Research In Action: Using Data to Fuel Changes in the Clinical Care of People Experiencing Homelessness and Addiction

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Plan

- Substance-attributable mortality
  - Presentation of the data
- Implications for our model of care
  - Facilitated discussion
- Example of practice redesign
  - Chronic disease management for overdose prevention

Substance-Attributable Mortality

ORIGINAL INVESTIGATION

Mortality Among Homeless Adults in Boston

Shifts in Causes of Death Over a 15-Year Period

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- Cohort of 28,033 adults seen at Boston Health Care for the Homeless Program (BHCHP) in 2003-2008
- Cross-linked to MA death occurrence files to determine rates and causes of death
- Compared findings to:
  - Massachusetts general population, 2003-08
  - Prior BHCHP mortality study, 1988-93

JAMA Intern Med 2013;173(3):189-195

Drug overdose:
The new epidemic

- Drug overdose was the leading cause of death
  - 1 in 3 deaths among those <45 yrs old, at rates 16-24 times higher than in MA population
- Opioids implicated in 81% of overdose deaths
- Compared to 1988-1993, the drug overdose death rate had tripled

The Boston Globe **Health & wellness**

Study: Drug overdose leadi cause of death among hom adults

By Chelsea Conal

90.9wbur

Drug Overdoses Are Now Leading Killer Of Boston's Homeless

Drug overdoses top AIDS as main cause of homeless deaths

Summary

- Over half of all deaths were attributable to tobacco, alcohol, or drug use
  - Rates dramatically exceeded those in MA population
- Substance-attributable deaths accounted for a disproportionate burden of excess mortality
  - But did not fully explain disparity with MA population

Implications for our Model of Care

Implications

- First, reactions to the data?
- Facilitated group discussion

Implications

- What should be the *role of addictions services* within HCH programs?
- Consider a *care model* designed to decrease mortality and improve health.
- What are concrete steps we can take to *evolve* our care models?

Implications (brainstorming session with notes below)

ROLE OF ADDICTION SERVICES?

- Help provide support for medical providers, more tools for having discussions with patients
- Assessment of substance use disorders is lacking in primary care
- Role of residential programs, safe space for recovery, trauma informed services, vocational opportunities
- Recovery housing
- How are we communicating addiction services to patients to combat stigma?
- More creative strategies to communicate to consumers

Implications (brainstorming session with notes below)

CARE MODEL DESIGNED TO ↓MORTALITY AND ↑HEALTH?

- Universal intake screening for addictions regardless of door patients come through for services
- Better links to detox, sobering services (lack of access), timely, expedited services
- EMR templates for assessment tools, universal approach
- Addiction specialist as core part of team, making addiction treatment a core goal of team. Better BH/primary care integration.
- Addiction services are inaccessible unlike other specialists
- Better integration with residential recovery programs
- Harm reduction model is critical

BHCP Task Force Recommendations

- **Clinical Guidelines**: Revision of BHCHP clinical guidelines for the prescribing of chronic opioid therapy for chronic non-cancer pain
- **Addiction Services**: Assessment of current addiction services; consideration of addictions intervention and management as a core part of our program identity
- **Public Health Approach / Advocacy**: Reflection on our role in a public health campaign to educate patients and homeless service providers about the risk and management of overdose
- **Chronic Disease Management for Addiction**: Consideration of a method of chronic disease management for a registry of patients at risk for overdose, evolving a disease collaborative approach to treating addiction

Example of Practice Redesign

The ACCESS Team: A Chronic Disease Management approach to addressing drug overdose in individuals experiencing homelessness

Program Goals

- Reduce unintentional drug overdose deaths
- Reduce health consequences associated with addictions
- Improve functionality and quality of life of patients with severe addictions at highest risk for overdose
- Do it in primary care context

A Promising Model: Chronic Disease Management (CDM) Approach

- Addiction is a chronic disease
  - No cure and a relapsing course
- Medical/psychiatric co-morbidities are common
- Requires longitudinal, comprehensive, and coordinated care approach

(Saitz, et al. J Addict Med. 2009)

CDM Model Definition

- Patient-centered
- Longitudinal, coordinated care
- Includes patient and provider education
- Evidenced based care plans
- Expert care availability
- →Enhancement for addiction includes stronger linkages and integration across addiction care spectrum

(Wagner, et al. BMJ 2000; Wagner, et al. Millbank Q. 1997; Saitz, et al. J Addict Med. 2009)

Why the CDM model?

