

Overdose Prevention & Response: Innovation & Partnerships in MOUD Access

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King County Board of Health

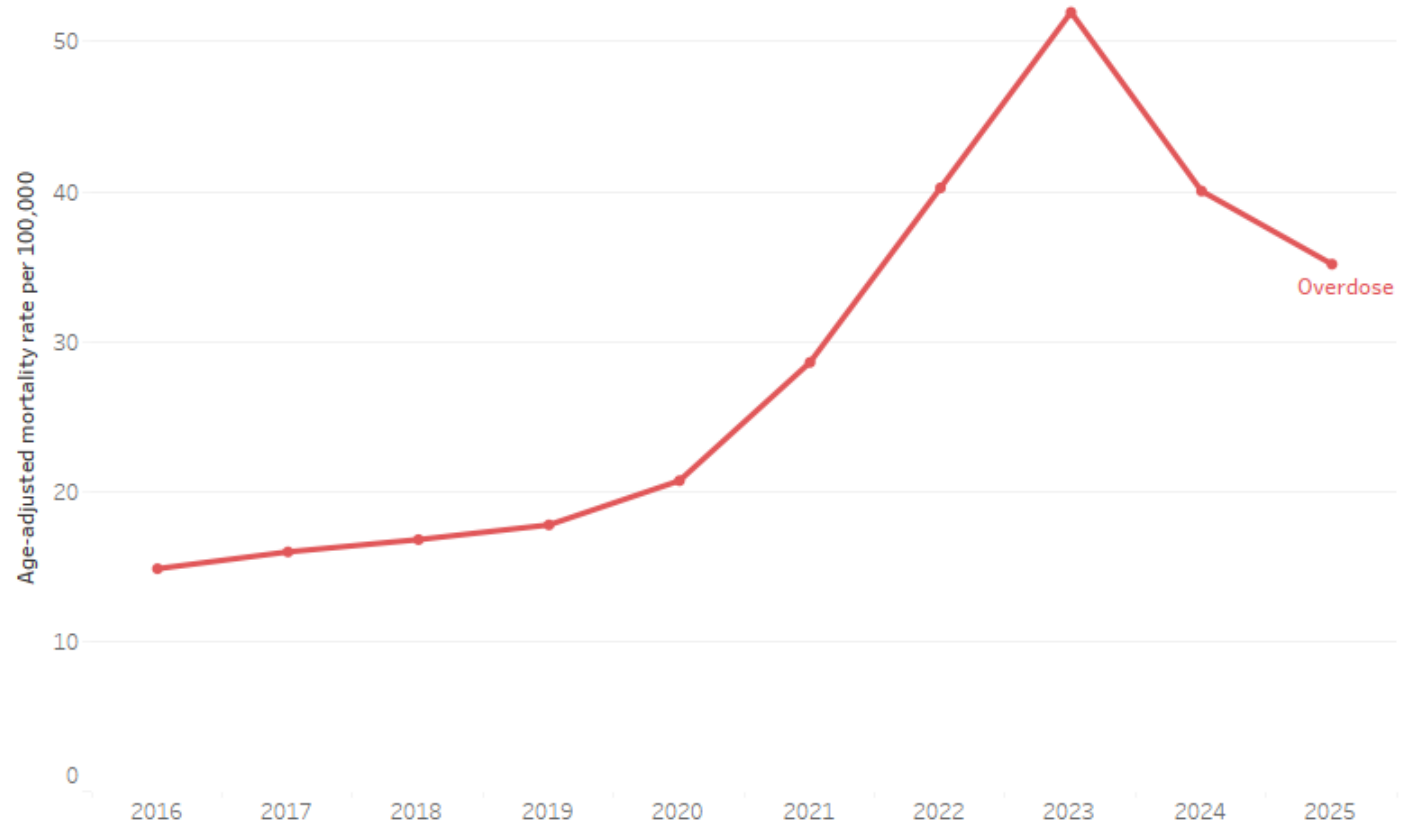
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Overview

- Data overview
- Low barrier Medications for Opioid Use Disorder (MOUD) clinical models
 - PHSKC Healthcare for the Homeless Network (HCHN)/Street Medicine
 - PHSKC Pathways & Mobile Team Pilot
 - DESC Opioid Recovery & Care Access (ORCA) Center & Patient Outreach Division (POD)

The overdose mortality rate in King County more than tripled between 2018-2023 and has since declined

- Fentanyl fueled the rapid increase in overdose deaths
- Overdose mortality rates **decreased 32% from 2023-2025**
- Nonetheless, 2025 overdose rates remain elevated relative to historical (pre-2022) data



