Alameda County
Health Care for the Homeless

StreetHealth Program (Oakland, CA): Bringing Mental Health Care to Those Who Need it Most

Aislinn Bird, MD, MPH, Psychiatrist
Seth Gomez, PharmD, BCPP

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Objectives

- Discuss the importance of public psychiatry
- Discuss StreetHealth: Psychiatry Backpack Medicine Program
- Discuss future directions

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Public Psychiatry

- Uninsured or public insurance
- Care provided in federal, state, county or not-for profit clinics, hospitals, and street medicine teams

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Behavioral Health Care is Needed:

- 1 in 5 US adults experience a behavioral health condition each year[1]
- 1 in 25 US adults experience a serious mental illness (SMI) each year[1]
- Suicide is the 2nd leading cause of death for people ages 10-34[1]
- Depression is the leading cause of disability worldwide[1]
- 43.3% of US adults with a mental illness received treatment in 2018[1]

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Lack of Psychiatry Providers:

- 40% of psychiatrist work in cash-only private practices[2]
- 10% decrease of psychiatrist working in the public and private health insurance sector from 2003-2013[2]

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Public Psychiatry Fellowships

UCSF Public Psychiatry Fellowship

- Started in 2011 & Modeled after Colombia University's fellowship
- Director: Dr. Christina Mangurian, MD, MAS
- Residency Data:
  - Total number of graduates: 29
  - Current class size: 4
  - Percent retained in the public sector immediately after graduation: 90%
  - Percent of graduates currently retained in the public sector: 76%

Stanford University

- Public Psychiatry Residency Track

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How This All Got Started

- Psychiatry Residency at Stanford University, Chief Resident (2012-2016)
- Attended UCSF Public Psychiatry Fellowship (2016-2017)
  - Alameda County Health Care for the Homeless/LifeLong Medical TRUST Clinic
    - Integrated care clinic for people who are houseless or housing insecure
- HRSA Access Increases for Mental Health and Substance Abuse Services (AIMS) Award
  - Started StreetHealth: Backpack street psychiatry program (2017)
- StreetHealth: Expanding to 14 teams to cover all of Alameda County
  - Multiple funding streams including HRSA and MHSA

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Houselessness in Alameda County

- Alameda County Point-In-Time Count (PITC). January 30, 2019.
  - 8,022 persons experiencing houselessness on this one night[3]
  - 6,312 persons unsheltered (literally homeless, HUD-defined homeless)[3]
  - Does not include people doubled up, incarcerated, hospitalized, trading sex for shelter

- Projected Yearly Count:
  - Urban Institute (2000): multiple the PITC single night count by 4.15-5.18 to give an estimated prevalence of yearly homelessness[4]
  - Estimate: 33,291 persons experiencing houselessness in Alameda County in 2019

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Barriers to Care

Stigma	Not feeling safe leaving belongings	Trauma
Limited clinical access	Not knowing community resources	Transportation
Lack of ID	Finances	Lack of coordination of care

