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# Triple Threat: Response to the Crises of COVID-19, Homelessness, and Opioid Use Disorder With a Novel Approach to Buprenorphine Delivery: A Case Series

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**Objectives:** In the setting of a 50% increase in opioid overdose deaths, the coronavirus disease 2019 crisis opened housing opportunities in the form of Shelter in Place (SIP) hotels to homeless San Francisco residents. Many who entered SIP hotels had opioid use disorder. In fall 2020, Community Behavioral Health Services Pharmacy partnered with SIP hotel medical staff to launch a pilot project, where on-site SIP medical providers prescribed buprenorphine (BUP) and clinical pharmacists hand-delivered BUP to SIP residents to increase BUP initiation and engagement.

**Methods:** A retrospective chart review of 3 patients living in SIP hotels starting BUP to demonstrate the feasibility of a SIP hotel BUP delivery program.

**Results:** In all 3 cases, patients were able to start and continue BUP with on-site medical staff visits and delivery of medications by pharmacists. Each case highlights different barriers that were overcome by this system.

**Conclusions:** Our findings suggest that this system of onsite medical care with pharmacist delivery is possible and has the potential to allow for greater outreach and increased ease of obtaining medications for patients.

**Key Words:** homelessness, low-barrier buprenorphine, on-site medical care, opioid use disorder, pharmacy delivery

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Written consent was obtained from the clients to report their cases in the medical literature and is available for review by the editors and publisher of the journal.

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When the coronavirus disease 2019 (COVID-19) public health emergency was announced in January 2020, the United States was already facing an overdose epidemic. San Francisco (SF) experienced a 50% increase in opioid overdoses in the 8.5 months after the shelter-in-place order was issued in March 2020.<sup>1</sup> Potential contributors included increasing fentanyl use and societal disruption from COVID-19, social isolation, and decreased access to opioid use disorder (OUD) treatment.<sup>2</sup> SF also had a 17% increase in the number of people experiencing homelessness (PEH) from 2017 to 2019 which was 50% higher than in average peer cities.<sup>3,4</sup> In response to the COVID-19 public health emergency along with the growing overdose crisis and high rate of PEH, SF embarked on novel treatment methods for those experiencing OUD.

In April of 2020, SF began to offer temporary housing to PEH meeting certain criteria (eg, age >65 years, or comorbidities associated with higher COVID-19 morbidity and mortality) as protection against the risk of COVID-19 infection from living either in congregate settings, unsheltered in encampments or in other marginal situations. In a period of 12 months, 2600 individuals were housed across 25 Shelter in Place (SIP) hotels. Case management, meals, laundry, and other services were offered. All were staffed by City Disaster Service Workers or contracted agencies offering behavioral health and medical services.

Approximately 30% of people entering SIP hotels were using opioids. On-site prescribers assessed residents for OUD treatment and offered buprenorphine products (BUP) covered by their insurance or the safety net. Residents interested in BUP were initially sent to a city-run pharmacy, Community Behavioral Health Services. However, only 50% of individuals picked up their prescriptions. An internal barrier analysis identified multiple barriers to access: limited ability to arrive at the pharmacy (due to mobility impairments, decreased bus service, etc), restrictive pharmacy hours, and impairments from mental health symptoms and substance intoxication or withdrawal. In October 2020, Community Behavioral Health Services began sending board-certified psychiatric pharmacists (BCPP) to deliver BUP and provide medication counseling. In this case series, we examine a pilot project of SIP onsite medical staff OUD treatment prescribing with same week BUP delivery by BCPPs. To our knowledge, this is the first

**TABLE 1.** Examples of Patient Medication Education Offered to By Board Certified Psychiatric Pharmacists

Patient Counseling*	Examples
Methods of Education	
Utilize nonstigmatizing terms	Instead of saying the medication is for “opioid addiction” say it is “to treat opioid use disorder”
Utilize teach back method to confirm understanding	“I want to make sure I did a good job explaining how to start the medication. Can you tell me how you will know when to start the buprenorphine?”
Common Topics Covered for Starting Buprenorphine	
Indication	“This medication is to help reduce opioid withdrawal and cravings”
When to start the medication	Counseling is tailored based on whether they are a traditional initiation where the client should be in moderate withdrawal versus low dose initiation or “microdosing” where patients can start at any time.
How to take the medication	“Place the medication under your tongue for it to get into your body. If you swallow the medication you will not get the full effect of the medication.”
Setting patient expectations for efficacy	Counseling is tailored to the dose of the medication in order for the patient to understand that they may still experience opioid cravings and withdrawal if they are not at a therapeutic dose of buprenorphine.
Side effects of the medication	“This medication can cause constipation.”
Drug interactions	Customized to the medications and substances taken by the patient.
Safe storage	Review how to safely store the medication in their shelter in place hotel.
Special instructions	Review of any special instructions such as orientation to blister packaging.
Common Topics Covered for Buprenorphine Refills	
Assessment of whether the patient needs to restart the medication	“When is the last time you took buprenorphine?”
Assessment of efficacy	“Have you been experiencing any cravings at this dose?”
Assessment of side effects	“Have you experienced any side effects from this medication?”

\*Not inclusive of all medication counseling because counseling is tailored to the patient needs.

publication describing a partnership between prescribers and pharmacists to deliver and counsel BUP for OUD treatment.

