Engaging marginalized people in MOUD: **harm reduction, relationships, and outreach**

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BACKGROUND

In 2018, RIZE Massachusetts awarded grants to 3 community health centers to partner with community agencies to implement novel OUD treatment initiatives:

- **Lynn Community Health Center (LCHC)** set up a low-threshold MOUD program serving individuals experiencing homelessness. LCHC engaged individuals by doing outreach at a local soup kitchen and placing staff in a local shelter and a harm reduction agency for engagement with clients and ease of access to treatment.
- **Brockton Neighborhood Health Center (BNHC)** formed a mixed-agency street outreach team to engage with individuals experiencing homelessness. BNHC co-located an employee at a local correctional facility who linked incarcerated individuals to MOUD upon release.
- **Boston Health Care for the Homeless Program (BHCHP)** established a low-threshold engagement program with co-located clinicians at a day shelter. BHCHP also increased MOUD capacity at multiple shelter sites.

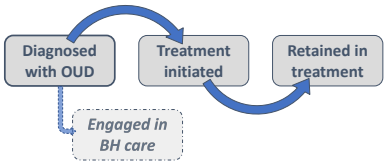
The Institute for Community Health conducted a mixed-methods evaluation of the grant program.

EVALUATION METHODS

→ **Quantitative:**

- Collaborative development of set of electronic health record (EHR) measures
- Data extraction from health center EHRs for 5 18-month time periods

MOUD cascade of care model used in RIZE evaluation

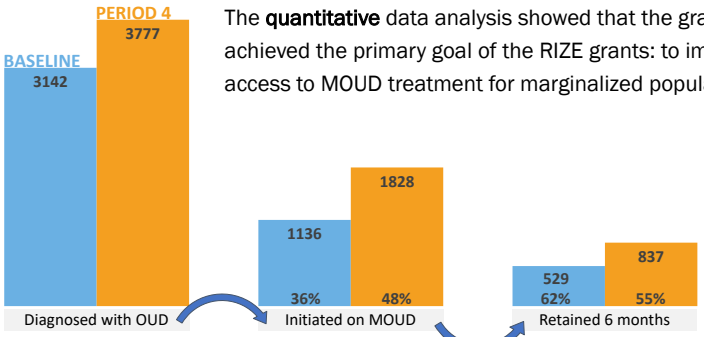


→ **Qualitative:**

- Implementation progress reports submitted 4 times during the grant period
- Semi-structured interviews with 26 individuals from grantee and partner agencies

RESULTS

RIZE grantee cohort: OUD diagnoses, MOUD initiation, and MOUD 6-month retention



The **quantitative** data analysis showed that the grantees achieved the primary goal of the RIZE grants: to improve access to MOUD treatment for marginalized populations.

The **qualitative** data showed **how** the grantees achieved the goal, with multiple interviewees emphasizing the importance of the strategies below:

> **"What made it work since the beginning, is people like [our nurse]...who just has nothing but compassion and the ability to connect with people and really meet them where they are.** And without that, it wouldn't have mattered how much we wanted to make it work...nobody would have trusted them, and it wouldn't have worked." *– Leadership at partner agency*

Relationship-building a prerequisite to engagement

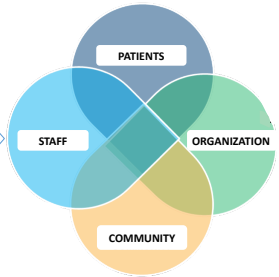
> "Really understand harm reduction like yes, this person is taking buprenorphine and yes, they're still testing positive for cocaine, and that's okay. And we're going to figure out where to go from there. And if going from there is the person is never going to stop using cocaine, we're still going to prescribe them buprenorphine, so they don't die. **Being comfortable with true harm reduction.**" *– Outreach worker*

Promoting real harm reduction

> "[The outreach worker] really has established herself as a trustworthy person in here that these guys will talk to, and will be open, and share, and have those honest conversations with...We haven't had anyone like that in here before." *– Staff person at partner agency*

Conducting strong outreach

The qualitative data also showed the interconnected impacts of the grantees' programming at four levels: **patients**, **staff, organization,** and **community.**



*Disclosure: Celero Systems, Springer Textbook, and UpToDate.

