

*August 2021*

# MEDICAL RESPITE PLAN

*For people experiencing homelessness in  
Butte County, California*

*Written by Housing Tools, on behalf of Butte County Public Health*

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## I. Executive Summary

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This Medical Respite Plan (MRP) was initiated by the Butte County Department of Public Health to inform decision making regarding the future of medical respite services for individuals experiencing homelessness within Butte County, to assist in the prioritization of resources, and to allow for the implementation of medical respite strategies and programs involving multiple stakeholders.

The Butte County Department of Public Health established a structure for the development of the MRP which included a Steering Committee to oversee the MRP development, and a Community Coalition of medical, shelter, and service providers to inform the needs assessment, sharing of quantitative and qualitative data, insight into current services and challenges, and discussion of potential models and scope of care. These groups met in a series of six meetings over the period of February through May 2021.

### **Key Findings**

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This MRP describes in detail the needs assessment and planning process that was carried out through an analysis of qualitative data, quantitative data, and a series of meetings with the MRP Steering Committee and Community Coalition, as well as stakeholder interviews. Summarized here are the key findings from this process:

**Scope of Care:** The scope of care and services provided in any initial programs should include:

- Clinical care for injuries/wounds, infectious and communicable diseases, chronic conditions, musculoskeletal conditions, and post-surgical/childbirth support.
- Support from and referral to behavioral health and drug/alcohol services, as mental health and substance use issues are frequently co-occurring conditions for those experiencing homelessness.
- Case management and care coordination to help clients overcome barriers to completing prescribed care and to connect to primary care providers for long-term support.
- A trauma-informed, low barrier approach to services. Meeting clients “where they are” and addressing how to eliminate or mitigate barriers to participation is needed in order to meet the objectives of improving the health and housing outcomes of the individuals served in medical respite care, with concurrent reductions in the utilization of both emergency and in-patient hospital care.

**Potential Models:** In discussing where initial efforts should be focused, the consensus of the Community Coalition was to consider “low hanging fruit” in terms of ease and cost of implementation, with an eye also toward effective housing models that already exist in the community. A majority of stakeholders concurred that initial efforts should be focused on utilizing existing shelters, where feasible and appropriate. During the discussion it was noted that some individuals may not feel comfortable using these shelter-based respite programs if the shelter service model has been a barrier to accessing services in the past. The other model that many found attractive is a master-lease contract housing provider, similar to the Mercy House program operated by Chico Housing Action Team (CHAT). It was also noted that residential care facilities with home health services may be a good option to further explore, as it allows the person more independence and freedom while receiving necessary support. The long-term vision was definitively noted to be freestanding respite units, located in both North and South Butte County. The freestanding model is clearly recognized by experts as the ideal model, as it provides the most appropriate environment for medical care and recuperation, along with the ability to effectively integrate other support services and control policies and procedures that best serve the needs of the guests. This model does involve a greater level of cost and planning, however, and will therefore take more time to implement.

## **Special Considerations**

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A number of special considerations that were discussed during the meetings, which should be further reviewed and discussed prior to the establishment of medical respite care programs in Butte County, are provided below.

### **Eligibility:**

Given the prevalence of behavioral health conditions which need treatment and are often co-occurring with other physical health conditions, the following questions were raised during the meetings, but not yet answered:

- How would a client’s behavioral health condition affect their eligibility to be referred to and served in the medical respite program?
- Are there certain diagnoses or thresholds of functioning that need to be considered as a program is being structured?
- What community supports and services can be made available to enable those with co-occurring behavioral conditions to engage in and benefit from medical respite services?

### **Referrals:**

During the Community Coalition meetings, it was the consensus that an ideal referral process would allow for a dual system: from hospitals to medical respite; and from shelters/service

providers/outreach organizations to medical respite. Established and agreed upon criteria must be developed so that it is clear to those making the referrals (case managers, social workers, shelter staff, etc.) what conditions are appropriate, with typical patient/guest profiles as examples. There should also be one organization or phone number that one would call for intake, which can then handle the warm handoff of the guest, i.e. someone who ensures the guest is connected to the service. The Butte-Glenn 211 system was identified as a potentially ideal way to assist with the screening, referrals, and warm handoff.

### **Realities and Limitations Due to Funding Sources and Health Care's Bureaucratic Structure:**

Local hospital and home health providers that participated in the Community Coalition meetings expressed concerns as to how the realities of the current Medi-Cal system in its dealings with home health services might impact successful implementation. Examples cited included:

- Payer limitations for home health services (assuming home health nurses are providing care): usually a lump sum of hours is authorized by the payer. All services, such as nursing, physical therapy, and a social worker, come out of a lump sum amount authorized, which can then influence the level of care provided.
- There are significant challenges finding physicians to help with follow up care once a patient has been discharged from the hospital. Often the hospitalist who treated the patient writes up orders, but then is gone for several days. Few physicians want to take on these difficult cases for the long-term. A home health nurse needs a doctor's orders to provide the care. In order to be successful, a medical respite program will need the dedicated time of a local physician to address these barriers. Without that dedicated time from at least one physician, the bureaucracy of Medi-Cal and Medicare becomes overwhelming from the perspective of a home health care or other adjacent operation.

