Overcoming OUD Treatment Barriers for People Experiencing Homelessness

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Presentation Slides

ASAM Annual Conference, April 5th, 2024, 3:00-4:15pm

Disclosure Information

- Nicholaus J Christian, MD, MBA, FASAM
  - No disclosures. This presentation was prepared by Nicholaus in his personal capacity. The opinions expressed are the author's own and do not reflect the view of the National Institutes of Health, the Department of Health and Human Services, or the United States government.
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  - No Disclosures
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  - No Disclosures
- Kelly Thompson, MA, President & CEO, Alliance for Living
  - No Disclosures

Learning Objectives

- Identify the drivers of substance use and challenges receiving substance use treatment among people experiencing homelessness.
- Discuss strategies to initiate medication for opioid use disorder (buprenorphine/methadone/naltrexone) for patients experiencing homelessness.
- Describe a peer-led model for treating addiction among people experiencing homelessness.
- Learn strategies to improve communication and enhance trust-building with patients experiencing homelessness.


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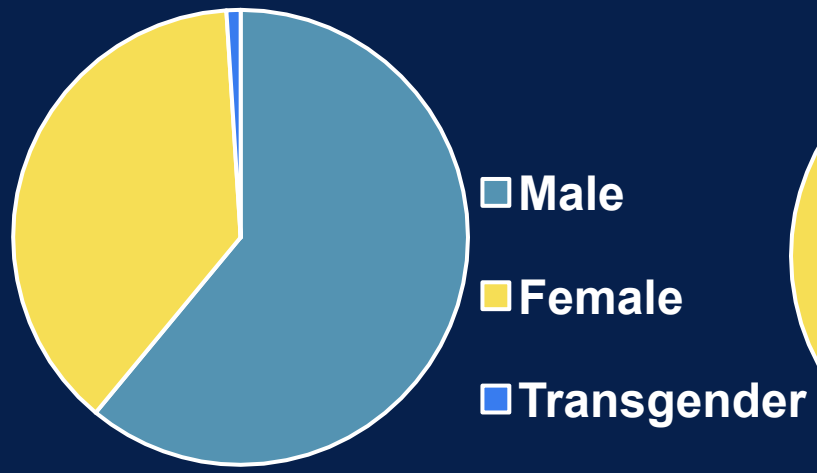
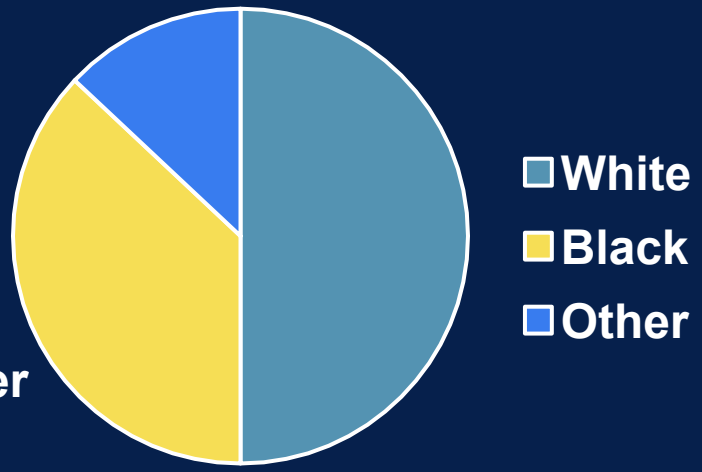
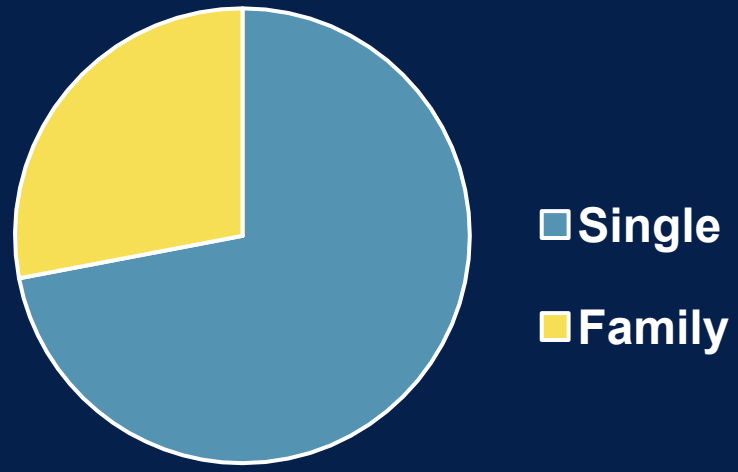
Intersectionality of SUD With Other Stigmatizing Identities

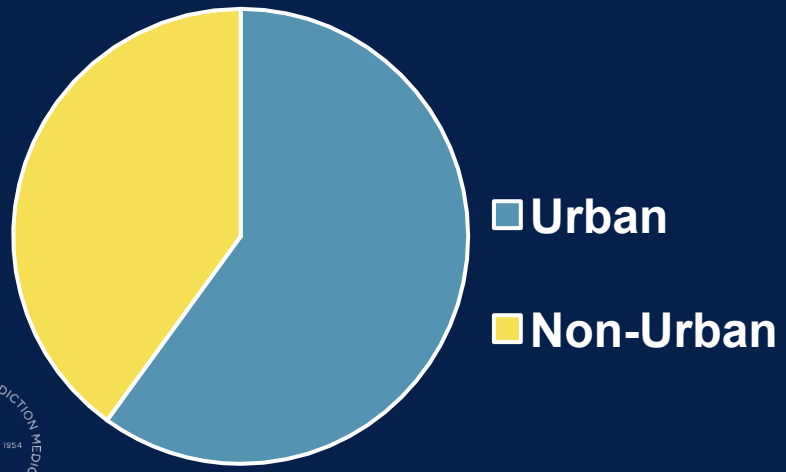
Challenges and Opportunities to Improve Addiction Care for PEH

