FOURTH STREET CLINIC  HOMELESSNESS HURTS. HEALTH CARE HELPS.

Wasatch Homeless Health Care

d.b.a. Fourth Street Clinic
409 West 400 South
Salt Lake City, Utah 84101

Capital Request

Proposal: Mobile Medical Clinic

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PROGRAM BACKGROUND

The mission of Fourth Street Clinic is to help homeless Utahns improve their health and quality of life by providing high quality health care and support services. Over the past 29 years, Wasatch Homeless Health Care, Inc. dba. Fourth Street Clinic (FSC) has worked collectively with the community to respond to the changing needs and healthcare environment for homeless individuals and families. As a Federally Qualified Health Center, FSC provides comprehensive medical services to individuals and families who experience homelessness. These services are provided on a sliding fee scale. Individuals and families who are at 100% of the Federal Poverty Level (FPL) or below are not assessed a fee. In 2016, FSC provided services to 5,105 unique individuals in over 27,700 encounters, 94% of patients were at or below 100% of the FPL. Utah's 2016 Comprehensive Report on Homelessness, estimates 13,460 individuals experienced homelessness; 8,903 of whom live in Salt Lake County. According to statistics from the National Healthcare for the Homeless Council, these individuals are three to six times more likely to become ill than those who are housed and the average life expectancy is decreased by twenty-five years. The Council also reports significant health disparities when comparing homeless and non-homeless populations. Individuals and families living at or below the FPL are the most vulnerable to experience homelessness and typically have inadequate access to affordable housing and health insurance coverage. Complicating matters, Utah has only recently expanded Medicaid (but for a *very* limited population).

Homelessness often creates new health problems and exacerbates existing ones. Individuals and families living in shelter and on the street, have greater exposure to illnesses and have higher rates of chronic conditions than the general population. Many of these conditions are preventable and treatable with access to appropriate health care. Often these conditions co-occur with a complex mix of mental health, substance abuse and social problems. Although housing is a key to ending homelessness, quality health care is an essential component to preventing and ending homelessness. Access to health care increases housing stability and quality of life for individuals and families who are homeless.

There is a collaborative effort among homeless service providers and within the community to proactively address the complex needs of individuals and families experiencing homelessness. Providing increased and low barrier access to services to those who are now housed is a vital component.

In early 2016, homeless service providers and community stakeholders convened a workgroup to address the growing and multifaceted needs of the existing homeless population. These meetings were originally called to address the unmet medical needs of homeless individuals living in permanent supportive housing programs, many of whom meet the Department of Housing and Urban Development's (HUD) definition of chronically homeless. Often these individuals are resistant to services and have complicated health needs. Housing staff expressed

concern after multiple deaths occurred in a short period of time, which may have been preventable with appropriate diagnosis and ongoing medical treatment. This program is in line with the shared outcomes defined by the Salt Lake County Collective Impact Committee (SLCOCI).

Additionally, the work group discussed the future healthcare needs of the proposed scattered shelter sites. It was identified through the work of the SLCOCI that comprehensive primary health care needs of this population should be included in the new homeless service delivery model. Several options and service delivery models were vetted by the workgroup before developing the Hub & Spoke Model consisting of a Mobile Medical Clinic and a community-based Nurse Care Management Model. The primary concept behind this model include the following:

- The current location of FSC will serve as the "Hub" for the medical services. Individuals and families served will have access to **all** services provided at the "Hub" including behavioral health, dental, specialty clinics, wellness classes and access to Fourth Street Clinic's pharmacy.

- The "Spokes" will be the various locations for homeless services; not limited to new and existing shelters/resource centers, domestic violence shelters, permanent supportive housing, transitional housing and various other homeless service provider locations.

This plan will be implemented using a Mobile Medical Clinic and a Nurse Care Management Program, in addition patients will be linked with Fourth Street's main clinic ("Hub") as appropriate. The "Hub" will provide oversight and supervision to the Mobile Medical Clinic and the Nurse Care Management Program as well as offer additional services that may not be available through the mobile clinic. The Nurse Care Manager (NCM), employed by FSC, will work on-site at the identified locations as a part of a care management team. Each site will be assessed on the needs of the population at each location to determine the appropriate staffing model. Through this care model, individuals who are or have experienced homelessness will have access to comprehensive medical services. These services include treatment or referrals for acute and chronic illnesses, preventive care, behavioral health services, and oral health services. They will also have access to prescribed medications. The NCM will assist in coordinating health care with providers at Fourth Street Clinic, Fourth Street's Mobile Medical Clinic or other Community Health Centers with the goal of assisting patients in establishing a Primary Care Medical Home. An emphasis will be placed on building rapport with patients and encouraging preventive care. The NCM will provide support to housing and shelter staff through ongoing care management of clients, including chronic disease management, triaged care, and medication management.

Chronic Disease Management: The NCM will provide self-management support to individuals diagnosed with a chronic disease through patient education, scheduled check-ins and linkage to a medical provider for regularly scheduled exams. Individuals will also have access to Wellness Groups at Fourth Street Clinic focusing on a variety of chronic conditions.

Triaged Care: The NCM will meet with individuals identified by the care management team who are in need of medical care. They will triage patients and prioritize based on severity. The NCM will consult with a medical provider and link patients to FSC, another medical clinic or mobile clinic. The NCM will also assist with linking patients to EMS services when appropriate.

Medication Management: The NCM will assist individuals in managing their medications based on individual needs through reminders, medication management tools such as daily or weekly pill boxes, and up to date medication lists. Education will also be provided on the use of medications along with possible side effects.

Many individuals who experience homelessness face barriers to medical treatment including lack of transportation. The mobile medical clinic will consist of three exam rooms and a laboratory, and be staffed with at the very least, a two medical providers, medical assistant, an intake staff driver/support staff.

The mobile medical clinic will travel to the various sites on a scheduled basis. The NCM at each site will identify individual with the highest need to receive priority care. The schedule will allow for fluidity to account for the transient nature of individuals who are homeless who may not show for a scheduled appointment. The NCM will be able to fill the “no show” appointment slots with urgent needs.

Mental Illness and substance use disorders are also prominent issues faced by this population. The mobile medical program will serve to reduce some of these barriers to care. This proposed solution for medical services for the homeless allows for flexibility to meet individual needs and the changing environment of the homeless community.

MOBILE MEDICAL CLINIC

FSC staff has conducted significant research on mobile medical programs across the country. In person and phone interviews have been conducted to learn from established programs and what are essential factors for success have been as well as challenges that were experienced in launching their programs.

Based on research conducted; vendors were identified, vetted and met. Proposals were collected from multiple vendors and reviewed. The budget included in this proposal was from the vendor identified to best meet the needs of the program. Additionally, included in the

budget are one-time expenses to equip the new resources centers and some of the existing sites identified for the mobile medical clinic.

Capital Budget

Mobile Medical Unit Base Cost	$683,748
Mobile Medical Equipment	$34,275
Medical Equipment at Resource Centers	$150,141
Subtotal	**$868,164**
Contingency (10%)	$86,816
Total	***$954,980***