- Effective model for other chronic diseases
- Key elements of CDM model shown effective for addictions
- Familiar model to BHCHP
- PCMH and care team infrastructure already in place at BHCHP

Additional Tailoring for Individuals Experiencing Homelessness

- Harm reduction approach
- Low threshold services
  - Open access appointments
  - Few patient requirements for participation
- Outreach capacity

Initial Action Steps

- Conducted focus group of BHCHP consumers around overdose prevention interventions
- Engaged stake holders both at BHCHP and with community partners
- Presented preliminary intervention ideas, including CDM addictions team model, to Board of Directors which included consumers

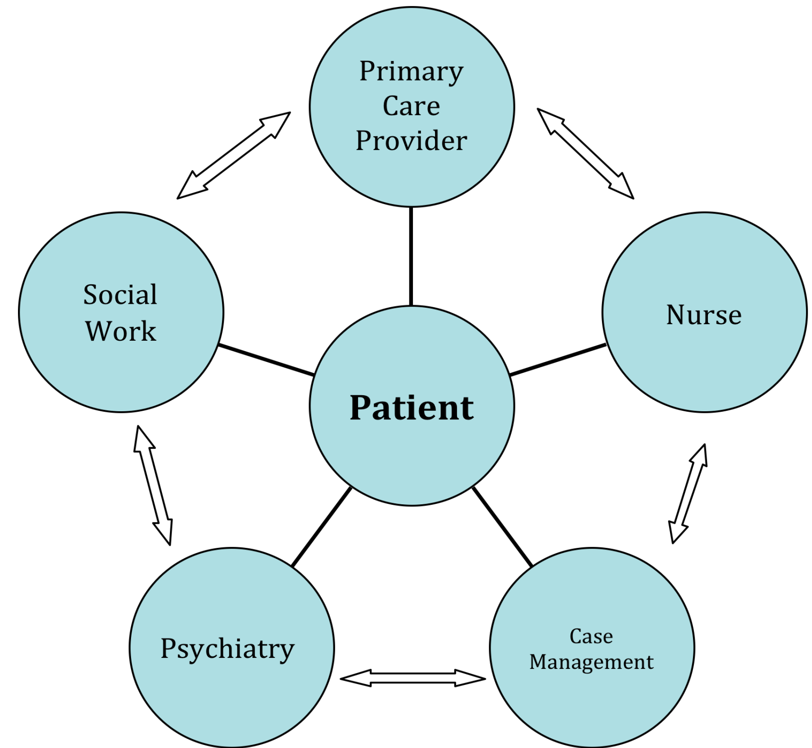
ACCESS Team

- Addiction Clinical Care and Expedited Support Services = ACCESS
- Multidisciplinary, addiction-focused primary care team
- Located in clinical site with established patient centered medical home
- High intensity, low threshold, expedited services
  - Primary care
  - Behavioral health
  - Case management and community accompaniment
  - Chronic care management
- Rolled out in December 2013

Target Population

- Small registry of homeless individuals at highest risk for drug overdose
  - Patients experiencing at least 1 unintentional drug overdose in the last 6 months
  - Only requirement from patients that they receive primary care from the team
  - Goal to enroll 50 patients in the first year

ACCESS Team Structure



2 PCPs , 1 RN Care Manager, 2 LICSWs, 1 Psych NP, 1 CM/community support person

Team Services

- Integrated primary medical and behavioral health care
- Nurse led chronic care management
- Intensive case management
- Community accompaniment
- Medication assisted therapies
- Motivational enhanced therapies
- Intranasal naloxone prescription and training
- BHCHP-wide OD focused health education

PCMH Addiction Focused Enhancements

- More behavioral health integration and staffing with weekly case conferencing
- Greater addiction expertise and on-going staff training
- Addiction-specific chronic care management
- More intensive case management
- Focus on smaller registry of patients
- More inter-agency collaboration

