

Creating a Comprehensive Service Delivery Model-

From Police to Housing



FOURTH STREET CLINIC
HOMELESSNESS HURTS. HEALTH CARE HELPS.

General Demographics

*as of 2016

- Salt Lake City Metro: 181,743 (90.5 square miles)
- Salt Lake County: 1.3 million (756 square miles) *most populous county in Utah
- Utah's median age in 2017 is 27.1 years, well below the national figure of 35.2 years
- 35th in the nation in population growth



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*Source: http://www.saltlakecityutah.org/salt_lake_demographics.htm

2016 Point in Time Count

Total Utahans Experiencing Homelessness: 2,807	Total Headcount in Salt Lake County: 1,891
1,810 Homeless Individuals	1,260 Homeless Individuals
979 Homeless Families	631 Homeless Families

- *67.3% of the entire state's total homeless population*
- *69.6% of the state's homeless individual population*
- *64.4% of the state's homeless family population*

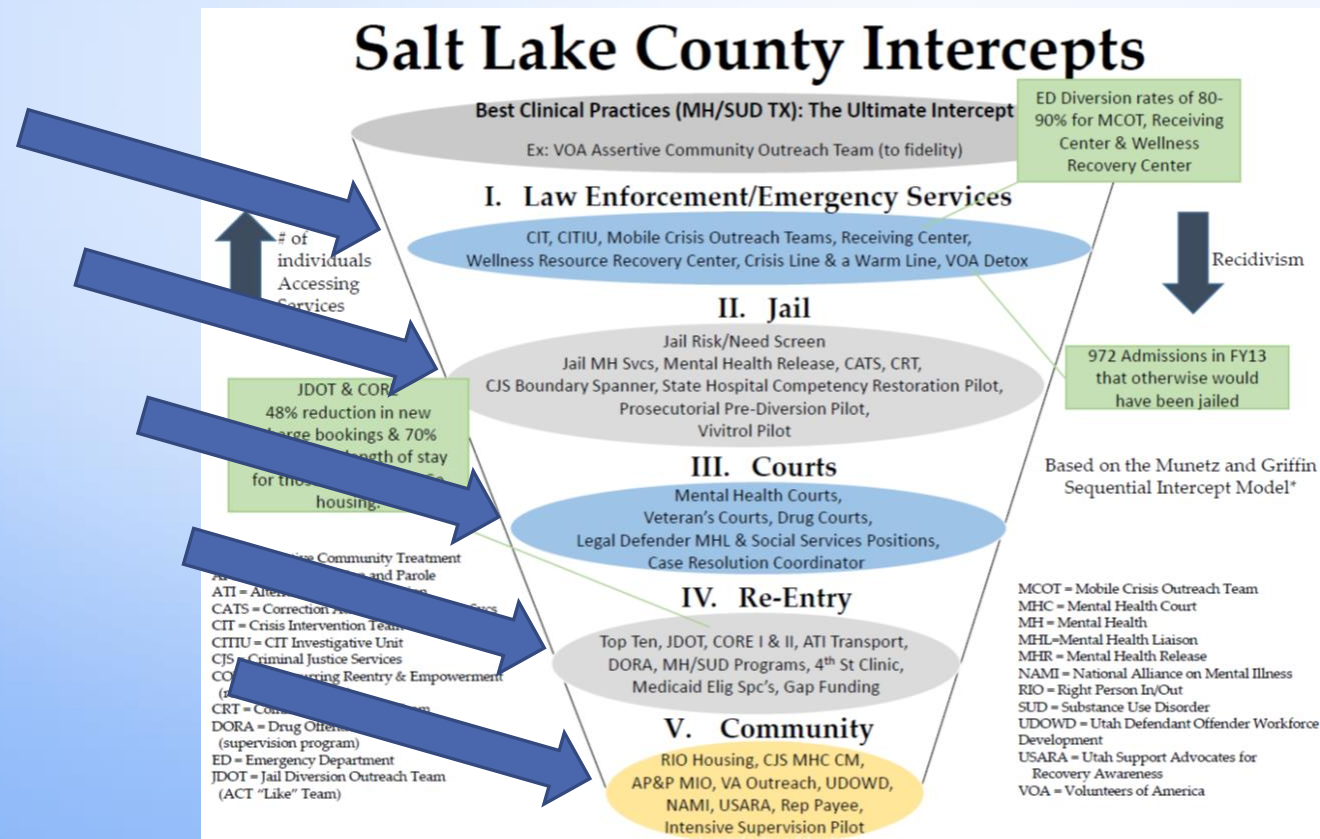


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“No Wrong Door” & “Sequential Intercepts”

