Collective Impact on Homelessness Steering Committee Meeting Notes
09.07.2016

Steering Committee members or alternates in attendance: Mayor McAdams, Laura Michalski, John Wilkes, Jean Hill, James Morgese, Kathy Bray, Joann Seghini, Erin Trenbeath-Murray, Jennifer Steele, Lori Bays, Matt Minkevitch, David Litvack, Pamela Atkinson, Johnathon Hardy, Mikelle Moore, Anne Burkholder, Matt Melville, Tara Rollins, Janice Kimball, Tiffanie Provost, Bill Crim, Mayor Biskupski

I. **Welcome and Introductions:** Mayor McAdams welcomed the committee and public and introductions were made around the room.

II. **Action Plan Update & Summary of Recent Activity:** Salt Lake City presented plans for moving the site selection forward. Nexus has turned their focus to 3 additional facilities, based on needed services and support.

- The first facility will be a detox and residential facility with supportive services for single women and single women with kids. The county is interested in using VOA's Murray facility.
- The second facility will be for single men and single men with children, similar to VOA.
- The third will be for families, providing education, healthcare, etc for the larger community.

We will need input from healthcare groups for the proposed rehab facilities. The final study is due to be finished at end of September.

Mayor McAdams told the steering committee that during the last month we presented several action plans to Salt Lake County council and Salt Lake City council, as well as other groups. The majority of the feedback we received has been positive. Over the next several weeks we intend to present the plan to the State of Utah leadership, in partnership with Salt Lake City and the Department of Workforce Services, to tie up loose ends before going into the legislative session. Mayor McAdams recognizes there are legitimate concerns, especially how to balance the shift between reducing demand and reducing emergency shelter. We will need to pay careful attention to that over time. Our Collective Impact initiatives are evidence-based and data-driven. If we do anything, we are going to do it at scale to make a difference for the community as a whole, both the public and the business community. We are accountable to each other in the system and need to design system-wide changes. Mayor McAdams reiterated: "As a community we will continue to provide emergency shelter to those who need it." Some recommendations are very well developed, some are still high-level and need to be modified to meet our specifications. The main agenda today is to hear from committee members and partners on healthcare, preventing homelessness for children and families, and facilities programming for services.

III. **Update & Discussion from the Healthcare Workgroup:** (Alan Pruhs) Our impetus came 9 months ago, when we were working with the Salt Lake County Housing Authority. The main question was, "How do we address the scattered-site model in a cost-efficient manner?" The 4th Street Clinic has the capacity to serve 5,500 unique patients annually. Last year they served 4,854 unique patients with 32,300 encounters including medical, dental, mental health, substance use disorder, vision, supportive services, etc.

1. Laura Michalski: Laura discussed the "No Wrong Door" approach. We have a goal of reducing emergency room visits. It has been proposed that we establish a fixed homeless health center at Palmer Court. We are also looking at establishing mobile services to provide bi-monthly medical services at supportive housing and shelter sites. We intend to establish nurse care management which will be on site 5 days a week. Homeless populations can also access medical homes through a network of primary care practices. All services can provide a sliding scale. Those in need of prescriptions can access 340B pharmaceuticals which provides very low cost medications. We have several housing partners: Grace Mary Manor, Kelly Benson Apartments, Sunrise Metro and Palmer Court. These locations will provide on-site nurse care management. We are working with multiple healthcare partners to assist with this program. Our scope of service is preventative care, episodic care and ongoing primary medical care for acute and chronic conditions. We will also provide lab & diagnostic services, some substance abuse services and some mental health services. Our partners will be hiring additional staff to support this model, including nurses, housing management, substance abuse counselors, etc.
2. Alan Pruhs: The time was turned back to Alan to discuss one-time capital funding. For a 6,000 sq ft clinic with potential to grow, the one-time capital needed would be $1.44M. To create a mobile clinic, the one-time capital needed would be $400K. This is a total one-time capital need of $1.84M. Mayor McAdams interjected that this is an investment in savings of emergency room and other medical costs. Alan stated that the underlying goal is to promote health, reduce EMS calls and lower the rate of avoidable hospitalizations. Shaleane informed the committee that ambulance calls are incredibly expensive for the City. Alan stated that the projected net loss would be approximately $189,895 - $390,290. We would eventually like to have no net loss, but we also don't want huge profits. Any profits we have will go right back into expanding the existing services.
3. Progress to Date: We have submitted a grant request to HRSA which is highly competitive. The award date for this grant will be sometime in January. If we are awarded the grant we will have 120 days to be fully operational. We may be able to apply for some extensions on this timeline but we don't plan on utilizing those extensions. We intend to pilot this on-site nurse care management sometime in the late fall of 2016 at Grace Mary Manor and the Midvale Family Shelter. We will also be providing limited mobile medical supported by Utah Partners for Health at Grace Mary Manor and the Midvale Family Shelter.
4. Next Steps: We need to seek additional funding through legislative appropriations, a Medicaid waiver, the Community Foundation of Utah, private foundation support and other federal funding opportunities (SAMHSA & HRSA). We need to strengthen