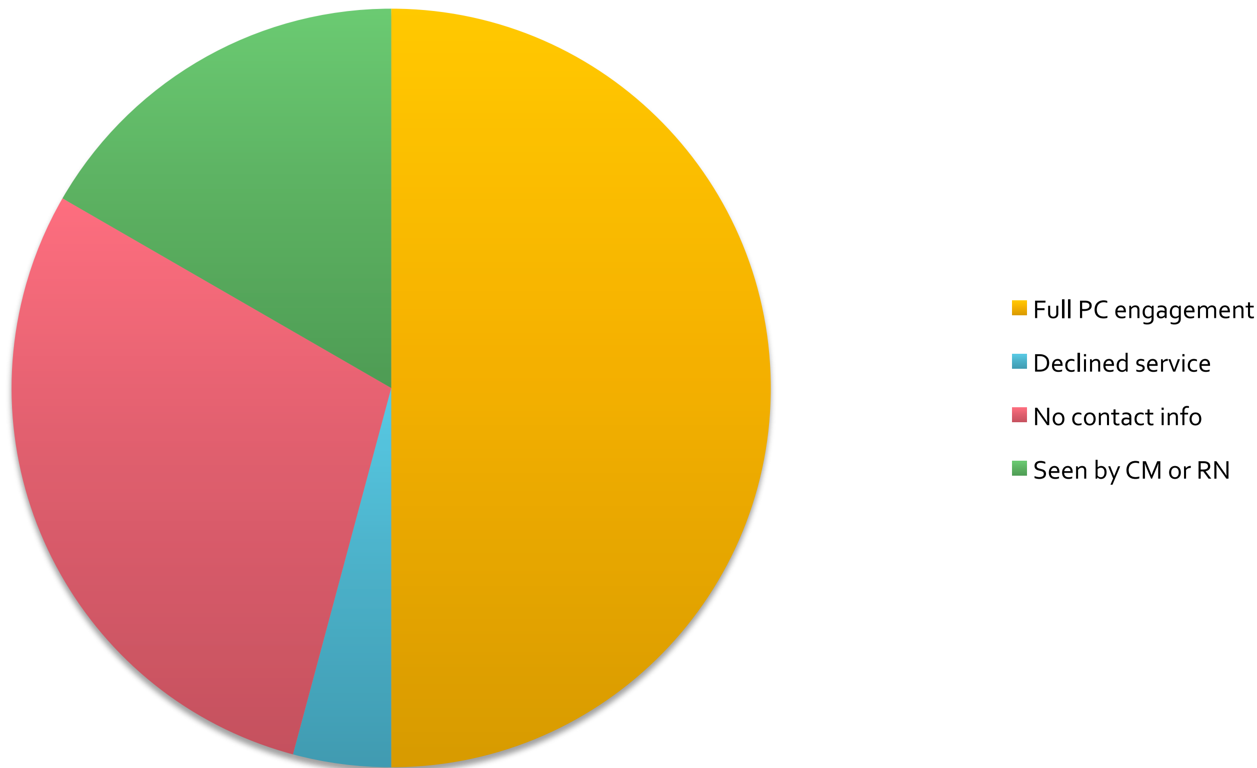
Team Operations and Roles

- **PCPs** see each patient every 1-4 weeks
  - Protected open access availability
- **Psych NP** has open access visit availability
  - (1-2 slots per week)
- **RN** provides chronic care management between PCP visits
- **LICSWs** run weekly addictions focused support group/available for therapy on open access basis
- **CM** works exclusively with team patients on daily basis
  - CM leads program-wide OD prevention education
- Team meets weekly for one hour to discuss patient care plans