- NWD: A universal gateway to community services and government programs
- SI: “Intercepting” individuals with behavioral health issues, linking them to services and preventing further penetration into the criminal justice system



Source: Salt Lake County Behavioral Health



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Salt Lake City Police Department's Community Connection Center

3 Teams, 1 Center



SLCPD Community Connection Center Mission Statement

“To provide a safe environment for people to
access individualized care, support,
and appropriate community services.”



- SLCPD started CIT 15 years ago
 - 3 officers, 1 sgt.
- Provides training to officers, service providers and citizens.
- Collaborates with other law enforcement agencies to create “CIT Metro”
- Provide follow-up for mental health calls which equal approximately 3,000+ calls per year
- Provide community collaboration to constant callers



- Started in 2011
 - 2 officers, 1 sgt.
- Responds to community complaints regarding homeless issues
- Finds those in need of assistance through proactive outreach (searching for encampments, speaking with individuals that are experiencing homelessness)
- Created a panhandling initiative- “HOST meters”



- Started in 2016
 - 4 licensed clinicians, 5 case managers, 1 program manager
- Triage of an individual and/or family
- Intermittent, short-term therapeutic intervention
- Care coordination between agencies
- Case Management, which includes but is not limited to:
 - Housing Application and Navigation Assistance
 - Basic Needs
 - Transportation Assistance
 - Employment Resources
 - Navigation of the Behavioral Health System
- Follow Up Outreach and Co-Response
- Appointments available for any citizen of SLC free of charge



Homeless Outreach



“Volunteers of America, Utah provides a bridge to self-reliance and health for vulnerable individuals and populations who struggle with homelessness, addiction and mental illness in our Wasatch Front communities through a safety net of services.”



- Homeless Services
 - Homeless Outreach Team
 - Library Engagement Team
 - Housing and Benefits Team
 - Youth Resource Center
- Prevention Services
- Residential Services
 - Young Men's Transition Home
 - Young Woman's Transition Home
 - Adult Detoxification Facility
 - Women & Children's Detoxification
- Treatment Services
 - Adult Treatment Services
 - Child and Youth Treatment Services
 - Domestic Violence/Mental Health Services
 - Assertive Community Outreach Team
 - Child Care



Volunteers of America- Utah and 4th Street Clinic

Medical Outreach



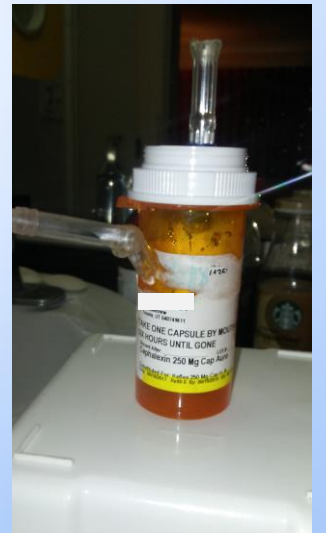
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Dual Agency Team: 4th Street Medical Clinic works closely with Volunteers of America, Utah to provide medical outreach

Mission of the Medical Outreach Team: is to meet the unmet medical needs of rough sleepers and those who are the most vulnerable

Services Include: a continuum of care which are medical, benefit enrollment, and housing applications that include case management



