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## Addressing the Opioid Crisis: Innovative Programs Serving People Experiencing Homelessness

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### INTRODUCTION

Health centers are increasingly seeing individuals who are suffering from Opioid Use Disorder (OUD) and other Substance Use Disorders (SUDs). Many of these individuals are also faced with housing instability or are experiencing homelessness. Innovation is being driven at the ground level by a variety of providers including health centers, public health departments, harm reduction agencies and supportive housing agencies that are all concerned with the impact of OUD and other SUDs on the health of the people they serve. Essential in any innovative care model are the services needed to ensure people experiencing homelessness have access to evidence-based care, including Medication Assisted Treatment (MAT).

This brief will describe the evolution of three unique model programs addressing the needs of this most vulnerable population. All three programs are either a health center in their own right or are essential partnerships created with local health centers to offer evidence-based care. The description will include their successes as well as the barriers to success they are encountering.

### THE ISSUE

Communities are seeing an increasing population of people who are experiencing OUD and homelessness or housing instability. Commonly these individuals have been actively using substances for some time and many of their supports systems are no longer available to them because of the side effects of long-term substance use. Health and housing disparities are evident in African-American and Native American communities who are over represented among those suffering from SUDs and homelessness. The challenges of addressing the needs of people experiencing homelessness and OUD are unique, and require a person-centered approach that engages people with respect, flexibility and a variety of approaches to meet their wide-ranging needs.

#### Medication Assisted Treatment or MAT

**Buprenorphine-** Office-based opioid agonist/ antagonist that blocks other narcotics while reducing withdrawal risk; daily dissolving tablet, cheek film, or 6-month implant under the skin.

**Naloxone-** Office-based short acting opioid antagonist.

**Suboxone-** The brand name for a prescription medication containing the ingredients buprenorphine and naloxone.

**Naltrexone-** Office-based, non-addictive opioid antagonist that blocks the effects of other narcotics.

## CASE STUDIES

This brief highlights three innovative care models that have evolved to meet the needs of their community:

- **Father Joe's Villages**, San Diego, CA: *A homeless services provider and Federally Qualified Health Center (FQHC) providing services to promote stabilization and end homelessness.*
- **San Francisco's Department of Public Health's (SFDPH) Low Barrier Buprenorphine Program**: *The city's public health department programming to address the twin crises of OUD and homelessness.*
- **Prevention Point Philadelphia (PPP)**, Philadelphia, PA: *Provides Mobile Substance Use Disorder services (M-SUD) and homeless services programs, as homelessness became a more common issue for the people they serve.*

All three providers responded to evolving crises in their communities by moving outside their areas of expertise, developing new partnerships and new capacity to meet the needs of the people they serve.

**Father Joe's Villages** cites creativity and flexibility as essential to adjust to the changing needs of the people they serve. Father Joe's Villages became a HRSA 330h grantee in 2008 and began offering MAT services in early 2018. San Diego has the fourth largest population of people experiencing homelessness in the nation. The organization's reach includes an onsite Federally Qualified Health Center (FQHC) that provides medical, dental, psychiatric and behavioral health care; a continuum of services from street based outreach to permanent supportive housing; a day center for homeless adults, employment and education services; and feeding programs. Approximately 25 percent of their shelter residents demonstrate symptoms of substance use disorders. To address the needs of program participants and community members experiencing homelessness and OUD, the health center collaborated with detox programs, residential SUD treatment programs, pharmacy and needle exchange programs. Village Health Center is also a subcontractor of the Hub and Spoke model which was pioneered in the state of Vermont<sup>1</sup> to ensure individuals are engaged in the appropriate level of care throughout their recovery journey. Through this model, participants can be referred to 'hub' partner, Fashion Valley Comprehensive Treatment Center, which provides a higher level of daily care and support. Alternatively, participants can be served by the onsite 'spoke', Father Joe's Villages Health Center, which can offer weekly, bi-weekly or monthly outpatient MAT support.

To evolve their programming to a harm reduction model, Father Joe's Villages clinic and shelter staff were trained to recognize and treat the unique needs of individuals with SUDs through evidenced based methods of treatment, including Motivational Interviewing, Trauma Informed Care and MAT. Father Joe's Villages also made it a priority to stock and train staff, program residents, and community members on the use of Narcan, a nasal spray that can reverse opioid related overdose.<sup>2</sup> Health Center leadership ensured primary care clinicians were DATA 2000 (x waiver) trained to treat patients and prescribe necessary medications which reduce relapse and overdose risk while promoting patient stabilization<sup>3</sup>. A monthly MAT Integration Meeting was facilitated so alcohol and other drug (AOD) counselors and primary care clinicians could share experiences, discuss care coordination, propose updates to workflows, and make recommendations for future program evolution. When participation in MAT programming at the Health Center expanded beyond what was expected, the MAT Integration team determined a group treatment model would allow for an improved use of available resources. Now, program participants attend weekly hour-long MAT groups facilitated by an AOD counselor while primary care clinicians pull participants, one at a time, for brief discussions of program progress and prescribing of medications. Leadership also applied for grants and sought new donors to expand

