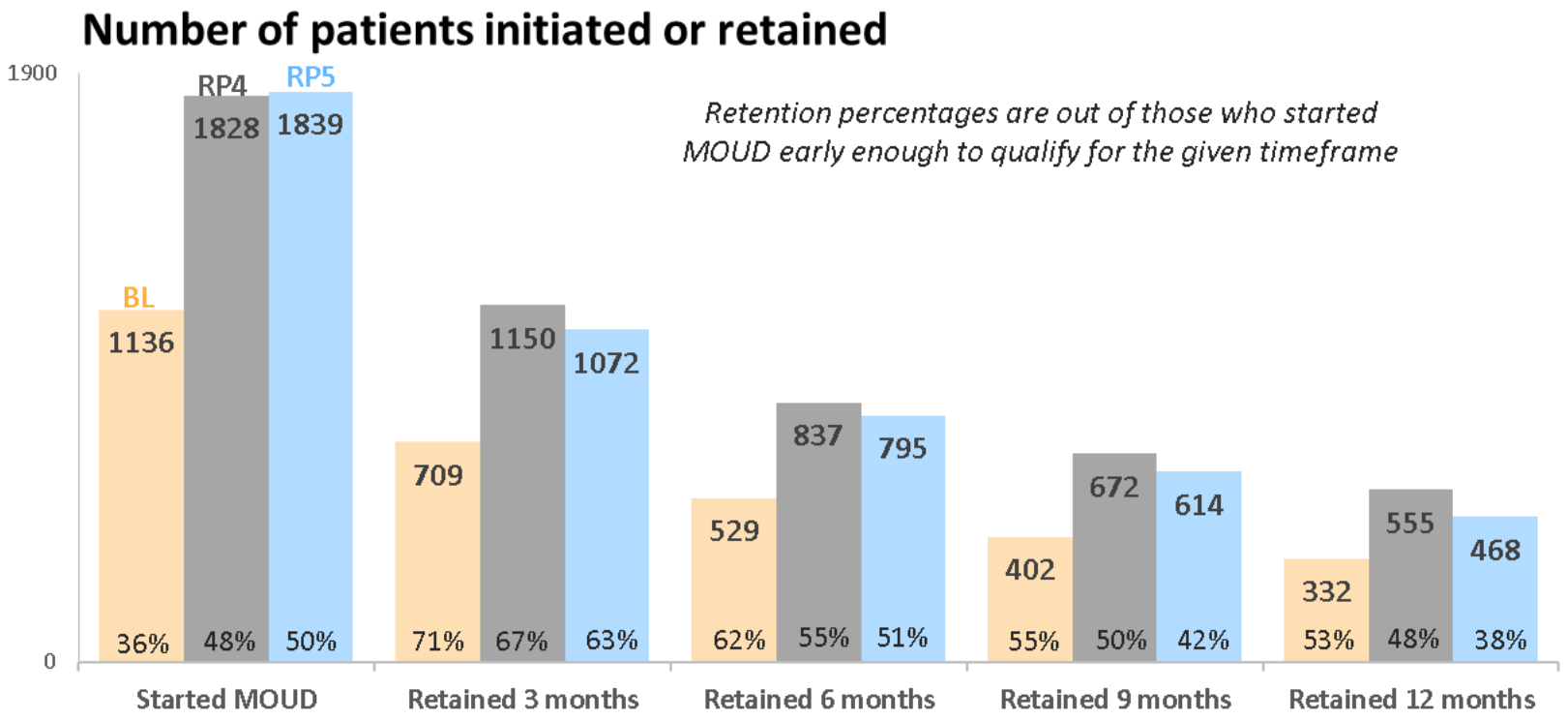
Engagement in BH care = 2+ visits with a BH treatment provider in last 12 months of reporting period

The proportion of patients engaged in BH care is much higher for subpopulation with serious mental illnesses

BH engagement rates have dropped since baseline, but have been steady from Period 4 to Period 5

INSTITUTE FOR COMMUNITY HEALTH

MOUD initiation and retention



MOUD initiation rate has increased significantly, and remains high in Period 5

Retention rates have decreased

Data for BHCHP, BNHC, and LCHC comparing baseline (18 months pre-grant), Period 4 (Jan 2019 – Jun 2020), and Period 5 (July 2019 – December 2020)

Initiation = 1+ MOUD prescriptions written during reporting period
Time retained = number of consecutive days with active prescription with gaps no longer than 29 days

INSTITUTE FOR COMMUNITY HEALTH

Discussion

- Challenges
- Successful strategies and recommendations
- Audience Q&A

INSTITUTE FOR COMMUNITY HEALTH