Integrating Services to Engage Stigmatized Patients in Care

"The Little Nonprofit that Does a Lot"

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Mobile Integrated Health Symposium

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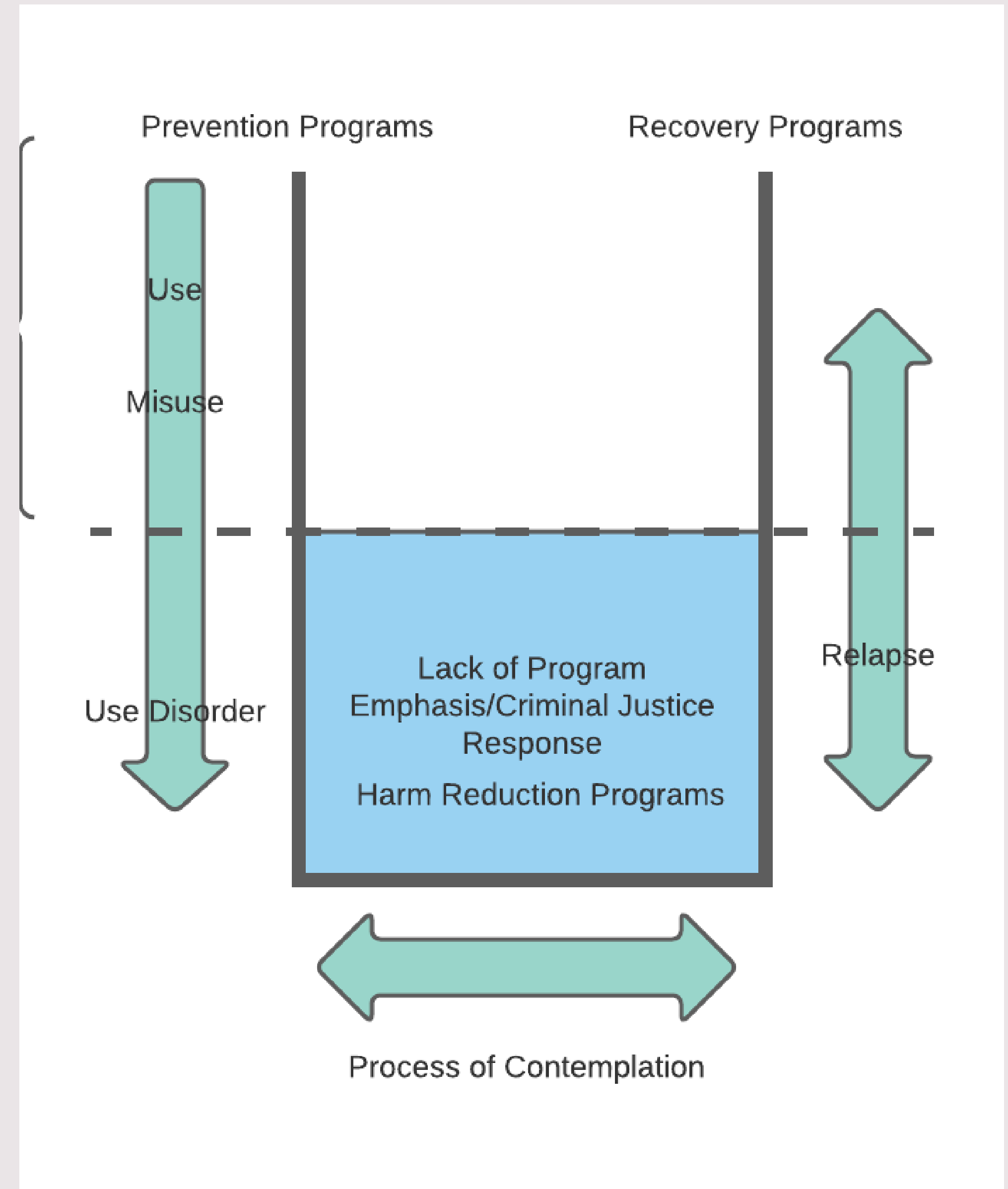
Behavioral Health Funding Emphasis

- In the last decade and more, public funding around opioid crisis response has prioritized prevention programs and recovery programs, with health insurance as the mechanism for much of the treatment space.
- This has de-prioritized people who use substances and who may not be interested in reducing or stopping their use.
- These are often the same people who due to stigma, also don't access traditional health care providers.



