Turning The Tide On Overdose
through Collaborative Outpatient Care

SFHN Primary Care & Whole Person Integrated Care

July 20, 2026

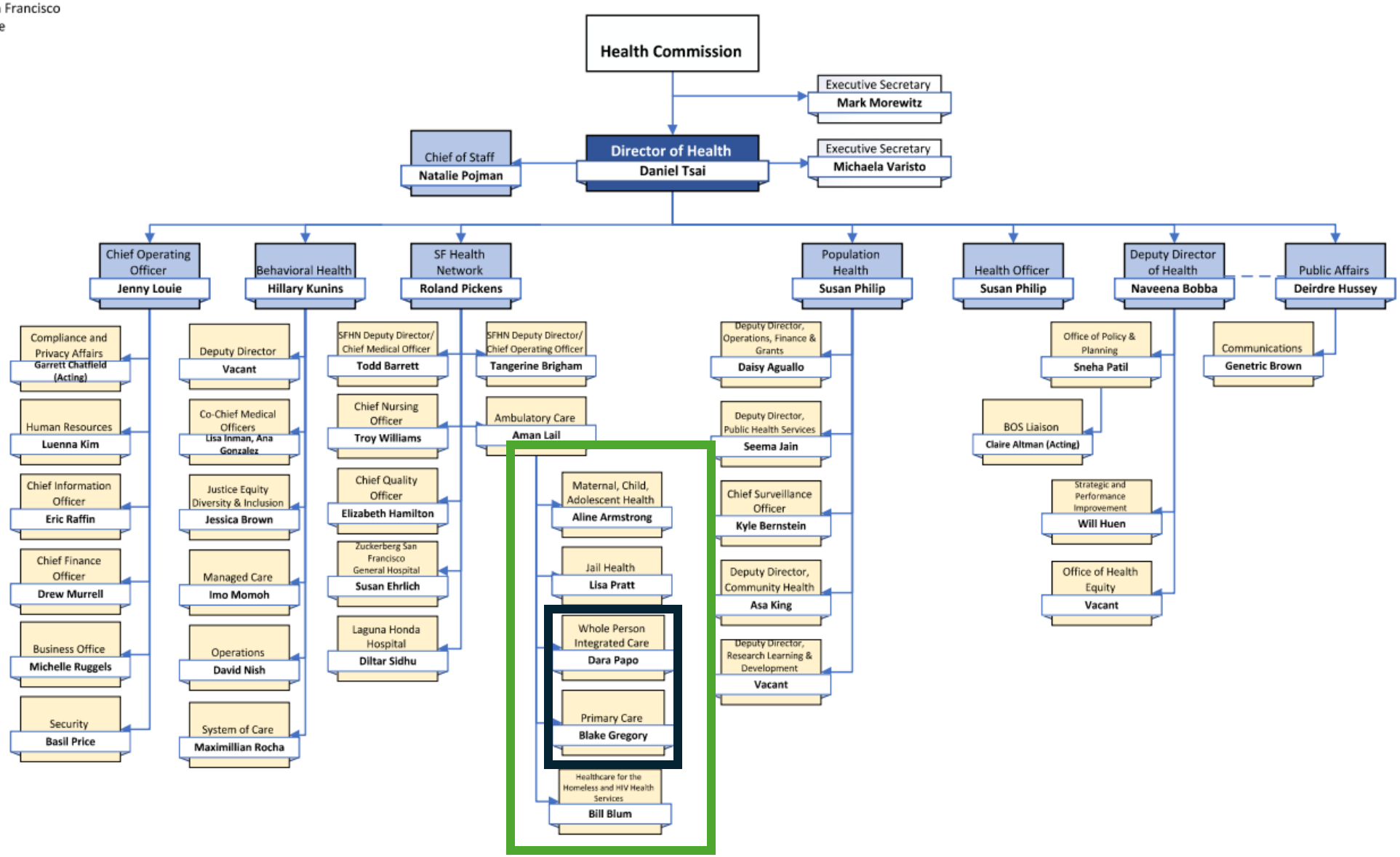
San Francisco
Department of Public Health

