

# SFD - MOBILE INTEGRATED HEALTH PROGRAM

Public Safety Committee

(02/24/2026)

SFD



City of Seattle

# Mission of MIH

**The mission of the Mobile Integrated Health program is to alleviate the strains placed on SFD Operations companies by high utilizers, behavioral, chronic medical, or social crises, and lower acuity alarms while providing response and case management services to those individuals in need.**

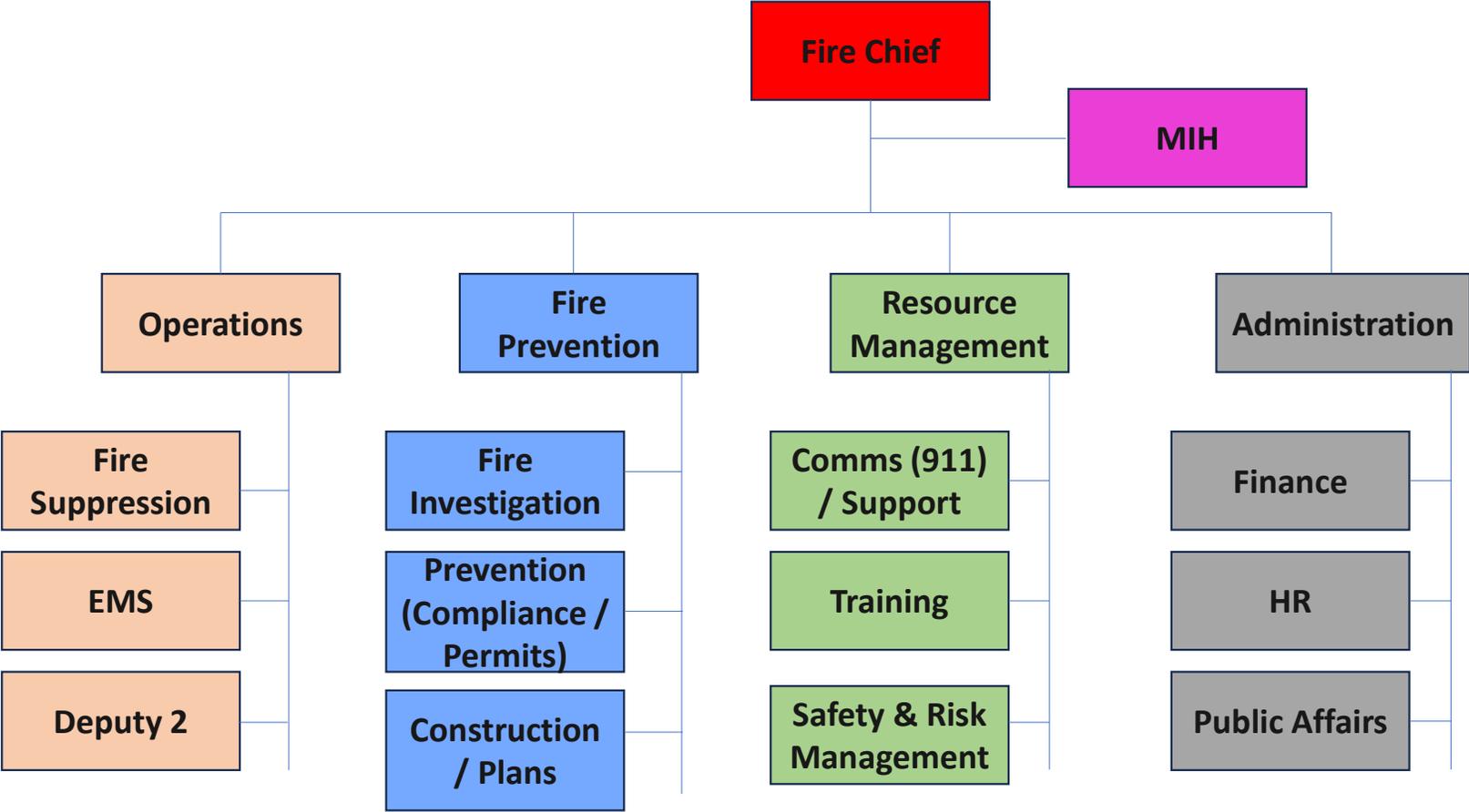


# Program History

- 2011 – Vulnerable Adult Program (with HSD)
- 2016 – Low Acuity Alarm Program (later renamed MIH)
- 2018 – Concept development and Council funding
- 2019 – Health One launch (November)
- 2021 – 2<sup>nd</sup> unit goes live
- 2022 – 3<sup>rd</sup> unit goes live
- 2023 – H99 goes live
- 2024 – ARNP program launches (in partnership with HMC)
- 2025 – H98 goes live
- 2026 – Weekend service launches