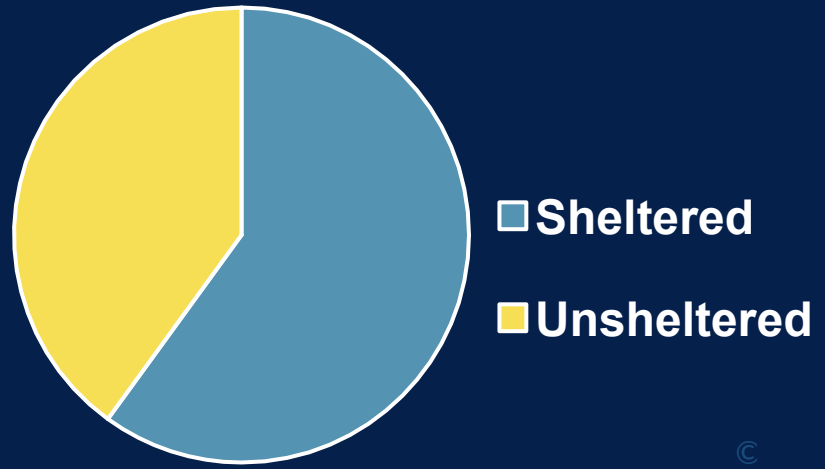
653,100 People Unhoused in 2023

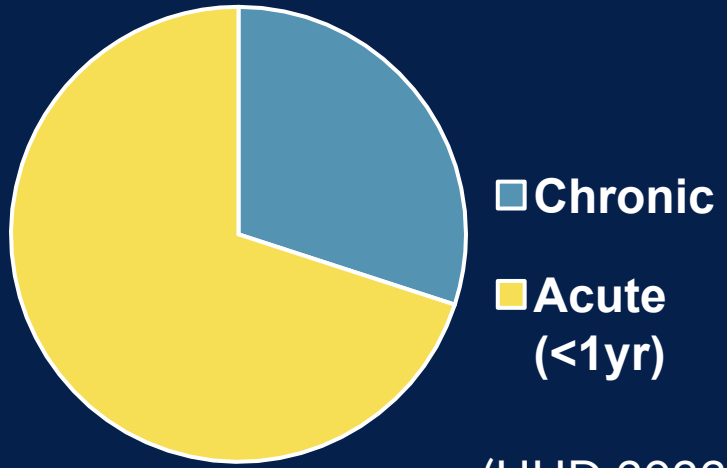






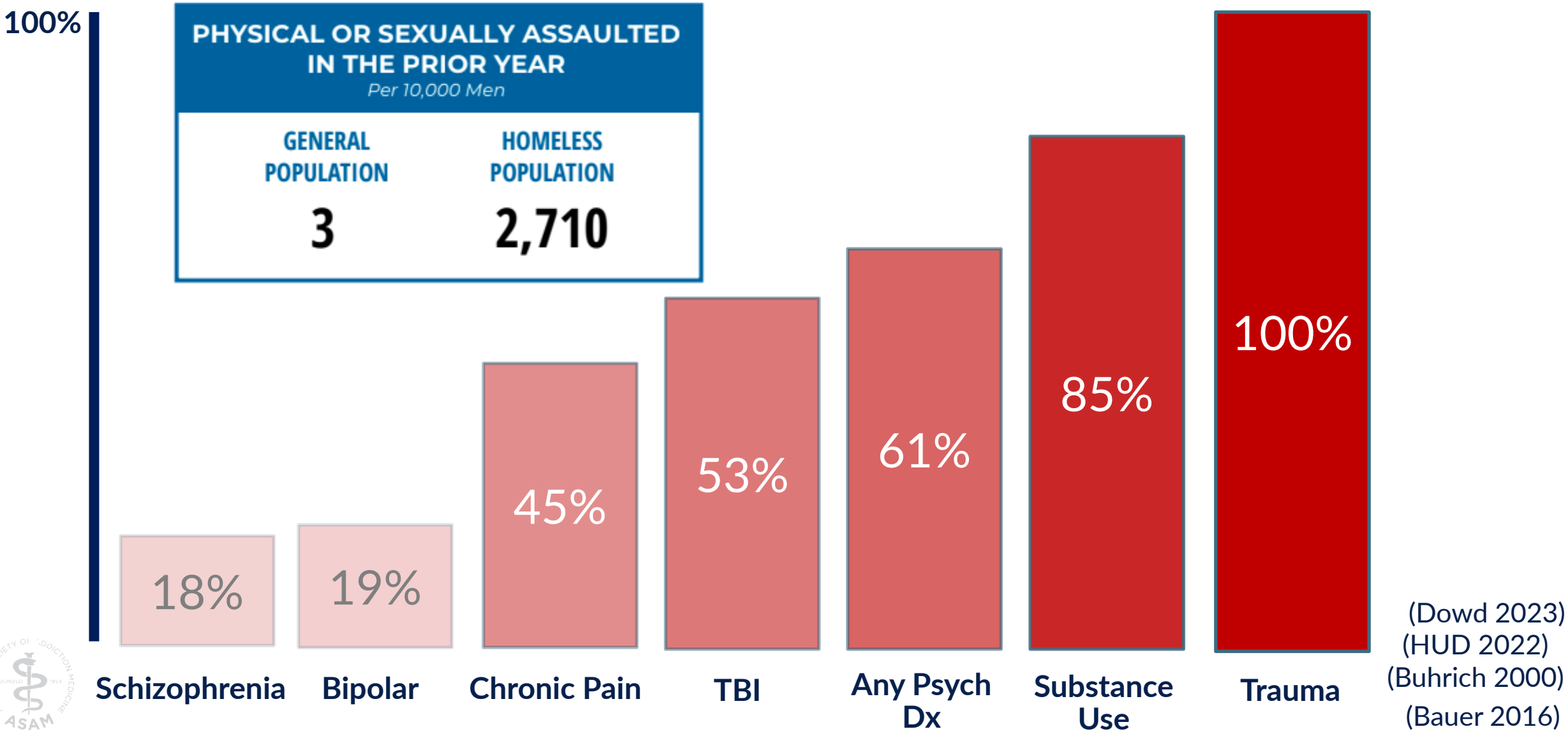






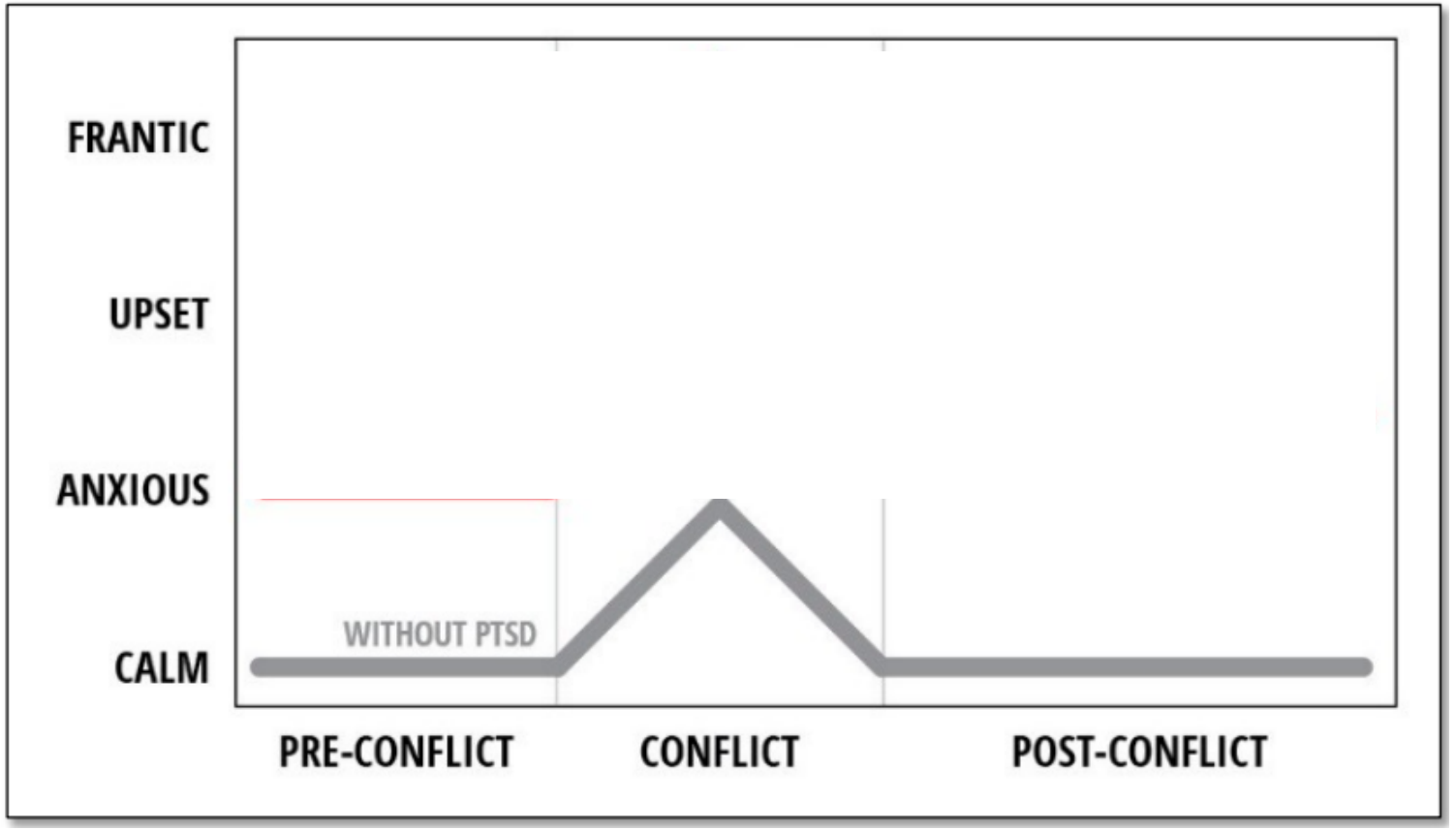
(HUD 2023)

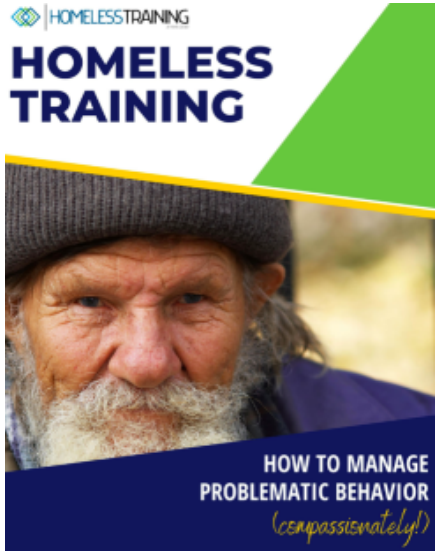
Chronically Homeless Population (>1yr)



(Dowd 2023)
(HUD 2022)
(Buhrich 2000)
(Bauer 2016)

Trauma's Effect in the Clinic





(Dowd 2023, www.homelesstraining.com)

1. **ANXIOUSNESS** ***"Hypervigilence"***
   Heightened state of tension even before an issue arises
2. **OVERREACTION** ***"Misperceiving threat stimuli"***
   Becomes upset easily over minor issues
3. **AGGRESSION** ***"Emotional Dysregulation"***
   Increased anger and reactive aggression
4. **DIFFICULTY CALMING DOWN** ***"Hyperarousal"***
   Trouble calming down after becoming upset

The Impact of Homelessness on Health

↑ infectious diseases

3x overall mortality

↓ life expectancy by **17.5 years**

12x overdose rate

(HUD 2022; Cawley 2021; Fine 2022)

Chicken or the Egg?

SUBSTANCE USE ⇌ HOMELESSNESS

Trauma
Education
Financial Instability
Mental Illness

SUBSTANCE USE HOMELESSNESS

(McVicar, 2015; O'Toole, 2004)


Substance Use
Homelessness

The Impact of Homelessness on Accessing Care

People experiencing homelessness are less likely to be in or receive treatment for substance use disorders.