San Francisco
Health Network

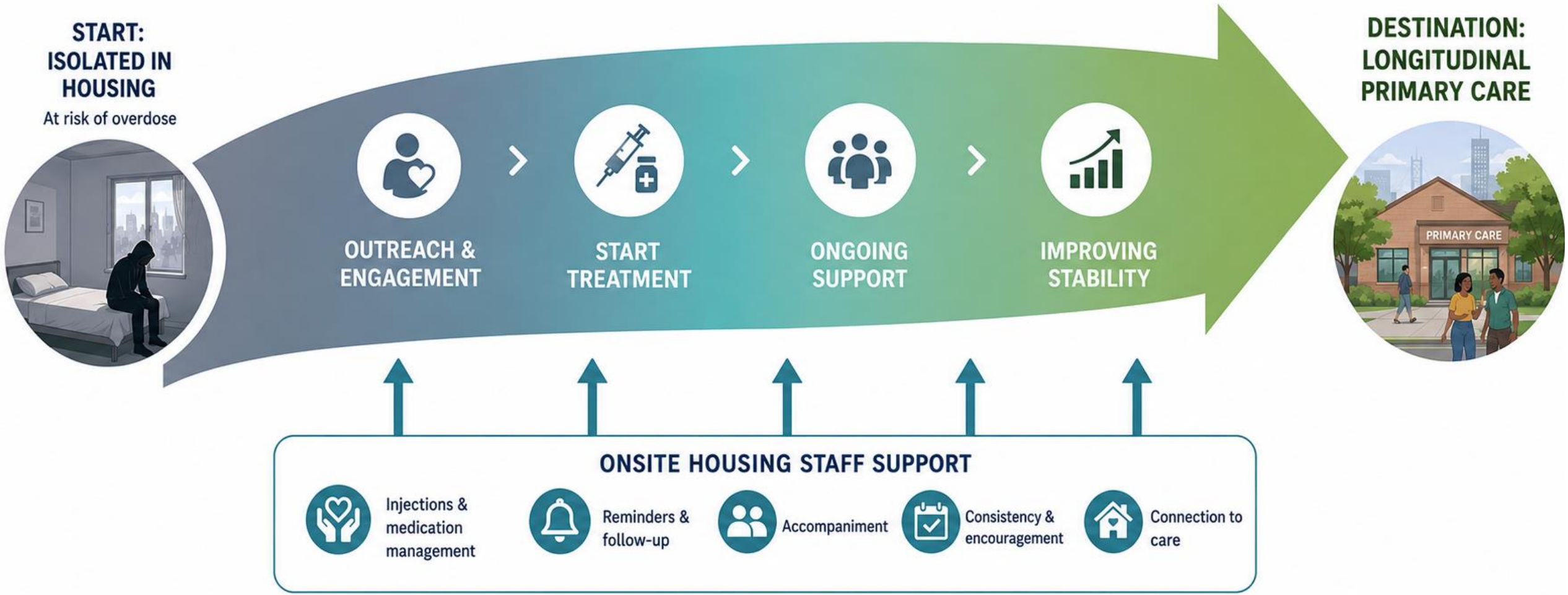
Organizational Chart

San Francisco
Department of Public Health

City and County of San Francisco
Daniel L. Lurie
Mayor



Agenda: *Understanding Collaborative Care Through a Patient Journey*



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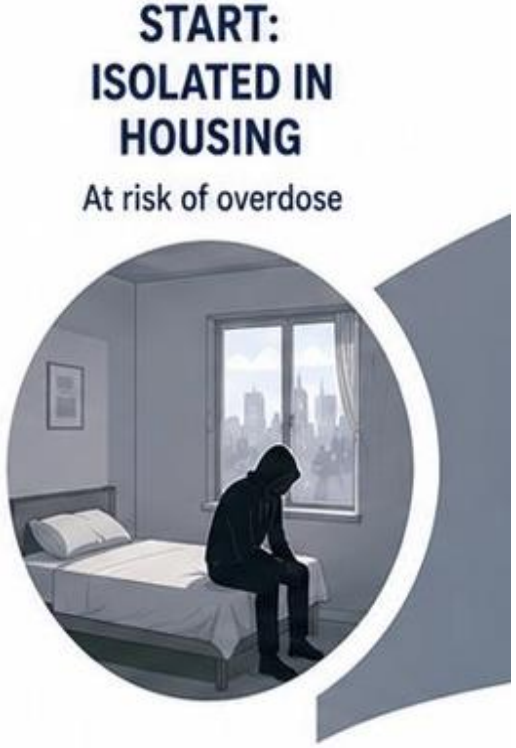
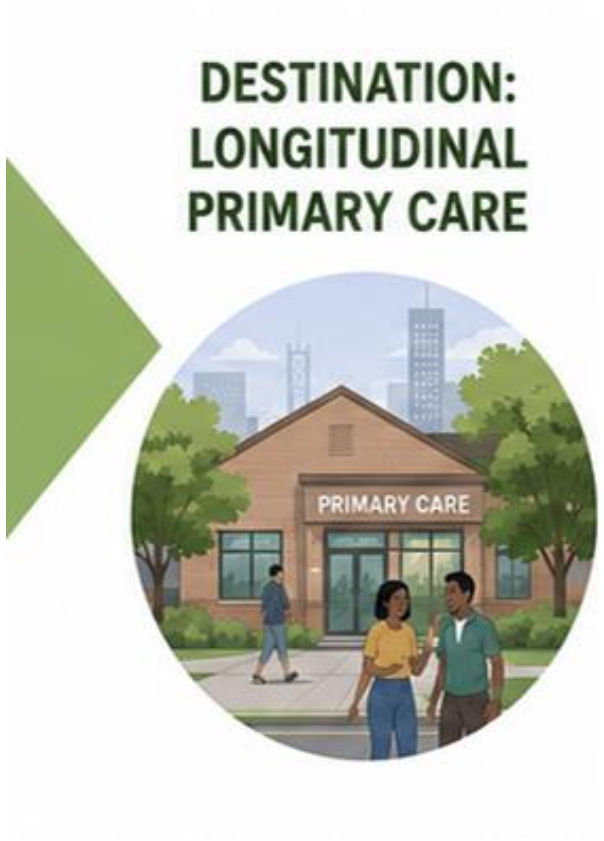


52 year-old* with:

- Severe **mental** illness: complex post-traumatic stress disorder (PTSD), bipolar depression --> coping with stimulant then opioid use
- Severe **physical** illness: heart failure, non-healing leg wounds with pain and reduced mobility
- Severe **social** needs: homeless for > 10 years after 5 years in prison; recently housed in Permanent Supportive Housing (PSH). Self-isolates. Unable to work due to physical limitations.



*composite patient based on several cases

Patient Journey: **Overdose**

52 year-old with PTSD, bipolar depression, stimulant and opioid use, heart failure. Homelessness for > 10 years, recently housed in Permanent Supportive Housing.

Experiences **unintentional fentanyl overdose** at home

- Naloxone (Narcan) given by neighbor trained as peer responder by Delivering Innovation in Supportive Housing (DISH) program
- Sent to Emergency Room for evaluation
- Discharged to Sobering Center for post-overdose care

Patient Journey: **Sobering Center**

Patient sent from ER to **Sobering Center** for post-overdose care

- Rests overnight with Nurse monitoring
- Requires naloxone (narcan) once
- In the AM, meets with Nurse Practitioner, reviews med options
- Decides to start buprenorphine by injection

Sobering Center: Overdose Prevention and Engagement

Impact at a Glance (last 12 months)

1100 clients served

658 (60%) started on medications

95% engaged in overdose prevention services

Elements of Sobering Center Opioid Response

01. 24/7 Intake Capacity & Nursing Care

02. Safe Recovery from Intoxication & Post Overdose Support

03. Rapid Medication for Opioid Use Disorder Starts

04. Close Partnership with Fire/EMS, Emergency Rooms/Hospitals, Residential Treatment Providers

05. Connection & Bridging to Ongoing Treatment

Patient Journey: **Starting Medication for Opioid Use Disorder (MOUD)**

Patient gets first buprenorphine injection at Sobering Center via "direct to inject" (DTI) method.

Sobering Center coordinates with WPIC **Permanent Housing Advanced Clinical Services** (PHACS) for follow up injections and ongoing care.

Day 1:
first starting dose

Day 2:
second starting dose

Day 3 and every 28 days:
maintenance injection

Permanent Supportive Housing Health Services: PHACS

Elements of Permanent Supportive Housing Advanced Clinical Services (PHACS)

Impact at a Glance

563 medications starts

297 Pharmacist home visits

~20 Post-overdose outreach visits each month

01. Home-based care for PSH residents with Opioid Use Disorder

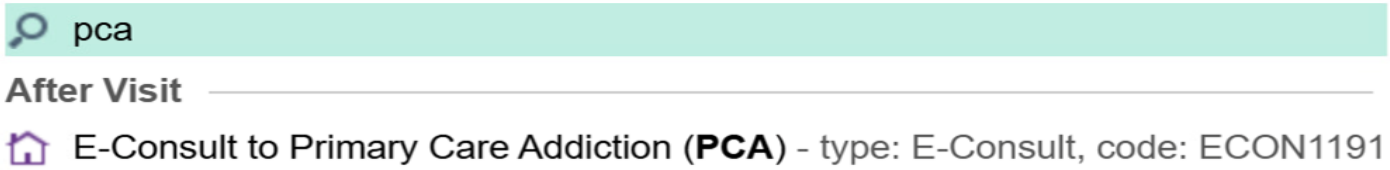
02. Targeted outreach to overdose survivors, high utilizers, clients lost to follow up

03. Pharmacist-delivered buprenorphine including injections

04. Partnership with and capacity building for on-site PSH Staff

05. Connection & bridging to ongoing treatment

Patient Journey: **Connection to Primary Care**



PHACS refers to **Primary Care Addiction (PCA) eConsult**. PCA offers scheduled and/or drop-in appointment

- Patient connected to Tom Waddell Urban Health Center via PHACS accompaniment.

- Patient connects to new Primary Care Provider (PCP) with addiction expertise
- During visit:
  - Heart failure meds ordered in bubble packs
  - Referred to In Home Supportive Services (IHSS)
  - Completed labs and wound care
  - Provided cane, urinal, wound supplies
  - Welcomed into PC Contingency Management program for MOUD
  - Scheduled for next injection

Primary Care Addiction E-Consult

Launched in January 2026, the **Primary Care Addiction (PCA) e-consult** supports rapid linkage to longitudinal addiction/medical/psychosocial support within Primary Care.