### **Pilot Projects:**

At the final Community Coalition meeting, stakeholders discussed the need to continue the momentum of the efforts that have been started. One thought was to consider what model might work for the highest users of services and design a small project around that. As an example, residential care facilities might work well if Medi-Cal authorization can be obtained for home health nursing services, since these facilities already provide support with activities of daily living, with low barriers for entry and more independence for the guests.

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## II. Introduction and Purpose of This Plan

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The Butte County Department of Public Health applied for and received a planning grant under the County Medical Services Program (CMSP) Local Indigent Care Needs (LICN) program to fund the development of this MRP. The purpose of the CMSP LICN program is to expand the delivery of locally directed indigent care services for low-income uninsured and under-insured adults that lack access to health, behavioral health, and associated support services in CMSP counties. The principal goals of the LICN program are to promote timely delivery of necessary medical, behavioral health, and support services to locally identified target populations; link these populations to other community resources and support; and improve overall health outcomes for these target populations.

Providing medical respite care for individuals experiencing homelessness and/or who are unstably housed was identified by Butte County and its partners as a high priority and appropriate use of the CMSP LICN grant. The development of a Medical Respite Plan (MRP) was initiated to inform decision making regarding the future of medical respite services for individuals experiencing homelessness within Butte County, to assist in the prioritization of resources, and to allow for the implementation of medical respite strategies and programs involving multiple stakeholders. The development of this MRP will also prepare the County to apply for a CMSP LICN Implementation Grant as well as other appropriate funding sources, which are further described in this document.

### Objectives

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Within this framework, three overarching objectives were identified early in the planning process:

1. The planning process and ultimate project implementation should be directed toward achieving meaningful objectives in improving the health and housing outcomes of the individuals served in medical respite care, with concurrent reductions in the utilization of both emergency and in-patient hospital care.
2. The MRP should identify a range of options that allow for countywide implementation.
3. The MRP should acknowledge and provide options for an incremental approach that may be broken down into multiple phases, while pursuing models and scope of care services that fully meet the needs of the individuals being served.

## Project Approach

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In addition, the stakeholders involved in the development of the MRP agreed upon the following principles in the MRP project approach:

1. **Data-driven:** The MRP development will seek to fully understand the medical respite care needs in the community, potential costs, and available resources, in order to strategically plan for the necessary models and services.
2. **Inclusive:** The MRP development will include a wide variety of stakeholders, including hospital personnel, shelter staff, health center staff, other providers of medical respite services, and people with lived experience. All perspectives and experiences are valued and respected.
3. **Trauma-Informed:** The MRP development will recognize the importance of using a trauma-informed model, with services that are low barrier in nature and incorporating health equity as the ultimate goal within the context of medical respite care services.

The MRP authors have utilized the resources published by the National Health Care for the Homeless Council in the development of this plan, especially the documents “Medical Respite Services for Homeless People, Practical Planning” published in June 2009, and the accompanying “Medical Respite Program Development Workbook”. Their recommended process, questions and insights are integrated into this MRP. Other consulted references are noted in parentheses and italics, as applicable.

## Definitions of Key Terms used in this Medical Respite Plan

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Below are definitions of key terms that are used throughout the Medical Respite Plan. People who work in various professional fields will often use the same term to describe different things or use different terms to describe the same thing. Key terms and their definitions are provided for this document to ensure readers will have clear understanding of the author’s intent.

- **Aggregate Data:** High level data that is computed by combining individual record level data into group or summary form.
- **De-identified Data:** Data with personal details removed from the data set such as name, address, email, birth date, etc.
- **Drug and Alcohol Use:** Use of any licit (legal) or illicit (illegal) drugs or alcohol, including alcohol, opioids, stimulants, hallucinogens, cannabis, and tobacco (*Rural Health Information Hub, 2020*).
- **Health:** A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (*Constitution of the World Health Organization, 1948*).

