Whole Person Integrated Care - Intersections with Behavioral Health

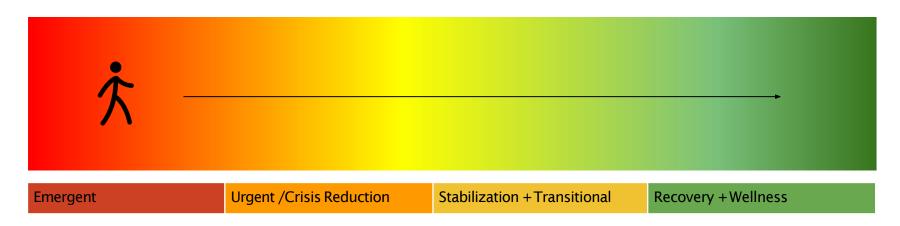
Dara Papo, LCSW Director, Whole Person Integrated Care

February 2023

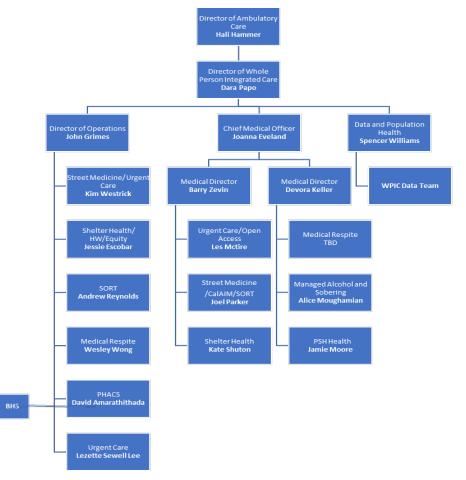


Whole Person Integrated Care (WPIC) is a section of the SF Department of Public Health's Ambulatory Care division that brings together existing non-traditional primary care, urgent care, and behavioral health clinical services primarily serving people experiencing homelessness.

WPIC services are part of San Francisco Health Network's homeless System of Care which includes specialty behavioral health services, acute and emergency services at ZSFG, and long-term care at Laguna Honda Hospital.



WPIC Organizational Chart January 2023



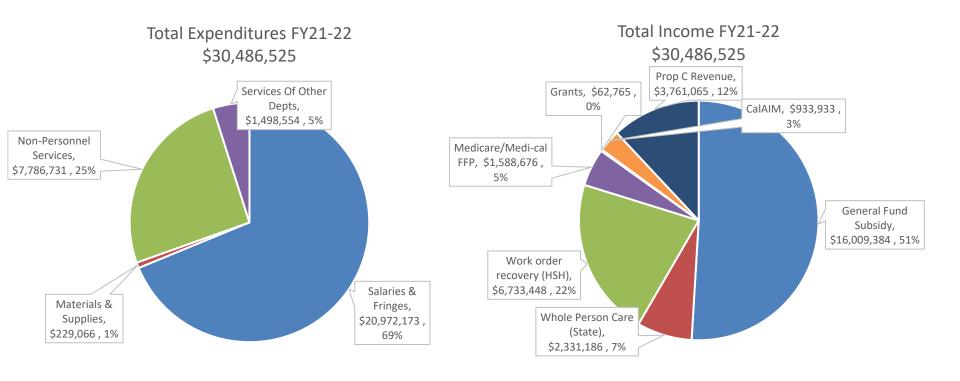
SF Department of Public Health | Whole Person Integrated Care

WPIC Data 2020-2022

	Distinct Clients			Encounters*			# Stays			# Days		
WPIC Dept	2020	2021	2022	2020	2021	2022	2020	2021	2022	2020	2021	2022
Medical Respite	386	309	340	See Stays / Days			347	302	357	18,737	19,871	21,063
Alcohol Sobering Center	455	376	371	2,386	1,482	2,066				,	,	,
PSH Nursing	411	395	516	758	871	985						
Shelter Health	1,438	713	1,368	5,159	2,171	6,684						
Street Medicine	3,981	3,714	3,319	20,519	21,507	13,084						
MXM Health Resource Center	3,073	3,981	4,208	7,860	14,458	14,354						
PHACS			499			2,309						
WPIC Combined*	7,068	7,328	7,945	36,682	40,489	39,482	347	302	357	18,737	19,871	21,063

^{*}WPIC Combined counts are not unduplicated. Includes: traditional face-to-face encounter types (Clinical Support, Immunization, Office Visit, Social Work, Telehealth) plus Documentation, Clinical Documentation Only, and Patient Outreach encounters.

