shelter the HOMELESS
242 West Paramount Avenue || Salt Lake City, Utah 84115

Medically Vulnerable People Interim Housing Program

Expanding Non-congregate shelter to Improve Housing and Health Outcomes for Individuals Experiencing Homelessness

BACKGROUND

Health conditions and injury can cause a person to experience homelessness, especially the aging population. Not having a home often exacerbates symptoms of chronic illness and delays injury recovery. Minor cuts or common colds can easily develop into larger problems, such as infections or pneumonia. (NHCH, 2019) Contagious diseases spread more quickly in congregate settings, including shelters and unsanctioned camps. As evidenced during the COVID-19 pandemic response, many experiencing homelessness have high rates of chronic and co-occurring health conditions.

We learned during the COVID-19 pandemic that non-congregate settings were the safest option for people experiencing homelessness to be stably housed, stay healthier, and curtail the spread of the virus. The life-saving pandemic response strategies Salt Lake County (SLCo) designed, implemented, and evaluated – the Stay Home, Stay Safe Vulnerable Population Hotel and the Quarantine and Isolation (Q/I) facility – confirmed this. The Stay Home, Stay Safe Vulnerable Populations Hotel program was created to mitigate the spread of COVID-19 among those experiencing homelessness shelters, where large numbers of individuals share sleeping, eating, and bathroom arrangements. Social distancing was increased, allowing the most vulnerable individuals, who were at risk of COVID-19 hospitalization and death, to shelter in place.

Additionally, Quarantine and Isolation (Q/I) recuperative care was implemented as SLCo's short-term emergency response to COVID-19 infection. As the pandemic evolved, a long-term proactive response was identified, with Fourth Street Clinic (FSC) taking the lead on Q/I operations. SLCo's Stay Home, Stay Safe Program was closed in June 2021 as the shift from our COVID-19 emergency response shifted to recovery.

Building upon the lessons learned, and the surge in COVID-19 cases, a program similar to the Stay Home Stay Safe Program was implemented, which also addressed part of the need for winter overflow in 2021/2022. Operated in partnership by The Road Home, Shelter the Homeless and Fourth Street Clinic, and known as the High Needs Housing (HNH) Program, this effort temporarily helped fill a gap and address the health and housing needs of an aging and medically vulnerable population.

The cost of housing continues to rise, and is becoming increasingly unaffordable for many Utahns, including those who are aging and on fixed incomes. The rising housing costs are leading to more housing insecurity, and even homelessness, especially among an older population. As those experiencing homelessness become older and develop more complex medical and health needs, we must have resources to help address their housing and health care needs.

This Medically Vulnerable People (MVP) Program will help address a critical need in our community with immediacy as we strive to better serve and house the increasing aging population. This program demonstrates a commitment that will provide a long-term investment to help improve housing and health outcomes for a very vulnerable, and growing population in our community.

PROPOSAL

The MVP program targets acquisition and rehabilitation of a motel to provide private and safe rooms to improve the health and housing outcomes of approximately 165 individuals experiencing homelessness. It will provide a non-congregate setting to address the acute needs of individuals experiencing homelessness who are aging, vulnerable, medically frail, in need of recuperative care, and/or have an underlying health condition or compromised immune system. This program has been endorsed as a top priority by the Salt Lake Valley Coalition to End Homelessness, has received funding from the State, SLC, SLCo and private donors, and when combined with additional deeply affordable housing, this project addresses an immediate gap of supportive care for this population. In addition, it is designed to be flexible and can pivot as the medical and housing needs of the community continue to evolve.

MVP is a pioneer project in Salt Lake County and Utah. It is built on the strengths of partnering organizations and the two existing proofs-of-concept, which can be leveraged and scaled to address existing service gaps. The MVP partner organizations bring operational expertise to the acquired facility. The Road Home will provide building operations and housing case management. Fourth Street Clinic will provide medical care, assessment, referral and care oversight. Shelter the Homeless will hold the asset and manage the property.

Program referrals will be made from Homeless Resource Centers (HRCs) and street outreach teams to the unsheltered who are camping. All tenants of the facility will be prioritized for placement using Salt Lake County's Coordinated Entry prioritization process for medically vulnerable individuals. The clients will remain in the MVP program with medical and housing support until suitable, permanent housing can be obtained that best meets the needs of each individual.

NEED

In Salt Lake County, 507 individuals aged 62 and older and 1,586 individuals with a chronic health condition sought homeless services in 2022. *Source - State Fiscal Year 2022, HRC and Winter Response, Salt Lake County, State Homeless Management Information System (HMIS).*

The MVP will provide approximately 165 beds to serve this population. HRCs do not provide a recuperative setting, since individuals recovering from surgery or with other medical ailments may have to walk long distances to shower, use the restroom, access meals, etc. Although this program will provide robust support, there will be limited resources for individuals who require support for activities of daily living, although in some instances home health services can be arranged; the program is not appropriate for individuals who require skilled nursing or other long-term care; and medical staff will not be on site overnight so after-hours support will be provided through a 24/7 call center.

Anticipated Medical Needs and Conditions

- Injuries
- Skin/Dermatological Infections and Wounds nb m
- Respiratory Infections
- Circulatory Conditions
- Digestive Conditions
- Musculoskeletal and Tissue Conditions
- Pre/Post Medical Procedure Recuperation (i.e. surgeries, endoscopies, etc.)

Key Components

- On site behavioral health and medical services
- Transition to housing and other supports
- Length of stay in recuperative beds are based on medical needs

Supportive Services

- Coordinated entry
- Housing focused and person-centered case management
- Long term housing connections for successful exits
- Supportive health services and connections to health services (medical, mental health)
- Supportive employment services and connections to related services and mainstream benefits
- Provision of meals, transportation, and security

OUTCOMES

- Permanent Community Asset – *Shelter the Homeless.* The MVP program will help address this critical need in our community with immediacy as we strive to better serve (and house) the increasing aging and medically vulnerable populations. It demonstrates a commitment to fill a gap in our continuum of care with a long-term investment.

- Targeted Medical Care – *Fourth Street Clinic*
  - Specialty Service Referral Type and Outcome (i.e. referral to neurology and appt completion)
  - Medical Case Management Acuity
  - Emergency Room Referrals
  - Length of stay and discharge disposition
  - Medical diagnosis and chronic care measures (diabetes management, hypertension controlled)
  - Patient Utilization of FSC Services – medical, dental, and behavioral health
  - Access to Preventative Care – i.e. cancer screenings

- Case Management and 24/7 Supportive Services – *The Road Home*
  - Client access and approval for Medicaid and Medicare
  - Client access to critical documentation to support housing process
  - Client utilization of senior specific housing and supportive services options
  - Client utilization of medical support specific housing and supportive services options

BUDGET

The MVP project cost is estimated at $16M for the acquisition, site evaluation and refurbishment, annual property management costs, medical services, and start-up operations and services. Ownership of the facility makes the annual operating budget, estimated at $5M, the most cost-effective approach.

SUMMARY

The MVP Program will provide a permanent solution to a top priority need in our community for interim housing options, allowing for disease mitigation and acute health care needs to be addressed in a non-congregate facility. MVP will serve individuals experiencing homelessness who are aging, vulnerable, medically frail, in need of recuperative care, and/or have an underlying health condition or compromised

immune system, in a supportive and appropriate environment and they are connected to permanent housing resources.

the ROAD HOME

4TH STREET CLINIC
HOMELESSNESS HURTS. HEALTH CARE HELPS.

shelter the HOMELESS

SALT LAKE COUNTY