- **Health Equity:** Everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care (*Robert Wood Johnson Foundation, 2017*).
- **Illness, Injury, or Condition:** Encompasses all acute and chronic physical and mental health diagnoses, whether they be an illness (e.g. pneumonia), an injury (e.g. laceration), or a condition (e.g. bipolar disorder).
- **LGBTQ+:** An acronym for Lesbian, Gay, Bisexual, Trans\*, Queer, questioning, and other identities. These terms are used to describe a person’s sexual orientation or gender identity. Trans\* is an inclusive term that encompasses all people whose gender identity varies or is different from the sex they were assigned at birth (*New York City’s Lesbian, Gay, Bisexual & Transgender Community Center, 2021; Stonewall Alliance Center of Chico, 2021*).
- **Low Barrier:** Services that “meet people where they are” and require fewer and less invasive steps to participate in programs. Examples of such include minimal obstacles to enter services (e.g. less required paperwork, fewer qualifications, shorter waiting list if any), minimal impediments while receiving services (e.g. program flexibility to meet individual needs, allowing companion animals, not requiring sobriety), and high threshold for removing clients from services (e.g. participation is behavior-based).
- **Mental Health:** Emotional, psychological, and social well-being that affects how people think, feel, and act. Helps to determine how people handle stress, relate to others, and make healthy choices (*Centers for Disease Control, 2018*).
- **Mental Health Condition:** Affects a person’s thinking, feeling, mood, or behavior, such as depression, anxiety, bipolar disorder, or schizophrenia. These conditions may be occasional or chronic and affect someone’s ability to relate to others and function each day (*Centers for Disease Control, 2018*).
- **North County:** Refers generally to the communities of Chico, Durham, Paradise, and Magalia, and all unincorporated areas north of Chico and Magalia, east to the border with Plumas County.
- **Nursing Care:** Provided by a registered nurse (RN) who has key responsibilities to 1. Perform physical exams and health histories before making critical decisions; 2. Provide health promotion, counseling and education; 3. Administer medications and other personalized interventions; and 4. Coordinate care, in collaboration with a wide array of health care professionals (*American Nurses Association, 2021*).



- **Permanent Housing:** Housing with no pre-determined time limit on how long someone can stay. Includes all types of housing such as multi-family (e.g. apartments, duplexes), mobile/modular, and single-family homes.
- **Permanent Supportive Housing (PSH):** Combines affordable housing (i.e. subsidized cost) and support services, with no pre-determined time limit on how long someone can stay. Residents have a regular lease where they pay rent and have the same rights and responsibilities of anyone renting housing. Housing is designed to help stabilize people with mental health conditions or disabilities who need support to thrive in their community.
- **Person Experiencing Homelessness:** An individual who lacks a fixed, regular, and adequate nighttime residence. Includes, but is not limited to, people who are couch-surfing, in cars/trucks/RVs, in motel/hotels, in temporary or transitional housing, in shelters, or living unsheltered (*Cornell Law School, n.d.; U.S. Department of Housing and Urban Development, n.d.*).
- **Person with a Disability:** A person with a disability may have a physical, hearing, visual, developmental, or mental health disability or multiple disabilities. Although “people with disabilities” may refer to a community of people, people with disabilities are a diverse population with a wide range of experiences and needs. Some prefer “identity-first” language such as “autistic person” (*Centers for Disease Control, 2020; University of New Hampshire Institute on Disability, 2021*).
- **Primary Data:** Data that is collected firsthand by researchers for a specific project. Used broadly to describe all sources that are original.
- **Qualitative Research:** Aim is to understand reality from the research participants’ perspectives. Focuses on descriptive non-numerical data such as audio, text, photographs, or video, and analysis of data usually involves identifying themes.
- **Quantitative Research:** Aim is to test relationships between things, make predictions, and generalize results to wider populations. Focuses on numerical or other measurable things, and analysis of data usually involves comparison using statistics or other mathematics.
- **Residential Care Facility:** Board and care homes, also called residential care facilities or group homes, are small private facilities, usually with 20 or fewer residents. Rooms may be private or shared. Residents receive personal care and meals and have staff available around the clock. Nursing and medical care are not usually provided on site. (*National Institute on Aging, n.d.; U.S. Department of Health and Human Services, n.d.*)
- **Secondary Data:** Data that has already been collected and is made available for researchers to use for their own projects.

- **Skilled Nursing Facility (SNF):** Provides 24-hour skilled nursing care, rehabilitative services, and other related services to residents. Residents have an individual plan of care and typically are living with a chronic illness or recovering from an illness or surgery that requires regular nursing care and other health related services that cannot be met at home or in a residential care setting (*California Department of Aging, 2021*).
- **South County:** Refers generally to the communities of Biggs, Gridley, and Oroville and all unincorporated areas south of Durham and Paradise, and east to the border with Plumas County.
- **Trauma-informed Care (TIC):** Aims to holistically understand individuals that are seeking services. When trauma occurs, it may affect an individual's sense of self, their sense of others, and their beliefs about the world. This can directly impact an individual's ability or motivation to connect with and use support services. Trauma can have significant effects on human physiology by disrupting the limbic system and diminishing function of the prefrontal cortex; this limits executive function, which interrupts the body's ability to govern when it should be in the heightened state of fight or flight. Executive function may be so diminished from trauma that basic tasks are unable to be performed. An organization using a TIC approach realizes the direct impact that trauma can have on access to services and responds by changing policies, procedures, and practices to minimize potential barriers. The organization also integrates knowledge about trauma into all aspects of services and trains staff to recognize the signs and symptoms of trauma and avoid re-traumatization (*University at Buffalo Center for Social Research, 2021*).