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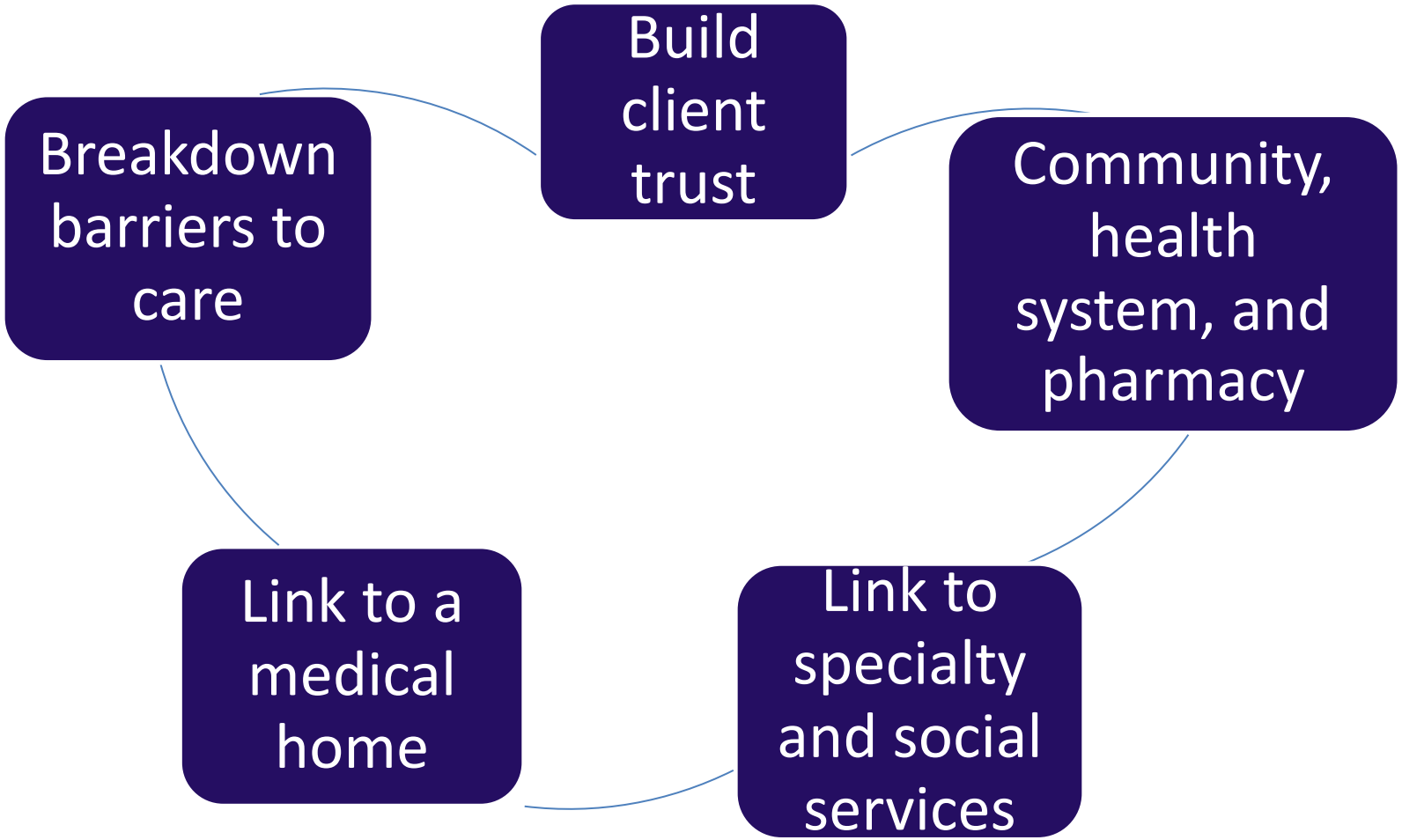
StreetHealth Goals



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StreetHealth Program Design: Go To People

- Backpack street medicine
- Registered Nurse-led multi-disciplinary teams
  - Scheduled encampment and street outreach
- Multi-jurisdictional coordination
- High level of community collaboration

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StreetHealth Services

- Behavioral Health Assessments and Treatment
- Substance Use Assessments and Treatment
- Risk assessments
- Intensive Case Management
- Social Services
- Basic First Aid
- Linkage to a medical home

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StreetHealth:
Role of Team Members

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Nurse Care Manager (RN)

- Mostly field based
- Outreach and engagement
- Health triage and basic first aid
- Schedules field appointments with providers
- Provides health education and wound care
- Monitors inventory of ‘backpack’ medicine

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Community Health Outreach Worker

- Mostly field based
- Outreach and engagement
- Coordinated Entry System (housing) applications
- Benefits enrollment
- Health related referrals (e.g. dental, optometry)
- Connects client with community resources

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Intensive Case Manager

- Mostly office based
- Supports clients with achieving their goals
- Assist with attending appointments
- Benefits and legal advocacy
- Employment assistance
- Reconnecting with family

