NATIONAL HEALTH CARE for the HOMELESS COUNCIL

THE OPIOID EPIDEMIC & HOMELESSNESS:

An Action Agenda for the HCH Community

Many federal, state and local proposals have been introduced to address the opioid epidemic. Community providers who deliver health care and other services to people experiencing homelessness have long-struggled to treat opioid addiction and prevent overdoses among a very vulnerable group of people. As public awareness of the problem has increased and a demand for policy change is intensifying, the HCH Community is well-positioned to be active participants in the solutions needed to improve the current system of care.

Below are priorities and recommendations in five key areas: increase capacity for emergency overdose response, increase capacity for harm reduction programs, expand access to evidence-based addiction treatment, expand workforce opportunities, and allocate additional funding for housing. These issues represent some of the most tangible solutions at the patient and provider level that will improve health and stability among those struggling with addiction—particularly among those also struggling with homelessness and housing instability.

1. **Increase capacity for emergency overdose response.** First and foremost, we must increase the capacity for emergency overdose response in order to stem the epidemic of deaths occurring from opioid addiction.

    - **Decrease cost and expand access to the overdose antidote naloxone.** Increasing numbers of overdoses (especially those involving fentanyl) are requiring multiple units of naloxone, but at tremendous cost to state and local public health systems. Frontline providers need greater access at lower prices in order to provide effective first response to those experiencing a life-threatening overdose. All communities should have “standing orders” that allow members of the public to access naloxone as well.

    - **Increase funding and training for naloxone distribution among first responders.** Law enforcement, fire, EMT responders, transit workers, and others in a position to respond to an overdose should be provided training on how to administer naloxone as well as have ready access to this life-saving antidote. Such trainings can also reduce stigma, and lead to more effective community engagement practices.

2. **Increase capacity for harm reduction programs.** Reducing the risks associated with opioid addiction must be a key component to stopping overdose deaths and reducing transmission of communicable disease. Including harm reduction as a principle of care throughout the health care field would also help reduce stigma and engage a greater number of people in treatment.

    - **Expand syringe exchange programs.** Providing access to clean needles reduces disease transmission and offers an opportunity for service providers to conduct outreach and engagement with people struggling with injection drug use disorders, leading to a greater willingness to consider treatment. Increasing funding and support for syringe exchange programs will enable more public health departments (or other health care providers) to reach vulnerable populations and connect them to care.

    - **Establish pilot supervised consumption sites (SCS).** There are now nearly 100 SCS programs (also called "safe injection facilities") in 65 cities all over the world, but none in the United States. These programs have been demonstrated through peer-reviewed, evidence-based research to reduce overdose deaths, facilitate entry into treatment, reduce disease transmission, and save public health care costs (among other benefits). It is well past time that harm reduction programs such as SCSs can be tested as part of a public health approach to overcoming the opioid epidemic.

3. **Expand access to evidence-based addiction treatment.** Primary care providers are at the forefront of treating opioid addiction but multiple barriers exist to accessing evidence-based treatment at all levels of care. Funding must be prioritized for treatment models that provide long-term clinical management of a chronic disease such as addiction.

    - **Expand and strengthen Medicaid in all states to individuals earning at or below 138% poverty.** Not only does health insurance pay for drug treatment, it also pays for medical and mental health care, which are often needed to address multiple health care conditions. Relying on ad hoc, grant-funded services does not provide the continuity of care and coordination needed to achieve good medical and behavioral health outcomes. The 19 states that have yet to expand Medicaid to single adults leave their most vulnerable citizens uninsured and unable to access needed comprehensive care. We also encourage Congress to incentivize greater use of 1115 waivers to add supportive services such as care coordination, case management, and housing support services to bolster the services needed to engage in care.

    - **Expand capacity for drug treatment at all levels of care.** Health care providers who are screening for and treating substance use disorders need to be able to refer patients quickly and easily to programs that offer an appropriate level of treatment. People with private insurance generally have a wider range of treatment options than Medicaid participants. We must ensure equity in access to treatment, and we must be able to secure placement for our patients in programs that will deliver the appropriate clinical level of evidence-based care. We recommend removing the policy barriers that prevent Medicaid beneficiaries from accessing residential treatment, and we cannot emphasize more strongly the need for stable housing as a critical part of effective treatment (see related recommendations below).

    - **Eliminate Medication Assisted Treatment (MAT) barriers like patient caps and additional paperwork requirements.** Clinical providers are currently able to prescribe much more harmful medications than buprenorphine, yet this drug is regulated more than

any other. Removing current limits on the number of patients allowed to be treated by an individual provider will allow more people to access care. Removing the requirement to keep patient logs will reduce regulatory burdens without decreasing quality of care. Eliminating both these measures will increase the number of providers willing to prescribe MATs.

- **Improve MAT provider training to be more effective.** Providers need support and training to effectively treat patients with addiction disorders; however, many providers in the field question the utility and efficacy of the current 8- and 24-hour trainings specifically required for prescribing buprenorphine. As larger changes to training in addiction medicine are being considered for primary care providers, MAT trainings should evolve to include more information about addiction treatment, pain management, and integration of care. This is especially true of the 24-hour training required of physician's assistants and nurse practitioners—the additional hours are a barrier to getting a waiver and thus reduce the number of providers authorized to prescribe buprenorphine.

- **Expand MAT access and improve continuity of care for both rural and incarcerated populations.** Allowing payments for telemedicine would enhance access to MATs, especially for people living in rural or underserved areas where transportation is limited and/or providers may not be accessible. Jails and detention centers should be required to provide MAT as part of health care services for those who are incarcerated, and should not be permitted to discontinue treatment already initiated by community providers.