***The Use of Various Terms that Refer to “People”:***

A number of stakeholders from different organizations and agencies that serve those experiencing homelessness were engaged in the planning and data collection process. Due to their unique professions, each organization uses different terminology to describe the people they serve. For example:

- Hospitals, medical clinics and other healthcare organizations: “patients”
- Emergency shelters: “guests,” “clients,” or “program participants”
- Social services: “clients,” “program participants”

Where data from these sources is quoted, the terminology used by these organizations has been preserved. Wherever possible, the term “guests” is used to describe those individuals who will be utilizing the medical respite care services as this was determined to be a best practice.

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### **III. Definition of Medical Respite Care for Individuals Experiencing Homelessness or Who are Unstably Housed**

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The National Healthcare for the Homeless Council defines medical respite care as “acute and/or post-acute medical care for people experiencing homelessness who are too ill or frail to recover from a physical illness or injury on the streets, but who are not ill enough to be in a hospital.”

These programs provide short-term residential services coupled with some level of clinical medical care and access to support services. These programs:

- Close the gap between hospitals/emergency departments and shelters that do not have the capacity to provide medical and support services;
- Provide a low-cost, high-quality and innovative discharge option to aid emergency department diversion and hospital discharge options;
- Serve as an integral component of the Continuum of Care (CoC) for homeless services within the community;
- Provide participants the opportunity to access medical and supportive services needed to assist their recuperation, and possibly transition to more stable housing, including transitional and permanent housing;
- Engage participants in the process of their recuperation and discharge planning;
- Allow a flexible service delivery model that reflects unique community needs, priorities and resources; and
- Show respect for human dignity by preventing unsafe and illegal discharges to the streets or shelters.

*(Respite Care Providers’ Network, National Health Care for the Homeless Council, “Medical Respite Services for Homeless People, Practical Planning” 2009)*

It should be noted that the terms “recuperative care” and “post-acute care” are increasingly used interchangeably with “medical respite care.”

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## IV. Why Provide Medical Respite Care?

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It is well documented in numerous scientific studies that individuals experiencing homelessness have much higher rates of ill health, both physical and mental, as well as higher rates of mortality, than people living in stable housing (*Fazel S, Geddes JR, Kushel M. The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations. Lancet. 2014;384(9953):1529-1540. doi:10.1016/S0140-6736(14)61132-6*).

The condition of living unhoused means a lack of access to proper nutrition and hygiene, exposure to the elements, greater exposure to communicable diseases, inability to rest and sleep properly, and the physiological and psychological effects of stress due to fear, uncertainty, and violence. In this situation, it is nearly impossible for someone to successfully manage a chronic health condition such as diabetes or hypertension, to keep acute injuries such as wounds clean, or take medications as prescribed (*National Health Care for the Homeless Council "Homelessness and Health: What's the Connection?," February 2019*).

The reality of health care systems in the United States is that medical care is heavily influenced by pursuing cost efficiencies wherever possible. This model means compressed timelines for outpatient procedures and hospital stays, which inherently assume that patients have a home to return to for recuperation and a stable support system of friends and family to aid in their recovery rather than receiving ongoing care in the hospital. In situations where patients do not have the supports listed above, the remaining options of discharge to the streets or non-medically staffed emergency shelters are rarely viable or appropriate. In addition, many individuals experiencing homelessness have complex medical cases with co-occurring disorders that require coordinated follow-up among medical providers and case management support to navigate health care systems. Without a stable place to recuperate and without the case management support to carry out the details of doctor's instructions, patients without the resources listed above return to the hospital's emergency department for support and treatment, creating and perpetuating a cycle which does not benefit their own health outcomes or the operating capacity of hospitals.

Given the environment of modern health care described above, the documented benefits of providing Medical Respite Care can be summarized as follows:

1. **Moral and Ethical**—Medical Respite Care provides people experiencing homelessness with a safe and dignified place to rest and recuperate after illness, childbirth, surgery or other medical procedures. It is also a step toward mitigating the stigma that those experiencing homelessness often experience when interacting with many healthcare providers. It offers relief from the emotional distress and isolation that might affect

people experiencing homelessness, effects that can be compounded by being injured or ill at the same time.

2. **Improved Health and Housing Outcomes**—Participating in a Medical Respite Program has been shown to support:
  - a. Successful resolution of acute health conditions;
  - b. Stabilization of chronic health conditions;
  - c. Successful scheduling of surgery and cancer treatment;
  - d. Improved continuity of care by helping connect patients to a primary care provider and establishment of a “medical home”;
  - e. Referrals to needed specialty care;
  - f. Linkages to other health and housing services, resulting in treatment for behavioral health and drug and alcohol services, as well as improved housing status outcomes (i.e. moving from unsheltered to housed); and
  - g. Preventing the spread of communicable diseases in emergency shelters and in the community.
3. **Reduces Hospital Utilization**—Medical Respite Care directly addresses the inefficient and often ineffective cycle of care that unhoused individuals and hospitals find themselves in:
  - a. Diversion from the emergency department—by providing a place to recover from illness or injury and connecting people to primary care, it decreases the need to seek health care in emergency settings;
  - b. Reduced hospital admissions—mitigates some of the need for admission to the hospital by providing care for conditions that can be addressed in an “outpatient” setting with a place to rest and receive nursing services;
  - c. Decreased hospital length of stay—when hospital stays are required, and there are no safe and adequate places to discharge an unhoused patient, hospitals often have no choice but to retain the patient for longer periods of time than necessary. Having the option to discharge someone to medical respite program mitigates this dilemma.