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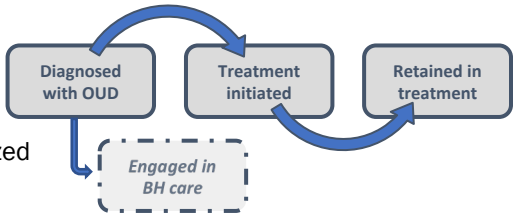
If you have further questions, please contact Ceylon Auguste-Nelson (caugustenelson@gmail.com) or Ranjani Paradise (rparadise@icommunityhealth.org).

EVALUATION METHODS

Cascade of care for OUD treatment

- The cascade of care framework was originally developed for HIV/AIDS treatment and can be translated to OUD treatment with the following stages: 1) diagnosis, 2) linkage to care, 3) treatment initiation, 4) treatment retention, 5) recovery, which is understood as abstinence from non-prescribed opioids.
- For the evaluation of the *Saving Lives, Improving* Health program, we created a modified version of the cascade that aligned with available data and the low-barrier approaches being implementing. First, we removed linkage to care as a separate stage because we were drawing from electronic health record (EHR) data and could only assess people who were already linked to care at the grantee institutions.
- The final stage of the cascade, recovery, was also removed from the cascade of care. Grantees utilized a harm reduction approach that recognizes that patients often have periods of relapse, and they prioritized retention in treatment over abstinence from non-prescribed opioids as their primary goal. Furthermore, toxicology screen data was highly incomplete, and we did not have a way to reliable assess abstinence from non-prescribed opioids. As such, retention in treatment became the final stage in the cascade of care for the evaluation.



MOUD cascade of care model used in the evaluation

Quantitative electronic health record measures

- In collaboration with RIZE's Chief Medical Officer and the grantees, evaluators developed a set of EHR measures aligned with the cascade of care.
- The measures defined the OUD patient panel as patients who had a documented visit with a recorded OUD diagnosis in a defined 18-month period. Other measures captured co-occurring mental health diagnoses, engagement in behavior health care, MOUD initiation and retention (defined by prescriptions written), and information about housing, social determinants, and insurance.
- Analysts from grantee health centers extracted data from EHRs at five 18-month time periods, starting with a baseline time period that was pre-grant. ICH provided analytic technical assistance to two of the grantees to support coding for retention measures, which were particularly complex.

Qualitative methods

- Implementation progress reports submitted four times during the grant period accompanied the quantitative measures, and allowed grantees to describe implementation progress, major accomplishments, and challenges.
- Through 10 group interviews and two individual interviews, evaluators conducted semi-structured conversations with 26 individuals from grantee and partner agencies to learn more about implementation and impact. Interviewees included organizations' leadership and frontline staff, and spanned various professional roles, including registered nurses, advanced practice registered nurses, recovery coaches, outreach workers, social workers, and physicians.
- Evaluators coded interview transcripts in a qualitative analysis software for major themes.

QUALITATIVE FINDINGS

Strategies for engagement:

- **Relationship-building as a prerequisite to engagement**: Interviewees emphasized the importance of building relationships with patients and potential patients. Genuine relationship-building can help engage people in the community who are not yet linked to care and is key to effectively engaging patients in treatment. Interconnected with relationship- and trust-building is providing consistent outreach and doing so with a true harm reduction approach.

> "Be a normal human being and treat them with respect…that's all people want out there is just to build a relationship. You can't go outside and be all clinical and just tell them what you have to offer. You've got to kind of see what they want offered to them."
> *– Outreach worker*

- **Promoting genuine harm reduction**: Multiple outreach staff described the harm reduction approach they took when building relationships with individuals they met in the community. They discussed not bringing their own agenda or goals to the interactions, instead letting the individuals direct their own path towards treatment, or, if they were not ready to begin MOUD treatment, towards safer using practices. Interviewees also discussed the importance of not judging patients for their substance use or treatment paths.