(Bauer et al., 2016; Deck and Carlson, 2004; Dunn et al., 2019; Eyrich-Garg et al., 2008; Kelly et al., 2018; Krawczyk et al., 2020; Lundgren et al., 2003; Reynoso-Vallejo et al., 2008; Rivers et al., 2006; Royse et al., 2000; Shah et al., 2000; Gaeta-Gazzola, 2023)

Compared to housed counterparts, PEH Entering MOUD have

- Higher rates of sexual and physical assault, comorbid psychiatric illness, and chronic pain
- Higher risk substance use behaviors
- Increased social vulnerability and compounding SDOH
- Higher rates of social isolation

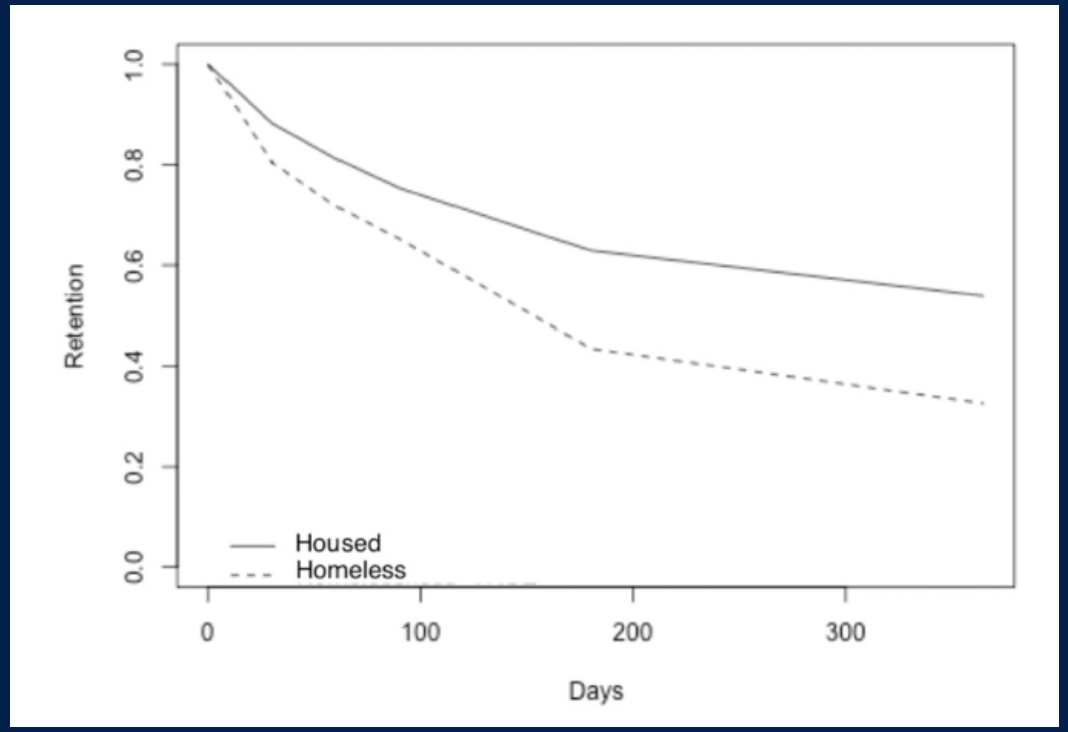
1 in 4 PEH entering outpatient methadone treatment have **no social support outside of their treatment team**

(Han et al 2022 JSAT); Gaeta Gazzola et al. 2022 JSAT); (Gaeta Gazzola et al. 2023 SAj)

PEH face intersectional barriers to accessing and remaining in traditional MOUD settings

Even among those able to enter MOUD…

- Homelessness is an independent predictor of poorer treatment engagement in MOUD
- Nationally, homelessness is significantly negatively associated with treatment completion and length of time in treatment



(Gaeta Gazzola et al. 2022 JSAT); (Gaeta Gazzola et al. 2023 SAj); (Krawczyk et al., 2021 JSAT)

Pair & Share

- What have your experiences been caring for people who are unhoused?
- Any participant/patient stories that come to mind?