**Ok, a team
finds
someone...
now what?**



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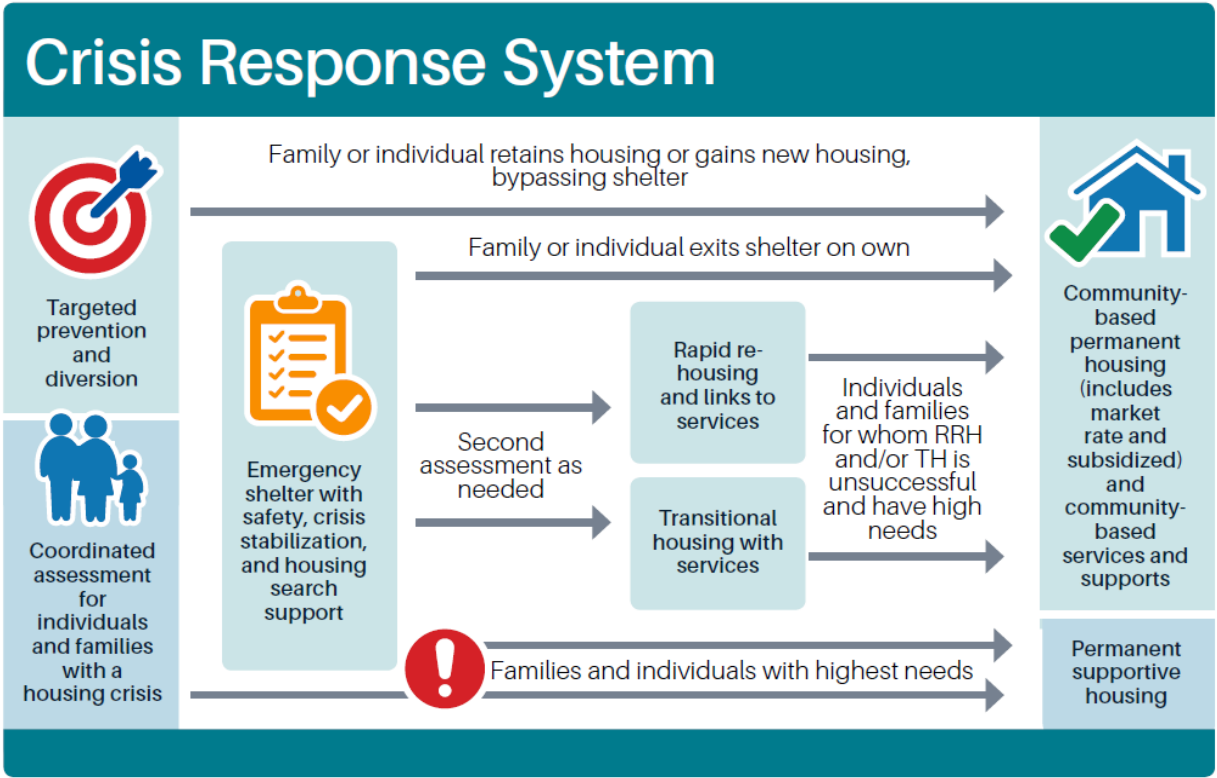
Hospitals, Receiving Centers, 4th Street

Hotel/motel dollars provided by SLC: \$80,000.00

Diversion: Utah Community Action

Housing Triage: How does SLC prioritize individuals?

Housing Crisis Response System



Source: United States Interagency Council on Homelessness



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VULNERABILITY INDEX - SERVICE PRIORITIZATION DECISION ASSISTANCE TOOL (VI-SPDAT)

SINGLE ADULTS

AMERICAN VERSION 2.01

Administration

Interviewer's Name	Agency	<input type="radio"/> Team <input type="radio"/> Staff <input type="radio"/> Volunteer
Survey Date	Survey Time	Survey Location
DD/MM/YYYY ____/____/____	____	_____

Opening Script

Every assessor in your community regardless of organization completing the VI-SPDAT should use the same introductory script. In that script you should highlight the following information:

- the name of the assessor and their affiliation (organization that employs them, volunteer as part of a Point in Time Count, etc.)
- the purpose of the VI-SPDAT being completed
- that it usually takes less than 7 minutes to complete
- that only "Yes," "No," or one-word answers are being sought
- that any question can be skipped or refused
- where the information is going to be stored
- that if the participant does not understand a question or the assessor does not understand the question that clarification can be provided
- the importance of relaying accurate information to the assessor and not feeling that there is a correct or preferred answer that they need to provide, nor information they need to conceal

Basic Information

First Name	Nickname	Last Name
_____	_____	_____
In what language do you feel best able to express yourself? _____		
Date of Birth	Age	Social Security Number
DD/MM/YYYY ____/____/____	____	_____
		Consent to participate
		<input type="radio"/> Yes <input type="radio"/> No

IF THE PERSON IS 60 YEARS OF AGE OR OLDER, THEN SCORE 1.