Models of Care in Rural Areas for Stigmatized Populations

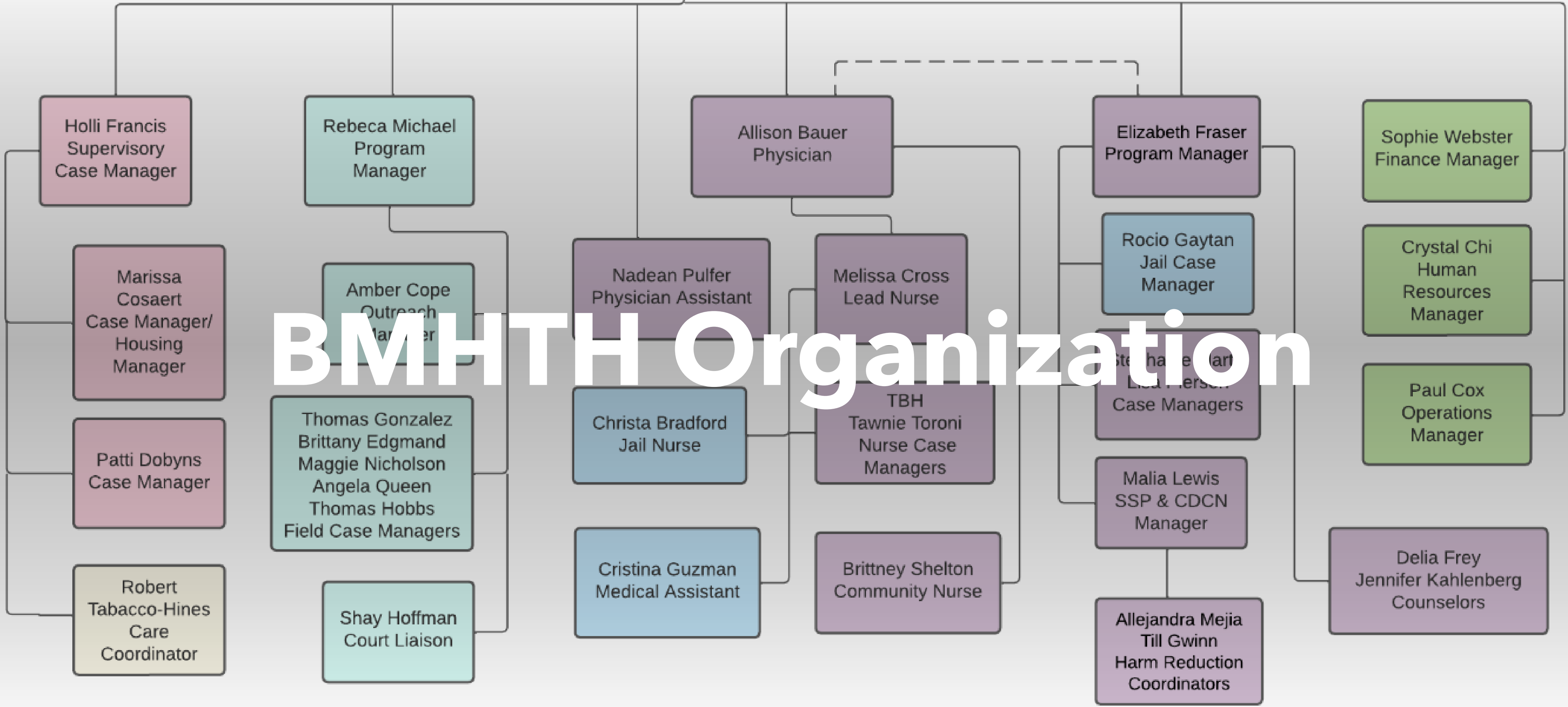
- Medication-Assisted Treatment Models
- Behavioral Therapy Models
- Harm Reduction Models
- Care Delivery Models
- Peer-Based Recovery Support Models
- Prevention Models
- Mobile Health Models

Source: https://www.ruralhealthinfo.org/toolkits/substance-abuse/2/program-models