For further reading, The National Institute for Medical Respite Care, an initiative of the National Health Care for the Homeless Council, released a summary of evidence regarding the positive impacts of medical respite care in March 2021, which can be downloaded at this link:

[https://nimrc.org/wp-content/uploads/2021/03/NIMRC\\_Medical-Respite-Literature-Review.pdf](https://nimrc.org/wp-content/uploads/2021/03/NIMRC_Medical-Respite-Literature-Review.pdf)

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## V. Process for Development of the MRP

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The Butte County Department of Public Health established a structure for the development of the MRP which included:

- A **Steering Committee** to oversee the development of the MRP in consultation with the County's selected consultant/MRP authors, consisting of:
  - County staff from the Departments of Public Health, and Employment and Social Services (Housing and Homeless Branch);
  - Professors/advisors from the CSU, Chico Department of Public Health and Health Services Administration; and
  - Representatives from two homeless services providers, one from Chico and one from Oroville;
- A broad-based **Community Coalition** of medical, shelter, and service providers from throughout Butte County to participate in the needs assessment, sharing of qualitative and quantitative data, insight into current services and challenges, and discussions of potential models and scope of care.

Meetings with the Steering Committee and Community Coalition were carried out from February through May 2021. Due to the COVID-19 pandemic, meetings were held online using the Zoom meeting platform. The meeting agendas are summarized below:

- **Steering Committee, February 25, 2021:** project timeline, size and make up of Community Coalition, data collection process, project goals, and objectives.
- **Steering Committee, March 29, 2021:** data collection survey, Community Coalition contact list and meeting agendas, CMSP Implementation Grant, and future RFP process to select Medical Respite Care partners.
- **Community Coalition, March 18, 2021:** introduction to MRP process, project approach, planning process and schedule, current efforts, funding secured to date, data collection process, brainstorming of medical respite care needs and gaps, and future meeting dates.
- **Community Coalition, April 22, 2021:** presentation by National Health Foundation Recuperative Care (Los Angeles and Ventura Counties), overview of medical respite models, and data survey results.
- **Community Coalition, May 6, 2021:** presentation by Yuba County Health & Human Services and Adventist Health, preliminary needs assessment findings, scope of care, potential models, and timeline for drafting the MRP and opportunity to comment.

- **Community Coalition, May 18, 2021:** wrap up of needs assessment discussion, scope of care and models, costs and funding sources, process to identify and select medical respite care partners, and MRP organization.

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## **VI. Recent Community Efforts to Address the Medical Needs of People Experiencing Homelessness**

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During the past 18 months, community shelter, housing and medical care providers across Butte County have collaborated to provide more services for people who are experiencing homelessness and are in need of medical respite and care. The programs noted below do not meet the definition of medical respite care, but have provided needed health and housing support services, thereby furthering the community's efforts and conversations around these needs.

### ***Safe Space: Casey's Place (operated for several months during late 2020-early 2021)***

Casey's Place was a program of Safe Space, a low barrier winter shelter. Casey's Place took limited numbers of people referred by Butte County's hospitals who were living unhoused while getting medical treatment. It was hosted on a rotation at First Baptist Church, Trinity Methodist Church, and First Christian Church in Chico. Referred patients could spend the night from 5:30 p.m. until 8:30 a.m. the next morning, with meals provided by the local popup Hunger Trolley. Case management was provided by Safe Space staff and Medspire Health Mobile Clinic, with limited medical support by visiting clinicians. Just over 20 people were admitted each night, with more referrals than available beds. One of the biggest challenges encountered was transportation for the guests as the site moved to different churches. Guests were provided with bus passes and one guest with a car gave others rides. The guests were provided cell phones to stay in touch with the staff. Staff indicated that many of the guests were elderly and had been camping in Bidwell Park. In terms of medical conditions encountered, many were living with congestive heart failure, diabetes, HIV, lung disease and cancer, which are worsened by living unhoused. (*Chico ER Article, March 2, 2021*).

