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Developing Mobile Buprenorphine Treatment for Homeless Patients with Opioid Use Disorder

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1 Background

- In the U.S. opioid-related overdose deaths have increased dramatically over the last two decades
  - *1999 rate*: 2.9 per 100,000 people
  - *2016 rate*: 13.3 per 100,000 people
- Opioid overdose deaths are particularly high in homeless populations, and may be a leading contributor to a dramatically increased mortality rate among homeless versus housed individuals
- Homelessness creates barriers to accessing structured, office-based buprenorphine treatment
- Lowering treatment barriers with a flexible, harm reduction approach may improve access for homeless populations, but implementation and evaluation of such programs has been insufficient

Methods

Literature review

Stakeholder interviews

Identify barriers and opportunities

Program design

2 Objectives

- Identify barriers to buprenorphine service specific to homeless patients and solutions to overcome them
- Describe the development and implementation of a mobile buprenorphine treatment approach integrated in a larger street psychiatry service

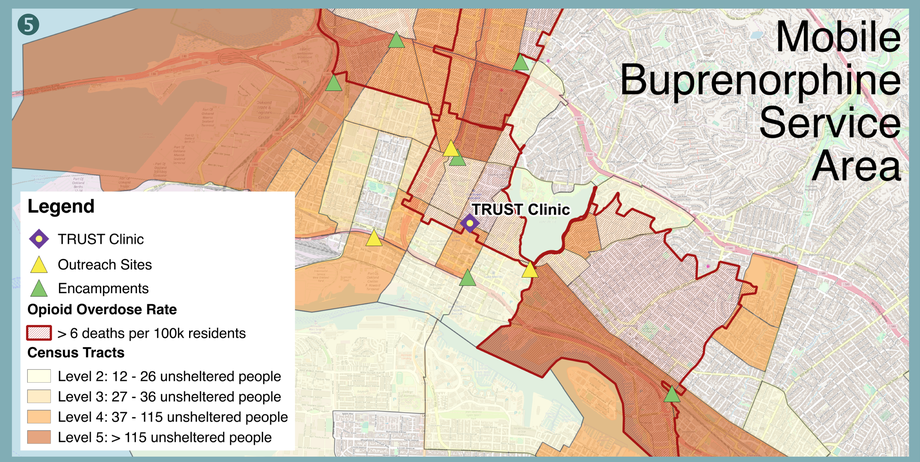
3 Study Setting

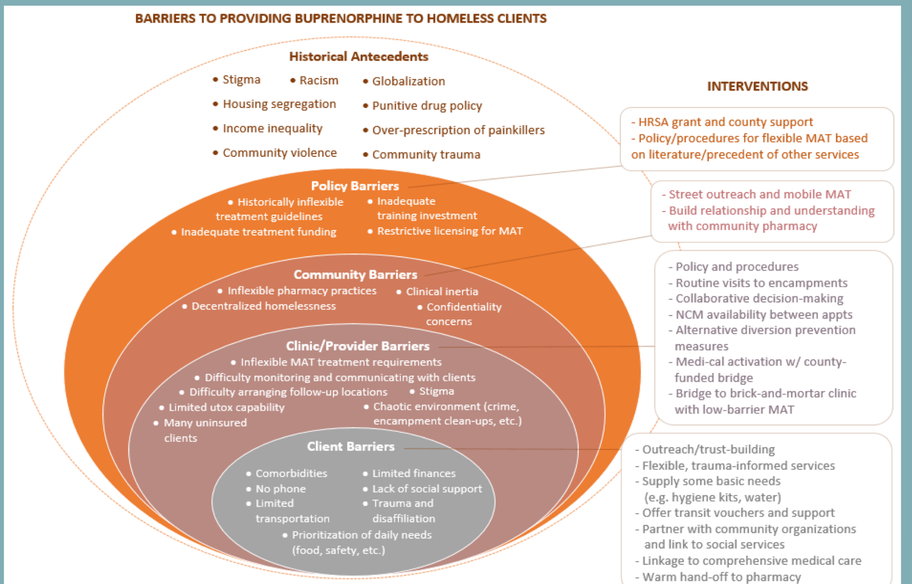
- The program is being developed by Alameda County Health Care for the Homeless, which serves a populous, urban county
- In Alameda County:
  - Opioid-related emergency visits has increased 29% between 2009 and 2014
  - Homelessness has increased by 39% from 2015 to 2017

4 Key Themes from Stakeholder Interviews

- **Need for consistency**
  - Poor retention without reliable follow-up location
  - Build trust through outreach, incentives, etc.
  - Better retention when patients are identified by outreach workers rather than "on the spot" by MDs
- **Procedures**
  - Under-dosing and tight timeframes worsen retention
  - Mostly "home" inductions: 8-32mg to 16-24mg, 1-7 days
- **Barriers**
  - Transport
  - Pharmacies (stigma, cooperation)
  - ID requirements
  - Inactive Medi-Cal
  - Picking up meds
  - Focus on higher-priority needs
- **Outflow problems**
  - Other services have higher barriers
  - Open access clinic fills up (e.g. SF Street Medicine)

5 Mobile Buprenorphine Service Area





7 Street Psychiatry Buprenorphine Service: Program Components

Initial Target
- 3 stable encampments
- 2 encampments with known opioid use concentrations

Medication Access
- Partnership with New Oakland Pharmacy: stocking and client ID agreements
- Transit passes and direct transport as needed
- Medi-Cal activation
- Potential county support to bridge gap if no active insurance

Diversion Prevention
- CURES review
- No utox in field
- Clinic follow-up with utox
- If there is diversion suspicion, do film counts, shorter prescription durations

Exclusions
- Refer adolescents*
- Refer pregnant clients*
- Consider referral for heavy and chaotic benzo and alcohol use
- Consider referral if concerns for liver disease

**Provide referral, offer transport*

Follow-up
- Within one week with prescriber (field or clinic)
- Interval follow-up with Nurse Care Manager (NCM) with cell phone availability
- Linkage to clinic whenever possible

Counseling
- Provide brief counseling during MD appointments with support from NCM
- Referral to counseling groups at TRUST clinic or partnering orgs

Safety
- Team-based treatment decisions and follow-up
- Partnership with Overdose Prevention Education and Naloxone Distribution (OPEND) in Alameda County
- Distribution at outreach as well as prescriptions
- Naloxone use tracked by county and our program
- Timely outreach in event of overdose reversal coordinating with Highland Emergency Department

8 Discussion

- **Traditional buprenorphine delivery models do not reach some of the patients who are most in need**
- **A flexible, harm reduction approach as part of a street psychiatry service may feasibly address barriers preventing buprenorphine access for homeless patients with opioid use disorder**
- **Community partnerships including flexible pharmacy services are a key to reducing barriers**
- **Future Directions**
  - Pilot testing with PDSA model
  - Additional sites
  - More prescribing capacity?
  - Open access clinics
  - Coordination with local emergency department, county buprenorphine induction clinic
  - Building partnerships with primary care clinics to enable outflow
  - More formal evaluation

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