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Providers

- Psychiatric Provider (MD/NP/PharmD):
  - Hybrid field/office based
  - MD/NP- initial & follow up behavioral health assessments
  - PharmD- follow up assessments
  - Prescribe and dispense medicines in the field as needed

- Medical Provider (MD/NP):
  - Hybrid field/office based
  - Assessment, diagnosis, treatment of health conditions
  - Consultation and telemedicine support for team

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StreetHealth:
Service Delivery Framework

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Street Health Psychiatry

CHOW/RN

5 days a week

- Identifies clients
- Completes consents
- Performs needs assessments and may use screening tools (e.g. PHQ-9, MDQ)
- Schedules office/field encounter w/ provider

Provider

2+ days a week

- Clinical evaluation and treatment

Medication

- Direct dispensing or administration (limited)
- Prescription sent to pharmacy

CHOW/RN

- Assists clients picking up meds from pharmacy
- Follows up with client in the field after starting meds
- Schedules f/u encounters

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Medication Related Services

- Wound management supplies
- Harm Reduction – naloxone distribution
- Psychotropic medications
- Medication Assisted Treatment

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Psychotropic Medications

- May take multiple encounters before medications introduced
- Anti-depressants
- Anti-psychotics
- Anti-anxiety medicine
- Long acting injectable anti-psychotics
- No controlled substances

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Medication Assisted Treatment

- May take multiple encounters before medications introduced
- Buprenorphine
- Naltrexone
- Nicotine Replacement Therapy

Medication Related Services

- Decisions to medicate are made collaboratively between providers and clients
- Prescribe (+/- dispense) 1-2 weeks medication supply
- Clear follow-up plan
- Support client to pick up medications as needed

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Street Health

Patients prescribed buprenorphine (Bupe) to date: 36

November 2018- April 2019

- Patients who were prescribed bupe: 19
- Never filled bupe prescription: 5
- Patients who filled prescription provided in the field: 9
- Patient who filled prescription provided in the clinic: 5
- Average weeks of prescription filled in the field: 2.6 weeks
- Average weeks of prescription filled in the clinic: 9.4 weeks

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Street Health

Data: July 1, 2018- June 20, 2019

- Individuals with trackable outreach encounters: 369
- Individuals with 1+ Enabling Service (HRSA UDS criteria): 254 (69%)
- Individuals with an enabling service linked to clinic: 54 (21%)
- People linked to clinic with 3+ visits: 25 (74%)
- Number of psychiatry evaluations: 50
- Number of individuals prescribed a medication: 35 (70%)
- Number of individuals prescribed buprenorphine: 22 (63% of all prescriptions)

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Case Examples

- DP: 64-year-old AA man, chronically homeless, h/o Schizophrenia and Opioid Use Disorder, mistrust for psychiatry.
- Eventually agreed to start a LAI, provided in the field by our RN.
- Improved engagement in care. Slow warm hand-off to a Full Service Partnership case management team which did not go well.
- Patient has declined the LAI since December 19, 2019.

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Case Examples

- DE: 40-year-old Latino man, homeless for less than a month, recently unemployed, h/o Opioid Use Disorder.
- Prescribed buprenorphine in the field on August 2018.
- Linked to Trust Health Center in August 2018.
- Established care with PCP who continued buprenorphine, last prescribed October 2019, when client moved out of county.

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Case Examples

- JB: 23-year-old Caucasian woman, homeless on and off since age of 14, recently unemployed, h/o Opioid Use Disorder, referred by Punks with Lunch.
- Started on buprenorphine in December 2019.
- Never established care at Trust Health Center.
- Last prescription on January 2020
- Lost to follow-up