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<sup>1</sup> <https://blueprintforhealth.vermont.gov/about-blueprint/hub-and-spoke>

<sup>2</sup> [https://www.integration.samhsa.gov/opioid\\_toolkit\\_firstresponders.pdf](https://www.integration.samhsa.gov/opioid_toolkit_firstresponders.pdf)

<sup>3</sup> <https://www.samhsa.gov/medication-assisted-treatment/training-materials-resources/apply-for-practitioner-waiver>

program services to address the changing needs of their program participants. In the early stages of program development, the team learned some crucial lessons to overcome barriers:

1. As with most homeless services, meeting people where they are at both physically, and in relation to level of motivation to address SUDs, proves fundamental to engagement.
2. Offering open access scheduling for X waiver providers (patients can walk-in and request to be seen same-day) is a valuable retention tool and decreases missed appointments.
3. Same-day induction (receiving Buprenorphine the same day as you first see a provider rather than waiting) facilitates MAT program engagement.
4. Communication with program participants outside supports - including case managers and residential staff contacts - proves helpful in decreasing program dropout rates.
5. Program growth spread by word-of-mouth marketing from program participants to other individuals experiencing homelessness in the community. As people's needs were met in a flexible and respectful manner, new participants were ready to sign on.
6. The team has had to manage consistent program growth and ensure more providers were buprenorphine X-waivered to increase patient access.
7. Weekly MAT group programming encourages program participants' connection with a supportive peer group and allows for integrated care provided by a team of AOD counselors and primary care clinicians.

Annually, over 12,000 people are served by Father Joe's Villages, through their array of services and over 3,000 receive assistance at the Village Health Center. Programming continues to evolve to meet the changing needs of people experiencing homelessness in the San Diego community.

**The San Francisco Department of Public Health (SFDPH)** describes its mission to "protect and promote the health of all San Franciscans."<sup>4</sup> The Low Barrier Buprenorphine program takes that mission to the streets, to ensure San Franciscans experiencing unsheltered homelessness and OUD also have access to the evidenced based models for treating SUD. The Street Medicine team recognizes the challenges faced in serving a medically needy and unhoused populations and the team works to develop the relationships that over time facilitate healing and recovery from trauma and SUDs for the people they serve. As a public health department, the team also recognizes the community concerns around the use of opiates including needle waste, public complaints and the visual distress of those suffering from SUDs on other community members.

To address these needs and concerns, the SFDPH team began in November of 2016 to deploy an outreach specialist staff person with homeless outreach services to address the specific needs of people experiencing unsheltered homeless. The target population was defined as people experiencing homelessness and engaging in injection drug use who were unable to access MAT in general and buprenorphine specifically. This population faced additional challenges including mental illness, a variety of physical illnesses, long histories of trauma, inconsistent benefits and high-risk behaviors. The goal was to increase access to recovery, treatment services, and MAT specifically.

#### **COMMON BARRIERS TO CARE INCLUDE**

- Identification
- Delays in Medication Induction
- Trauma Histories

The SFDPH team views harm reduction services as core to their mission and the philosophy that underlies all their work. Harm Reduction, prioritizes the relationship and addresses the needs as identified by the person in need, not the person delivering services. While the SFDPH team are public health professionals, they work to address the many varying needs of the people they serve.

Operating simultaneously at the person, program and system level, they collaborate with a variety of programs in the city to assist including shelter and housing programs, health clinics, pharmacies,

<sup>4</sup> <https://www.sfdph.org/dph/comupg/aboutdph/jobs/>

hospitals and needle exchanges. They collaborate with teams at each of these organizations to break down barriers to care for those with whom they engage on the streets.

The team's intakes occur on the street where they engage and build trust with individuals in need of care. Part of the intake involves completing an assessment of basic needs and a comprehensive assessment of medical needs and risk. The goal for the outreach team is to start buprenorphine within two to four days and is not required to be in a site-based facility. Follow-up is commonly weekly or bi-weekly to start and can be as often as daily. The frequency of Urine Drug Screens (UDS) to determine impact of treatment is jointly decided by clinical professionals based upon clinical indications, participant stability and the program participant's wishes. The team and their pharmacy partnership allows the participants to pick up medications as often as is decided by the team and participant and the team has the ability to monitor dosing. As the participant becomes more engaged in active recovery, referrals to higher levels of care can happen. The team has an expedited process for these referrals and can support participants through the referral process and toward more positive outcomes.

