Whole Person Integrated Care Overview and Overdose Prevention Strategies

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SF Department of Public Health
Whole Person Integrated Care

Agenda

- Overview of WPIC programs
- Review trends in service utilization
- Deep dive into overdose prevention initiatives

Whole Person Integrated Care (WPIC) is a section of the SF Department of Public Health's Ambulatory Care division that brings together existing non-traditional primary care, urgent care, and behavioral health clinical services primarily serving people experiencing homelessness.

WPIC takes a data-driven, collaborative approach to caring for our highest risk patients and facilitating citywide care coordination.

SF Department of Public Health
Whole Person Integrated Care

Serving People Experiencing Homelessness across the SF Health Network care continuum

Maria X Martinez Health Resource Center:
+ Urgent Care
+ Transitional primary care

Shelter Health
+ Shelter health nursing
+ Shelter based clinics

Street-Based services:
+ Street Medicine
+ Street Overdose Response Team
+ Post Overdose Engagement Team
+ Enhanced Care Management

Permanent Supportive Housing services:
+ Nurse-supported buildings
+ PHACS Team
+ Enhanced Care Management

Recuperative Care:
+ Medical Respite Program
+ Sobering Center
+ Managed Alcohol Program

Whole Person Integrated Care Original Programs

Street Medicine

Street-based low-barrier outreach, engagement, and care for unsheltered people experiencing homelessness.

Shelter Health

Healthcare teams located in shelters, navigation centers, and SIP hotels to address health issues and provide connections to ongoing care.

PSH Nursing

Nurse case management within select permanent supportive housing buildings to help stabilize residents and provide chronic disease management.

Alcohol Sobering Center

A place for people intoxicated on alcohol to safely sober off the streets, out of the emergency department and out of jail.

WPIC Urgent Care/Open Access Clinic

Low barrier health care for urgent issues and transitional primary care for high risk/high vulnerability people experiencing homelessness not getting their needs met elsewhere

Medical Respite

Post-acute recuperative care for people experiencing homelessness who are too sick to navigate the streets or the shelter system, but not sick enough to be in the hospital.

Whole Person Integrated Care Expansion Programs

Cal-AIM Enhanced Care Management

Medical and behavioral health team to provide ongoing services to a caseload of highly acute individuals experiencing homelessness and who have Medi-Cal. Referrals will mostly come from managed care plans.

Managed Alcohol Program (MAP)

MAP provides a monitored, residential, setting to directly dispense alcohol to individuals with Alcohol Use Disorder (AUD) with the goal of decreasing life-threatening withdrawal seizures, emergency service utilization, and binge drinking behavior. Once individuals stabilize, multidisciplinary staff focuses on addressing biopsychosocial needs

Permanent Housing Advanced Clinical Services (PHACS)

Prop C funded medical and behavioral health care services for tenants in PSH along with capacity building for housing providers. Program sits within Behavioral Health, but health staff are hired and supported by WPIC.

Street Overdose Response Team/Post Overdose Engagement Team

Partnership with Community Paramedics to work with individuals who survived non-fatal overdoses in attempt to prevent future overdoses.

Maria X Martinez Health Resource Center

New home for 50 Ivy and 101 Grove teams! Integrating care with partner organizations.

WPIC Service Utilization 2021-2023

WPIC Clients and Services by Calendar Year

	Distinct Clients			Encounters*			# Stays			# Days		
Timeframe	**2021**	**2022**	**2023**	**2021**	**2022**	**2023**	**2021**	**2022**	**2023**	**2021**	**2022**	**2023**
Medical Respite	282	313	343	See Stays / Days			307	349	404	20,361	18,487	18,776
Sobering Center	354	326	329	849	901	1,017						
Managed Alcohol Program	17	27	24	See Stays / Days			16	34	28	3,159	3,539	4,625
PSH Nursing	389	510	512	851	967	1,913						
Shelter Health	708	1,360	1,763	2,160	6,682	7,562						
Street Medicine	3,689	3,279	3,342	21,195	12,915	12,915						
MXM Health Resource Center	3,345	3,869	4,731	11,230	12,569	17,994						
PHACS	N/A	501	799	N/A	2,300	6,330						
WPIC Combined	**7,254**	**7,852**	**9,140**	**36,285**	**36,334**	**47,731**	**323**	**383**	**432**	**23,520**	**22,026**	**23,401**