For more data and information visit: www.kingcounty.gov/overdose/data

Data source: King County Medical Examiner's Office, 2016–2025

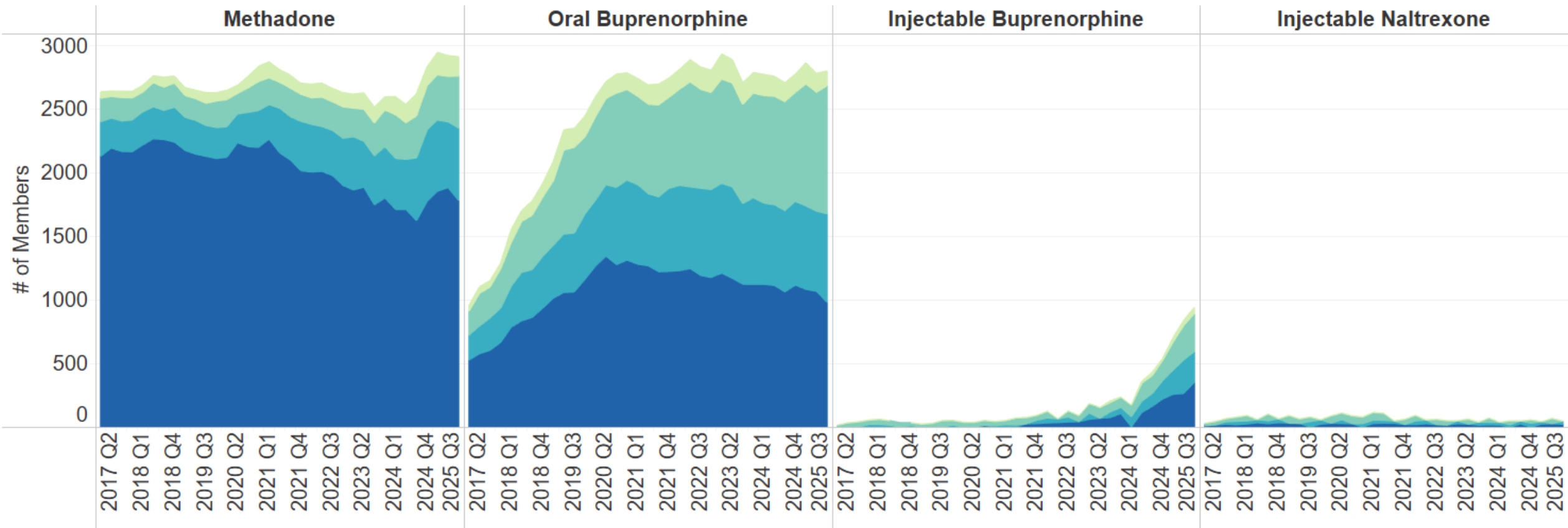
Key disproportionately affected populations

- Housing status:
 - Almost half (47%) of all 2025 fatal overdoses occurred among people who were unhoused (22%), at a housing service site (21%), or other temporary arrangement (4%)
- Race/ethnicity:
 - Black/African American people experience a rate of opioid overdose three times higher than people of all other racial/ethnic groups and are significantly less likely to receive MOUD and possess naloxone
 - Overdose rates measured for American Indian/Alaska Native people are also elevated compared to other groups

Medicaid OUD & MOUD Indicators, Stratified by Medication Type

Number of Days Covered by MOUD Prescription(s)

■ 1-6 days
 ■ 7-30 days
 ■ 31-60 days
 ■ >60 days



Evolution of Care

- Care and treatment for substance use disorder has evolved over time, focusing more on low-barrier and mobile programs
- Collaborations across organizations to meet the needs of people with complex behavioral health needs
- Increasing access to long-acting injectable buprenorphine

PHSKC Strategic Plan Overdose Prevention Objectives

Harm Reduction	Treatment
Increase equitable access to lifesaving tools and support for the people who use drugs	Improve equitable access to evidence-based and emerging treatments for substance use disorder that promote dignity and support individual well-being

SUD Treatment & Harm Reduction Services for People Experiencing Homelessness

Street Medicine Teams & HCHN Community Network | 2025 Data

- HCHN intentionally prioritizes engagement of clients with SUD needs
- Overdose crisis has had a well-documented, disproportionate impact on PEH
- 5,800+ clients provided with substance use disorder treatment, prevention, counseling, and/or case management services in 2025

SUD Services Provided by HCHN

2,000+

Clients with an SUD diagnosis received services in 2025

Substance Use Treatment

- Alcohol use disorder assessment & treatment
- Opioid use disorder (OUD) management: 600+ clients prescribed MOUD
- Other substance-related disorder care
- Referrals to MAT / MOUD programs

65%

of clients receiving SUD services have co-occurring mental health diagnoses or service needs