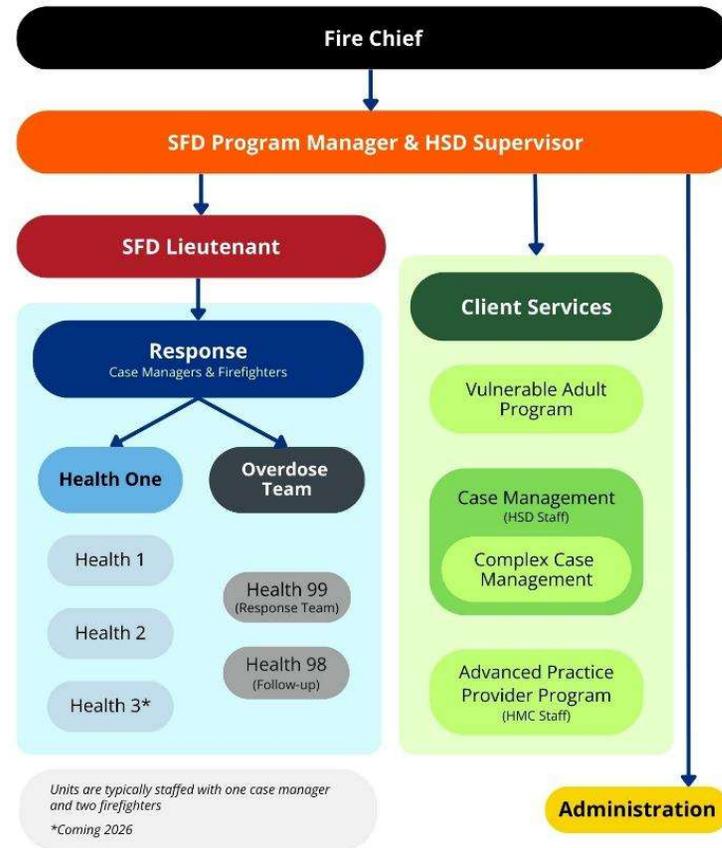


# Org Chart (simplified)



# MIH Org Chart

## ORG CHART



# MIH Operations

## Staffing

- 11 FTE case managers (14 by 2027)
- SFD/HSD managers, 2 admin staff
- Pool of ~32 firefighter/EMTs (48 by 2027)
- 1 admin FF lieutenant
- 1 Harborview ARNP (soon 2)
- Daily full Health One staffing: 4 CMs, 7 FF/EMTs

## Deployment

- Health One units typically 2 FF/EMTs, 1 case manager
- H1 out of Pioneer Square
- H2 out of Belltown
- H99/H98 out of Pioneer Square
- H3 (later this year) out of Northgate / SODO



# MIH Operations (cont.)

## Health One Response

- City-wide operations
- Mon-Sun, 09:00-19:00
- Code Yellow response (Health One), Code Red (H99)
- Apparatus: crew cab pickups, ADA wheelchair van, passenger car, ambulance
- Full EMS equipment, food, clothing

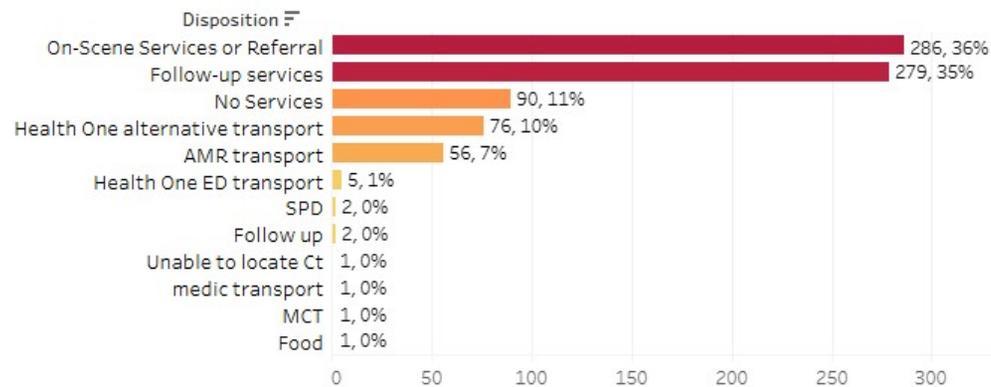
## Response Types

- Direct 911 dispatch: BH crisis and suicidality
- Live Operations requests
- Self-dispatch (overdose, new referrals, or existing clients)