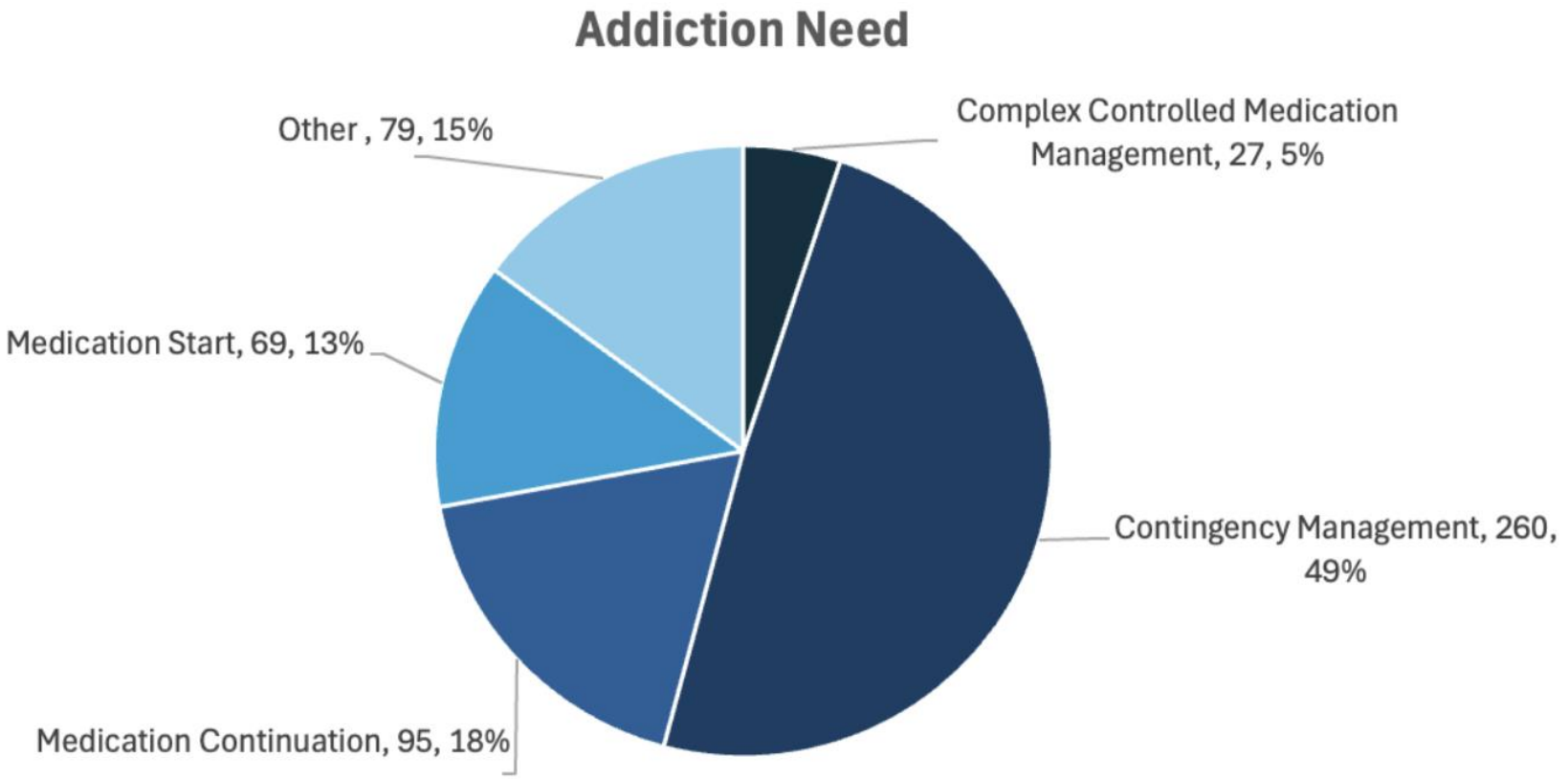
Impact at a Glance (last 6 months)

470 unique e-consults in the last six months

26% of eConsults for patients NEW to primary Care

30% of eConsults for patients experiencing homelessness

61% request scheduled appointments. 28% opt for drop-in

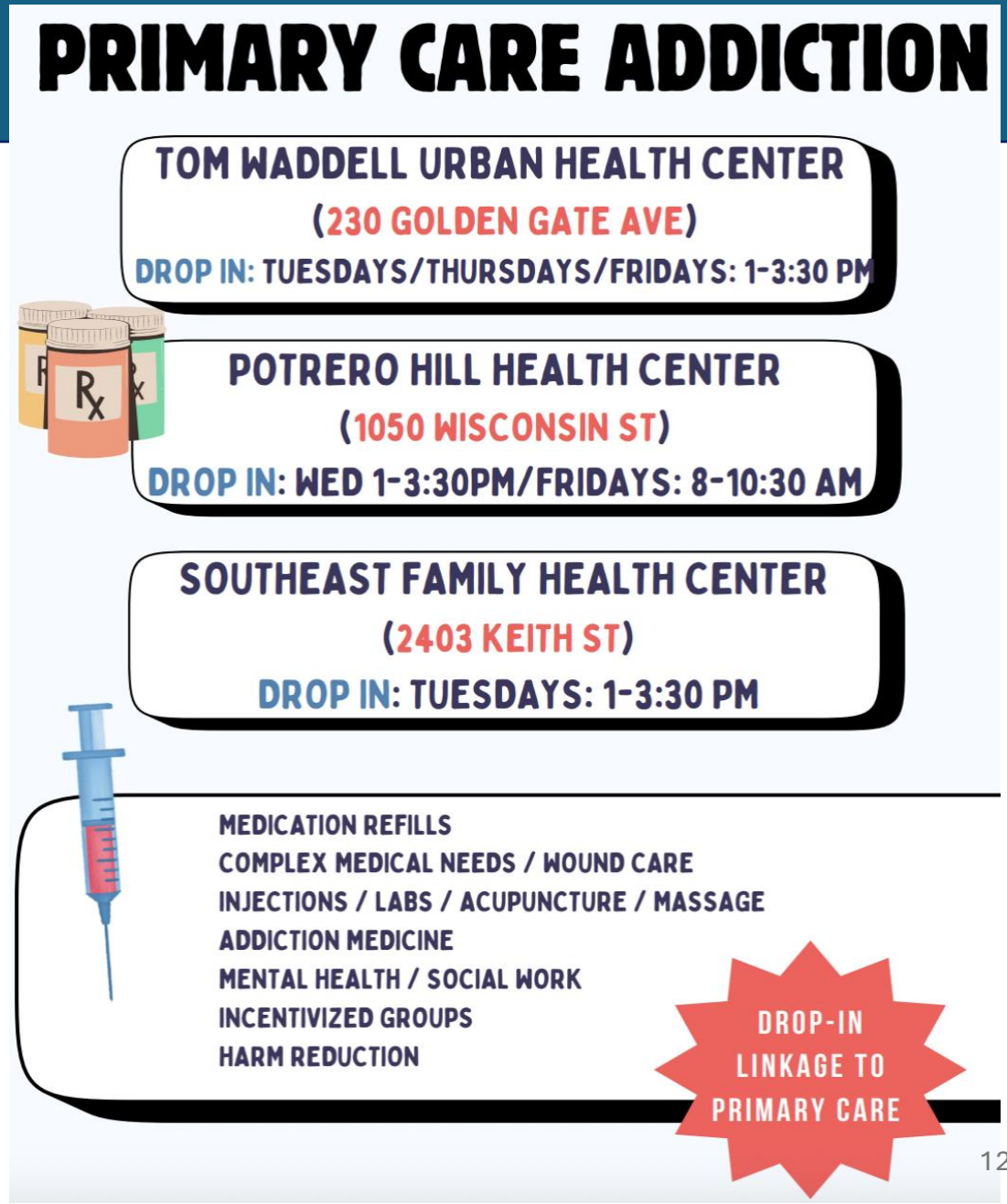


Primary Care Addiction Drop-in Access

Impact at a Glance (last 9 months)

156 NEW patients connected to PCA via scheduled and drop-in visits.

3 PC sites with drop-in access across San Francisco



Primary Care Addiction Patient Navigation

Impact at a Glance (last 6 months)

1324 unique patient encounters completed by our PCA navigator.