### ***Chico Housing Action Team (CHAT): Mercy House***

Mercy House is a program of CHAT and local faith leaders which provides permanent housing for medically fragile individuals who were living unhoused. The house is being rented to CHAT by the mother of the Faith Lutheran minister, who has been an active supporter of CHAT's work. Members of the Faith Lutheran congregation, along with Chico synagogue Congregation Beth Israel, provide support to residents at Mercy House. The house is now occupied by four women who were previously living on the street and are stabilizing their health through safety, improved nutrition, and companionship. One resident, who was previously subsisting only on fast food is now preparing meals with her fellow residents and enjoying eating fresh fruits and vegetables (*CHAT Newsletter, Spring 2021*).



### ***Ampla Health: Mobile Medical Unit***

The Mobile Medical Unit (MMU) is a program of Ampla Health. The MMU is a fully-equipped mobile unit that is staffed by Certified Medical Assistants, an Licensed Vocational Nurse (LVN), and a Nurse Practitioner. At the time of this data collection, the MMU has operated for approximately six months, accounting for various stoppages and delays. They served over 300 people in those six months, with a downward trend in patients over time. Areas served are congregate settings across Butte County including Concow, Oroville, and Chico. Approximately 50% of the people they served were unhoused at the time of service. Diagnostic trends in the data show that the majority of visits (507) were for preventative care. The remaining visits were categorized as visits for headache symptoms (91), visits for mental health or addiction related care (89), visits for musculoskeletal conditions (71), visits for a skin condition or dermatitis (47), visits for chronic obstructive pulmonary disease (COPD), asthma or other lung conditions (41), visits for diabetes care (39), visits for hypertension or cardiac conditions (37), visits for HIV and/or Hepatitis (A, B, C) (26), visits for COVID-19 infections (23), visits for stomach GERD or reflux conditions (18), visits for urinary or kidney conditions (15), visits for injuries or broken bones (6), and visits for toxins or burns (2) (*6 Month Report from Ampla Health for Butte County Department of Public Health*).

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## VII. Needs Assessment Findings

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### ***Background***

The Butte County Department of Public Health and the MRP authors conducted a thorough needs assessment to identify the magnitude and complexity of the community’s need for a medical respite program and related services. The needs assessment consists of primary, secondary, quantitative, and qualitative data that has been incorporated into the Medical Respite Plan (MRP).

### **Qualitative Data**

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This section describes the methods, data results, and key findings from primary qualitative data. These data focus on medical respite needs for people experiencing homelessness from the perspective of service providers who work with this population.

### ***Qualitative Methods***

Butte County Public Health and Housing Tools staff developed and conducted a survey to help identify potential quantitative data and interviewees. Staff used SurveyMonkey which is an online survey development cloud-based software tool. The survey, “Medical Respite Plan Data Collection Survey” (see Appendix A) invited Community Coalition members to list both what quantitative data they could share with the County (discussed in the Quantitative Data section below) and identify if they would like to be interviewed. The County and Housing Tools then set up phone and Zoom interviews with interested parties. Additional interviewees were identified through subsequent interviews and Community Coalition meetings.

The County and Housing Tools developed a semi-structured interview tool to ensure consistency across interviews (see Appendix B). The tool included an introduction script and questions for service providers. A semi-structured format was chosen to allow for interviewers to ask follow-up questions, change the question order, and be flexible with the flow of the conversation to collect rich data. Interviews were not recorded. Interviewers took extensive notes, directly quoting interviewees when possible. A table detailing a summary of the interviews is provided below in Table 1.

**Table 1: Summary of Qualitative Interviews**

<b>Number of total interviews</b>	4
<b>Number of total interviewees</b>	6 (two interviews consisted of two interviewees)
<b>Number of organizations represented</b>	5
<b>Average length of interviews</b>	20 to 60 minutes
<b>Type of interview</b>	2 over the phone 2 over Zoom
<b>Sectors represented</b>	Medical services (1) Local government (1) Non-profit (3)
<b>Job types represented</b>	Direct service: case manager (2) Mid-management: program facilitator/manager (2) Upper management: assistant director/director (2)
<b>Number of interviews conducted by each entity</b>	Butte County (1) Housing Tools (3)
<b>Dates of interviews</b>	April-May 2021

In addition to the four formal semi-structured interviews, Butte County and Housing Tools collected two additional sources of qualitative data that are included in this section: an informal interview with a medical services provider, and correspondence with a non-profit agency’s direct services team. Housing Tools also utilized data obtained through focus groups and surveys of those with lived experience during the 2018 update to the Butte Countywide Plan to End Homelessness. These sources help to address a gap in available qualitative data identified by the County and Housing Tools during the needs assessment analysis.

**Qualitative Results**

The themes identified through reviewing and coding the qualitative data can be organized into six categories: 1. Illnesses, injuries, or conditions; 2. Unmet needs; 3. Disasters; 4. Service model; 5. Staff support; and 6. Program design. The sections below describe each category in more detail.