## METHODS

We focused on 2 SIP hotels in SF’s South of Market district. Combined, these SIP hotels had 248 guest rooms, approximately 75% of which were occupied at any time. The majority of guests entered directly from street homelessness. An initial nursing assessment was offered upon entry including use of nonprescribed opioids. A nurse practitioner or physician assistant was on-site 1–2 times per week and followed up regularly with those who reported non-prescribed opioid use to assess for interest in BUP treatment using the low-barrier model.<sup>5</sup> In this pilot project, guests in either SIP hotel who were written a prescription for BUP were offered the choice of picking up medication at a pharmacy or having a pharmacist deliver the medication at a set time each week. Extensive education was offered (Table 1). The intent was to stabilize patients and transition them to services in the community. Consent was obtained from the clients to report their case in the medical literature. This study was reviewed and approved by the University of California San Francisco Institutional Review Board.

## RESULTS

### Case 1

Case 1 is a 31-year-old woman with a family history of SUD. She started using methamphetamine at 14 years old and heroin at 17. At 29 she transitioned from heroin to fentanyl because it was less expensive and used methamphetamine several times a day. She was stable on BUP for 7 months while staying with her mother in 2019. However, she felt uneasy in this sobriety and missed her previous life. She came to SF in

early 2020, where she stayed with friends for several months. She discontinued BUP and returned to her previous use pattern of over 1 gram daily of fentanyl. During this period, she tried to teach herself to sleep standing to prevent sexual assault.

She moved into a SIP hotel in June of 2020. She was offered BUP as a way to stabilize her opioid use. Her goal was not to discontinue her fentanyl use, as it eased and enhanced her social interactions, but to increase her control and be free from experiencing both withdrawal and the threat of overdose.

A late riser, she struggled to be awake for deliveries, rarely making it to the pharmacy if she missed her delivery. BCPPs text message reminders helped her. Urine drug screens (UDS) confirmed her reports of maintaining on Suboxone 8mg twice daily while continuing to use 1/3 gram of fentanyl daily – a fraction of her previous use.

### Case 2

Case 2 is a 60-year-old man from New Orleans. He moved to SF in 1990 in an effort to make a new life after coming out of prison. He started using Ts and blues (pentazocine and tripelethamine) at 17 years old and heroin at 40.<sup>6</sup> By his mid-40s, he was injecting a gram of heroin daily. When he moved into a SIP hotel, “he was ready to be done with all that and have a different kind of life.” We started him on Suboxone 8mg twice daily. His continued use was verified by regular UDS. A convivial person, his room was a social gathering place. Regular pharmacist and prescriber home visits allowed us to start several of his acquaintances on BUP.

### Case 3

Case 3 is a 39-year-old man from the East Bay, California. He began using opioids when he was 24, after being prescribed oxycodone extended-release (XR) for back pain. One year later he was unable to get further prescriptions and began buying

oxycodone XR on the street. Soon after, he began experimenting with heroin. He participated in a BUP clinical trial in 2008 and was stable on BUP for 2 years. He stopped the trial due to losing housing and moved back to the East Bay where he had 2 daughters. He started methadone in 2014, which he took regularly until 2016. When his relationship with his children's mother ended, he returned to SF and began using fentanyl. When our team met him, he was using 1–2 grams of fentanyl a day. He expressed interest in getting on methadone but was never able to arrive at a clinic. He was motivated to get back on BUP when he learned about the BUP delivery pilot. His regular BUP use was confirmed by UDS. He hopes to continue BUP when he left the SIP hotel. His goals were to get permanent housing, employment and spend more time with his children, and he stated that he needed to stay away from fentanyl to accomplish them.

## DISCUSSION

Prior medical literature has not identified a pharmacy/provider partnership in which pharmacists deliver to patients' residences. This case series highlights several clinical vignettes of patients meeting their goal of obtaining BUP treatment through this novel program.

Case 1 highlights how patients' schedules may not line up with pharmacy hours and the ability to personalize delivery with a reminder system can facilitate treatment. Operational hours of pharmacies and long wait times have been identified as barriers for PEH.<sup>7–9</sup> It also highlights the importance of utilizing communication opportunities such as text messaging. In PEH, there is interest in text messaging-based interventions which highlights how individual preferences should be considered.<sup>10,11</sup> Lastly, this case also brings attention to the way BUP can be used as harm reduction for those whose goals do not include sobriety.

Case 2 highlights how home visits can be a pathway to treatment for others who gather in the patient's home. As we became regular, trusted visitors, we gained the confidence of our patient's acquaintances, allowing us to offer BUP in a more relaxed, social setting.

Case 3 highlights the willingness of patients to go back on BUP after hearing about the delivery program. Clients may lose interest in care if the experience becomes difficult.<sup>12</sup> Getting treatment may not be someone's first priority when they are struggling to get housing.<sup>13</sup> In this client's case, the difficulty of getting into a methadone clinic, losing housing, and personal emergencies are factors that contributed to not being able to restart or stopping treatment.

In all cases, clients were not able to retrieve their medications. Studies highlight other barriers, including transportation or perceived discrimination from others.<sup>7,9,13</sup> Interventions include pharmacy delivery systems combined with counseling to ensure care.<sup>13–15</sup>

The pilot shows promise at increasing access to BUP. A limitation of this study is that it is a case series which may be subject to selection bias. Also, it lacks a comparison population.

Despite these limitations, the partnership implemented is novel. Future research could examine BUP adherence rates in SIPs before and after the expansion of this delivery system.

## CONCLUSIONS

Our findings suggest that this system of onsite medical with pharmacist delivery is possible and has the potential to increase medication access to those with OUD and marginal housing.

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