>500 patients with substance use rely on *single* navigator for texts/calls.

Maleika Edwards
Patient Navigator

Two-way reliable longitudinal connections = Better engagement over time.

Patient Journey: **Continuity is a Systemwide Effort**

Impact at a Glance (last 6 months)

259 buprenoprhine injections have been given within PC

337 naltrexone injections given in PC

45% of injections for substance use disorders are managed in PC

Patient attends 2 scheduled follow ups at TWUHC.

When he misses the following injection with PCP, the patient navigator texts patient and **re-connects them to PHACS** for home-based care.

- Primary Care manages injections, works with other teams (Whole Person Integrated Care, Behavioral Health Services, Jail) to help bridge continuity when lost to care

Injection # 1	Sobering Center
Injection # 2, #3	PHACS Pharmacist
Injection # 4, # 5	Primary Care – Tom Waddell
Injection # 6	Mobile Nurse

Permanent Supportive Housing Health Services: Mobile Medication for Opioid Use Disorder (MOUD) Nurse

Impact at a Glance (last 3 months)

32 unique patient referrals for MOUD Nursing.

19 patients currently on monthly treatment via MOUD Nursing (goal panel size = 25)

Elements of Mobile MOUD Nursing

01. Developed after mapping barriers to MOUD initiation and longitudinal MOUD care for PSH residents

02. Roving model of RN with pharmacist support serving high risk people with OUD in PSH

03. Overcomes regulatory barriers

04. Proactive outreach in PSH with DPH and CBO partners to build relationship and educate on LAI bup services

05. Connection & Bridging to Ongoing Treatment

Patient Journey: **Community Engagement via Programs and Behavioral health Integration**

During PHACS outreach, patient reports increased stimulant use, manic symptoms and forgetfulness due to sleep deprivation.

- PHACS team supports drop-in to clinic with direct warm hand-off to Behavioral Health Clinician and appointment with onsite psychiatrist
- Patient enrolls in 12-week Contingency Management program for stimulant use at Tom Waddell

>50% of patients active at Tom Waddell and PHACS have a severe mental illness

Psychiatry | Social Work | Case Management | Crisis stabilization | Linkage to Specialty Mental Health

Contingency Management

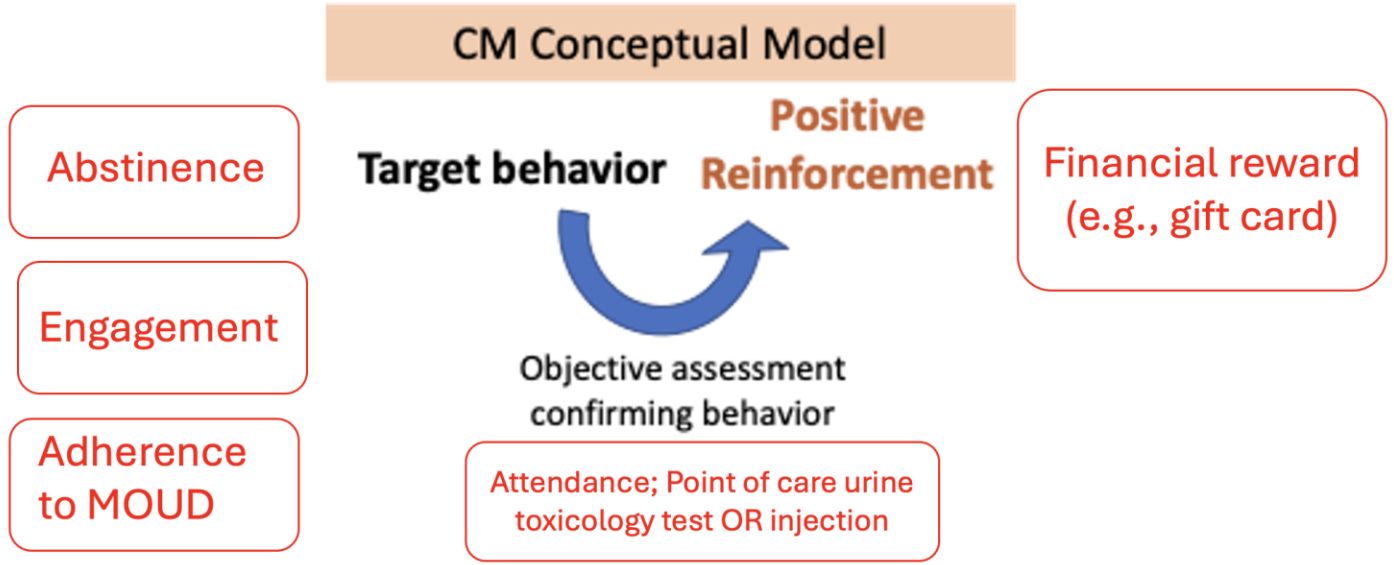
Contingency management (CM) is an evidence-based behavioral intervention for substance use disorder

Impact at a Glance

5 active CM programs across Ambulatory Care (PC/WPIC)

82% report CM programs help them stop or reduce their substance use

92% report feeling more connected to their clinic/program where they get CM



"Has truly changed my outlook on drugs and thinking"

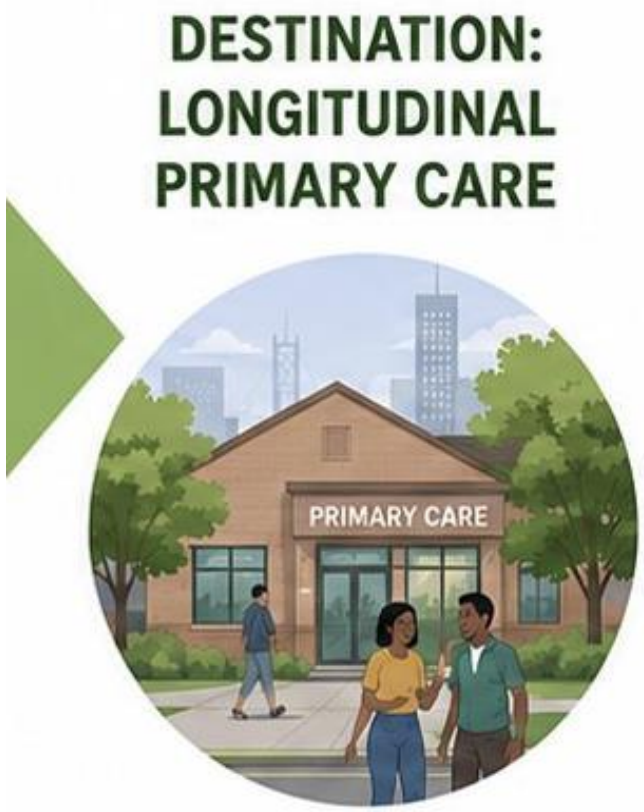
"Was like a job, and brought structure to my life"

"Made sure it was a safe space, and I felt seen without judgement"

Patient Journey: **Retention in Care**

Patient continues injectable buprenorphine, follows up with Primary Care and Psychiatry at TWUHC, engages in peer support groups

- Patient completes INSPIRE Contingency Management program and starts to attend "grad group." He is exploring how to become a peer navigator
- Improved mobility with good adherence to heart failure medications and wound care
- Psychiatrist further optimizes medications (starts anti-psychotic)
- If patient misses appointments Mobile Nurse and PHACS support outreach and complete injections on-site. **No further overdoses**



SUPPORT ALONG THE WAY. CARE THAT LASTS.