WPIC Budget FY 21-22



WPIC Programs:

Integration of Behavioral Health and Physical Health

Program: Street Medicine

- Population of focus: People experiencing homelessness with medical, mental health, and substance use needs and not connected to care.
- Services: Assessment of need for emergency care; episodic care for acute medical conditions and exacerbations of chronic conditions, low barrier buprenorphine. Care provided in streets, parks, encampments, harm reduction sites, etc.
- Model of Care: Standing community clinic sites, MXM, scheduled/focused street outreach, integration with BHS street teams, ECM team.
- Connections to BHS: Street Response Teams, Hummingbird, Dore, SOMA Rise, BHS Pharmacy, Opioid Treatment Programs, Behavioral Health Services Center, Residential Treatment, PES, Psychiatry

67% have documented SMI or SUD disorders

Behavioral Health Staffing:

- 0.5 FTE Social Workers
- 0.3 Psychiatrist
- 1.5 FTE Psych NP's

Enhanced Care
Management Team including
2.0 FTE Social Workers

Maria X Martinez Health Resource Center: WPIC Urgent Care/Open Access Clinic

- Population of focus: 75% are experiencing homelessness, high risk/vulnerability individuals not otherwise able to access needed care.
- Services: Assessment and care for non-life-threatening illnesses or injury needing immediate assistance. low barrier medications for addiction treatment, transitional comprehensive primary care services. limited dental and podiatry services offered onsite.
- Monday Saturday 8:30 am -5pm.
- Connections to BHS: Street Response Teams, Hummingbird, SOMA Rise, BHS Pharmacy, Opioid Treatment Programs, Behavioral Health Services Center, Residential Treatment, PES

69% have documented SMI or SUD disorders

- 1.5 FTE Social Worker
- 0.3 FTE Psychiatrist
- 1.0 FTE Psych NP





Shelter Health

- Population of focus: People experiencing homelessness in Shelters and Navigation Centers.
- **Services:** Provides chronic disease management, urgent and emergent care on site, linkage to ongoing care.
- **Health Staffing Model:** Ideal staffing ratio of 0.5 RN and Health Worker per 100 clients. Current staffing presence per site ranges from 1-5 days weekly.
- Connections to BHS: Shelter Behavioral Health Services, Hummingbird, BHS Pharmacy, Opioid Treatment Programs, Behavioral Health Services Center, Residential Treatment

53% seen by SH staff have documented SMI or SUD disorders

- 0.2 Psychiatrist
- 0.5 Psych NP
- Partner with BHS shelter behavioral health services

Program: Permanent Supportive Housing (PSH) Nursing

- Population of focus: Previously chronically homeless individuals housed in Department of Homelessness and Supportive Housing funded PSH. Residents are medically and psychiatrically complex and are often High Users of Multiple Systems, end of life, and not connected to care.
- **Services:** Provides onsite nursing services including chronic care management, linkages, medication adherence support, direct nursing care, triage, clinical consult.
- **Staffing Model:** Current staffing model is 9 RNs (7 DPH, 2 UCSF) ranging from 0.6 FTE to 1.0 FTE / building with active med-management caseload ratio 1:50. Serve 880 tenants.
- Connections to BHS: Outpatient clinics, Dore, Hummingbird, BHS Pharmacy, Opioid Treatment Programs, Behavioral Health Services Center, Residential Treatment

65% seen by PSH staff have documented SMI or SUD disorders

Behavioral Health Staffing:

DPH nurses partner with onsite support services

Program: Permanent Housing Advanced Clinical Services (PHACS)

