Establishing a MAT Clinic for the Homeless in New Orleans

Neil Nixdorff, MD, Verella Morris, MPH and Celeste Roell, LCSW

2019 National HCH Conference, Washington DC May 23, 2019

CITY OF NEW ORLEANS
MAT

- Medication-assisted treatment (MAT) is the use of medications with counseling and behavioral therapies to treat substance use disorders and prevent opioid overdose -- SAMHSA. Gov

| 1:00 PM - 2:00 PM | Reducing Disparities in Addiction Care: Low-Threshold Buprenorphine for Unsheltered Patients  
Constitution CDE  
For the past year our team has been prescribing buprenorphine on the spot for any patient seen by our medical outreach van meeting DSM V criteria for opioid use disorder (OUD). In this talk we will discuss the outcomes of our low-threshold buprenorphine trial as well as review our harm reduction approach towards treating OUD. We will also review the details of the pharmacology, safety profile and mortality benefit of buprenorphine as a treatment for OUD. We hope this talk will generate a discussion about how programs can change their approach towards treating OUD with buprenorphine and increase access to this life saving medication,
Goals of this Presentation

- To share our experience developing and implementing a MAT clinic focused upon the homeless
- To demystify MAT and demonstrate it as an important tool in primary care for homeless populations
- To foster introspection and external critique of our methods for quality improvement.
City of New Orleans Healthcare for the Homeless is a FQHC that operates out of the City of New Orleans Department of Health. We service two locations to provide care for nearly 4,000 patients with almost 9,000 clinical visits in 2018.

Per 2018 UDS report

- 75% self identify as homeless
- 92% are 100% or below FPG
- 93% Medicaid or Uninsured
In CY16, New Orleans EMS administered \textbf{785 doses of naloxone} of which were due to opiate-related cardiac arrest, heroin usage, or suspected heroin usage. This is a \textbf{22 percent increase} in opiate related naloxone administrations in a 1-year period.

According to Emergency Services for the City of New Orleans, opioid misuse was responsible for more than 600 emergency service overdose calls in 2015, and more than 780 in 2016.

According to the Orleans Parish Coroner’s Office, the number of accidental drug-related overdose deaths in the City of New Orleans in 2016 exceeded the number of murders for the first time in the city’s history.
OPIOID OVERDOSE DEATHS

ORLEANS

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EAST BATON ROUGE

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JEFFERSON

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ST. TAMMANY

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<td>'18</td>
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Source: Various parish coroner's offices

Advocate graphic

DEA-NOX-BUL-161-17
MAT landscape for Medicaid in New Orleans

Insurance Coverage – Medicaid Expansion in 2016!

Medicaid Providers of detox, rehab and OP services:

- **RiverOaks** – only MAT via inpatient detox
- **ODH** – inpatient detox, no SB, only Vivitrol
- **DOC** – Groups and AA/NA attendance required; exclusions for severe mental illness and ETOH/BZO dependency
- **ACCER** – must be involved in IOP program
- **ARRNO** – must be involved in IOP program
- **Crescent Care** – Strict abstinence policy, 9 hours of group per week
Addiction as a Chronic Disease

Percentage of Patients Who Relapse

- TYPE I DIABETES: 30 to 50%
- DRUG ADDICTION: 40 to 60%
- HYPERTENSION: 50 to 70%
- ASTHMA: 50 to 70%

Relapse rates for drug-addicted patients are compared with those suffering from diabetes, hypertension, and asthma. Relapse is common and similar across these illnesses (as is adherence to medication). Thus, drug addiction should be treated like any other chronic illness, with relapse serving as a trigger for renewed intervention.

HCH MAT Philosophy

- Addiction Management vs. Addiction Treatment – IOPs and zero-tolerance UDS as barriers to care; referrals to higher level of care
- MAT as catalyst for primary care
Program Operationalization

- Admitting/Discharging patients
- Tracking Patients
- Handling Rx and Prior Authorizations
- Case Management / Behavioral Health
- Pathways to care – word of mouth, referrals from needle exchange, discharges from detox facilities
Program Integration

- Development of Behavioral Health Integration
- Identifying supportive grants
- Institutional on-boarding
Our MAT patients

- 214 patients oriented to MAT program, started treatment
- 80% new patients to clinic

- Age median/mean-mode was 39-41 (Overall clinic: low 50’s)
- 77% identify as Caucasian, 17% as African American (Overall clinic: 66% African American, 25% Caucasian)
- 68% male (Overall clinic: 56% male)
- 36% were HCV positive at time of presentation
MAT Outcomes

- >500% increase in visits for substance-related disorders. 175 patients making 864 visits (2018 UDS data)
- > 50% patient retention
- PPV for + BUP at initial visit was 71%
Problems/Difficult Situations

- Diversion
- Induction
- Dose Management
- Buprenorphine vs. Buprenorphine/Naloxone
- Benzos and Gabapentin
- Logistics
Where ‘Dat Suboxone?"

75 pharmacies queried 3 times over 8 month period over the phone.