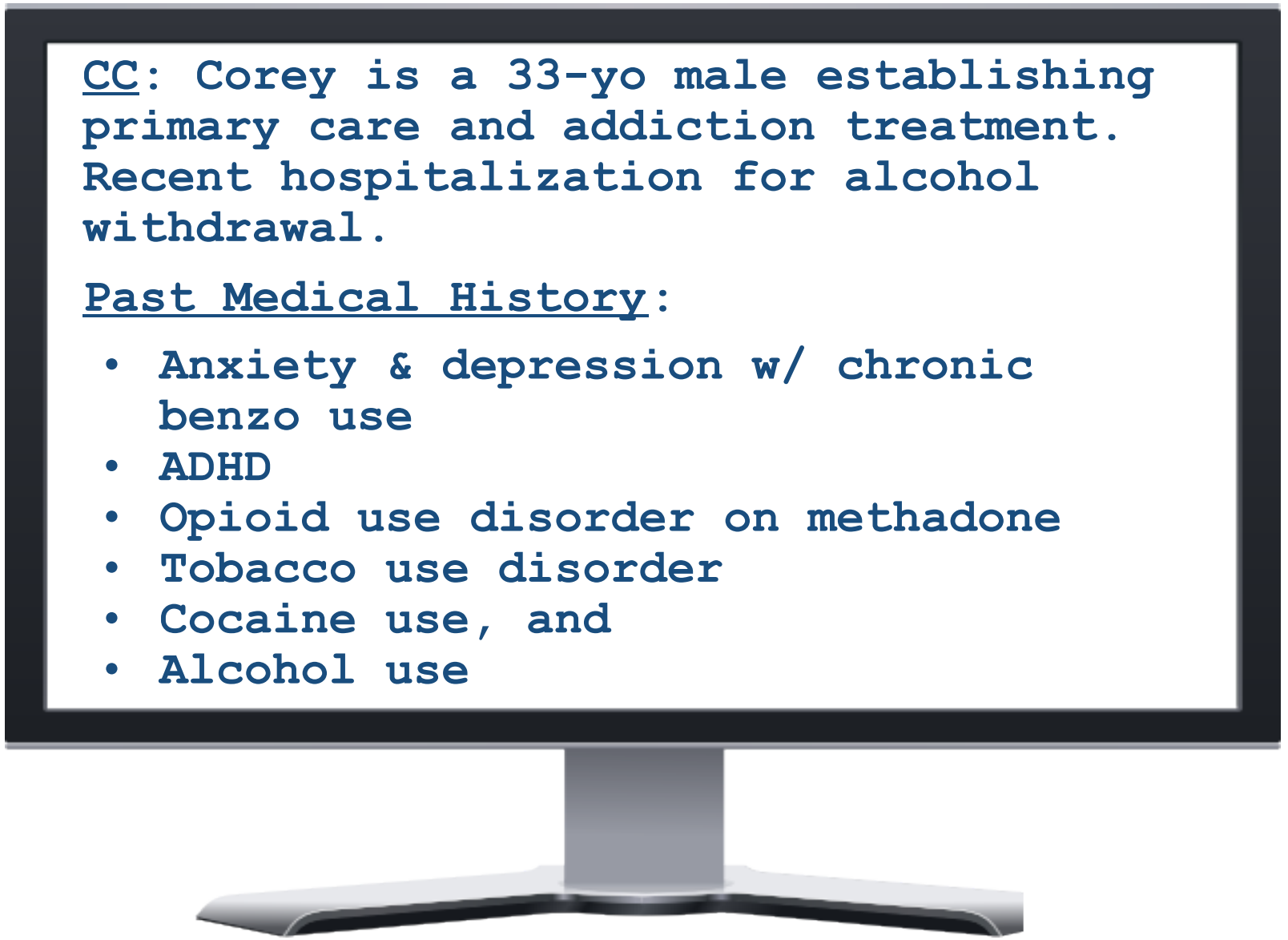
The Power of Peer Support

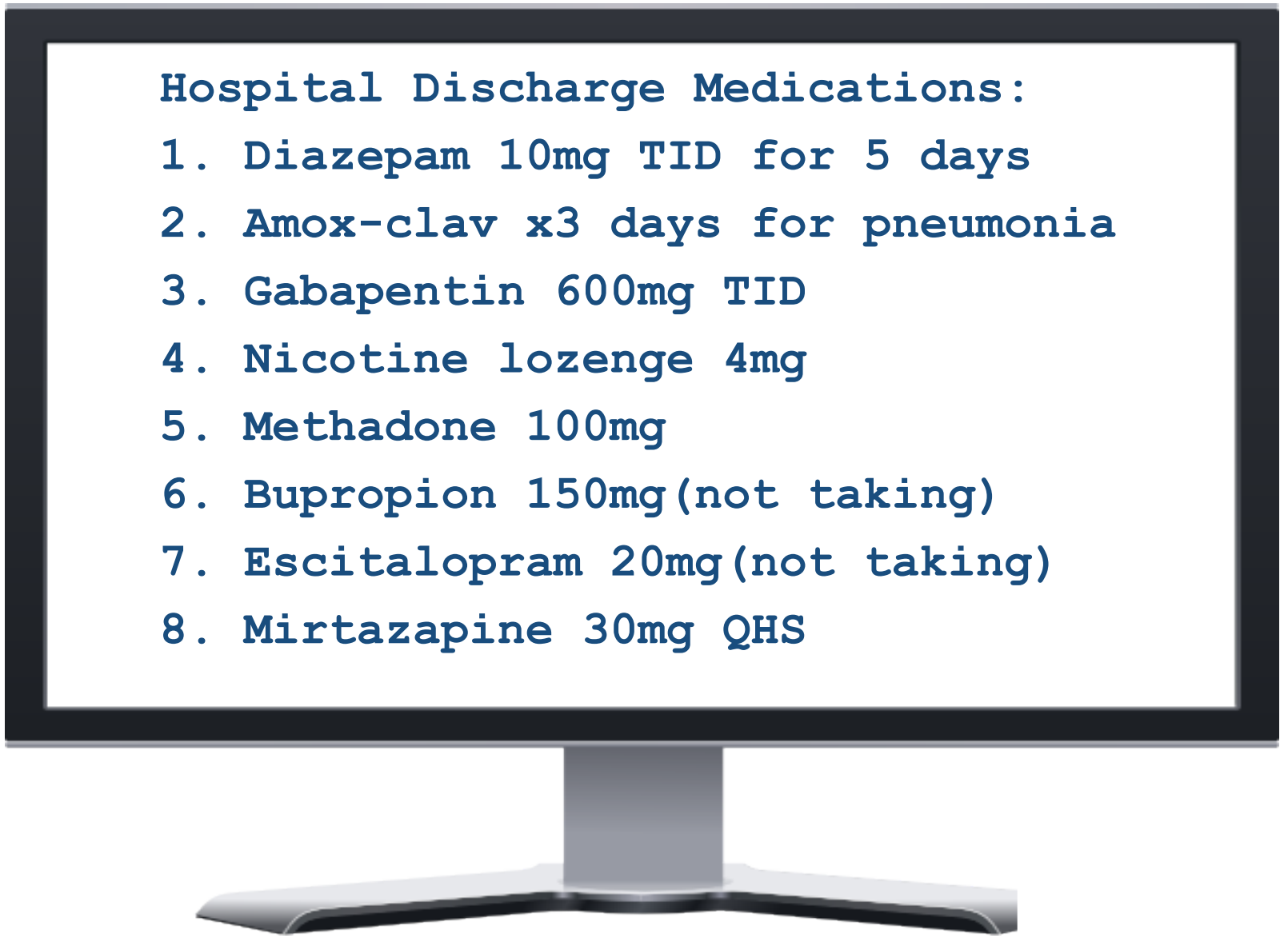
Tips for Trust-Building

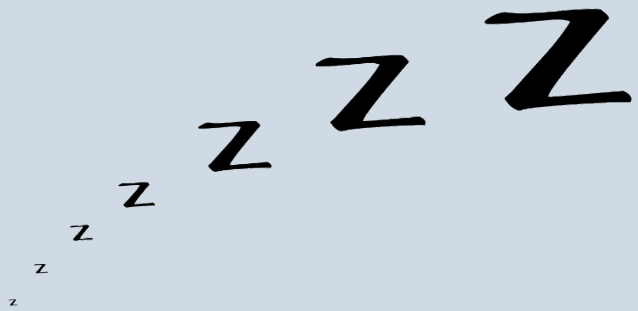
Developing an OUD Care Plan for PEH

Presentation Slides

In Clinic


CC: Corey is a 33-yo male establishing primary care and addiction treatment. Recent hospitalization for alcohol withdrawal.
Past Medical History:
• Anxiety & depression w/ chronic benzo use
• ADHD
• Opioid use disorder on methadone
• Tobacco use disorder
• Cocaine use, and