and further refine our existing partnerships with providers who offer mental health and substance use disorders care. We also need to identify new partnerships. The current Salt Lake County homeless population is estimated to be around 10,175 individuals. The 4th Street Clinic serves 5,500; Palmer Court and mobile medical will serve 1,500; that still leaves over 3,000 individuals without a medical home. Our capacity could grow to accommodate those left unserved with an expanded payer source. Mayor Biskupski asked Alan to clarify "expanded." Alan explained he is referring to individuals who are not staying at a shelter who could go to one of these clinics for services. We want patients to be able to choose their medical home. Mayor Biskupski advised the group of an incident where she and her family came across a homeless woman who had chosen to take a street drug because she did not have access to medical services and appropriate medications. She was unable to drive because of the drug she took. If she had access to a medical home, would she have access to the prescriptions she needed? Laura Michalski responded that yes, she would have access to the prescriptions she needed, whether these can be provided on-site, through participation with pharmaceutical companies who support a bulk donation program, or we pay for the prescription at a pharmacy via a voucher or pre-established agreement with the pharmacy. We currently have such an agreement with Smith's Pharmacy. Alan added that it does not do us any good to provide treatment or therapy that the clients cannot afford. Laura advised the committee that the 4th Street Clinic has an on-site pharmacy. Mayor McAdams asked someone to clarify that under a limited extension of Medicaid, 30% more individuals would be approved for coverage. Alan answered that we currently estimate about 30% more individuals will be approved with the extension, but it could be more than that. Mikelle Moore asked, with 3,000 who don't have a medical home, what portion of existing community health centers accommodate those unserved? Also, can a sliding fee go down to zero? Alan answered yes, we can take some of those 3,000 individuals. A lot of community health centers are already reporting serving homeless populations because their definitions are different than HUD. The sliding scale is currently higher than we would like to see, but there is a federal regulation that service providers cannot prohibit care if the individual is unable to pay. Shaleane asked Alan to clarify what his organization does and clarify different homeless definitions. Alan advised the group that they are considered a primary care organization in the State of Utah. They provide training and technical assistance to health care centers and work to expand operations. They do not own any centers. Pamela Atkinson interjected that there are medical providers who want to volunteer on a regular basis, physicians who are willing to take 2 – 3 extra referrals a month at no cost for the homeless community. The medical community is eager to help. Alan advised the committee that the medical community's determination of disability is less strict than HUDs. His organization still has questions about what is considered a disability. Mayor McAdams reminded the committee that a full medical expansion would cover 85 – 90% of homeless individuals. Alan agreed and stated with that coverage we can provide more robust services, such as dental services which Medicaid does not cover. Mayor McAdams

reiterated to the group that we are looking for $70M in federal funding. Salt Lake County will be providing $30M for Medicaid expansion. We may be able to free up some of those funds to help homeless populations. Jennifer Steele (VA) suggested integrating mental health into the team to make transitions more seamless. She said there is a strong correlation with people who have mental health problems seeking healthcare, a high number of which are abusing opiates. Alan advised the committee that we are working now with SAMHSA and HRSA for opioid therapy. Mayor Seghini advised the group that there are a variety of community providers who have free services, but there is a problem with transportation. Most homeless individuals don't have cars and can't afford public transportation. Would it be possible to develop a program with public transportation that would allow a person who is deemed homeless to use public transportation to access medical care? Pamela Atkinson reminded the committee that Uber and Lyft have agreed to partner with organizations to provide free services.

IV. **Report from Child & Family Stability Workgroup:** Jen Godfrey led the discussion regarding their 4 primary areas of focus:

1. Focus prevention and pre-shelter diversion efforts on the very youngest children aged birth to 6 years. This workgroup and the initiative as a whole should consider long-term, pre-shelter strategies to help stabilize these young children and their families.
2. As a prevention strategy, define improved housing security as part of a spectrum of infant and child well-being that includes improved health, education, and opportunity outcomes. Brand the initiative so that it makes these positive outcomes for the very youngest children the clear, common goal. The initiative should be used to develop and support interventions that improve these outcomes in relation to each other and, in so doing, help prevent entries into the homeless services system. Stakeholders should view an episode of homelessness for a child aged 0-6 as one indicator of very poor progress towards and/or failure to achieve these outcomes.
3. Focus housing-related crisis diversion and mediation efforts on very young parents and parents-to-be (ages 14 – 21) who are currently in crisis or who have previously experienced an episode of homelessness involving a stay in shelter. Interventions should prevent these parents from re-entering the homeless services system and increase health, education and opportunity outcomes for their children.
4. Prioritize the following interventions immediately for these very young children and very young parents:
    - Develop a coordinated intake, referral and assessment ("no wrong door") policy for children and their families that integrates homeless services with each other and with other public and private systems to include health and human services, job training and employment, legal services and the public education system.
    - Develop targeted education, job training and life-skills programs for very young parents and parents-to-be (ages 14-21) who are currently homeless, who have previously experienced homelessness and/or who are aging-out of the foster care system. Rather than establishing a separate workgroup for increasing job training

and employment generally, stakeholder efforts should first focus on developing related programs for families with children.