**1. Illnesses, Injuries, or Conditions**

Interviewees were asked about the types of illnesses, injuries, or conditions and health needs their clients experiencing homelessness live with as well as instances of readmission to a hospital’s emergency department (ED). There were a wide range of responses that the researchers grouped together by type. The types include activities of daily living (ADLs), blood pressure, cancer, communicable diseases, chronic conditions, diabetes, drug and alcohol use/withdrawal, gastrointestinal, mental health, nutritional deficits, oral health, physical disabilities, seizures, and wound/skin care. Table 2 lists the grouping types with descriptions and examples in alphabetical order.

**Table 2: Illnesses, Injuries, or Conditions from Qualitative Data**

<b>Illness, Injury, or Condition Type</b>	<b>Descriptions/Examples from Interviews</b>
<b>Activities of daily living (ADLs)</b>	<i>Older adults; colostomy bags; mobility; mental health related</i>
<b>Blood pressure</b>	<i>Blood pressure issues</i>
<b>Cancer</b>	<i>Prostate cancer, concern of metastasizing</i>
<b>Communicable diseases</b>	<i>Hepatitis A; Hepatitis C; HIV; sexually transmitted infections (STIs); tuberculosis</i>
<b>Chronic conditions</b>	<i>Dementia; dialysis; lung nodules; respiratory failure; rheumatoid arthritis; underlying medical conditions</i>
<b>Diabetes</b>	<i>Uncontrolled diabetes; diabetes management; “How to manage diabetes when cooking off a camp stove?”</i>
<b>Drug and alcohol use/withdrawal</b>	<i>Intravenous (IV) drug use; venous issues; breakdown of veins; tripping and falling while actively using; self-medication for mental health conditions; withdrawal complications such as tremors, nausea, vomiting, diarrhea, and flulike symptoms</i>
<b>Gastrointestinal</b>	<i>Hyperemesis and cyclical vomiting from chronic cannabis use; gastric bypass recovery issues; irritable bowel syndrome; constipation</i>
<b>Mental health</b>	<i>Bipolar disorder; lithium injections; psychosis; post-traumatic stress disorder (PTSD); schizophrenia</i>
<b>Nutritional deficits</b>	<i>Nutrition is challenging when living unsheltered</i>
<b>Oral health</b>	<i>Abscesses; cavities; loss/degradation of teeth; other oral health issues</i>
<b>Physical disabilities</b>	<i>Mobility; cane; wheelchair ramps and lifts; walker; bathroom equipment; medical mattress for neck and leg pain after serious injury</i>
<b>Seizures</b>	<i>Seizure disorders</i>
<b>Wound/skin care</b>	<i>Overall poor hygiene; skin picking; skin rashes; untreated wounds; wound botulism; burns due to Camp Fire</i>

## **2. Unmet Needs**

Interviewees were asked about any health and shelter services currently missing in Butte County that would be helpful to their clients experiencing homelessness. The responses from this question and other portions of the interviews can be described more generally as “unmet needs.” In sum, unmet needs center on low barrier, trauma-informed service models, coordination across the County and between providers, and lack of/access to specific resources and services.

- **Low barrier, trauma-informed service models:** Needs identified include greater service provider flexibility to meet needs of the population, using a continuum approach and comprehensive framework based on clients' level of need instead of "all or nothing" approach, options for abstinence and intermittent drug/alcohol use, allowing pets, reducing barriers to access services, greater client privacy, and addressing fear, stigma, distrust, trauma, or judgment from previous experiences with care or services.
- **Coordination throughout Butte County and between providers:** There can be delays in appointments and treatments due to a lack of providers, referrals out of the area, limited access to transportation, and clients not being able to attend appointments due to transportation or mental health conditions. One provider commented that insurance and referrals are both "mazes." Another provider noted a need to incorporate South County into the system of care and move away from being a Chico-centered service model.
- **Lack of/access to resources and services:** Multiple service providers noted a trend of people struggling to find a place to be released to from the hospital. One provider noted a significant gap in services between those who would be appropriate for discharge to a skilled nursing facility (SNF) with a higher level of care and those who would be appropriate for more basic respite care with a lower level of care. Many providers noted a need for more transitional and permanent housing options, with one reflecting on how large the gap is between homeless shelters and permanent housing using a Housing Choice Voucher, stating that helping a client move into a permanent housing unit is "an act of Congress on its own." Other unmet resources and services include access to medications, access to phones and internet, COVID-19 testing onsite, drug and alcohol support services, medical appointment transportation, storing personal property and medications, and help with addressing barriers to permanent housing such as low credit scores, debt, and eviction histories.

### 3. Disasters

Interviews were conducted in April and May of 2021, about two and a half years after the 2018 Camp Fire in eastern Butte County that destroyed Concow, the Town of Paradise, and parts of Butte Creek Canyon, Magalia, and Yankee Hill. Interviews illustrate the continued effect of the Camp Fire on Butte County as whole, as well as its residents and service providers.