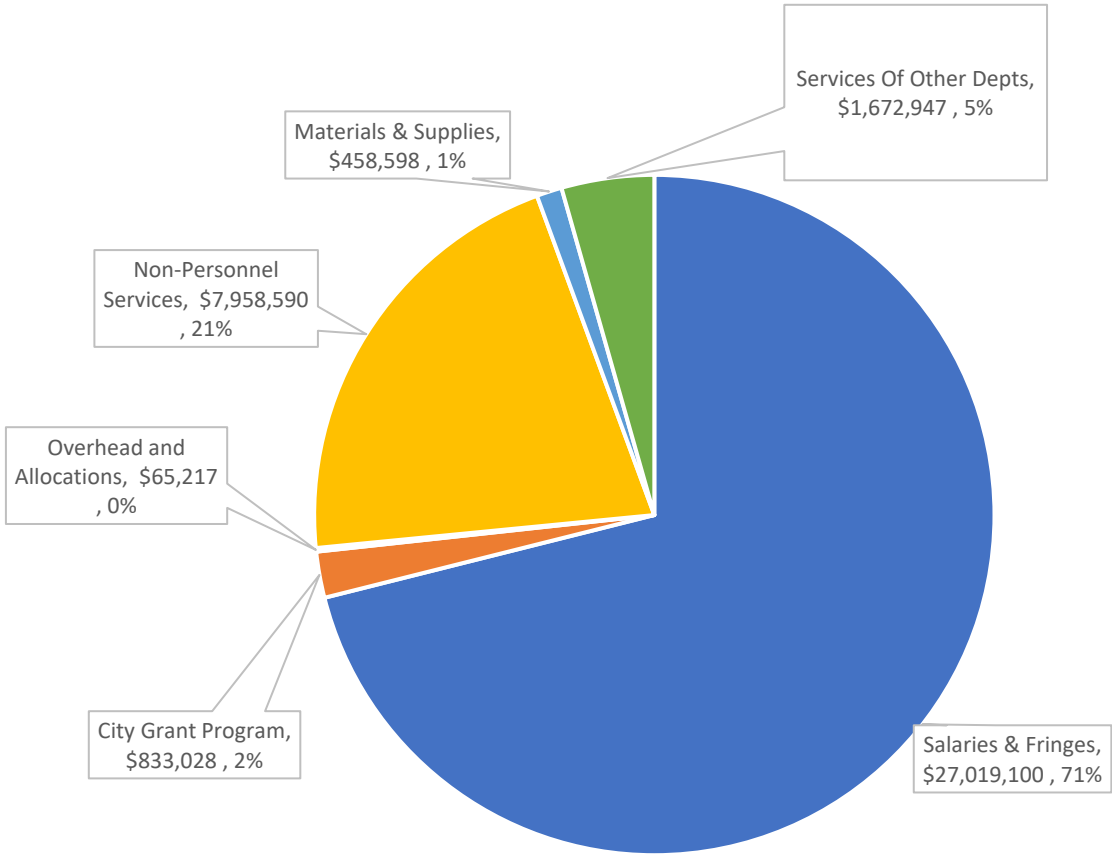
**For all programs except MXM HRC, Encounters include Traditional face-to-face encounter types (Clinical Support, Immunization, Office Visit, Social Work, Telehealth, Procedure Visit) plus Documentation, Clinical Documentation Only, and Patient Outreach encounters.*

MXM HRC includes only the six traditional face-to-face types listed above.

