Whole Person Integrated Care

Annual Health Commission Update

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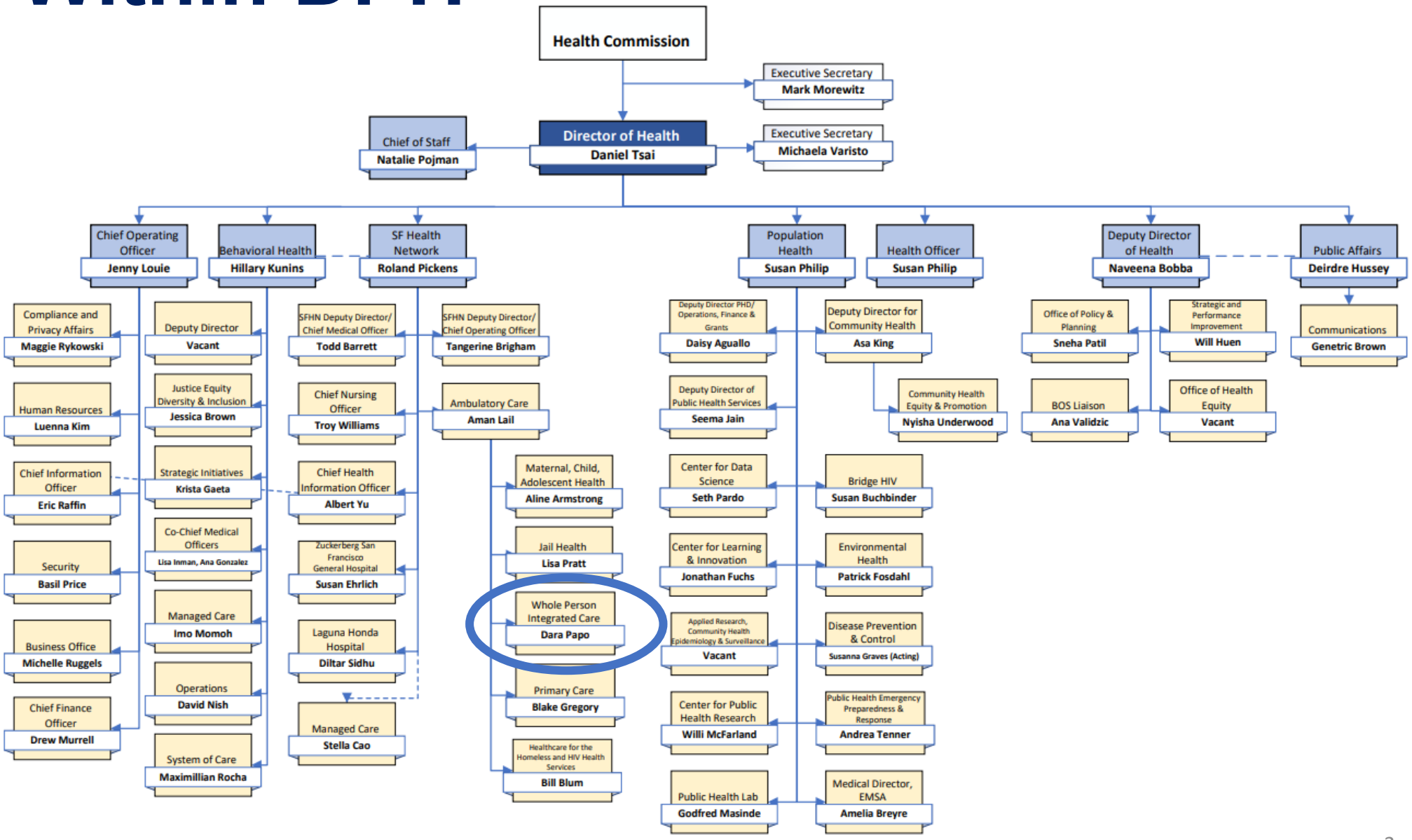
Agenda