SCORE:

0



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What we are finding:

- An aging population with:
 - Physical & mental health issues
 - Incarceration & substance abuse issues
 - Lack of social support
- Older adults (50+) represent 25-30% of Salt Lake County's homeless population
 - THIS NUMBER IS PROJECTED TO DOUBLE BY 2050



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- **ONLY** non-profit hospice care (& respite care) in the United States for individuals experiencing homelessness
- ***Mission:*** To end the tragic history of vulnerable people dying on the streets of our community by providing a supportive and safe haven for individuals who have nowhere else to go in time of medical crisis



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**What about
those that
you deal with
time and time
again?**



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Crisis Response System (CRS)

- Monthly meeting regarding frequent utilizers of systems
 - These are people that are typically difficult to place
 - We have staffed and placed over 150 individuals
- Cross-System Participation
 - FBI
 - Homeland Security
 - Service Providers
 - Behavioral Health
 - Medical Health
 - Homeless
 - Ambulance Services
 - Hospital Emergency Rooms
 - Crisis Intervention & Hospital Diversion
 - Police Departments
 - Fire Department



42 Year Old Female

- Wheelchair Bound, Incontinent, Homeless, HIV Positive- non-compliant with appointments, Co-Occurring Dx, Non-compliant with medications, Prostituting Self

SLCPD Police-Related Events

January- July of 2016 = **33**

Emergency Room Visits

January- July of 2016 = **72**

**this is just 3 hospitals*

Grand Total for 7 months

= **\$174,433.95**

SLCPD Police-Related Events

July of 2016 to date = **0**

Emergency Room Visits

July of 2016 to date = **0**

**this is just 3 hospitals*

Grand Total for 18 months

= **\$ 0.00**

**cost of the care center is \$54,000 total*



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**Are there any other
organizations that have
been involved to increase
services & housing to
individuals experiencing
homelessness?**



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Operation Rio Grande: A Multi-level, Multi-agency, Cross-System Collaboration

OVERALL OUTCOMES

1. Reduce the average length of stay in the shelter: Baseline SFY 2017 — **48.5** days
2. Increase the number of positive housing exits: Baseline SFY 2017 — **119**

Measurement will take place at the end of each State Fiscal Year.

PHASE I OUTCOME



Improve public safety & order by reducing the crime rate.

Measurement:
Part one offenses
Weeks 49-52 (December)

2017 **164**
3-year avg. 2014-2016 **188**

PHASE 2 OUTCOME

Support people struggling with mental illness & drug addiction so they can return to a path of self reliance.

Measurement:
Individuals entering treatment through the new drug court program

13

Current month

84

Total to date

PHASE 3 OUTCOME

Prepare & connect individuals to income that supports housing.

Measurement:
Individuals employed



14

December placements
(Dignity of Work began Nov. 9, 2017)

For more details, click the buttons below

Updated 2/5/2018



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Targeted Adult Medicaid

- What is it?
 - Utah specific approach to reduce the number of uninsured adults
- Who is eligible?
 - Adults without dependent children
 - Age 19-64
 - U.S. Citizen or qualified alien
 - Resident of Utah and not in a public institution
 - Earning up to 5% of the poverty level
 - Ineligible for any other Medicaid program (with the exception of medically needy or refugee Medicaid)
 - Fall into one of the following targeted categories:
 - Chronically homeless
 - Involved in the justice system through probation, parole, or court ordered treatment needing substance abuse or mental health treatment
 - Needing substance abuse or mental health treatment



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**However, there
are still
challenges...**



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Current Challenges

- Number case managers available to assist once a person is placed into housing
- Availability of affordable housing units
- Income vs Rent
 - You have to make \$19.00/hour to support a 1 bedroom apt. in Utah
 - Minimum wage is \$7.25/hour
- Specific targeted housing units (i.e. aging population, TBI, SPMI)
- Respite Care
- Traditional Medicaid vs. Targeted Adult Medicaid
- Mental Health and Substance Use Treatment Capacity