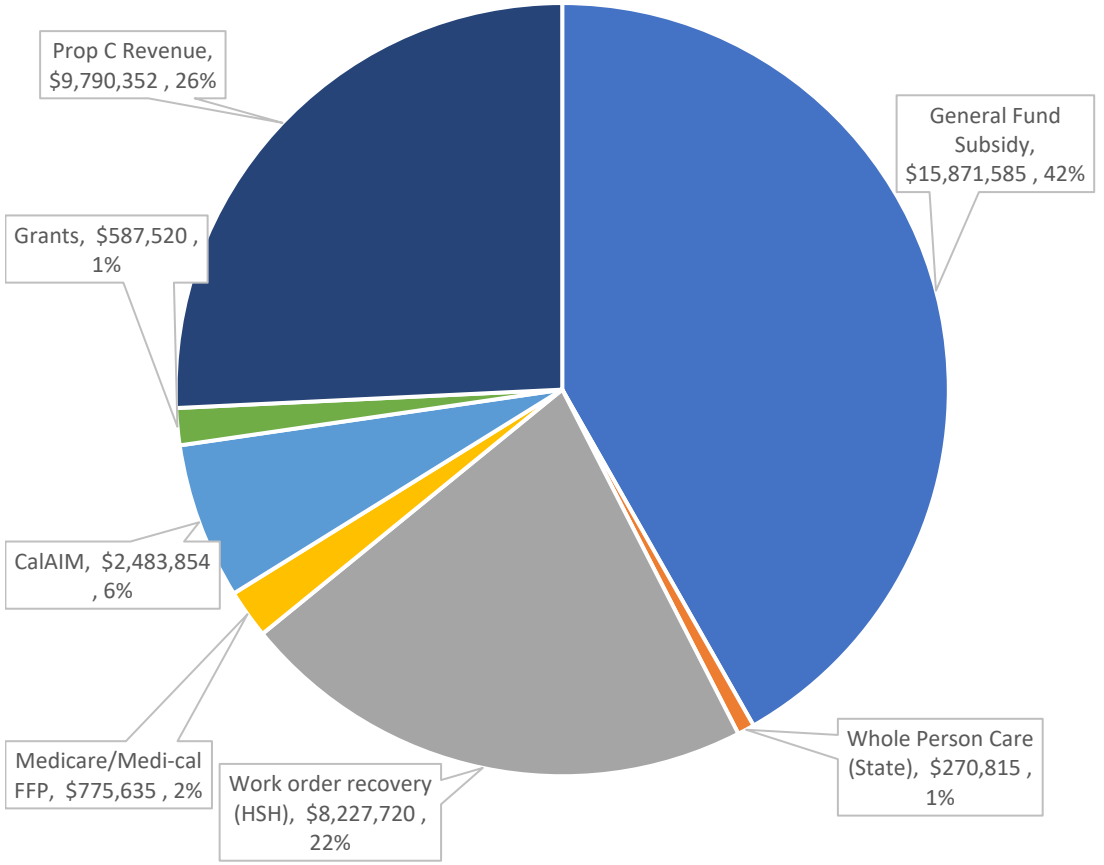
Sobering Encounters counted using Sobering Center methodology.