1. Overview of WPIC & the DPH Roadmap for Behavioral Health and Street Conditions
2. Share Progress towards a Comprehensive Pathway to Recovery
   - Neighborhood Based Street Health teams
   - SCOPE Sobering Center Opioid Treatment pilot
   - RESTORE Shelter + Substance Use Treatment program
3. Preview next steps: Enhanced Shelter Services

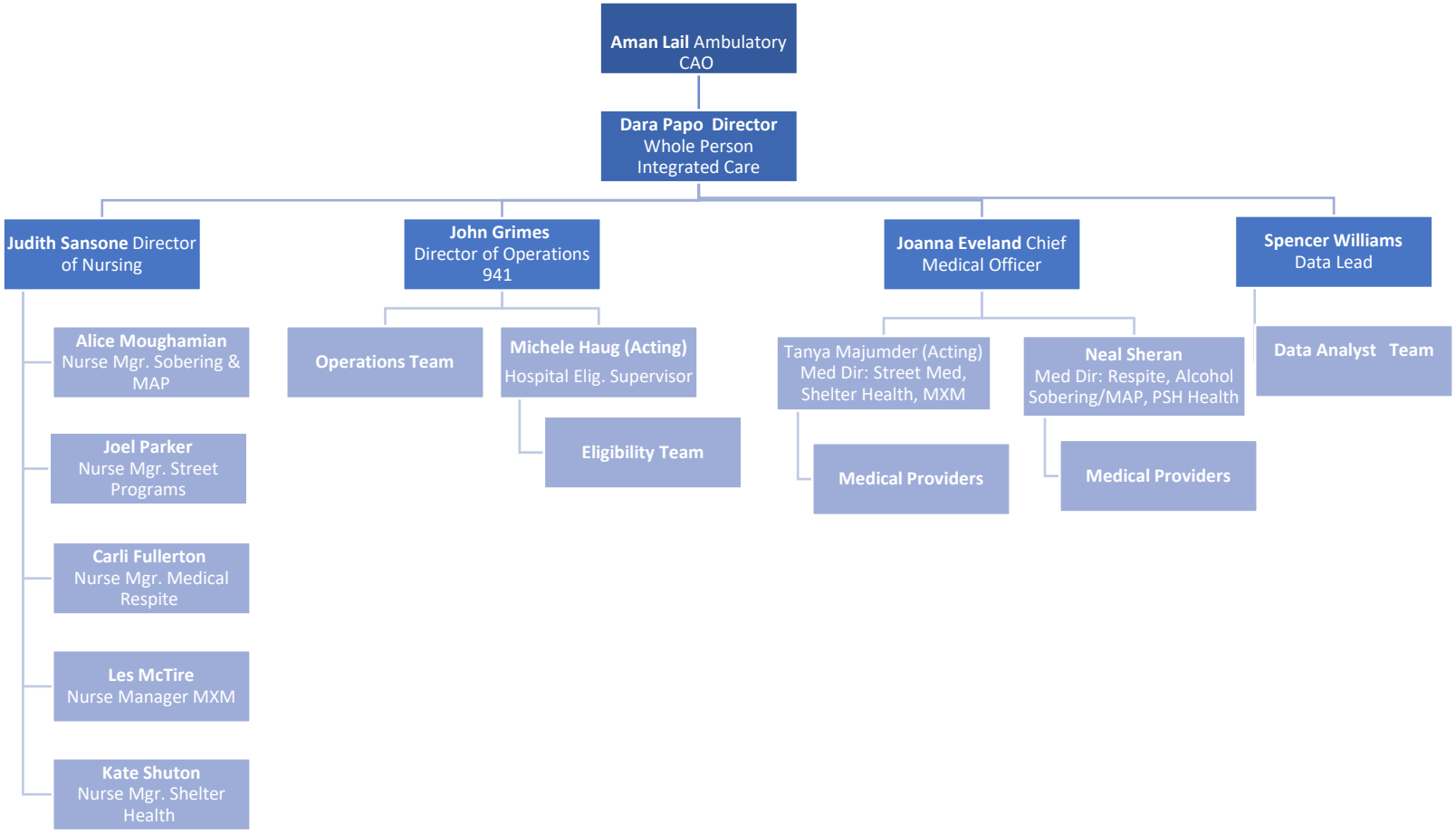
WPIC Within DPH



WPIC At a Glance

Whole Person Integrated Care (WPIC) is a section of Ambulatory Care that brings together low-barrier medical and behavioral health services, primarily serving People Experiencing Homelessness.