• Alcohol use


Hospital Discharge Medications:
1. Diazepam 10mg TID for 5 days
2. Amox-clav x3 days for pneumonia
3. Gabapentin 600mg TID
4. Nicotine lozenge 4mg
5. Methadone 100mg
6. Bupropion 150mg(not taking)
7. Escitalopram 20mg(not taking)
8. Mirtazapine 30mg QHS



Patient is asleep in the waiting room.

History

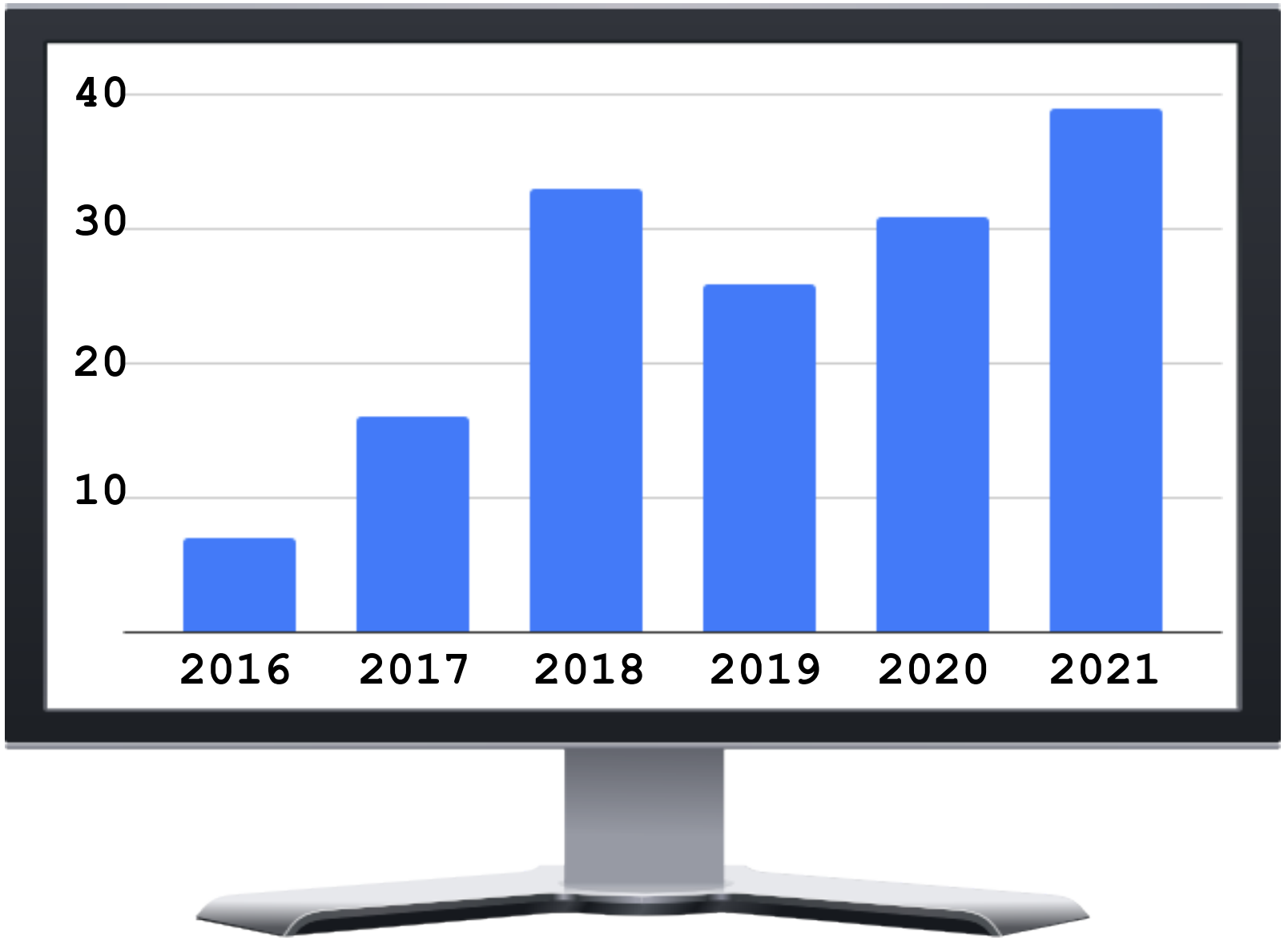
"I have really bad anxiety right now. I'm taking 5 Ativan [lorazepam] pills and it's not helping."

"I'm tired of chasing around substances."