START: ISOLATED IN HOUSING

At risk of overdose

OUTREACH & ENGAGEMENT › **START TREATMENT** › **ONGOING SUPPORT** › **IMPROVING STABILITY**

DESTINATION: LONGITUDINAL PRIMARY CARE

ONSITE HOUSING STAFF SUPPORT

- Injections & medication management
- Reminders & follow-up
- Accompaniment
- Consistency & encouragement
- Connection to care

Collaborative care across departments = Meaningful patient-centered trajectory

Key takeaways

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Medication for opioid use disorder saves lives, and treatment on demand with direct-to-inject is a powerful new tool in our toolkit.

SFHN Primary Care and Whole Person Integrated Care continue to work together on treatment linkage and retention: there's no wrong door for making change.

Sobering Center | Mobile Care in PSH | Primary Care | Integrated Behavioral Health

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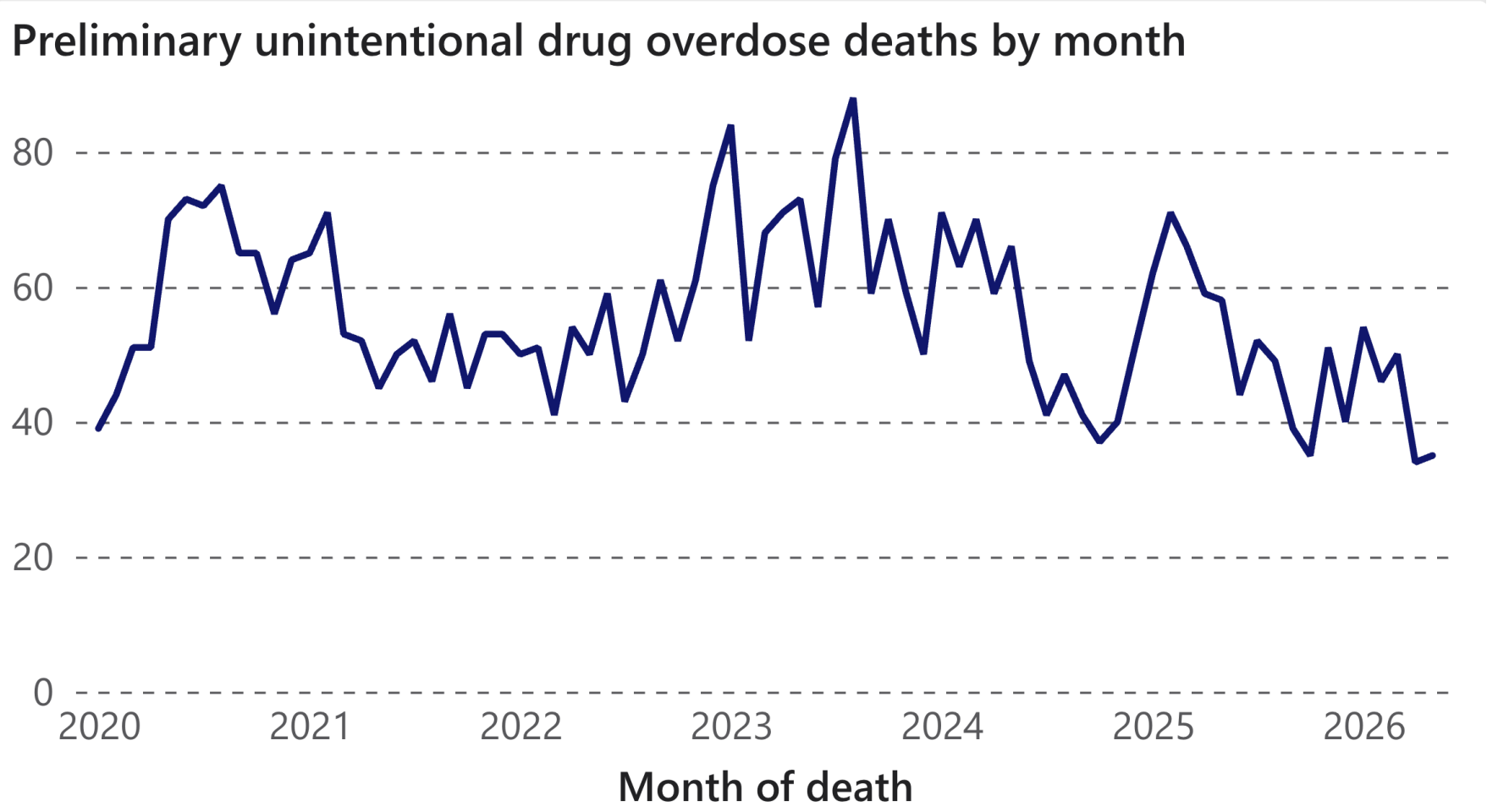
Addenda

Every overdose death is preventable and unacceptable. Our goal is to dramatically reduce overdose deaths.



Total fatal overdoses have trended downward. The city recorded 624 accidental deaths in 2025, a drop from 635 deaths in 2024 and significantly lower than the peak of 810 deaths in 2023