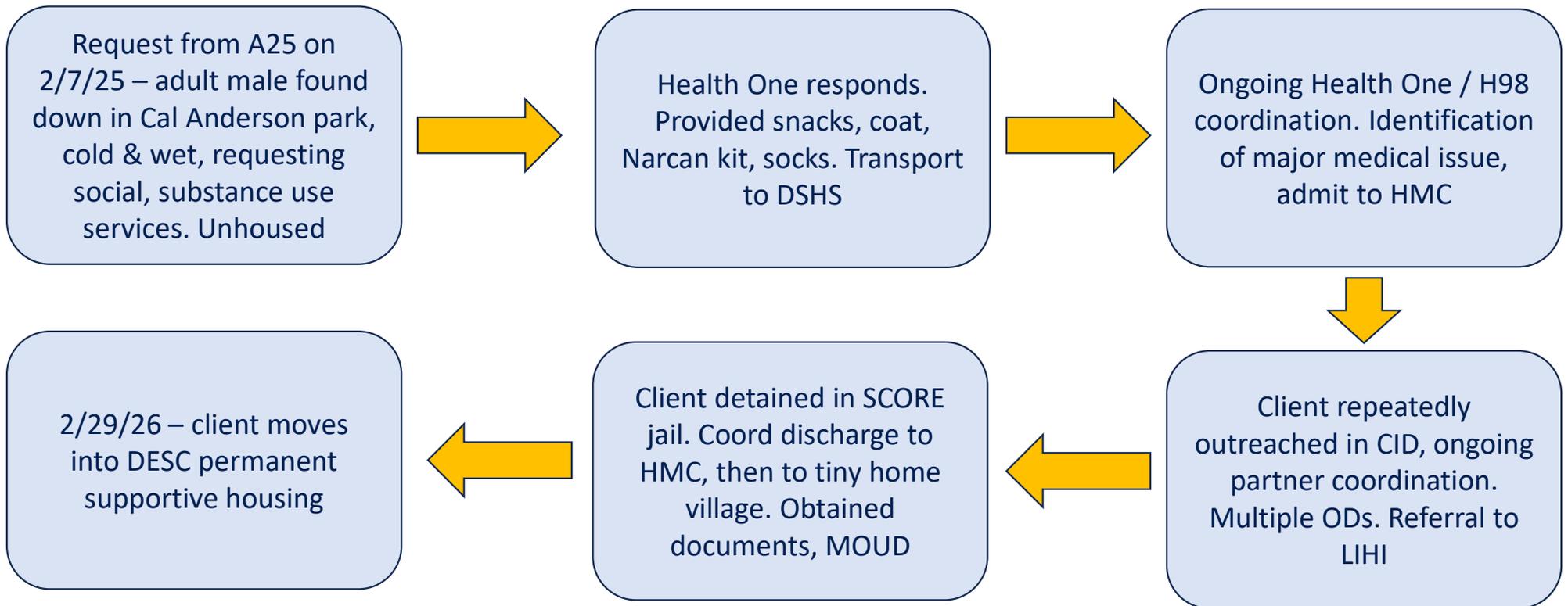


# Health One on Scene

- Average scene time: 42 minutes
- Wide array of alternate transport destinations
- 1,234 dispatches in 2025
- Capabilities: EMS, wheelchair transport, essential items, crisis intervention, phones, warm handoffs



# Condensed Case Study - Health One

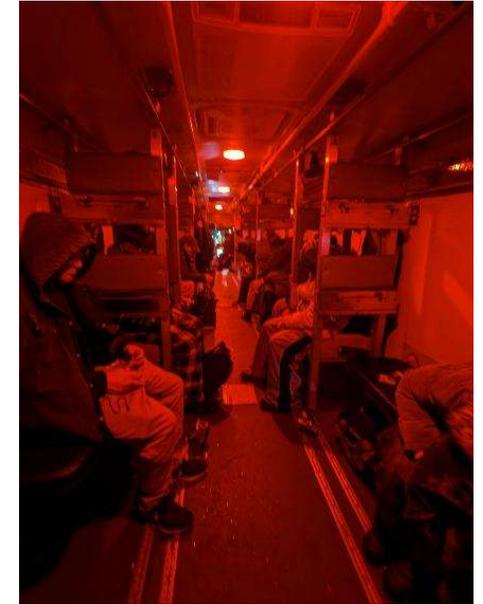


# Severe Weather Response

- Health One can switch to 24/7 operations for inclement weather
- Focus on outreach, essential items, life safety, Ops support, transport
- Coordination with SFD resources, EOC, KCRHA
- Can mobilize SFD Mobile Ambulance Bus for mass sheltering