WPIC Budget FY 22-23

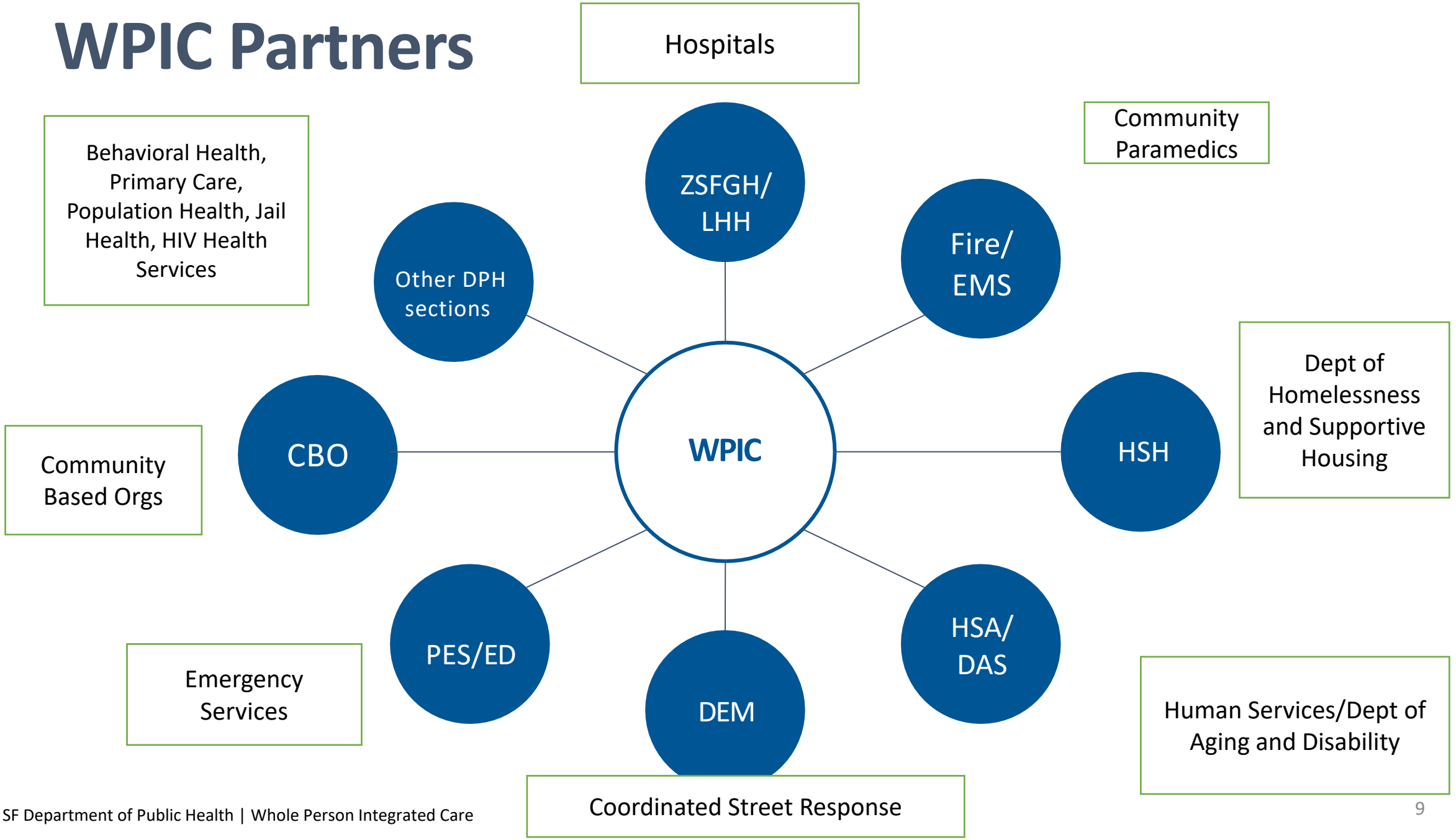
Total Income FY22-23: $38,007,480



Total Expenditures FY22-23: $38,007,480



WPIC Partners



WPIC clients are Disproportionally Impacted by Overdose/ Overdose prevention work occurs across all WPIC programs

People experiencing homelessness with multiple overdoses:

- High rates of **mental health** issues
- **Hard to locate**
- **Not all** have a clear **diagnosis of opioid** use disorder
- About a **third had been on MOUD** at some point

In the last 12 months, WPIC had:

- **46%** of patients report **alcohol, tobacco or drug use**
- **2730** prescriptions written for **Buprenorphine**
- **115 patients** receiving **long acting injectable MOUD**
- **2860 visits** with a primary **diagnosis of Opioid Use Disorder**
- **321 Contingency Management visits**

Patient Story: street care programs

48 yr old man previously sober for 14 years, relapsed on fentanyl and meth a year ago

Stays on the street, severe leg wounds

Engaged by Code TL night navigators, had evening telehealth visit for bupe start

Placed at the Adante Hotel through MOUD stabilization pilot

Daily support from staff including bupe delivery to hotel due to limited mobility

Shelter Health nurse provided wound care and connections to ongoing health care

Transferred to Medical Respite for wound care with goal of improving mobility to meet his goals to participate in residential treatment/stay sober

Evening Telehealth for MOUD

Started March, 2024

Problem: MOUD decreases the risk of fatal overdose by at least 50% but there is limited access to MOUD at night

Pilot sits in WPIC, moving to Behavioral Health

- Pilot in partnership with Code Tenderloin Night Navigator program

•**8pm-midnight** Navigator can connect client interested in treatment to **telehealth** phone visit with a provider who can ***real time* prescribe** and counsel on MOUD

•Buprenorphine **prescription sent to 24/7 pharmacy** or plan made for **next day methadone clinic enrollmen**t

Night Telehealth Pilot Outcomes: First 4 weeks

- 179 telehealth visits with 173 unique patients
- 161/173 (93%) with plan to start MOUD
- 82% obtained Bup prescription, 18% chose Methadone
- Of 132 Bup prescriptions, 80% microdosing
- 33% (n=44) picked up buprenorphine

MOUD Shelter + Substance Use Treatment

Started: March, 2024

Problem: People who start MOUD through night telehealth need ongoing follow up and support to succeed.

Navigators can place clients who are starting MOUD in a few rooms at the Department of Homelessness and Supportive Housing's Adante hotel for a weeklong intensive stabilization.

- **Daily check ins** with case managers to address barriers to treatment (ID, insurance, transportation)

- **On site Shelter Health** nursing for health needs

- **Accompaniment/Transportation** to pick up medication OR bupe delivery to hotel
- Referral to ongoing case management, health care services

- **Discharge planning** for linkage to residential treatment or shelter

56 clients linked to Adante
78% picked up MOUD
21% went to **residential treatment or withdrawal management**
23% went to shelter on MOUD