WPIC serves people wherever they need care, including the street, community sites, shelters, in Permanent Supportive Housing, and at the Maria X Martinez Health Resource Center.



DPH Roadmap for Behavioral Health and Street Conditions

Our Goal: Build a more responsive and proactive behavioral health system of care that will help move people quickly from the streets into effective treatment and sustained recovery.

1. **Expand Treatment Beds and Services –** Quickly, at right levels of clinical intensity, including shelters.

2. **Accelerate and Simplify Entry to Care –** We want to engage and plug people in quickly and simply to treatment and stabilization services – whenever someone needs or is ready for treatment.

3. **Support People To Progress Through Care –** We need to do a better job being "sticky" – supporting people to engage and remain in evidence-based treatment and recovery – without falling through the cracks.

4. **Pair Safer Use Supplies with Proactive Linkages to Care –** We are affirming evidence-based public health interventions like sterile syringe access, and piloting smoking supply policy focused on proactively and intentionally connecting people to treatment.

5. **Build a Comprehensive Pathway to Recovery –** We need all the tools in the toolkit, ranging from low-barrier stabilization to sustained recovery, to achieve meaningful health outcomes.

Patient Journey: Street Engagement

- 74-year-old man with **polysubstance use** and untreated **psychosis**
- Unhoused in downtown SF **on the same block for 10+ years**
- Referred to housing and services but **never engaged successfully**
  - What was missing?
    - An **Integrated, Outcome-Focused, Neighborhood Based Street Team**

Street Health

Model:

A multi-disciplinary, placed-based team stabilizes unhoused people in distress and bridges them into the right level of treatment and care

5 Elements of Street Health

01. **Integrated Team:** BHS, WPIC, and CBO partners

02. **Coordinated**: Unified model across multiple City departments

03. **Place-Based**: 5 Neighborhoods teams are coordinated by a DEM Neighborhood Captain

04. **Shared Priority**: Small team caseloads of high acuity clients prioritized for services

05. **Care Coordination:** High touch, assertive stabilization and connection to ongoing services

Neighborhood Based Street Health Teams

Street Health Outcomes: First 6 Months

22,000+ client engagements

1400+ connections to medical care

600+ connections to mental health

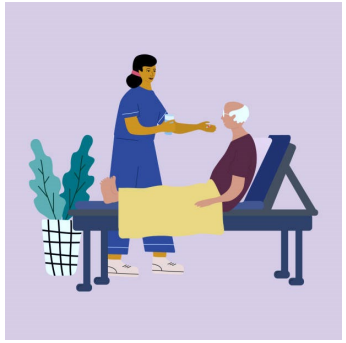
800+ connections to substance use treatment

800+ connections to shelter

Definitions: Engagement= face to face encounter, referrals given; Connection=Client assertively linked to a service/resource

Patient Journey: Sobering

- Brought to **Sobering Center Overdose Prevention and Engagement** pilot (SCOPE) after overdose
- **Stabilized on buprenorphine** for the first time
- Transitioned to monthly buprenorphine **injection**