A program evaluation included the 95 participants who were a part of the program for a one-year period starting in November 2016. The evaluation found:

- 62% were retained in care after one month; and
- 22% remained in care after 12 months.
- 37% remained on buprenorphine after one month; and
- 22% remained on the medication after a year.
- 14% of program participants remained drug free throughout the year of program participation; and
- 34% had at least one negative UDS throughout the year.

The program staff found this a much higher retention rate than expected. With such promising results, the SFDPH expanded the pilot and as of June 2019, the program is now serving over 500 participants through its low barrier buprenorphine program.

**Prevention Point Philadelphia (PPP)** began in 1992 as an outgrowth of ACT UP offering syringe exchange services to combat the AIDS crisis. Over the past 25 years they have grown to a full service public health agency, leading harm reduction services in the city. As such, PPP is uniquely positioned to create innovative solutions to the opioid crisis. Their programming currently includes site based services like an on-site needle exchange, HIV and other primary care services, MAT services, case management, a drop-in center, soup kitchen and mail services. PPP partners with a local FQHC, the Stephen Klein Center of Project Home and the needle exchange now operates in over ten mobile locations across the city.

The City of Philadelphia has seen a significant increase in Medicaid beneficiaries receiving OUD services, growing from over 7,300 in 2010 to over 12,400 by 2018. PPP is also one of the few agencies in Philadelphia offering MAT which does not require total abstinence. Their clinicians believe MAT offers the potential for increased safety and stability allowing for the trust building needed to engage in more intensive services. Their M-SUD services including Mobile MAT, engages vulnerable people otherwise lost to care.

PPP believes that the model of M-SUDs services addresses a variety of barriers to care including the traumatic histories of most persons with SUDs as well as the trauma from an active SUD, including being present when friends overdose, engaging in sex work or other traumatizing experiences. The PPP programs are all trauma-informed, working to realize the impact of trauma and build pathways to recovery, recognize signs of trauma in both participants and staff. PPP's teams operate from a harm reduction perspective, limiting barriers as much as they are able while remaining in compliance with state and federal requirements. Staff also recognize the impact of stigma and strive to maintain a constant welcoming and open environment for program participants. The team sees their role as not

solely offering treatments, but addressing barriers to treatment, as well as connecting to services not offered by PPP such as legal services or supportive housing.

In the first 5 months of offering this model, the team served 118 new people. Of that sample, 81% were homeless or experiencing housing instability, 61% were insured at first engagement and use of multiple substance was common. Through the M-SUDs model, 76% returned for a second appointment and 34% remained engaged with services at 120 days after initial engagement. The team sees these outcomes as a great success. Their work will continue to offer services that are as flexible as resources and regulations allows.

#### **SOLUTIONS INCLUDE**

- Medical-Legal partnerships to help acquire identification.
- Mobil MAT.
- All staff trained in trauma informed systems.

### **THEMES ACROSS THE CASE STUDIES**

A number of themes were consistent across all three agencies and programs:

- The agencies served complex, multi-disabled populations for whom co-occurring disorders of mental illness, HIV and other physical health challenges was the norm, rather than the exception.
- The agencies were committed to a harm reduction approach continuing to serve individuals, no matter the individual's current commitment to a substance free lifestyle or current substance use.
- The agencies had expanded their mission and services to address the crisis requiring the expansion of their partnerships.
- The agencies recognized the impact of trauma on the people they served and their own staff. All strove to provide trauma informed care and ensured a trauma informed perspective was evident in any potential partners.
- The agencies either offered, or hoped to offer mobile MAT to people who were experiencing unsheltered homelessness. All agencies found the regulatory concerns around offering the service challenging, but all were committed to breaking through barriers to address the crisis.

### **CONCLUSION**

The confluence of federal funding targeted to treating opioid use disorder and enhanced HRSA funding for health centers makes this an opportune time for health centers to expand their scope either within their agency or through partnerships. Common partnerships can include substance use treatment services, harm reduction agencies, legal aid, Continuums of Care and other homeless services funded providers, and public health agencies. All these entities share a general goal of improving health and addressing the opioid crisis specifically among people experiencing homelessness. All programs discussed here partner with other mainstream services to expand services and treatment options for individuals who are homeless. With flexible services and barriers to care effectively addressed, a strong percentage of people who are experiencing homelessness and substance use disorder can be connected to care. The agencies profiled here exhibit a strong commitment to mission, creativity in planning and operations, expanding networks and services and above all a focused approach to assist the evolving needs of their community.

## ABOUT CSH

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