- Population of focus: Previously chronically homeless individuals housed in Department of Homelessness and Supportive Housing funded PSH. Residents are medically and psychiatrically complex and are often High Users of Multiple Systems, end of life, and not connected to care.
- **Services:**.ECM, CBO capacity building consultation, triage, linkages, chronic care management, medication adherence support, direct nursing/medical care.
- Connections to BHS: Street Response Teams, Hummingbird, SOMA Rise, BHS Pharmacy, Behavioral Health Services Center, Residential Treatment, PES

69% seen by PHACS staff have documented SMI or SUD disorders

- 2.0 FTE BHS Social Workers
- 1.0 FTE Psych NP
- RFP in process to contact behavioral health services to housing service providers

Program: Medical Respite

- Population of focus: Adults experiencing homelessness being discharged from the hospital with an acute resolvable medical need or referred Shelter system with medical need more then Shelter Health can support.
- **Services:** Care coordination, bridging primary care, urgent care needs, medication adherence support, nursing care (wound care, etc.), residential services such as 3 meals/day, transportation to appointments.
- **Staffing Model:** Nurse driven care, NP/PA providers, behavioral health services on site.
- Connections to BHS: Street Response Teams, Hummingbird, SOMA Rise, BHS Pharmacy, Behavioral Health Services Center, Residential Treatment, PES

- 0.15 FTE 1 Psych NP (leveraged will be increasing to 1.0 FTE)
- 4 Behavioral Health Staff

Program: Alcohol Sobering

- Population of focus: Adults acutely intoxicated on alcohol, high utilizers of emergency services due to alcohol use disorder
- Services: Nursing care and monitoring while acutely intoxicated
- Clients Served: Average length of stay for traditional sobering is 6-8 hours
- Connections to BHS: Street Response Team, Hummingbird, SOMA Rise, BHS Pharmacy, Behavioral Health Services Center, Residential Treatment, PES

- UCSF Cityside social workers
- 0.15 FTE Psych NP (leveraged)

Program: Managed Alcohol (MAP)

- Population of focus: Individuals with severe Alcohol Use Disorder (AUD), many of whom are frequent Sobering clients
- Services: Nurse supported residential setting focused on decreasing life-threatening withdrawal seizures, emergency service utilization, and binge drinking behavior. Once individuals stabilize, multidisciplinary staff focuses on addressing biopsychosocial needs
- What's next?: Currently 10 beds, looking for a permanent location and will scale to 20 beds, with 10 focusing on Latinx and indigenous Mayan clients.
- Connections to BHS: BHS Pharmacy, Behavioral Health Services Center, Residential Treatment

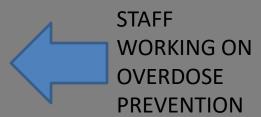
- 1.0 FTE Social Worker
- 24/7 Behavioral Tech

Program: Street Overdose Response Team (SORT)

- Population of focus: Individuals who have recently survived an overdose.
- Services: Community Paramedic and peer respond to 911 calls, offer resources include connections to services and low barrier medications for addiction treatment. Within 72 hours the Post Overdose Engagement Team (POEt) outreaches to continue engagement and offer connections to services and ongoing care.
- Key Partners: Community Paramedics, Behavioral Health, Hospitals, Community Based Organizations (RAMS/HRTC)
- Connections to BHS: Street Response Teams, Hummingbird, SOMA Rise, BHS Pharmacy, Opioid Treatment Programs, Behavioral Health Services Center, Residential Treatment, PES

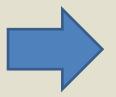
- Harm Reduction Therapy Center
- Leveraged support from Street Medicine





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SORT TEAM MEMBERS



What's Next: WPIC in 2023

- New home for Sobering Center and expanded Managed Alcohol Program
- Considering addition of site-based Isolation and Quarantine for PEH needing recuperative care in a supportive environment.
- Integration with Behavioral Health
 - Referral pathways or embedded staff (piloting Behavioral Health Access Center staff colocating at Mara X Martinez Health Resource Center)
 - Coordination on Street Teams responses and integration with neighborhood-based street teams
- Expansion of CalAIM programs