Substance	First Use	Current Use Pattern
Opiates 	Age 20 Prescribed hydrocodone → snorting fentanyl	Last used 6 mos ago. On methadone 100mg, stable dose for months.
Benzo. 	Age 22 Prescribed clonazepam	Alprazolam 8-12 mg daily. Recently discharged w/ diazepam 10mg TID.
Alcohol 	Age 18 Binge pattern	Drinking 750mL vodka daily, last drink yesterday. +Withdrawal seizures
Cocaine 	Age 27, smoking $120 worth weekly	No use in several weeks.
Tobacco 	Age 18	10 cigarettes a day


SMILOW CANCER HOSPITAL
ONE WAY
NO TURN ON RED
YaleNewHavenHealth

Corey's Emergency Department Visits



What would you address first?

a. Opioid Use Disorder
b. Alcohol Use Disorder/Withdrawal
c. Benzodiazepine Use Disorder/ Withdrawal
d. Overdose Risk
e. Somnolence
f. Housing
g. Cocaine Use

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Clinical guideline for homeless and vulnerably housed people, and people with lived homelessness experience

STEP 1

Housing & Income Assistance

STEP 2

Case Management (Connection to Care)

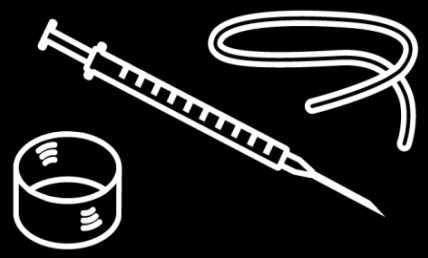
STEP 3

Harm Reduction

(Pottie, 2020)

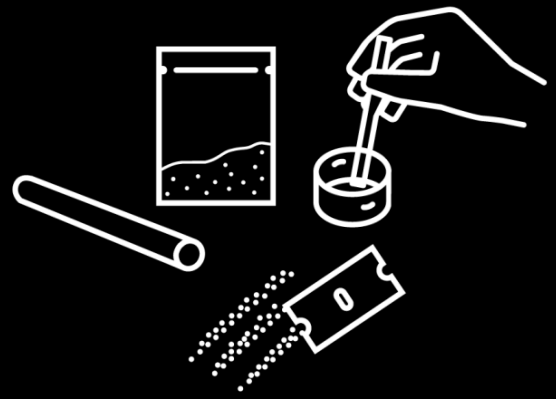
Slide courtesy K Sue

Harm Reduction Services

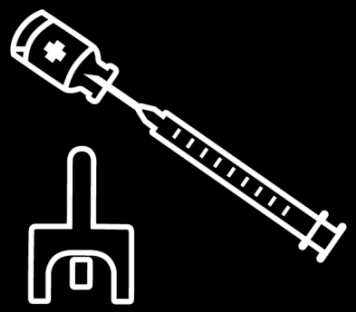


Syringe Access

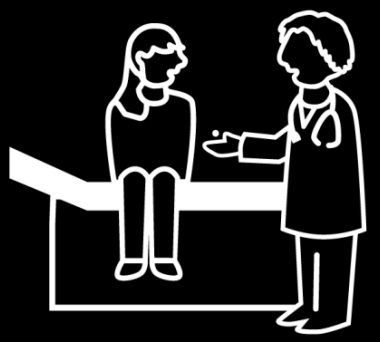
Syringe Disposal



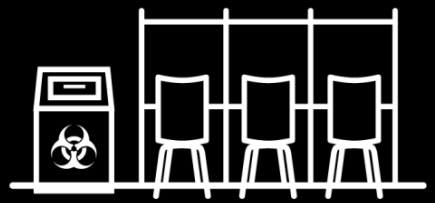
Safer Drug Use



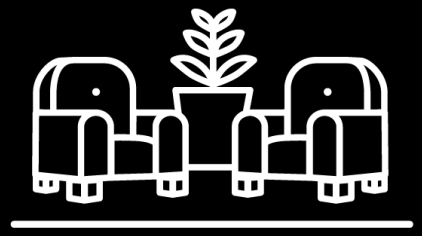
Naloxone



Medication Treatment



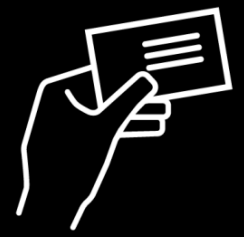
Supervised Consumption Services



Drop-In Centers

Housing First

Pharmacy Access



Referrals

STEP 1

Housing & Income Assistance

STEP 2

Case Management (Connection to Care)

STEP 3

Harm Reduction

STEP 4

Start evidence-based treatment for substance use disorders.

(Pottie, 2020)

Assessment & Plan:

33M w/ PMH anxiety & depression on chronic benzodiazepines w/ a sedative-hypnotic use disorder, OUD on methadone, AUD on gabapentin, and ADHD untreated w/ intermittent cocaine use. HIGH OVERDOSE RISK. Treat benzo/alcohol withdrawal overlap below.

- Prescribed naloxone, counseled on OD
- Prescribed clonazepam 1mg TID
- Called patient's mom & case manager
- Showed patient how to call 2-1-1

Mobile Check-in w/ Corey

- More alert. Has black-eye from getting jumped. Wallet/ID/phone stolen.
- Had a slip, now using intranasal fentanyl. Discontinued methadone.
- Interested in starting buprenorphine.

How would you approach Corey's mobile care?

How would you start buprenorphine?

	STANDARD	LOW DOSE NON-OVERLAP	LOW DOSE OVERLAP
Wash-out period	8-72 hours	6 hours	n/a (continue agonist til day 7)
Dosing	Standard: 4-8mg, give additional 4-8mg if tolerating Macro: 16-32mg	Day 1: -0.5mg q2hrs x 4 doses (first 6 hours) -1mg q2hrs x 2 doses (next 4 hours) -2mg q2hrs x 2 doses (next 4 hours) -8mg (2 hours after last 2mg dose) Day 2: -8mg BID	Day 1: 0.5mg daily Day 2: 0.5mg BID Day 3: 1mg BID Day 4: 2mg BID Day 5: 4mg BID Day 6: 4mg TID (STOP agonist) Day 7: 8mg BID
Clinical notes	**Simplest, careful with standard regarding precipitated withdrawal.**	**Anecdotal data says works well with fentanyl, reduces time not using. Simpler than overlap.**	**Best for patients on prescribed agonist. Good for methadone transition to buprenorphine.**
Handout/more info			

6-months after first visit

No emergency department visits since September.