Co-occurring Mental Health

- Depression & other mood disorders
- Anxiety disorders
- Post-traumatic stress disorder (PTSD)
- Integrated BH screening & brief intervention

15,000+

SUD outreach & case management visits in 2025

Outreach & Enabling Services

- Street outreach by mobile teams
- Case management & care navigation
- Trust-building & relationship continuity
- Insurance eligibility assistance

Services reflect intentional outreach and engagement — meeting patients where they are

Harm Reduction: Street Med Approach & Challenges

Harm Reduction Approach

Meet patients where they are

Outreach to encampments, shelters, and street locations — no clinic visit required

Non-judgmental, low-barrier care

Services available regardless of sobriety status or prior engagement with systems

Relationship continuity

Consistent staff build trust over time, especially with patients who avoid formal systems

Overdose prevention focus

Naloxone distribution, fentanyl awareness, and connection to OUD treatment

Integrated physical + behavioral care

SUD services delivered alongside medical care for chronic conditions

Key Challenges

Premature mortality

Too many patients dying before age 60 — overdose crisis hits this population hardest

Trust & system avoidance

Significant time investment required before patients will engage with care; cannot be easily quantified

Patients in constant motion

Unsheltered patients move frequently, making follow-up and continuity exceptionally difficult

Advanced-stage presentation

Patients often present with complex, late-stage conditions compounded by SUD

Workforce demands beyond health care

Street teams must address shelter, food, and safety needs alongside clinical care

HCHN teams deliver care in non-traditional settings — shelters, encampments, and street locations



Pathways Clinic & Mobile Team Pilot

Pathways Clinic & Mobile Team Pilot

Pathways Clinic



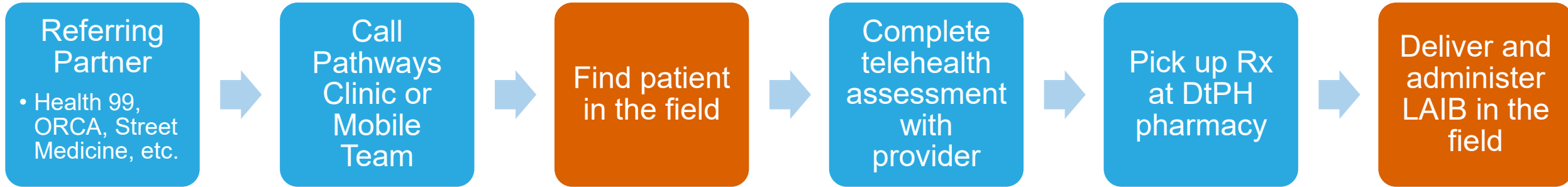
- Began in 2017 as a recommendation of the Heroin and Prescription Opiate Task Force
- Provides **low-barrier access to buprenorphine** in the Downtown Public Health Center in Belltown
- **Co-located** with a Syringe Service Program (SSP), primary care clinic, dental clinic, and pharmacy
- Offers a variety of **basic medical services and community referrals**
- MD, ARNPs, RNs, MSW, CHW (Community Health Worker), Substance Use Disorder Professional (SUDP)

Pathways Mobile Team Pilot



- Funded by city of Seattle in 2025
- Provides access to **long-acting injectable buprenorphine (LAIB) in the field** for patients with significant barriers to accessing care in clinic
- Priority population is **patients experiencing unsheltered homelessness**
- High intensity outreach
- **Coordinates** closely with PHSKC Street Medicine, DESC/ORCA, and other HCHN providers
- 1 RN, 1 SSP (Social Services Professional), with support from Pathways Clinic providers and staff

Pathways Clinic & Mobile Team Pilot



Pathways Clinic

Sept 2025 – March 2026

- **1,868** Encounters
- **556** Unique patients
- **184** Patients on LAIB
- **519** Injections administered

Mobile Team Pilot

Jan – March 2026

- **240** Outreach attempts
- **45** Injections administered in field
- **19** Patients started on LAIB in field

Mobile Team Patient Example

- HCHN nurse referred 23-yo female living at a tiny home village.
- Mobile Team met patient at her tiny home and **began her buprenorphine injection** in the field.
- She received her second monthly injection but then **lost her tiny home placement** and returned to the streets.
- Mobile Team successfully found her living outside in Capitol Hill and **administered her 3rd monthly injection**.
- Received **her 4th injection in clinic**.
- Also **referred her to Ryther**, an organization serving young adults, so she can receive intensive case management including shelter/housing support, a phone, mental health treatment etc.
- Mobile Team **continues to outreach** her.