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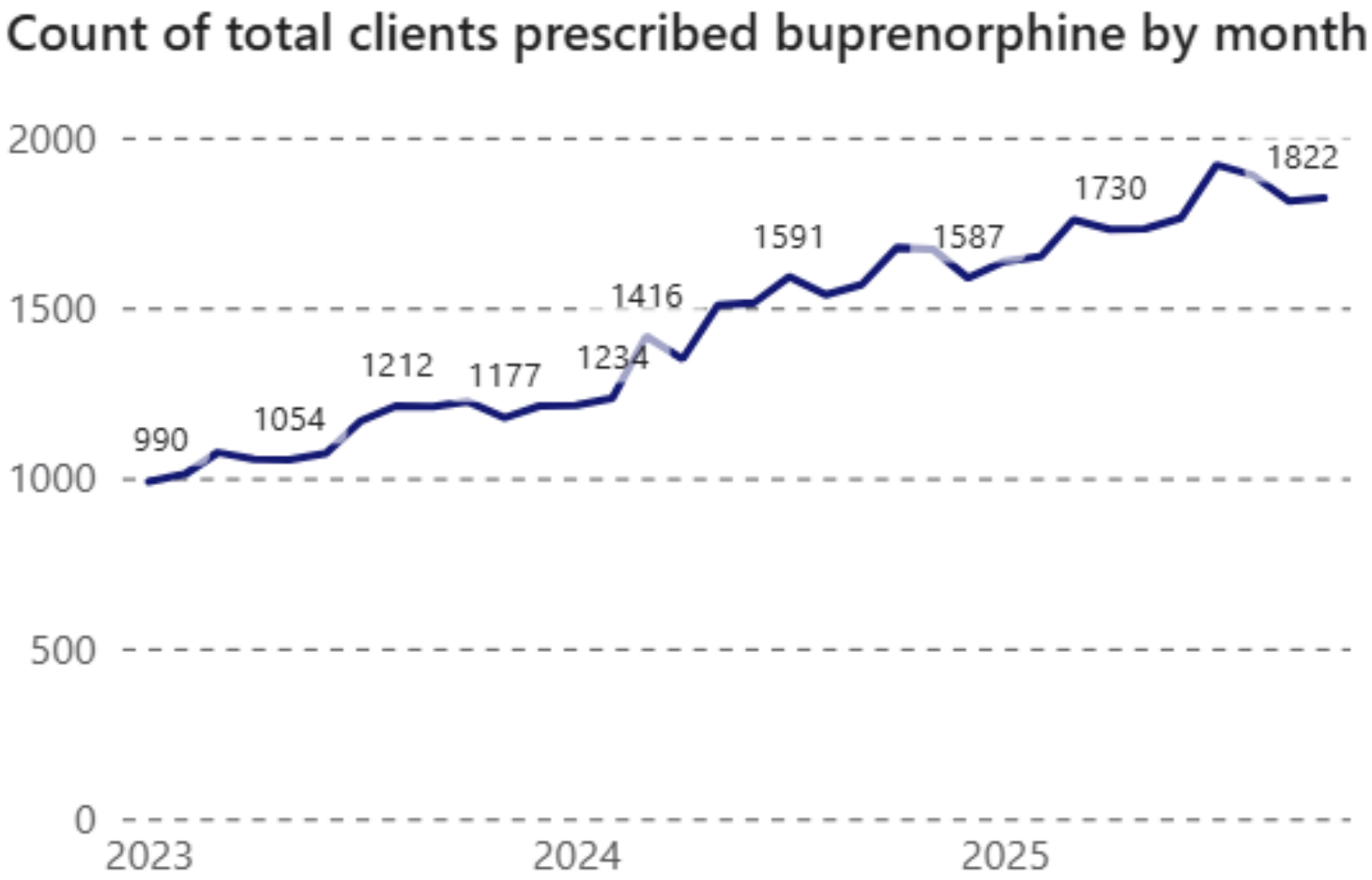
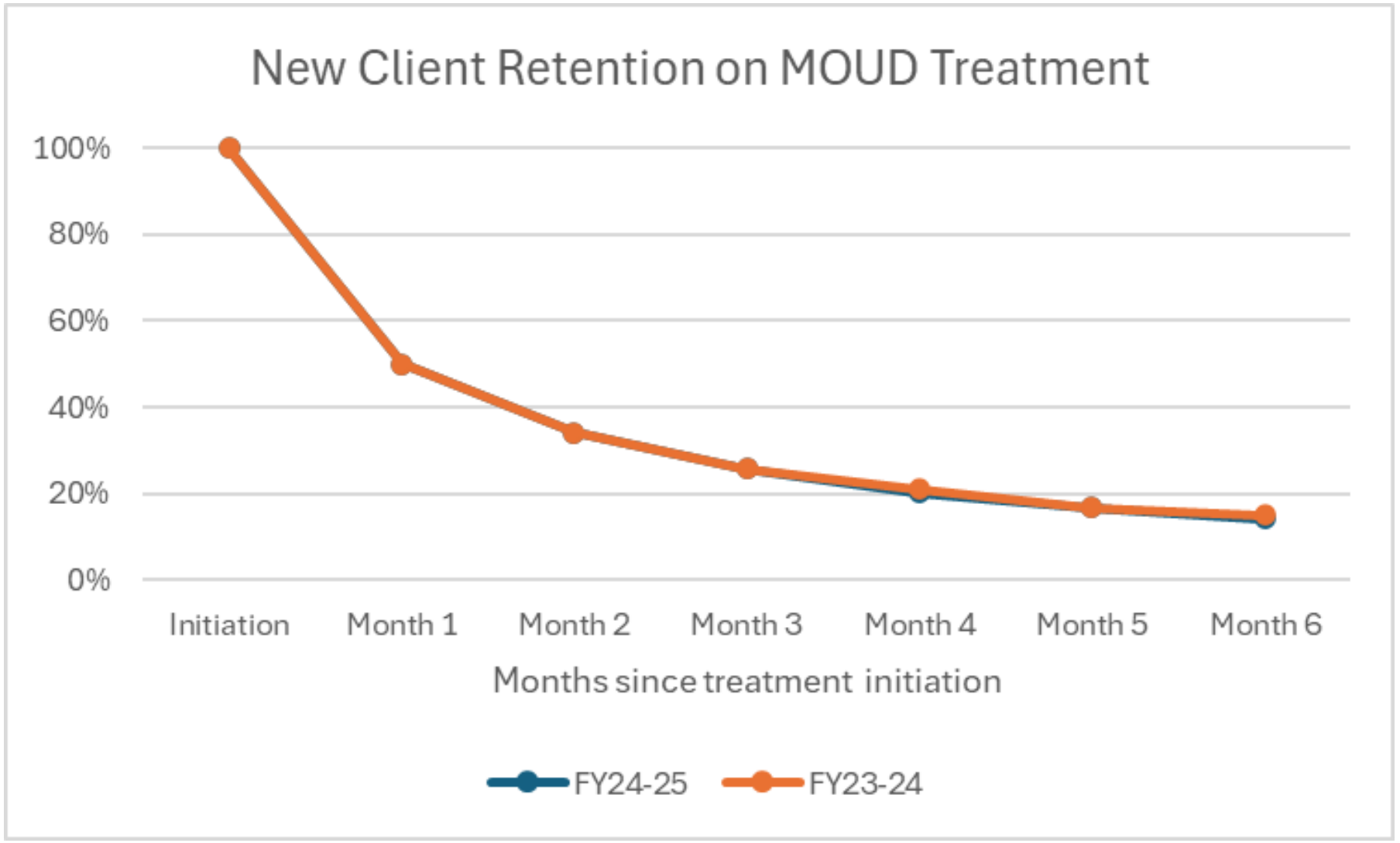
DPH has dramatically increased the number of people on buprenorphine



Growth in clients on buprenorphine:

- **+32% in 2024 v. 2023**
- **+20% in 2025 v. 2024**

Our biggest challenge is early retention on MOUD



SFDPH Response

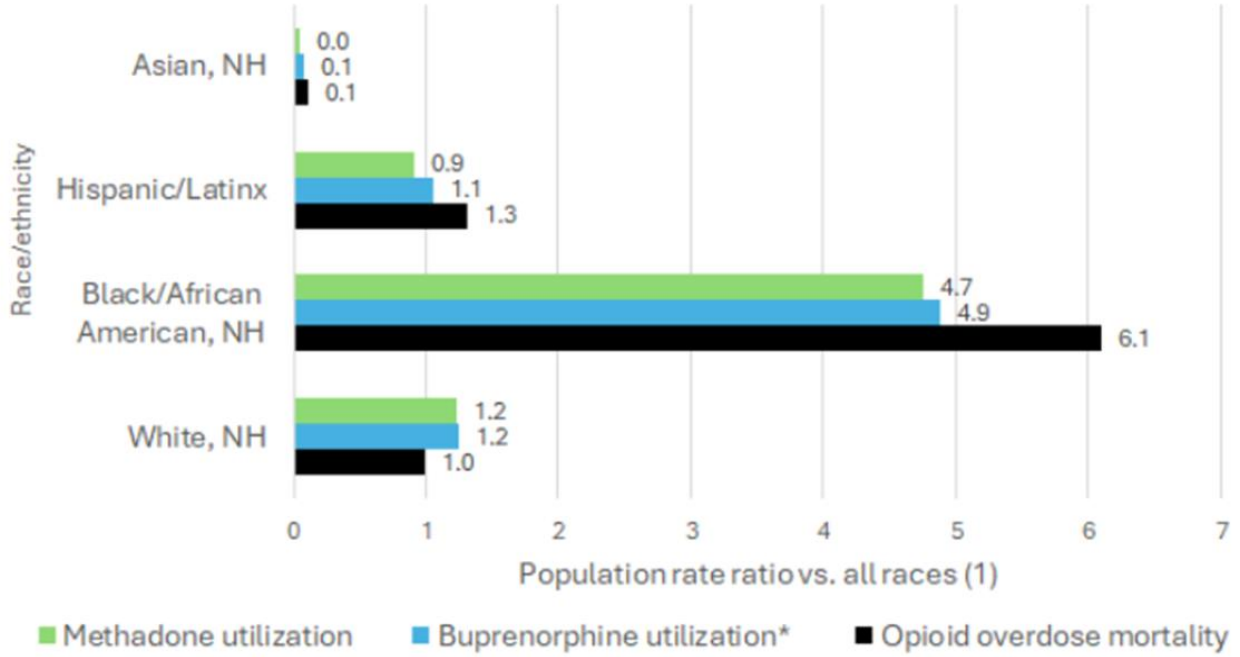
Ensuring immediate access to the most effective form of treatment that supports retention

Not all populations are impacted equally

Black San Franciscans experience overdose at 6x the rate of other races/ethnicities

Black San Franciscans access MOUD Treatment at 5x the rate of other races/ethnicities

Figure 2: Rate-ratios of MOUD utilization and opioid overdose mortality by race/ethnicity, CCSF 2023



**Buprenorphine includes only SFHN providers and outpatient dispensing. Rates not shown for groups with fewer than 10 events. NH = Non-Hispanic. See Appendix for data sources.*

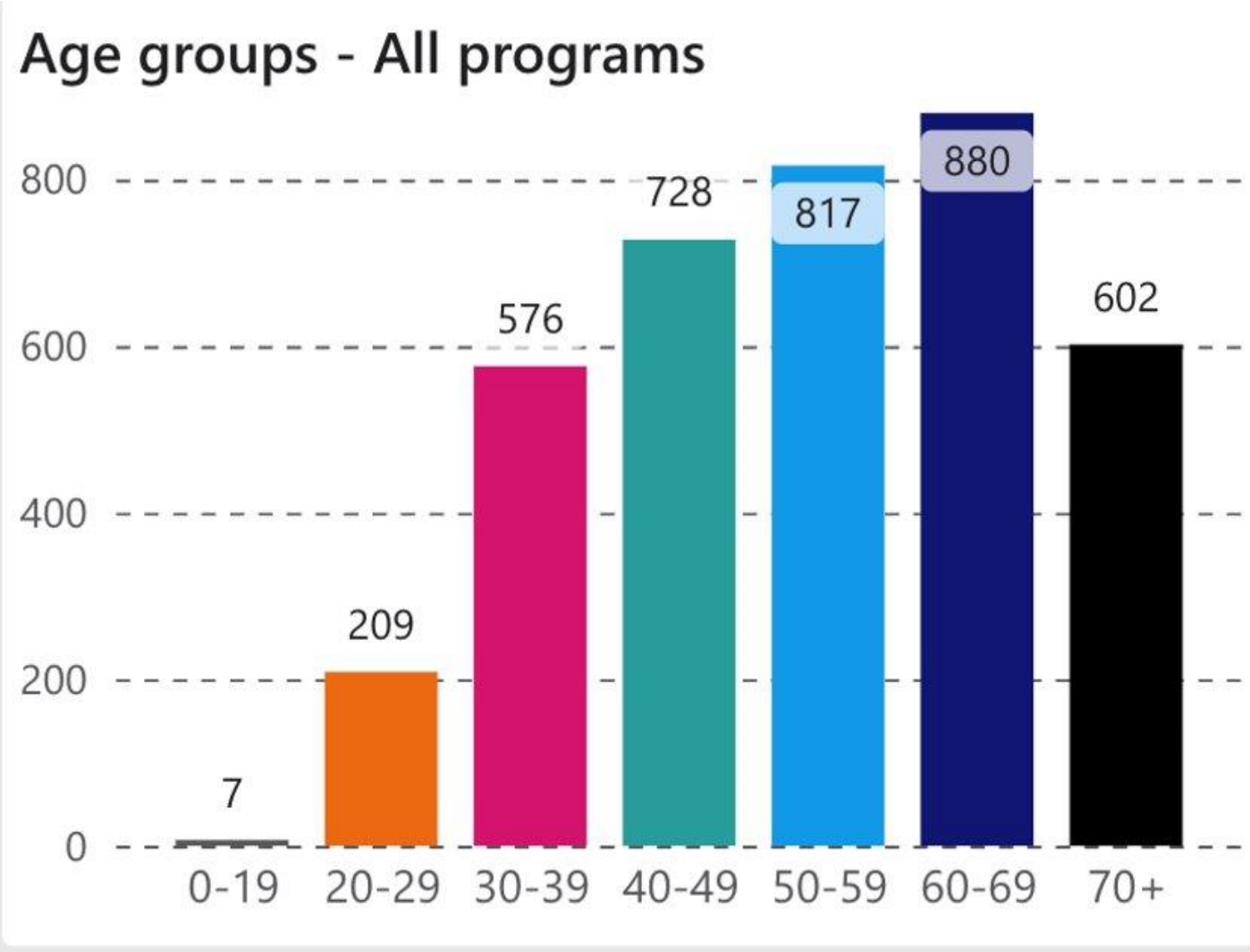
Overdose disparities parallel inequalities in wealth and housing

People experiencing homelessness in San Francisco had 33 times the rate of opioid overdose as compared to all Californians

Black San Franciscans disproportionally experience homelessness or live in permanent supportive housing

There is no racial disparity in overdoses by race when stratifying by housing status