Patient Story: POET and INSPIRE Programs

- **24** year old woman
- Smokes **fentanyl and meth** daily
- History of multiple prior **overdoses**
- Street Medicine brought her to MXM for "toenail problem", **doctor discussed medication** for opioid use disorder
- Initially unsure, had past unsuccessfully attempts to start oral bupe
- After discussion of risks/benefits, **started same day** long-acting injectable version of **bupe**
- **Did well for 2 months** but then lost to follow up, **restarted** fentanyl use
- **Reengaged** by the Post Overdose Engagement Team (POET), **re-started** bupe shot and POET will **bring her to follow up appointments**.
- Connected to INSPIRE, WPIC's **Contingency Management** program for stimulant use

POET: Post Overdose Engagement for People Experiencing Homelessness

POET= Post Overdose Engagement Team

Started: November, 2020

Problem: People with a prior non-fatal overdose are at high risk for future overdose death

POET data FY 22-23
* 1/3 started Bupe
* 20% started methadone
* 55% linked to MXM

- **Outreach** to highly vulnerable **unhoused people post overdose**
- **Multidisciplinary team** including **peer specialists** with lived experience
- Ongoing **case coordination**
- Linkage to **MOUD and inpatient treatment**
- **"Hot Spot"** outreach to neighborhoods/blocks highly impacted by OD
- Work done in **collaboration** with SORT Team (Community Paramedics + peers responding immediately post overdose) and UCSF HOPE Team (post overdose outreach to people who are housed) and other outreach teams

Civic Bridge Program: Improve collaboration between overdose response teams

Problem: Opportunities for increased collaboration between the multiple teams serving people who have experienced a non-fatal overdose

Started: April, 2024

Partners:
* Mayor's Office of Innovation
* DPH
* Fire
* Dept Emergency Management
* UCSF
* ZS Consultants

- Partership with the **Mayor's Office of Innovation** which leverages community partnership to help address key city priorities.
- Partnering to better **coordinate to serve overdose** survivors.
- **4 month** project to implement a series of feasible changes to coordinate a data driven system of care.

INSPIRE= INcentive Support Program for Improvement and Recovery

CM is an evidenced based behavioral treatment that positively reinforces a desired behavior

Started: November, 2023

Problem: People with Stimulant Use Disorder are at high risk for unintentional opioid overdose

INSPIRE: Low Barrier Contingency Management (CM) for Stimulant Use Disorder

- Low-barrier **contingency management** (CM) program for people with stimulant use disorder. Collaboration between WPIC's **Maria X Martinez Health Resource Center** (MXM) and SFHN's T**om Waddell Urban Health Center.**

- INSPIRE includes:
  - **Twice weekly** sessions for **12 weeks**
  - **Community group** and **one-on-one check-ins** every session
  - **Gift cards for attendance** and optional **urine testing for stimulants**
  - **Overdose prevention counseling** and referrals for medication

INSPIRE is graduating its second cohort of participants and preparing to start a third cohort.

INSPIRE Outcomes

- **58%** of clients reported a **prior overdose** but **only 1** INSPIRE client reported an **overdose while enrolled** in the 12-week program
- **High rates of engagement** and **regular attendance**, participants appreciated the community building component of the program.
- **100% reported a reduction in substance use**
- **25%** providing urine testing **negative for stimulants**

“I managed to eliminate my usage gradually by setting small goals each week.” –INSPIRE Participant

Civic Bridge: Mid-point Interventions in Process

Pain point	Intervention
Many sources used to track clients	Use standard high utilizer list to see how many other street teams are serving clients
Standardized training to address overdose solutions (including those involving stimulant use)	Alignment around standardized trainings
Warm handoffs between teams	Alignment around which clients/for warm handoffs/process
Lack of standardized documentation	Standardize documentation

Summary Patient Story

58-year old woman

Became **homeless after leaving an abusive relationship**. **Living in her car** in the Bayview

20 year history of Stimulant Use disorder (methamphetamines). Started using to stay awake while working 2 jobs

Multiple unsuccessful attempts to quit "cold turkey." Unable to do residential treatment due to work schedule

Experienced an **unintentional opioid OD** last year
after smoking from a pipe that she thought contained meth

Referred to **MXM INSPIRE** program and over 12 weeks was able to **gradually reduce use and then stop**. Started **addiction treatment medication** and **continues to attend group and individual counseling**

After her experience at MXM, **referred her daughter to come to clinic for addiction treatment**

In Summary

- WPIC serves people experiencing and transitioning out of homelessness across the continuum from street to shelter to clinic to housing
- WPIC clients are uniquely vulnerable to overdose
- WPIC is responding to the overdose crisis with a range of new initiatives
- WPIC uses a creative, data driven and patient-centered approach to minimize barriers to substance use treatment