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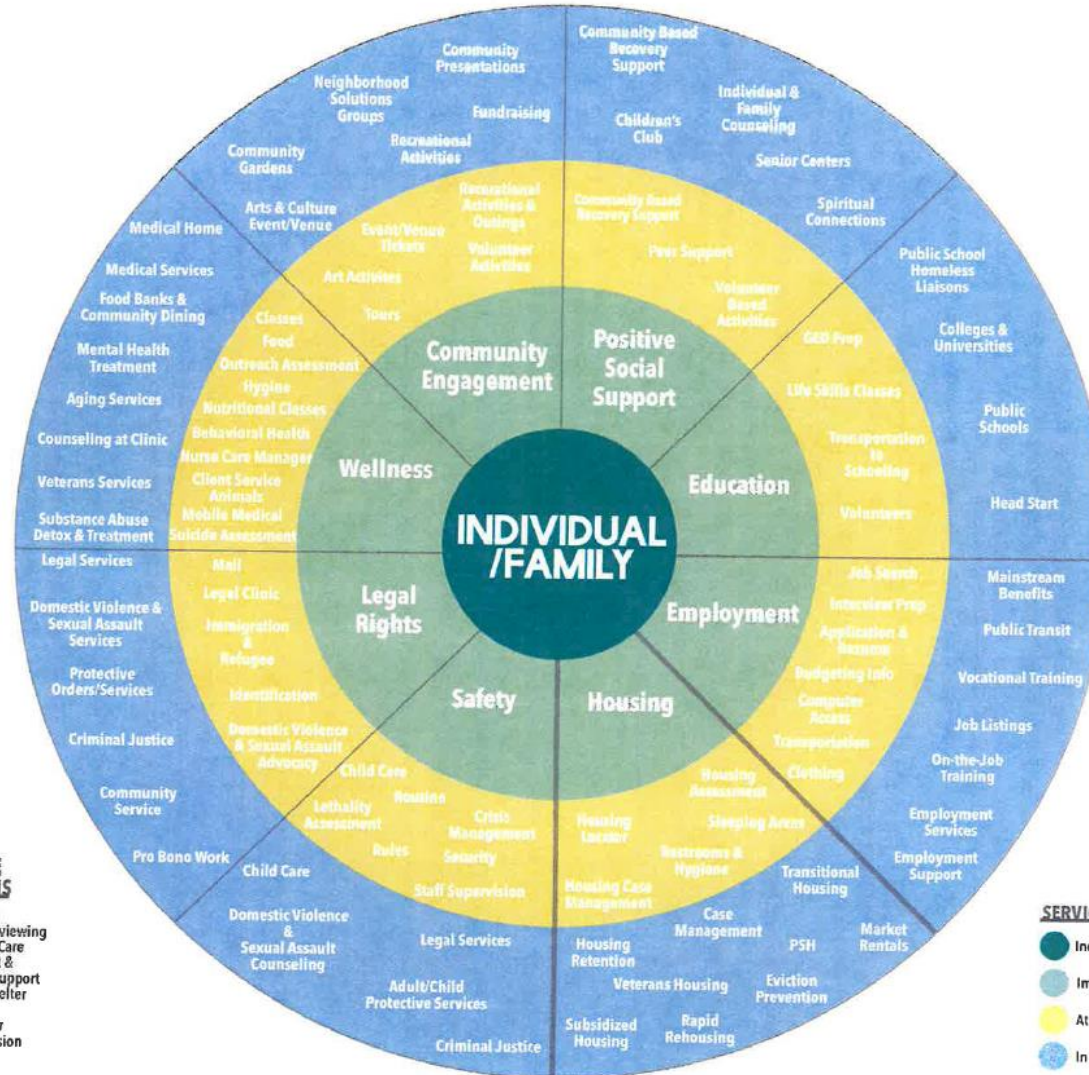