> "I think a lot of people out here have felt like people are forcing things on them whether it was treatment or ultimatums…so not just trying to push your own agenda even if it's coming from a good place, it's still your own agenda." *– Outreach worker*

> "We try really hard to be where they're at in the moment and say we can help you with this." *– Outreach worker*

- **Consistent, multifaceted outreach**: All three grantees, often in collaboration with partner agencies, implemented creative outreach programming that sought to meet individuals where they were at - both literally within the community, whether in encampments, shelters, or correctional facilities, and in terms of their stage of substance use or treatment readiness. Grantees also worked to ensure that outreach could be consistent, to reduce gaps in services and to facilitate the necessary relationship- and trust-building.

> "Be[ing] able to see people consistently in [different walk-in clinics and partner agencies]…we might be able to notice something else that's going on with them and try to engage them to possibly talk about it and utilize the nurse practitioners and nurses and try to engage them in care. *– Nurse*

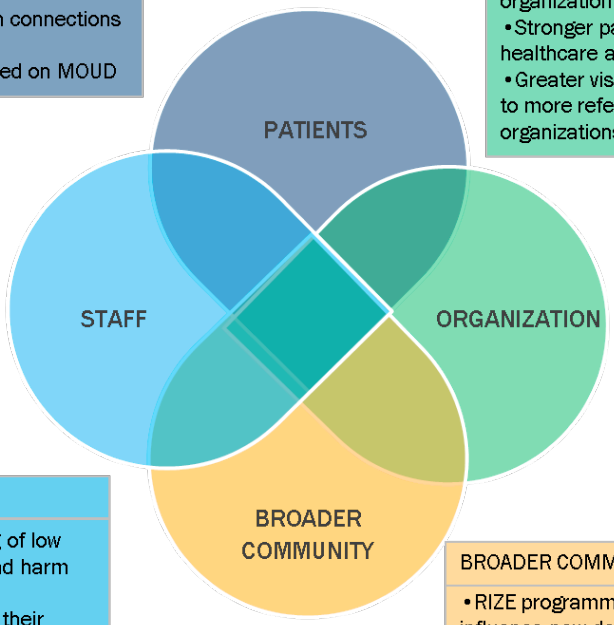
> "We're the team that does homeless outreach, we're the folks that we might not be your primary care but what we can do is make sure you get what you need…we'll see you, we'll come to you in your tent…or we'll come to the needle exchange and check on you. People are much more likely to actually then follow up with their care is what we've seen."
> *- Leadership at partner agency*

QUALITATIVE FINDINGS

Impact: In addition to the increases in MOUD initiation and retention measured through EHR data, grantees described many other impacts that they felt resulted from their programs. These impacts occurred at **multiple, interconnected levels – patients, staff, organization, and broader community.**

PATIENTS
- Experience improved access to compassionate, non-stigmatizing care
- Develop more trusting relationships with care providers
- Have clinical and other needs met
- Establish or reestablish connections to health systems
- Are initiated and retained on MOUD

ORGANIZATION
- Increased capacity to treat patients with OUD (bigger teams, dedicated spaces)
- Cultural shift to a low threshold mindset and corresponding operational changes across the organization
- Stronger partnerships between healthcare and community agencies
- Greater visibility of OUD work leads to more referrals within and across organizations



STAFF
- Increase understanding of low barrier OUD treatment and harm reduction approaches
- Feel more supported in their roles through training and counseling, more coordinated processes, and more team members to work with
- Approach patients nonjudgmentally
- Work to get patients into treatment more quickly, with fewer barriers

BROADER COMMUNITY
- RIZE programming and philosophy influence new developments at partner agencies, and in the larger community
- Community stakeholders become more aware of harm reduction and low barrier approaches, and know where to refer people

- The main **interconnected** grant impacts included:
  - Increased capacity, staffing, and space dedicated to low-threshold programs through funding provided.
  - Stronger partnerships forged with other community agencies through the creation of collaborative initiatives.
  - Reduced stigma and increased acceptance of low-threshold approaches and harm reduction among patients, staff, and organizations.
  - Interviewees felt that grant programming had an impact beyond their organizations, in the broader community.

> "The staff across organizations are doing a much better job of talking to one another and making linkages to one another, just to refer people to and from the programs that all of us are running. - *Leadership*

> "The theory of harm reduction has become more prominent among the staff overall." – *Social worker*