- In developing these and other interventions, stakeholders should not be restricted by any federal definitions of homelessness. All strategies and interventions developed should *at a minimum* support the broad definition of homelessness used by the U.S. Department of Health and Human Services (HSS): https://www.nhchc.org/faq/official-definition-homelessness/.

They want to ensure there are no barriers put into place by the definition they use. Shaleane reminded the committee that if we look at an initiative to end childhood homelessness, we would need to brand that initiative appropriately. Public services would consider ANY homelessness in very young children as a failed outcome. This includes all children ages 0 – 6, as well as their families and siblings. David Litvack asked if there is any leveraging with inter-generational poverty efforts. Jen responded that the Department of Workforce Services has endorsed this, state school systems are also onboard. We are working toward eliminating inter-generational poverty. Palmer DePaulis said that he may be able to provide help on community resources that may fit into section three.

V. **Report from Housing-Based Prevention Workgroup:** Tamera Kohler led this discussion. They are focused on pre-shelter affordable housing incentives which developers can help us achieve. The intent of this group is to define the problem, and help us explore potential financial solutions. The group has made recommendations and have identified where the gap is in them providing affordable housing services. They have identified developers who are committed to getting costs down and coming up with solutions. These developers are willing to start putting housing units into place. We are working toward getting several permanent supportive housing (PSH) communities in place. They will do a full presentation down the road. They are working with Salt Lake City's plan for affordable housing, and with the State Taskforce on their efforts. Tamera Kohler advised the committee that they have developers on both the City and State committees. There is a willingness to look at what we need to do to make affordable housing. It has been a good working group, it is an alignment of best interests. Developers are looking outside of funding that currently exists. This is still in infancy but there is a willingness to have extremely affordable units. Matt Minkevitch clarified that they are referring to dollars needed to construct housing. Shaleane responded yes, developers want to make money, so what is the funding gap for developers setting aside a certain number of units as low income? We are looking at a variety of funding methods. Matt Minkevitch asked if that also includes operating funding. Shaleane answered yes. David Litvack interjected that one of the conversations in the city is focused on mixed income developments. He wanted to clarify if the funding gap comes from the premise of mixed income units, or if they are referring to strictly affordable housing without any incentives or tax credits. Janice Kimball would like to make sure that any units built are going for the population intended, so some sort of tracking or legal documentation from property management. A committee member stated that once a property is constructed, in many cases the developer does not continue to be a

landlord or property manager. So there is another issue, it's not just developing property, but we need to have mechanisms and subsidies in place so that those low income units can be continuously occupied. Let's not forget in this conversation that it isn't simply a matter of brick- and-mortar and set asides. How can low income families afford less than 30% of income year after year? Tiffany Provost stated that we want to make sure that the property management companies don't turn properties into something unintended. Shaleane reminded the committee that affordable housing will require a huge, statewide initiative. This working group is providing a critical missing piece, and they will hand off the information provided to us to the other efforts going forward, especially at the State level. Mayor McAdams added that this is what Collective Impact does. Our goal is not to have more units here and more units there—one-off projects. We want to add ***at scale*** and move the needle ***at scale***. We've done some great things over the last year, but just that intervention will not move the needle far enough in the direction we need it to move. We need all hands on deck. We need private sector developers, better access to transportation, policies to ensure those in need are getting access to housing and more. The problem is daunting. It's going to take collaboration from the state, county, all cities. We are not gaining ground, we are just losing ground more slowly. A member of the workgroup advised the committee that developers are putting together numbers of what it would take to keep properties running on-going. It's difficult to target correct populations, but there are different strategies which can be employed. David Litvack asked if there any other cities who are involved in this working group with developers. Shaleane answered that right now we are very focused on developers, but will evolve over time to include other cities and services statewide. This is an education and fundraising tool. Mayor Seghini reminded the group that many of these developers and property managers have very few skills in regard to maintaining a property with residents that require supportive services. Sunrise Manor has people on-site daily. There needs to be case management at some of the properties. There needs to be follow up somewhere. How do we interject that case management follow up? We need to look at summer programs where school age kids who are experiencing homelessness were bussed to Boys & Girls Club, so that parents could continue to work. Those pieces need to be meshed together. Shaleane acknowledged these sentiments and advised the committee that we will be getting concrete deliverables in a couple of weeks.

VI. **Next steps and closing remarks:** Mayor McAdams advised the committee that he will be meeting with Mayor Seghini and others to prepare for the upcoming legislative session. Our next meeting will devote additional time to housing and family stability. Also the next meeting will have a presentation about a proposal to evolve the Shelter the Homeless Board. The next meeting will be held Tuesday Oct 4, not Wednesday the 5th. Will be sending out materials in advance.

Meeting ended 9:56 am.