Building Workforce Skills and Competency to Address the HCV & Opioid Epidemics: One FQHC Experience

Colleen Lane, MD
Whitman-Walker Health
Disclosures

• None
Whitman Walker Health

- Federally Qualified Health Center (FQHC) located in Washington DC

- Two Clinical Sites:
  - Northwest Washington DC, Logan’s Circle neighborhood
  - Southeast Washington DC, Anacostia neighborhood
Whitman Walker Health History

- We were founded in 1973, our earliest program being a Gay Men’s Venereal Disease Clinic
- Whitman Walker Addiction Services (WWAS) is one one of the first programs developed along side our HIV, LGBTQ, Gender Affirming and Primary Care Services
- A key of Whitman Walker’s clinic model is integrated care
- Behavioral health, medical, pharmacy, community educators and research staff all work together on care teams
Patient Demographics

• We serve over 20,000 patients annually
• Of that number, we serve 1,585 transgender or gender non-conforming individuals
• We care for 3,594 people living with HIV
• Most of our patients (70%) live in DC
• About 40% of our patients identify as Black
• 60% of our patients are ages 21-40
Patient Demographics

**Age Distribution:**
- 0-20: 6%
- 21-30: 35%
- 31-40: 25%
- 41-50: 14%
- 51-60: 13%
- 61+: 7%

**Race/Ethnicity Distribution:**
- Black: 40%
- White: 37%
- Other/Unknown: 17%
- Asian: 5%
- American Indian and/or Alaskan Native: 1%

**Sexual Orientation Distribution:**
- Gay, Lesbian, Bisexual: 53%
- Heterosexual: 44%
- Other: 3%

*Please note that Native Hawaiian and Other Pacific Islander is included in "Other/Unknown." Of the patients who shared their race and ethnicity with Whitman-Walker, 15% identify as Hispanic.*
Patient Demographics

AIDSVU DC https://aidsvu.org/state/washington-d-c/
Opioid Epidemic in DC

- There were 83 opioid related deaths in 2014, then 114 in 2015, 231 in 2016 and **279** in 2017
- That means there was a **178% increase in fatal overdoses** due to opioids from 2015 to 2016
- Overall 81% of all deaths were among African Americans
- 74% of deaths were male
- 89% of DC opioid users are over 40 years and **58% are more than 50 years**
- 22% have been using heroin more than 40 years, 59% for more than 25 years and **88% for more than 10 years**
- From 2014 to 2017 opioid related fatal overdoses were most prevalent in Wards 7 and 8

---

1. DC’s Strategic plan to reduce opioid use, misuse and related deaths. December 2018
Opioid Epidemic in DC

- This is not a new phenomenon
- Heroin is the opioid of choice in Washington DC (as opposed to pills/prescription opioids)
- Modes of use: injection, snorting, smoking and skin popping
- What changed? Fentanyl
- Who are the people at risk? Many are the patients we are already seeing
Substance Misuse Treatment

• When we started our substance misuse treatment (SUD) program it was primarily housed in our behavioral health/Psychiatry department
• This created a bottleneck with few providers able to see patients, but a high demand for services
• About 3.5 years ago Psychiatry and Primary Care partnered to create a low barrier “rapid” entry into care
• Goal: To reduce overdose deaths, engage people in medical and behavioral healthcare, and reduce risk of overall morbidities associated with substance misuse disorder
Welcome MAT

- Modeled after our HIV rapid entry into care approach called “Red Carpet”
- Patients can walk in or call in, and asked to be connected to substance use disorder treatment including medication assisted treatment (MAT)
- Patients are able to see a primary care provider with a data waiver
- MAT treatment includes: Buprenorphine-naloxone, long acting naltrexone, and oral naltrexone
- Non medication interventions: peer and addiction specialist lead support groups, individual therapy and psychiatric care
- We aim to identify, link to care and begin treatment the same day the patient presents
- We use a risk reduction model
Entry Into Care: Patient Calls

Patient calls asking for MAT

Call center or Front desk connects patient to behavioral health addiction specialist

Insurance verified or connected to public benefits

Patient scheduled with MAT provider 40 min appt - Rapid Induction done at that visit

Provider gives a warm hand off or TE to Peer Support specialist

Peer connects Pt to group, individual and schedules a full BH intake
Entry Into Care: Patient Walks In

Patient self schedules/walks in

Provider sets expectation that may need 2 visits to complete insurance and medical visits

First visit goal - gather history, +/- Labs and connect with public benefits if needed

Provider gives a warm hand off or TE to Peer support Person

Patient schedules the follow up in 3-5 days for induction visit

Peer support connects Pt to group, individual and scheduled BH intake
Risk Reduction

- Our program goal is to meet patients where they are
- Encourage building trust and good relationships with their providers
- We use a risk reduction approach, not strict abstinence based approach
- **Risk reduction**: Aims to reduce the health, social and economic consequences of substance use
  - Naloxone training and distribution- including a standing order at our onsite pharmacy
  - Working with patients to taper substance use (again many patients have been using substance for over 25 years)
  - Helping to connect to community resources to offset loss of income/social and family networks
  - Education on risks of concurrent substance use (i.e. Benzodiazepam, ETOH and buprenorphine)
Why MAT in Primary Care?

- Substance misuse is a very stigmatized disease
- Many people have been out of primary care for several years
- Patients are often afraid to bring it up the topic with their providers
- Many patients have not received preventative health care services such as vaccines, dental care, cancer screenings, or screenings for diseases such as HIV or Hepatitis C
- We treat SUD as a chronic illness, like hypertension, diabetes, or chronic kidney disease
- Chronic relapsing condition that takes into account each patient and provides individualized care
Co-Morbid Conditions

- Providing entry into SUD treatment via primary care allows for screening and treatment of co-morbid conditions such as trauma, depression, HIV and Hepatitis C
- Hepatitis C is often viewed as more shameful or stigmatized than HIV
- Many patients have been told Hepatitis C treatment is not possible until they are “drug free”
- There is a misunderstanding about treatment (interferon vs. the newer treatments)
Hepatitis C: Why Screen?

- We offer walk-in free HCV testing for patients as well as non patients
- For patients who test positive for either virus, they are immediately connected to care
- We offer integrated HCV treatment and cure in our primary care clinic

https://dchealth.dc.gov/HAHSTA2018AnnualReport
Take Home Points

• Our integrated approach has allowed us to increased the number of providers with a Data Waiver from 2 to 14
• We increased health center wide Naloxone training, and have a pharmacy standing order to access this medication without a stigmatizing diagnosis
• Providing a low barrier entry into care allows for quicker access to medication and/or behavioral health interventions and therefore improved retention
• Our patient population in SUD care increased from 24 to ~80 in the first 6 months
• By integrating primary care and substance misuse care, it allows for screening and treatment of HIV, HCV, trauma along with other primary care conditions
Thank you!