*Mobile Ambulance Bus: Exterior*



*Mobile Ambulance Bus: Interior with Clients*

# Clients & Case Management

- All MIH responses presume short-term case management
- Case management allows MIH to move from **episodic, incident-driven** interactions to **longitudinal, client-centered relationships**
- HSD case managers have access to state-level benefits and long-term care databases, plus hospital records (with documentation)
- MIH team directly receives all SFD Adult Protective Services reports – vulnerable clients not typically seen by other teams/services
- ★ New in 2025: complex case management
- 2025: 1,564 non-duplicated clients
- **Average 76% reduction in 911 call volume, 69% reduction in ED utilization**



# Clients & Case Management (cont.)

- Deliberate focus on vulnerable, underserved populations, impact on Ops
- Mean client age 67 (17% of H99 clients geriatric)
- 95% of clients on public insurance
- Disproportionately serve clients experiencing homelessness, in supportive/low-income housing, racial/ethnic minorities
- Large number of “unseen” clients: housed, poorly-served, only interfacing with EMS

|                                   |  |       |
|-----------------------------------|--|-------|
| <i>MIH referral reasons, 2025</i> | Automation: Multiple Falls Calls - 50+ | 879   |
|                                   | MH/SUD                                 | 847   |
|                                   | High utilizer                          | 825   |
|                                   | Low acuity medical                     | 720   |
|                                   | Living conditions                      | 593   |
|                                   | Homeless                               | 556   |
|                                   | Neglect/abuse/no self-care             | 551   |
|                                   | Falls                                  | 497   |
|                                   | Vulnerable Adult                       | 306   |
|                                   | Other                                  | 223   |
|                                   | Grand Total                            | 3,528 |



# Complex Case / High Utilizer Example

- 34 year old female
- Permanent supportive housing
- End-stage renal disease, HD noncompliant
- Methamphetamine use disorder
- 210+ SFD responses in 4 years
- 150+ AMR responses in 2025 Q4
- Highly served



# Overdose Program: H99

- Launched summer '23 – MO Executive Order
- Modeled on other FD programs
- 2 FF/EMT & 1 CM or ARNP
- City-wide self-dispatch (M-F), focus on high-volume areas (3/Pike, 12<sup>th</sup>/Jackson)
- Training: OUD, medications for OUD, harm reduction, trauma-informed care
- November '24 – first-in-USA EMT buprenorphine program
- 133 admins, 0 adverse outcomes to date
- ~80% post-OD ED diversion rate
- ~1000 responses in 2025



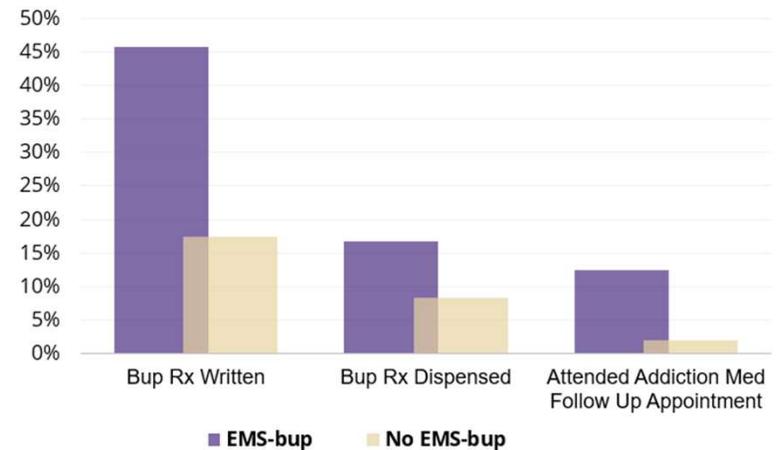
# Overdose Program: H98

- Post-overdose outreach, follow-up, and case management: hours/days post OD
- Goals: connection with ongoing MOUD (focus on LAI buprenorphine), general case management, referrals
- ~300 outreaches since '25, higher rates of engagement
- Reliance on partners: DESC, REACH, Ryther, LEAD, etc.
- Strong/growing partnership with DESC ORCA:
  - Daily coordination call
  - Almost all post-OD transports
  - Real-time client navigation, follow-up