**We are moving
in a new
direction...**



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BEST PRACTICE INTERVENTIONS

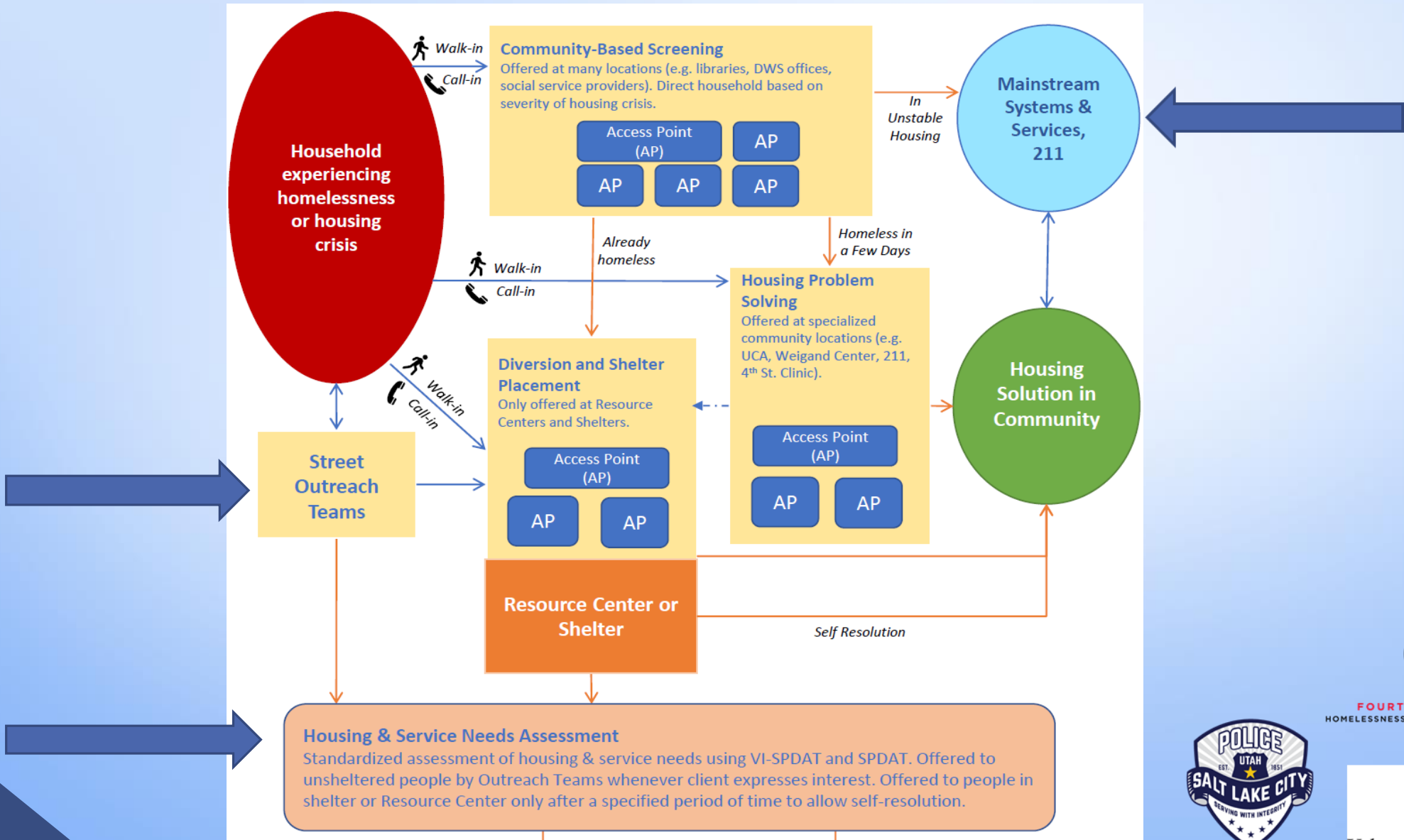
- Coordinated Entry
- Motivational Interviewing
- Trauma-Informed Care
- Case Management & Other Individual Support
- Diversion From Shelter
- Housing First
- Low Barrier Shelter
- 24/7 Staff Supervision