DESC Opioid Recovery & Care Access (ORCA)

ORCA Center + ORCA Patient Outreach Division (POD)
Rachel Marhill + Callan Fockele

What is ORCA?

ORCA Center provides 24/7 post-overdose care and same-day medications for opioid use disorder (MOUD) access

ORCA Patient Outreach Division (POD) brings MOUD care to clients in DESC permanent supportive housing and emergency shelters

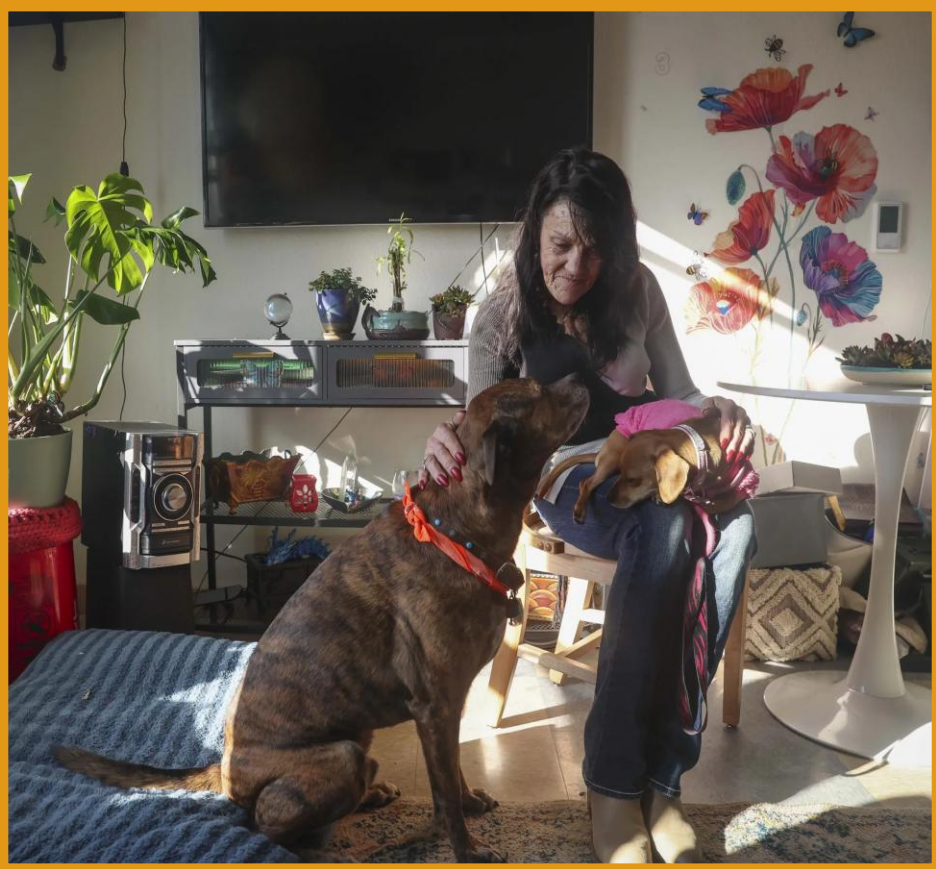
Goal: Create safe spaces to meet people where they are

ORCA Center



- Safe space to recovery from overdose
- Start or continue MOUD
 - Sublingual and long-acting injectable **buprenorphine**
 - **Methadone** using the 72-hour rule → warm hand-off to opioid treatment program (OTP)
- Access to **showers, snacks, & laundry** during treatment
- Connections to **behavioral health, shelter, & housing navigation**

ORCA POD



(Kim, Greg. 2024. Seattle Times)

- Brings care directly to people in **DESC permanent supportive housing and shelter**
- Provides **MOUD & peer support** in the setting that works best for each person

ORCA Outcomes (Sept 2025-Mar 2026)

Encounters

- **344** post-overdose admissions
- **5738** walk-in/outreach visits for MOUD care

MOUD

- **542** clients started on MOUD
- **296** clients started monthly LAI buprenorphine

Client Story



- Woman with a long history of OUD, previously treated with methadone, experienced an **overdose** in her apartment
- **SFD H99** self-dispatched and responded on scene
- Patient was initially hesitant to start buprenorphine due to prior experience with **precipitated withdrawal**
- H99 team used **motivational interviewing grounded in harm reduction principles** to explore concerns and build trust
- **Prehospital buprenorphine** was offered to treat withdrawal symptoms and support patient-centered decision-making
- Patient agreed to transport and stayed overnight at the **ORCA Center**, where she received monthly **LAI buprenorphine**
- **PHSKC Pathways team** provided ongoing outreach at her home, given **mobility limitations** (wheelchair use)

**Questions?
Contact:
KCBOHAdmin@kingcounty.gov**