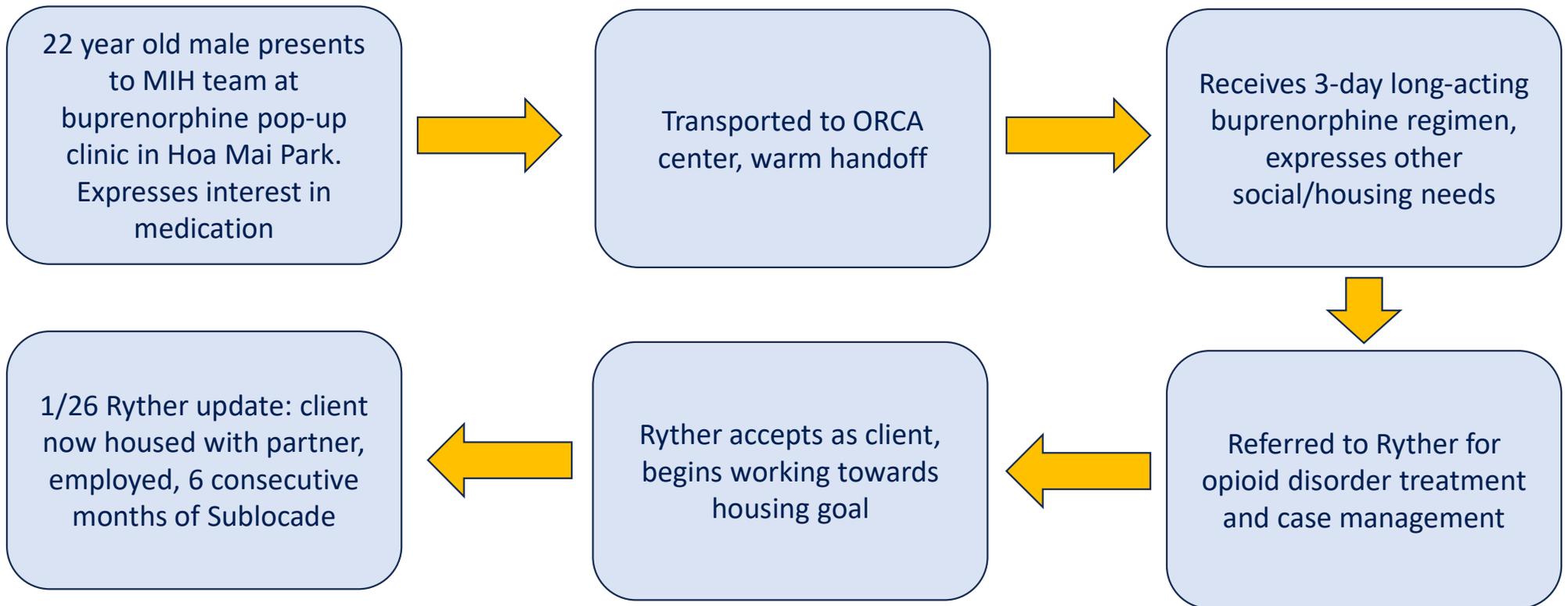
## ED Impact

Fig 6. Comparing Buprenorphine Prescription & Linkage to Care 30 days from Index Overdose for Cohort of Patients Who Received EMS-Buprenorphine vs Patients Who Did Not Receive EMS-Buprenorphine 03/2024 – 07/2024



Gressman et al.: Prehospital Buprenorphine: Facilitators, Barriers and Impact Using a Systems Analysis and Improvement Approach (SAIA)

# Condensed Case Study - H99



# Advanced Practice Provider Program

- Partnership with HMC Hobson Clinic
- Currently 1 ARNP – time split between Health One and H99
- Clients/bodies of work:
  - Complex illness management (e.g., CHF, COPD)
  - Street medicine
  - Intakes/assessments / referrals
  - Med admin / new prescriptions
  - Support for H99
- Initially funded by Congressman Smith CDF, now city-funded
- Planning 2<sup>nd</sup> position

UW Medicine

HARBORVIEW  
MEDICAL CENTER



# Future Growth, Challenges, and Gaps

## Growth

- Lieutenant starting 2026
- 2<sup>nd</sup> ARNP
- Expansion of complex case management
- Expansion of ORCA partnership
- Expansion of H98 capability
- Additional north/south end coverage
- More vehicles (ambulance, van, pickup, car)

## Challenges/ Gaps

- Shelter capacity
  - General population
  - High-acuity needs
  - Families with children
- Post-overdose stabilization: shelter, tiny homes
- Crisis options
- PSH and low-income housing capacity



# Questions?