BMHTH Organization

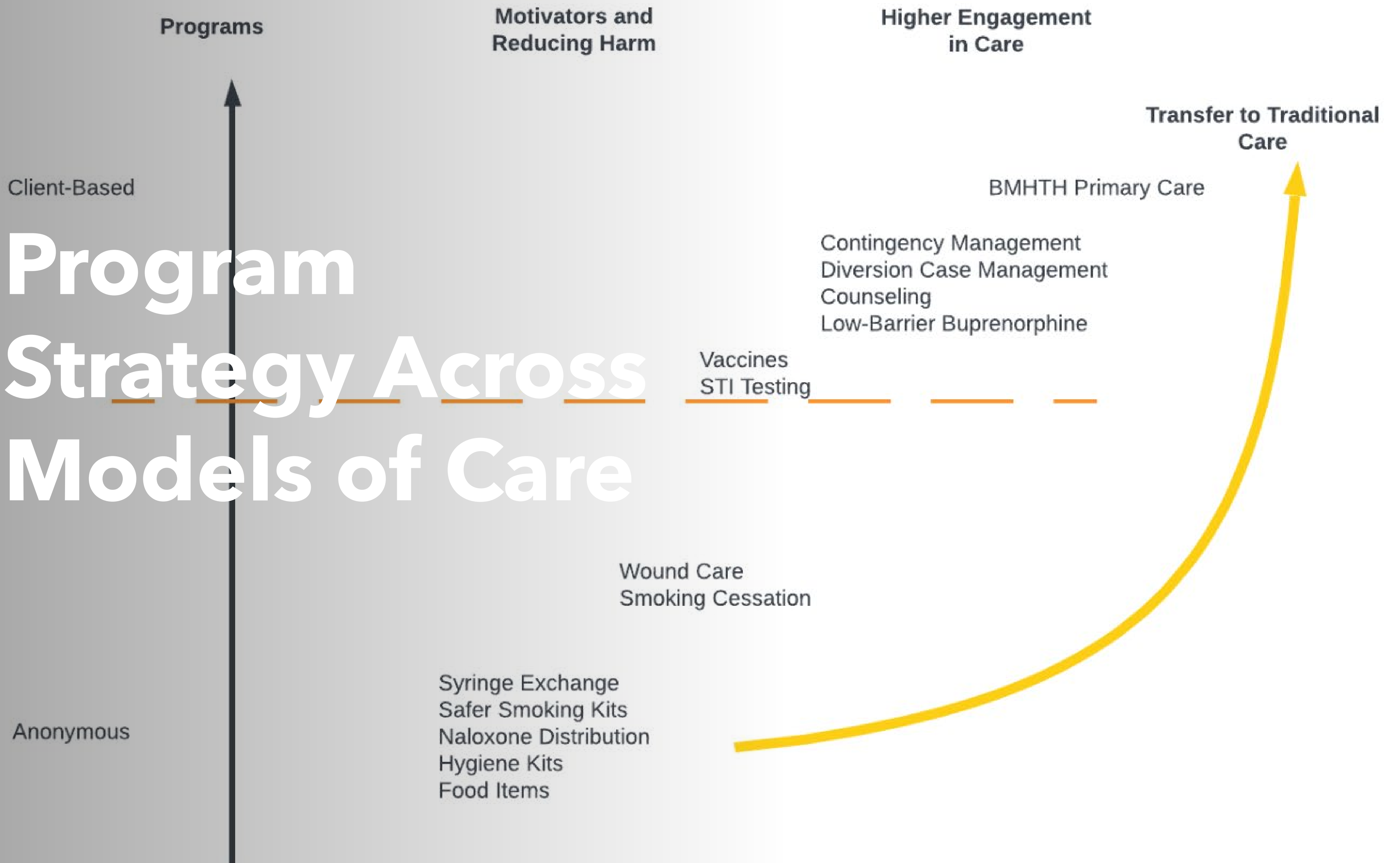
Executive Director

Organization
August 2024

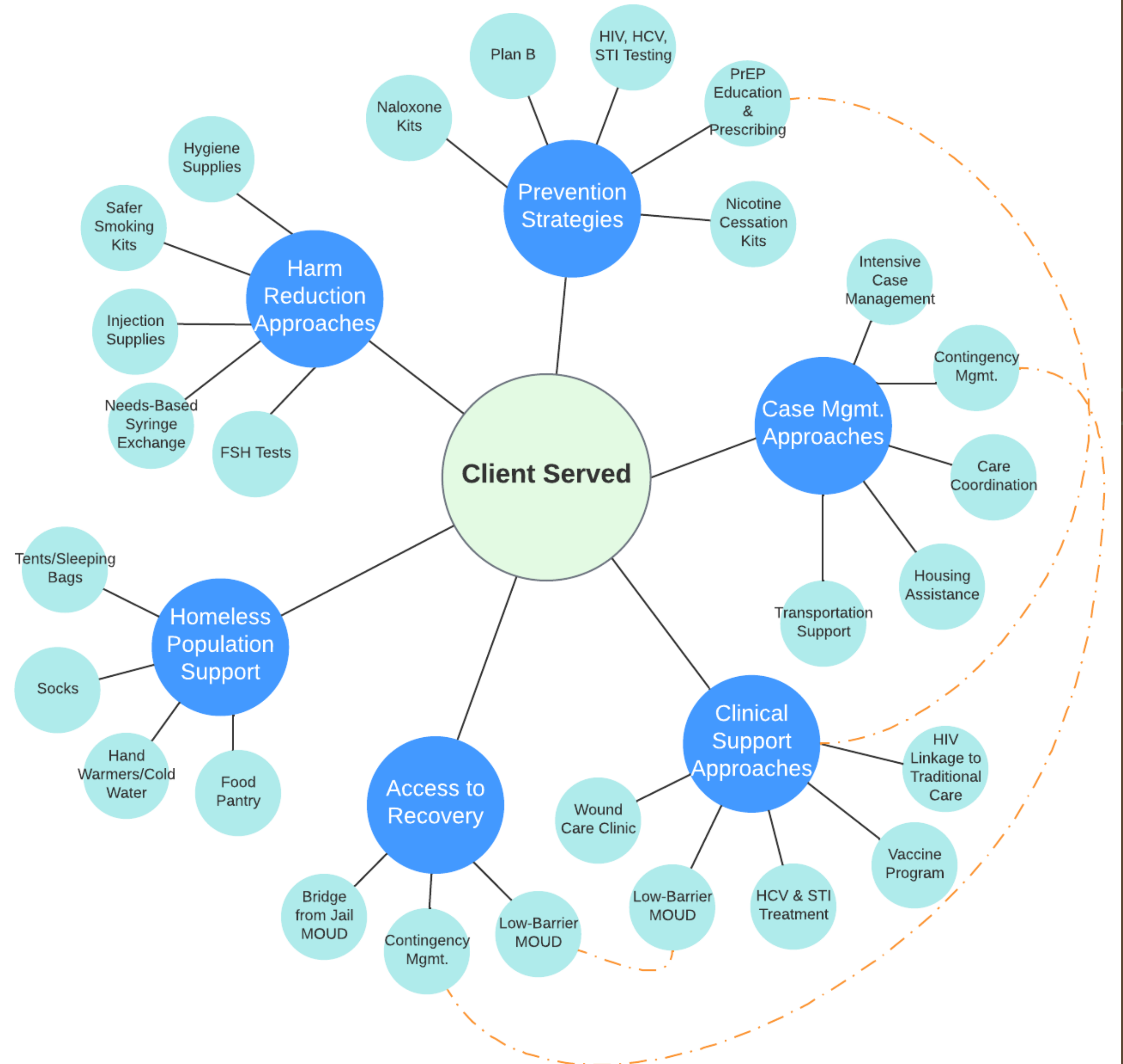


Ryan White Program | Jail Medical Program | Drug User Health Equity Programs | LEAD Programs | Care Connect Program | Administration

Program Strategy Across Models of Care



No Wrong Door Approach



What Do We Do? Current Programs

- HIV Case Management via Ryan White Care Act
  - 42 clients, 4 counties
  - Housing, nutritional support, medical transportation, counseling support, dental support, case management and care coordination, in-house therapist
- HIV and STI Testing and Prevention
  - Rapid testing for HIV, HCV; testing for STIs (6,500 square mile service area)
  - PrEP education and prescribing
  - Syphilis outbreak, we enhanced our testing