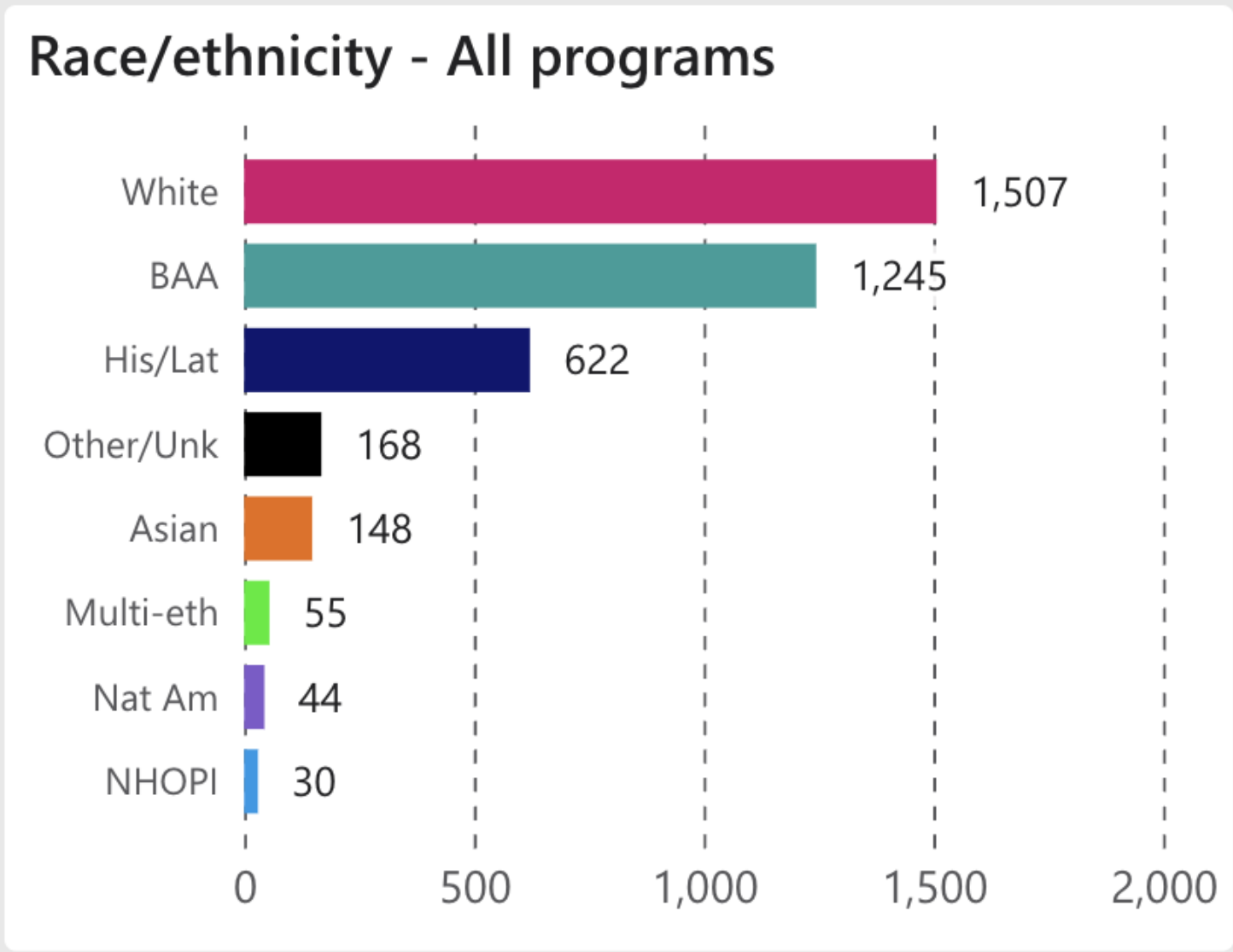
Permanent Housing Advanced Clinical Services (PHACS) Demographics: Patient Age



Summary: PHACS serves adults of all ages. The majority of PHACS patients are 50+

Source: CORE PHACS dashboard

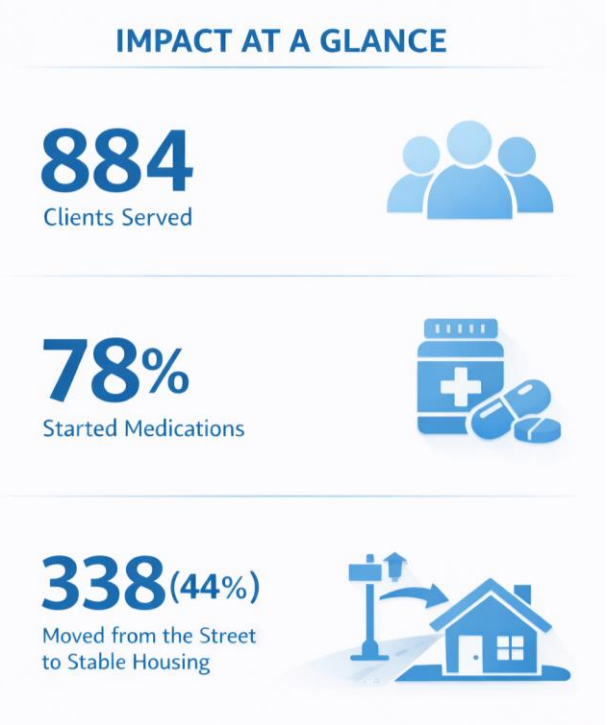
Permanent Housing Advanced Clinical Services (PHACS) Demographics: Race and Ethnicity



Summary: PHACS client demographics are similar to those of People Experiencing Homelessness people living in Permanent Supportive Housing in San Francisco. More than half are non-White

Source: CORE PHACS dashboard

RESTORE: From the Street and into Shelter + Treatment



Elements of RESTORE

01. **Immediate, 24/7 access to services** to get someone off the Street

02. **Requirement to enter Treatment** by agreeing to a structured treatment plan to enter program and receive a bed

03. **Gold-standard MOUD** (Medication for Opioid Use Disorder)

04. **Daily Case Manager meetings** required to assertively and proactively support progress into longer-term treatment and recovery

05. **Proactive discharge planning** and warm handoffs into next level of care, including treatment and recovery services

Direct-to-Inject

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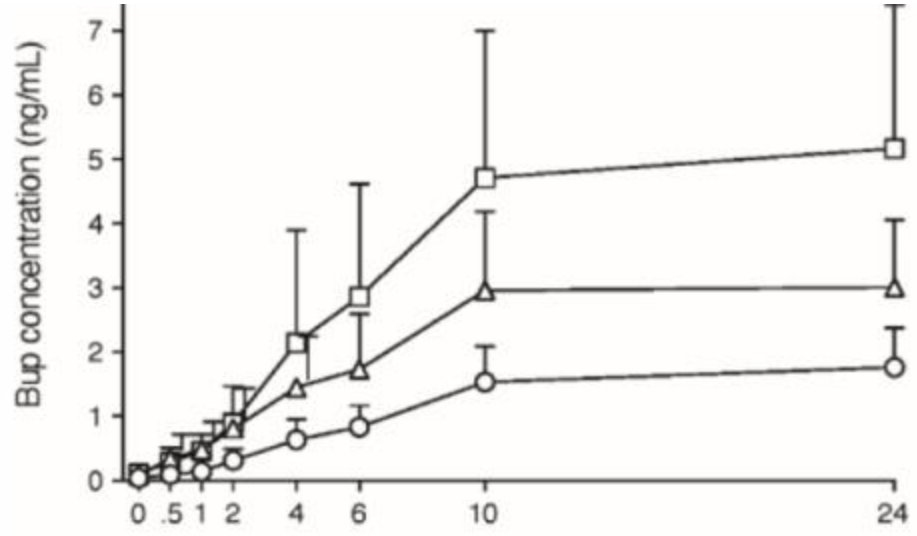
Start buprenorphine directly with a weekly injection, which builds up slowly in the body over 24 hours

Buprenorphine levels peak at 24 hours and last up to a week

Can get monthly injection 24 hours later



CAM2038 investigators brochure

Advantages of Injections

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Long-acting (monthly) easier than pills

Tailor to individual patient's situation

Excellent adherence, minimal side effects

Decrease cravings and withdrawal --> decrease fentanyl use

Robust overdose protection

Robust early retention

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SFDPH DTI buprenorphine data

- 30-day retention: 61% [304 patients]

SFDPH low-dose buprenorphine data

- 28-day retention: 20%

PMID: 39853975
PMID: 41442975

Positive patient experience

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Generally well-tolerated, with low rates of severe withdrawal.

"I never thought this could work for me."

"This was so much easier than last time. Everyone should try this!"

"My friend did the injections and is doing great. Can I try that too?"