- Only 2/75 stated each time that they could fill a “Suboxone” Rx
- 20/75 pharmacies stated at least once that they could fill a “Suboxone” Rx
- Of all responses, 60% were “No” and only 15% were “Yes”

Developing partnerships/collaborations with specific pharmacies

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On the horizon / Year 2

- HCV Treatment
- Peer Support Groups
- Expanding access
Health Care for the Homeless (HCH) Medication-Assisted Treatment (MAT)
Outreach and Community Engagement

Verella A. Morris, M.P.H
Outreach/Grants and Quality Performance Manager

City of New Orleans
May 23, 2019
I. Awarded the 2018 SUD-MH supplemental funding to implement and advance evidence-based strategies to expand access to integrated substance use disorder (SUD) and mental health (MH) services.

II. Funding supports the implementation of the MAT program, staff trainings (MAT workshops, harm reduction, etc.), behavioral health services (staffing LCSW,
I. **Process Objective**: Implement Medication-Assisted Treatment coupled with Behavioral Health Therapy and Community Outreach Support Services to at least 20% of HCH patients who report an opioid dependence by April 1, 2021.

A. Implement MAT in all HCH clinics.

B. Partner with Catholic Charities Archdiocese of New Orleans: Health Guardians (HG) to provide patients at risk with Behavioral Health Therapy.

C. Incorporate Community Outreach Supportive Services (COSS) by building a HCH MAT coalition from existing HCH community partnerships and HCH Consumer Advisory Board Members.
# MAT Outreach and Community Engagement

<table>
<thead>
<tr>
<th>Situation</th>
<th>Priorities</th>
<th>Inputs</th>
<th>Outputs</th>
<th>Outcomes-Impacts (short and long term)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioid abuse has risen to a level of national crisis, disproportionately affecting homeless individuals.</td>
<td>To create a comprehensive community-based Medication-Assisted Treatment Program serving opioid dependent homeless individuals.</td>
<td>Community Partnerships, Collaborative meetings, health fairs, wellness events, MHSD, local shelters, churches, food banks, etc., HCH Staff</td>
<td>Increase community knowledge of MAT availability, Stronger community relationships, Increase in patient participation in HCH MAT, Increase community awareness, Reduce homeless stigma.</td>
<td></td>
</tr>
<tr>
<td>Funding</td>
<td>Create bus advertisements, MAT literature, and promo items</td>
<td>HCH Staff</td>
<td>HCH Providers and Staff, MHSD, HCHAB</td>
<td>Improved understanding of the community and MAT methods, Implement harm reduction techniques in HCH MAT clinics.</td>
</tr>
<tr>
<td>Training</td>
<td>Provide MAT trainings to educate staff.</td>
<td>HCH Providers and Staff, MHSD, HCHAB</td>
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<td>Increased patient social supports, Increases patient and community empowerment.</td>
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<td>HCH MAT Coalition</td>
<td>Provide Outreach support services: mental health and substance abuse counseling, case management, peer support, etc.</td>
<td>HCH Providers and Staff, MHSD, HCHAB</td>
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MAT Outreach and Community Engagement

Lead Agency: Health Care for the Homeless (HCH)

Committee of Program

Coalition

Metropolitan Human Services District (MHSD)
Health Care for the Homeless Consumer Advisory Board (HCHCAB)
HCH Providers and Staff

Implementation

Provide Behavioral Health Therapists (BHT) to HCH MAT Patients
Serve as Peer Advocates to bring awareness to HCH MAT services and distribute helpful resources
Provide Medication-assisted Hayden to HCH Patients

Evaluation

Complete and review HCH provider reports
Work closely with HCH Provider to ensure comprehensive care plan
Complete and Review MATIntl and C0Bs from meetings, compiling results and findings together
Review HCH MAT patient provider reports regularly, follow up with patients to ensure comprehensive care
Coalition Empowerment

MAT Outreach and Community Engagement

- Allows the community to be well defined
- Trusted community relationships
- Collaborative focus will promote a more effective program and incorporate feedback from several community perspectives serving homeless individuals

- Gaining trust and commitment of community organizations
- Scheduling meeting time that works for everyone involved.
- Establishing an equitable partnership where each organization’s input is incorporated within the HCH MAT program.
### Reporting

**SUD-MH Tri-annual Progress Reporting (2/3)**

<table>
<thead>
<tr>
<th>2. Substance Use Disorder (SUD) Services</th>
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<tbody>
<tr>
<td>Enter total patients and visits from 9/1/2018 to the end of the current reporting period. Report all patients and visits, regardless of funding source (do not limit responses to activities supported by SUD-MH funding).</td>
</tr>
<tr>
<td>2a. Number of unduplicated patients who are receiving SUD services.</td>
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<tr>
<td>2b. Number of visits of patients who are receiving SUD services.</td>
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</tbody>
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<table>
<thead>
<tr>
<th>3. Mental Health (MH) Services</th>
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<tbody>
<tr>
<td>Enter total patients and visits from 9/1/2018 to the end of the current reporting period. Report all patients and visits, regardless of funding source (do not limit responses to activities supported by SUD-MH funding).</td>
</tr>
<tr>
<td>3a. Number of unduplicated patients who are receiving MH services.</td>
</tr>
<tr>
<td>3b. Number of visits of patients who are receiving MH services.</td>
</tr>
<tr>
<td>3c. Number of unduplicated patients who are receiving Screening, Brief Intervention, and Referral to Treatment (SBIRT) services.</td>
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<tr>
<td>3d. Number of visits for SBIRT services.</td>
</tr>
<tr>
<td>3e. Number of patients aged 12 years and older who were screened for depression with a follow-up plan documented on the date of the positive screen.</td>
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Questions?