- **Require Medicare and Medicaid to cover at least one form of buprenorphine and eliminate prior authorizations for prescribing any form of MAT.** Buprenorphine is no longer an experimental intervention. Its use over the last 20 years has demonstrated it is an effective treatment without adverse consequences, yet many insurance plans continue to require prior authorizations. Limited formularies and delays caused by administrative processes such as these only impede entry into treatment and raise the chances of an overdose. It's past time to make buprenorphine an integrated part of primary care, especially in the midst of an opioid crisis.

- **Continue expanding funding for SAMHSA and HRSA.** Safety net providers, especially in states that have not expandedf Medicaid, need additional resources to care for people who remain uninsured. Even in Medicaid expansion states, not all services are reimbursed through Medicaid. Funding from previous legislation (e.g., the Comprehensive Addiction and Recovery Act) was a good start, but will not meet the extensive need for treatment and support in our communities. We urge ongoing investments in these programs.

4. **Expand workforce opportunities.** As demand for treatment continues to grow, we need to ensure we have a highly trained workforce ready and able to meet those needs—particularly for people with unique needs such as those who are homeless and battling addiction.

   - **Increase funding for peer specialists, case managers, care coordinators, outreach workers, community health workers, and other social support roles.** Successful treatment requires coordinated care and support beyond the exam room and therapy sessions. These health care disciplines are critical parts of interdisciplinary teams that engage clients in care, and help support them in recovery. Many of these roles can be filled by people who are themselves in recovery, thereby creating additional employment opportunities.

- **Expand the National Health Service Corps.** Every state needs a greater number of primary care and behavioral health specialists working in underserved areas. The loans and scholarships available through the NHSC are vital for growing a workforce that is dedicated to vulnerable populations in safety net settings.

5. **Expand funding for housing.** Housing must be a part of the package of solutions in order to make treatment effective and reduce the overall levels of opioid addiction. **Homelessness makes entering treatment more difficult and presents nearly impossible odds of staying in recovery. High rates of relapse are understandable when one is living on the street or in emergency shelters.** Expanding access to treatment must be accompanied by addressing housing needs.

   - **Dedicate more funding for stable housing.** Federal housing programs administered by HUD are chronically underfunded and the need for housing continues to grow. Only 1 in 4 people who qualify for housing assistance currently receive it, and those with addiction are at a much higher risk for housing instability and homelessness. Housing is a crucial component to enabling individuals to enter treatment, and be successful in recovery. Providing drug treatment only to discharge into homelessness is not helpful for individuals with addiction (and may serve as a disincentive to enter treatment), and is not an effective use of health care resources. Congress must increase investments in housing so that vulnerable people have a stable, affordable, and accessible place to live.

   - **Ensure a broad range of housing options are available.** Recovery housing, transitional housing, supportive housing, and other housing models are all needed in the continuum of treatment. Each model has its advantages and disadvantages, but for those with the greatest addiction problems, programs need to be non-time limited, low-barrier and provide the supports needed for individuals and families to live in an environment that supports their recovery.

Finally, current proposals to restrict access and reduce federal funding for Medicaid, food assistance (SNAP), and housing only undermine the goals related to preventing and treating opioid addiction, and facilitating successful recovery. We are encouraged by the attention being given to the wide range of changes needed to address the opioid crisis that has claimed far too many lives, but **limiting access to basic human needs through the implementation of work requirements, time limits, and other barriers is entirely counterproductive.** While some exemptions are being made for those in treatment, we emphasize that only 1 in 10 people with an addiction disorder are receiving treatment. As lawmakers consider solutions to the opioid crisis, these issues should not be considered in isolation from one another.

For more information on the National Health Care for the Homeless Council's opioid policy agenda please contact Regina Reed, MPH, Policy Organizer, at rreed@nhchc.org or 443-703-1337

Endorsing Organizations

Local organizations:

AIDs Foundation of Chicago, IL
Alabama Regional Medical Services, AL
Albuquerque Health Care for the Homeless, NM
Ascending to Health Respite Care, CO
Boston Health Care for the Homeless Program, MA
California Consortium of Addiction Programs & Professionals, CA
Care for the Homeless, NY
Central City Concern, OR
Central Outreach Wellness Center, PA
Circle the City, AZ
Colorado Coalition for the Homeless, CO
Daily Planet Health Services, VA
Duffy Health Center, MA
Eliot Community Human Services, Inc. MA
Greater Light Ministries, LA
Healthcare for the Homeless- Baltimore, MD
Health Care for the Homeless - Houston, TX
Health Care Center for the Homeless, FL
Heartland Alliance for Human Needs & Human Rights, IL
Homeless Health Care Los Angeles, CA
Homeless Union of Greensboro, NC
Illumination Foundation, CA
Mercy Care, GA
Nasson Health Care, ME
Neighborhood Health, TN
New Horizon Family Health Services, INC, SC
Pathways to Housing, DC
Petaluma Health Center, CA
Peak Vista Community Health Centers, CO
The Manners Housing Foundation, FL
URAM Community Health Center, NY
Unity Health Care, DC
Yakima Neighborhood Health Services, WA
YIMBY Action, CA

National organizations:

A New PATH
American Medical Student Association
Corporation for Supportive Housing
Faces & Voices of Recovery
Harm Reduction Coalition
HerStory Ensemble
HIV Alliance
National Alliance to End Homelessness
National Association of Clinical Nurse Specialists
National Coalition for the Homeless
National Law Center on Homelessness & Poverty
National Low Income Housing Coalition
NETWORK Lobby for Catholic Social Justice
Rights and Democracy Education Fund Board
Treatment Communities of America
Trinity Health
Western Regional Advocacy Project
Young People in Recovery