Sobering Center Overdose Prevention and Engagement (SCOPE) Pilot

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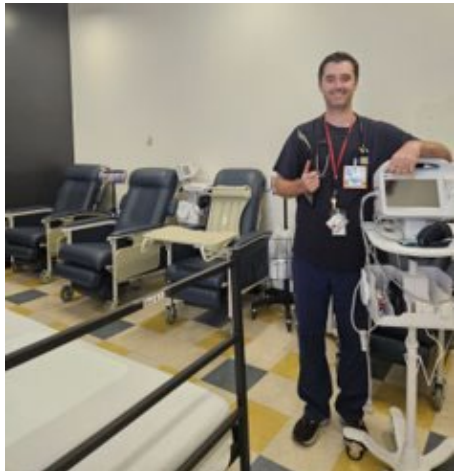
What is SCOPE:

4 beds at the DPH Sobering Center for patients with opioid intoxication and/or recent overdose to safely sober and begin their recovery journey



Elements of SCOPE

01. **24/7 Intake Capacity & Nursing Care**

02. **Safe Recovery & Post Overdose Support**

03. **Rapid Medication for Opioid Use Disorder Starts**

04. **Close Partnership with Fire/EMS, ED/Hospitals, Residential Treatment Providers**

05. **Connection & Bridging to Ongoing Treatment**

SCOPE Outcomes: First 12 Months

212 visits with 148 unique patients

57% referred by EMS or Street Health

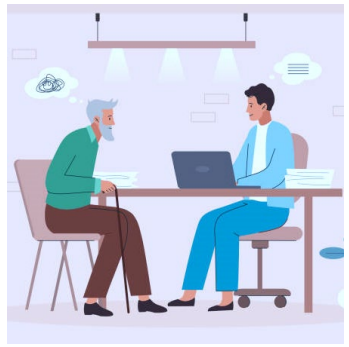
61% engaged with Street Health at SCOPE

44% started buprenorphine or methadone

20% discharged to treatment program

Patient Journey: RESTORE

- Transferred from Sobering Center to the **RESTORE** Shelter + Substance Use Stabilization program at the Adante Hotel
- **Connected** to transitional medical and behavioral health care
- Continued **buprenorphine**



RESTORE:
Rapid Engagement Shelter & Treatment for Opioid Recovery

RESTORE program: An innovative, new model to help people quickly move from the street into treatment + a bed

Problems we are solving for:

- Quick, 24/7 way to get someone directly from the street into treatment
- Ability to combine offer of a bed ***and*** requirement to begin treatment
- Ability to serve people who have historically been resistant or unable to navigate treatment

6 elements of RESTORE

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

02. Must agree to structured treatment plan to enter program/get a bed

03. Clients receive gold standard MOUD* (buprenorphine or methadone)

04. Clients must meet case managers daily, who will proactive and assertively help progress to longer-term treatment and recovery options

05. NEW: Planning daytime programming with structured outpatient care

06. Discharge planning and warm handoffs to treatment, recovery and next level of care

RESTORE Outcomes: First 12 Months

380 unique clients served

75% started medication for opioid use disorder (58% buprenorphine, 17% methadone)

50% exited to a stable location (shelter on medications, residential treatment, housing, or relocation services)

22 pregnant women served to date (linked to prenatal care during program)

Average length of stay 14 days

Patient Journey: Enhanced Shelter Services

- Found to have serious **cognitive and functional deficits**
- Needs: Assistance with Activities of Daily Living, Capacity Assessment
- Unable to be safely discharged to traditional shelter

Planning:
Enhanced Shelter Services

Enhanced Shelter Services:
Right levels of care and clinical intensity

Problems we are solving for:

- Patients are too complex medically and behaviorally for existing shelters
- Distressing street behaviors and utilization increased when the right level of care is not available

Elements of Enhanced Shelter Services

01. **Focus on Shared Priority Clients**

02. **On-site Medical Services**

03. **On-site Behavioral Health Services**

04. **Activities of Daily Living support (bathing, toileting, dressing etc.)**

05. **Facilitate Connection to Ongoing Services & Safe Care Transitions**

In Conclusion:
WPIC is Part of the DPH Comprehensive Pathway to Recovery

We offer:

- 24/7 engagement in care
- An integrated continuum of low barrier Substance Use Treatment
- Shelter paired with multidisciplinary, evidence-based services