“This is the first time in the past 5 years I’ve given a clean [appropriate] urine.”

“That was the first Christmas I’ve been with my family in a long time.”

Exemplar Care Models Reaching PEH

Mobile Care Outreach

1. Specific purpose driven (i.e. Medicaid enrollment)
2. Peer/community health worker led (frequent 1:1 support)
3. Coordinated entry system work ("front steps" programs)
4. Health care outreach (***promoting access*** to services)
5. Formalized medical outreach (***providing*** medical services)

Medical Outreach Continuum

STREET MEDICINE
Care on foot

MOBILE UNIT
Care in vehicle

National Healthcare for the Homeless: Street Medicine and Outreach: Bringing Care to People…

Low-Barrier Buprenorphine

Easier access→ Engages minoritized groups.

- 52% of clients nationwide identify as non-White and 40% identify as Hispanic in mobile care

Connects with high-risk populations.

- HIV screening higher at MMUs (54% in MMU vs. 7% in traditional clinic)
- Higher positive HIV tests at MMUs (5% in MMU vs. 2% in traditional clinic)

Higher retention rate than non-HCH clinics

- Homeless clinic group visits → 70% retention @ 6 mos

Other Programs

- Yale Street Psychiatry (Gibson, 2023)
- San Francisco (Carter, 2019)
- Boston HCHP: CCIR, CareZone
- Homeless veterans (Iheanacho, 2020)
- Peer driven model, New London, CT (Alliance for Living)

(Regis et al, 2020; Yu 2017; Doorley 2017)

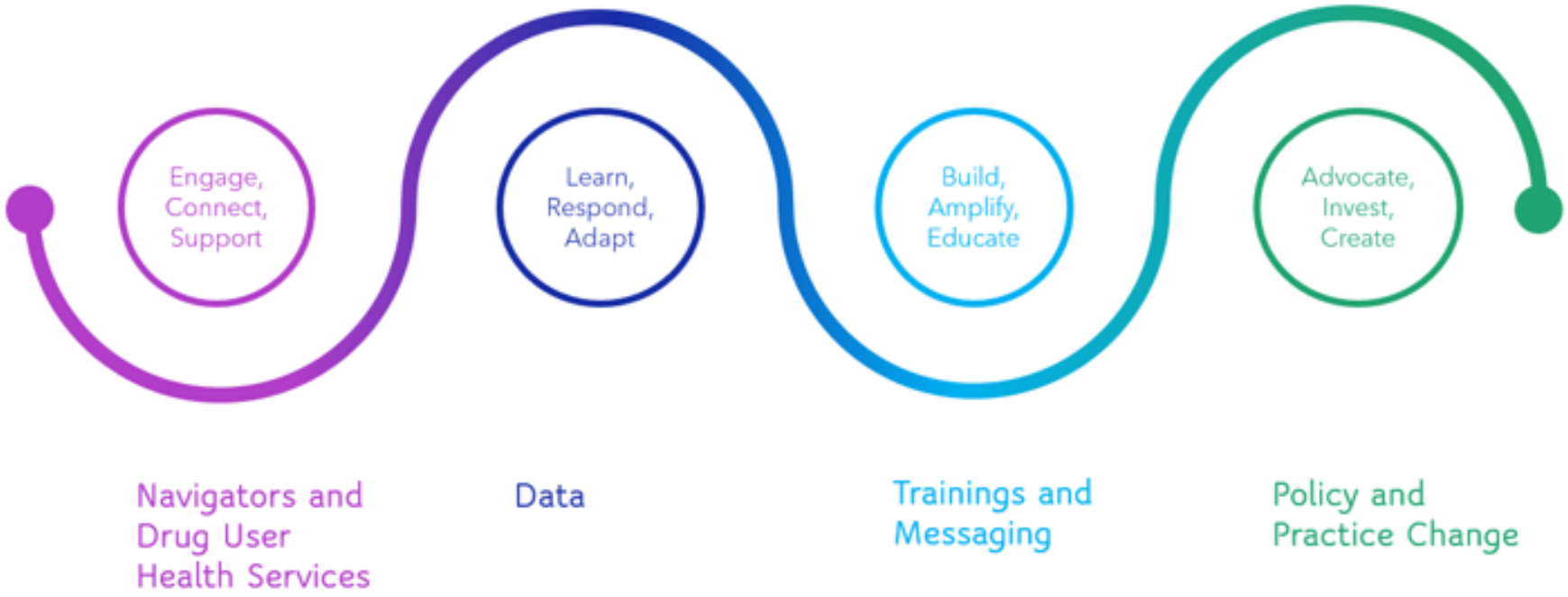
Coordinated Access, Resources, Engagement and Support (CARES)

Developing a collaborative, comprehensive public health approach to the overdose crisis

Our approach

- Centers and follows the data to create change at the individual and community levels
- Prioritizes increasing access and choice for individuals, saturating our community with naloxone and reducing stigma and discrimination against people who use drugs
- Requires a commitment to working across organizations and sectors to activate all expertise and resources in coordination and collaboration

Our community **CARES**



- Lead with the people we serve - whether in our direct interactions, in looking at the data, in teaching community groups about overdose response or in advocating for policy change.
- Learn from the people we serve - the true knowledge and solutions are in our communities. Trust building takes time, you have to keep showing up, but partnership with the people most impacted is a requirement.

Advocate to change systems - but don’t wait for systems to change

- Our approach the first year was to develop the peer outreach and work with existing systems to expand access to medication
  - In year two we integrated a clinician on the team and immediately saw results
    - seven years later we are still waiting for meaningful expanded access in those systems
- We continue to push the systems and at the same time continue to expand and enhance the access we have created
- We continue to advocate for policy and practice change at the provider, state and federal level
- We continue to draw connections so that policy makers understand the multiple intersecting systems that impact people’s health, wellbeing and safety

Q & A!

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