Syringe Services Program

- Co-location with supplemental services:
- Wound care clinic
- Low-Barrier buprenorphine
- Contingency management
- Vaccination program (shingles, tetanus, hepatitis B, influenza, COVID-19)
- Naloxone/overdose reversal program
- Plan B
- Nicotine cessation kits
- Safer smoking kits
- Drug checking service
- Limited food pantry
- 8,000+ people served annually
- 3 fixed sites, 1 mobile SSP, 1 mobile clinic

Health Engagement Hub

- Two fixed sites, one mobile program
- Walk-in screening & buprenorphine prescribing (SL & LA)
- Case managed program with wraparound services
- 8-week contingency management for psychostimulant use
- Bridge program with local hospital, co-responder program forthcoming
- Focus on increasing accountability to support warm handoff to primary care/long-term medication for opioid use disorder (MOUD)
- >650 clients ever enrolled, 2 providers, 3 nurse case managers, 2 social workers, 2 therapists

Diversion Programs

- Arrest & Jail Alternatives
  - Three case managers
  - First LEAD site east of the Cascades
- Recovery Navigator Program
  - One program manager
  - One outreach manager
  - Three case managers
  - One court liaison
  - WW and Columbia County catchment
- 300+ clients ever enrolled, current caseload of 112

Jail MOUD & Medical Program

- One nurse, one medical assistant, one onsite case manager, one PT therapist, twice weekly sick calls, on call service
- 15-26 clients on MOUD at any given time
- Multiple buprenorphine products
- Case management support during and after incarceration
- Jail-based SUDP support

Fentanyl Presence in the Underground Drug Supply

		January	February	March	April	May	June	July	August	September	October
Kennewick	overdose administrations	27	53	44	47	62	57	57	96	123	99
Distribution	naloxone	94	105	128	131	137	91	86	108	114	89
	narcan	239	207	266	304	262	225	152	260	203	181
	unspecified refills*										
Walla Walla	overdose administrations	18	29	35	27	79	54	26	38	87	117
Distribution	naloxone	54	74	59	116	97	43	52	108	137	193
	narcan	138	298	204	358	172	139	108	175	282	222
	unspecified refills										
Clarkston	overdose administrations	10	1	5	21	7	8	13	12	25	30
Distribution	naloxone	48	28	51	87	105	109	36	56	68	91
	narcan	71	54	76	89	96	80	50	72	84	94
	unspecified refills										
Ovedose Reversal Admins by Month		55	83	51	92	148	119	96	146	235	246

How Does the Underground Drug Market Shape Our Client Base?

- Clusters of overdoses, due to volatility
- Rapid loss of support systems for consumers
- Avoided medical treatment (e.g., wounds, prenatal care, HCV tx)
- Overwhelmed workers in health care, housing, downtown businesses, corrections, and law enforcement
- Barriers to higher-level care–we have no detox and no inpatient treatment
- Most fentanyl users want to reduce or stop their use (UW, 2022)

Alignment & Layering of Programs

How Health Engagement Hubs Work

- Multiple referral pathways, many non-traditional
- Low-barrier intake, eligibility determination
- Insurance navigation if needed
- Multidisciplinary team support for patient care
- Collaborations with ED, Fire/EMS, adult jail, LHJ, state agencies, other funders
- Hot hand offs after sustained engagement

Strategies of the BMHTH HEH

- Continuously analyze needs of patients and barriers to their care, orienting program approaches to address both
- Support high morale, work/home balance, appropriate compensation packages for staff
- Include people with lived experience at all levels of the organization (e.g., advisory boards to board of directors)
- Dedicate approaches to the evidence base unless an innovation is called for
- Identify champions at the local, state, and national levels
- Collect data thoughtfully and with an eye toward continuous improvement