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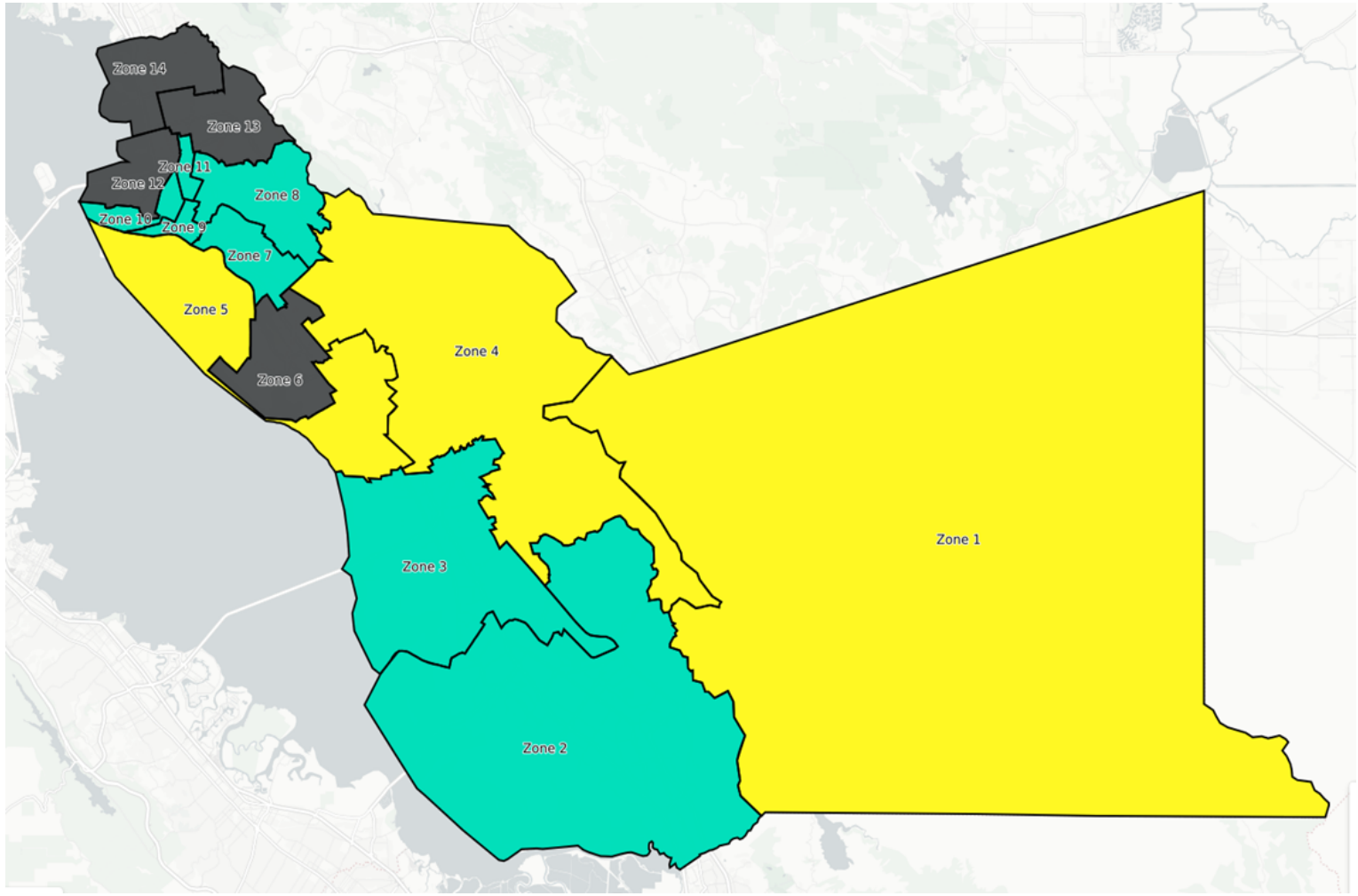
Future Directions



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Street outreach teams provide direct services and linkage to care to our most vulnerable neighbors

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QUESTIONS

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Contact Information:

Aislinn Bird, MD, MPH: Aislinn.Bird@acgov.org

Seth Gomez, PharmD, BCPP: Seth.Gomez2@acgov.org

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References

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