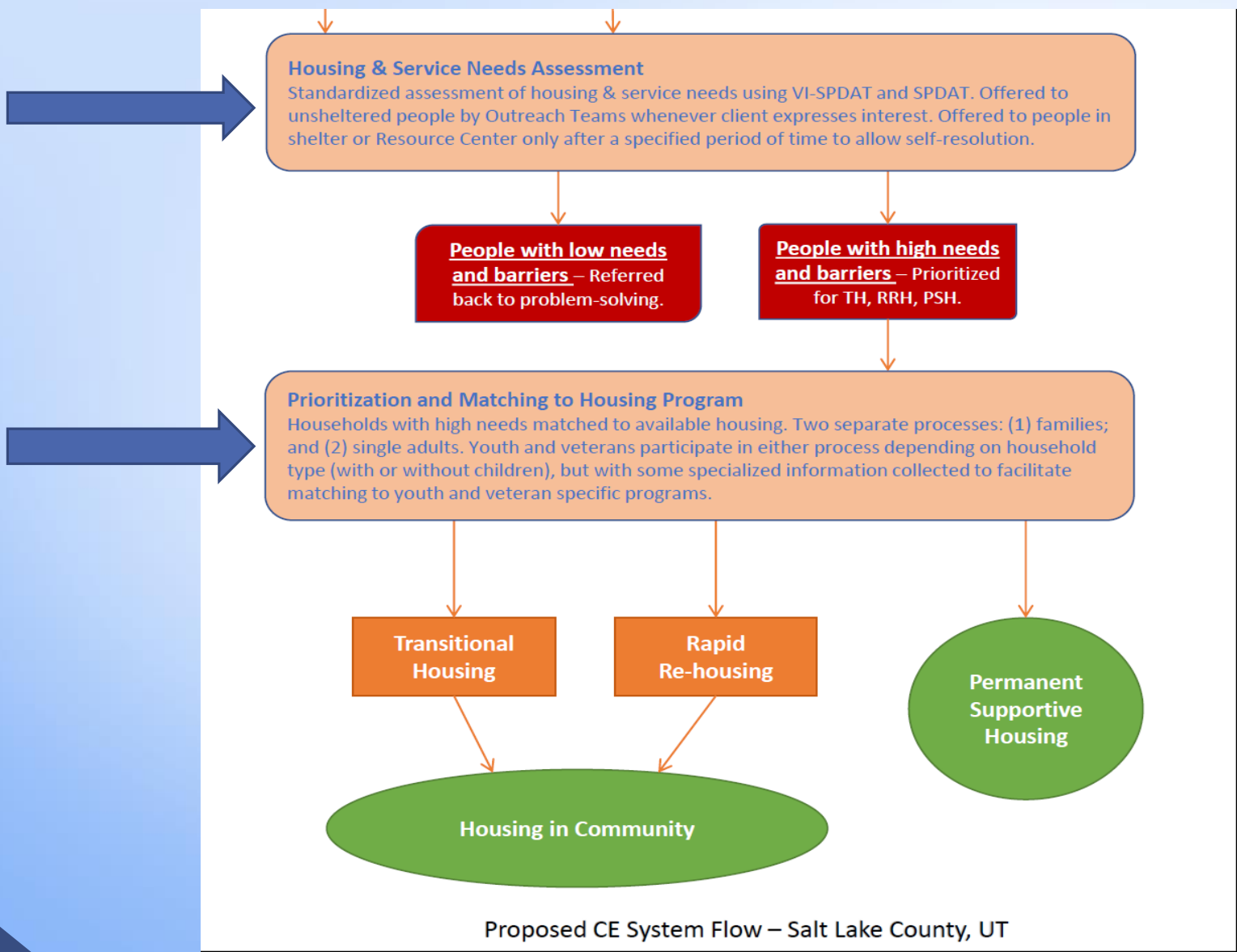
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- Communication & patience are KEY
- Multi-level, multi-agency, cross system collaborations can occur with motivated stakeholders are at the table
- Information can be shared, it is a matter of how you approach it
- Track your cost-savings
- Emergency service entities, like law enforcement, are necessary to involve
- Work toward getting ahead of the aging population
- Mental health and substance use treatment capacity are a necessity- as well as the payor resource associated those



Thank You & Questions?



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