Health Hub Activities

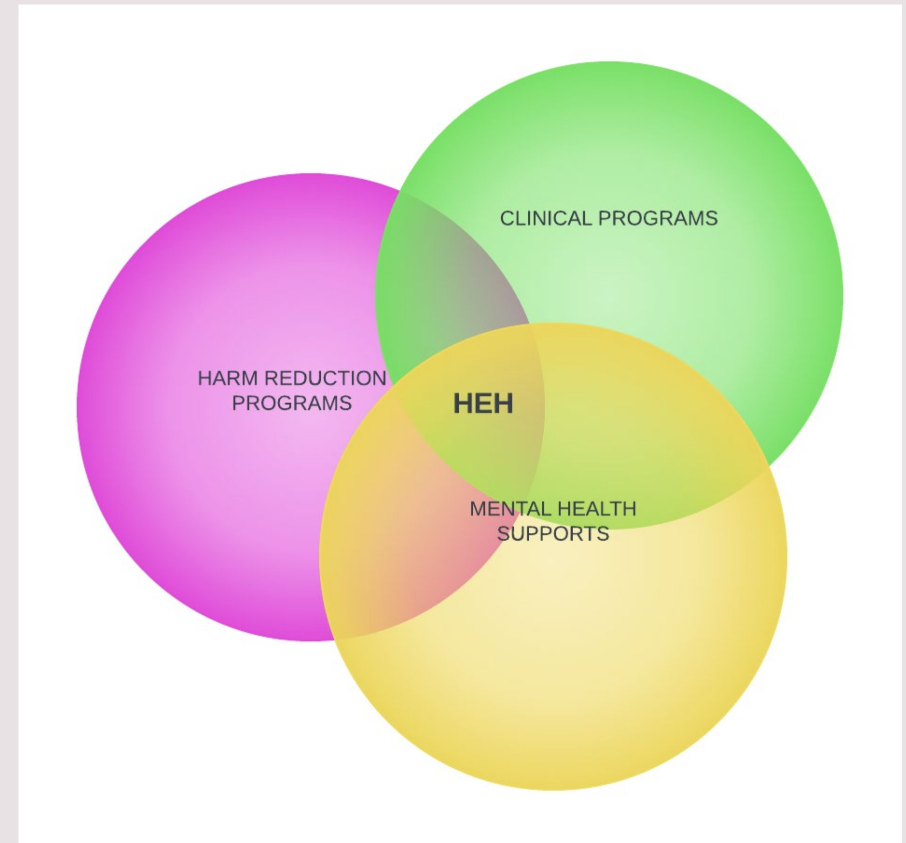
Service	Activities	Provider Organization(s)
Medication-Assisted Treatment	Buprenorphine prescribing (outpatient Suboxone, Subqtex, and Sublocade) Case management Care coordination Linkage to primary care Wraparound care (transportation support, nutritional assistance, housing assistance)	BMHTH
	Methadone prescribing (outpatient, daily dosing)	BMHTH in satellite agreement with regional OTP
Contingency Management	Contingency management Case management Care coordination Linkage to primary care	BMHTH
Primary Care (General Internal Medicine)	Annual physical evaluations Related blood lab work, screenings (inhouse and external) Preventive care HIV and STI testing and treatment HCV testing and treatment Management of chronic conditions Vaccinations (influenza, hepatitis A/B, shingles, tetanus, RSV, COVID-19) Wound care, basic	BMHTH External lab
Reproductive Health Care	Contraception education and prescribing Family planning Pelvic and vaginal exams Pregnancy testing and comprehensive options counseling	BMHTH
	Breast cancer screening Emergency contraception Pregnancy termination	Planned Parenthood of Walla Walla
Mental Health Care	Individual Counseling (non-prescribing) Case management Care coordination, linkage to medical services Linkage to higher-level mental health services Limited medication support	BMHTH

History of Success with Mobile Care

- 2021–2023, CDC Center of Excellence, COVID-19 vaccine program: 168 vaccines provided in frontier areas of SE WA counties; wound care and mobile STI testing also offered
- 2019–2020: influenza, Twinrix, tetanus vaccines given at parks and housing shelters; mobile STI testing
- 2018–2019: mobile harm reduction built trust with participants

What is the Innovation?

- Multiple, often non-traditional pathways in
- Care services predicated on anticipating the patient's barriers to access (this is where mobile health helps a lot)
- Linkages to larger team of support (e.g., responding to DV, houselessness)
- Behavioral health inclusion, trauma-informed
- Agile responses to a chaotic service environment



Success Stories

"I wouldn't be alive today if it weren't for Heart to Heart."

"My case manager cared about me before I learned to care about myself."

Michael, 60s, on Suboxone for more than 2 years, re-established in permanent housing.

Andrea, 40s, on Sublocade for 6 months before transitioning to SL bupe, reentered the workforce.

Sandra, 38, treated and cured of HCV, still looking for permanent housing.

Juan, 26, released from jail and transported directly to inpatient SUD treatment. Six months later, he is still in recovery.

Contact

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