Funding and Resources

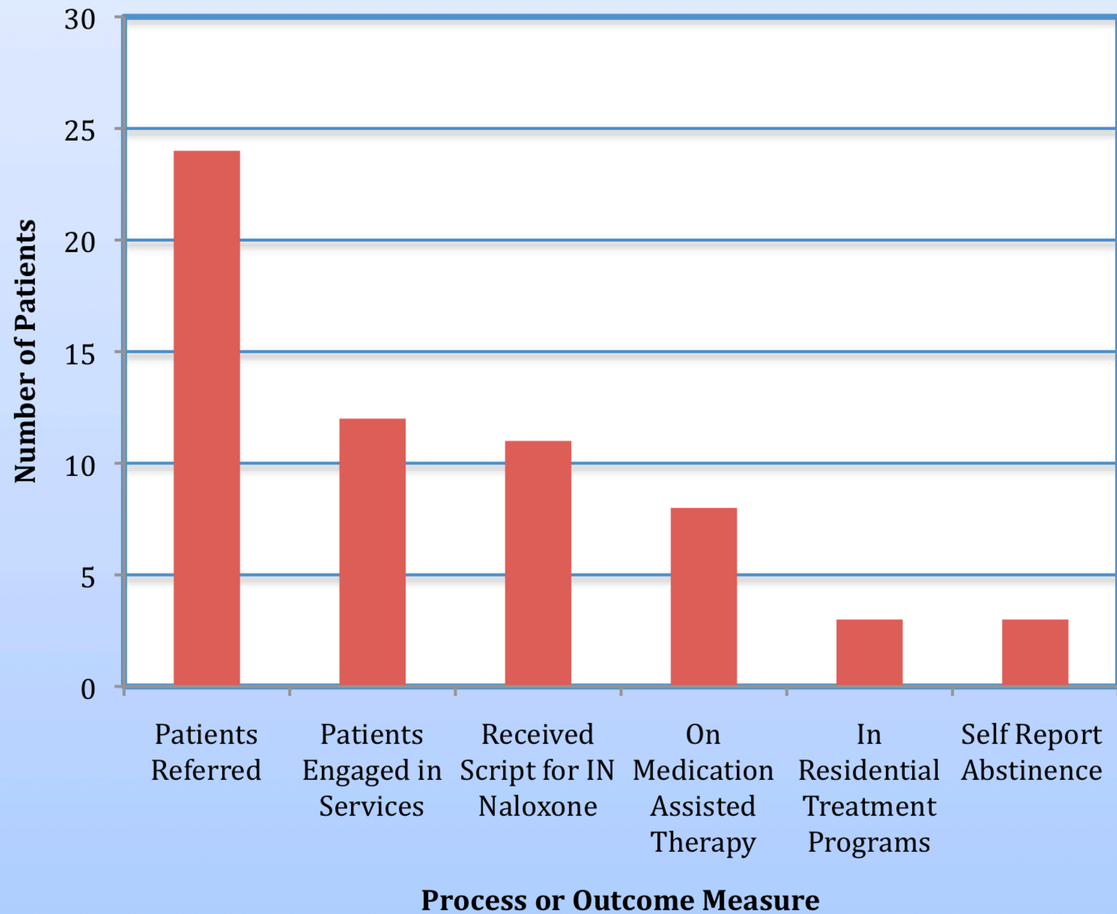
- All team members are pre-existing staff, except case manager
- Team meets during lunch hour
- Team physician had a 2-year fellowship to support work on the project
- Most non-CM visits are billable
- The role of payment reform and global payments to support/sustain team efforts?

Engagement: Early Results



Of 24 referrals

- 12 engaged*
- 1 declined service
- 7 had no contact information
- 4 seen only by the team RN or CM



Of **24** referrals:

12-Engaged
11- Given IN naloxone
8- MAT
3– In RTPs
3- Self report abstinence

ACCESS Team Patients

- Men: 17
- Women: 7
- Average age: 38yo (range 23-57)
- Co-morbidities
  - Chronic HCV: 58% (14/24)
  - HIV/AIDS: 8% (2/24)
  - Mental health diagnosis: 83% (20/24)

Key Lesson

- Engagement and establishment of the therapeutic alliance are critical, but the road can be long
  - Harm reduction, low threshold, non-judgmental approach plays critical role

Key Challenges

- Relatively low (50%) initial patient engagement after referral
  - Lack of contact information with inadequate team outreach capacity
  - Poor patient follow up after initial contact made
- Unacceptable barriers and delays in initiating medication assisted therapies
- Insufficient mechanisms for following patients and across many care systems including incarcerated settings
- Very high no show rates particularly for behavioral health
- Questions remain regarding how to best address challenging patient behaviors

Next Steps

- Increase team's outreach capacity
- Reduce barriers to starting MAT
- Strengthen collaboration with community partners including methadone providers and the corrections system
- Conduct focus group with enrolled ACCESS Team patients regarding unmet needs and barriers to care
- Solicit further input from our CAB
- Formal evaluation of effectiveness is underway

In Conclusion

- Data can be an important validation of what we think we're seeing anecdotally.
- Ideally, data can be used to provide an empirical basis on which to advocate.
- There is a need for evolution of our care model based on new experience and population-level data.
- Repurpose existing infrastructure, even in small steps, to address existing barriers to care for people with SUD.