One provider noted that disaster survivors who are experiencing homelessness are likely to have suffered significant trauma and loss, and may distrust services. Another similarly reflected that survivors commonly experience mental health conditions such as post-traumatic stress disorder (PTSD) and feel abandoned by the government and service providers due to a lack of resources and support. Survivors also may experience isolation and loss of community connections. Providers noted that disaster survivors may be living unsheltered in encampments, campgrounds, cars, or trailers or living temporarily in Federal Emergency Management Agency (FEMA) provided housing. Some survivors who have relocated want to

move back to The Ridge (Magalia, Paradise) to reconnect with family, friends, services, and community. Providers commented that a lack of housing, especially affordable housing, is a barrier to people returning to The Ridge. Multiple providers highlighted that The Ridge has a large proportion of older adults. A provider also commented that many community-based organizations have been taxed and stressed due to the Camp Fire and COVID-19 and are at or over their level of capacity for providing services.

#### **4. Service Model**

Service provider interviewees emphasized the need for a health equity and trauma-informed model. One provider noted that Butte County residents as a whole experience high rates of Adverse Childhood Experiences (ACEs) and drug and alcohol use. Another provider noted that the medical respite service model will need to address co-occurring illnesses, injuries, or conditions, such as drug and alcohol use and mental health conditions. They suggested a need for flexible and individualized service plans for clients based on their unique backgrounds and situations. Multiple providers commented that people experiencing homelessness may feel overwhelmed, may not have the tools to access resources, and face barriers to completing prescribed care for illnesses, injuries, or conditions.

Congregate shelters may be challenging for people experiencing homelessness and living with PTSD or other mental health conditions. People that are unsheltered are often accustomed to more open space and distance from others than what they experience in congregate shelters. Multiple providers commented that people experiencing unsheltered homelessness may experience anxiety or other challenges such as feeling constrained when transitioning to a temporary shelter environment, and that a trauma-informed approach is needed. One provider noted a need for new, different service model options as there are clients who have tried existing service models and do not feel like those models are a good fit for them. Multiple providers commented that congregate shelters may not be viable options for those with chronic conditions or compromised immune systems, as well as during future pandemics or disease outbreaks. One provider noted that clients with compromised immune systems may not be able to stay in a congregate shelter while waiting for an individual room. This points to a need for a health equity approach to services.

#### **5. Staff Support**

One provider noted that a trauma-informed approach is key to providing support for frontline staff and medical providers. In order to provide quality services, staff need intentional support that is built into the organization's day-to-day work and not solely offered outside of work like an Employee Assistance Program (EAP). Another provider commented that there are layers of bureaucracy and "hoops" between the client they are serving and the help that client needs. This has impacted the provider who reflected that they feel jaded. Another provider gives insight that for clients with a high level of need or trauma, case managers will make and attend appointments with clients. Findings from the Disaster section are also relevant here, in

particular that community-based organizations are taxed and stressed due to the Camp Fire and COVID-19 and are at or over their level of capacity for providing services. These findings point to a theme of providers experiencing burnout and secondary trauma and needing resources and support.

## 6. Program Design

Interviewees were asked about reasons why their clients would or would not use a program that offers a short-term place to stay and health care to recover from an illness, injury, or condition for up to 90 days. They were also asked about any concerns they would have, what would make the program a good fit for their clients, and what would not. The responses from these questions and other portions of the interviews can be described more generally as “program design.” In sum, themes of program design center on the administrator/service provider, culture, and eligibility and services.

- **Administrator/Service Provider:** One service provider noted how the program administrator’s organizational culture, philosophy, and tone is key to the success of the program. They also suggested implementing checks and balances on the program and the program administrator to continuously evaluate how the program fits in with the Continuum of Care and addresses community needs. Collaboration with health and social service providers, and clear referral criteria, can help maximize the program’s potential.
- **Culture:** One service provider commented that the quality of the overall culture of the program would determine whether it would be a good fit for their clients. A good fit for their clients would include a stable and supportive “home-like” community environment, with private accommodations, place to store and prepare healthy foods, building friendships and trust with staff and other clients, access to case management and flexibility in treatment, and being given options or participating in decisions. The provider notes the following client concerns when entering services: hierarchical, punitive structures in which clients are afraid of being denied or punished, a general mistrust of service systems and “anyone with a badge,” and being talked down to or criticized (e.g. “they talk to me like I’m stupid”).
- **Eligibility and Services:** One provider noted a need for creating a place to connect with services, rest, and heal that fills the gap between shelter and permanent housing models. Another commented that clients may experience barriers to eligibility requirements that involve paperwork, as rural areas tend to have higher rates of “handshake agreements” for temporary or short-term living arrangements. Multiple providers commented that if the program has enforceable time limits, but clients have no permanent housing options to move on to after their time is up, they may have a setback in their illness, injury, or condition recovery and re-enter the program. Related to this is helping clients navigate the Emotional Support Animal process if they qualify, for removing barriers to housing options. One provider suggested having health advocates

for clients that can help them communicate with providers and track and attend appointments. Providers also noted accounting for COVID-19 and future pandemics, disasters, or wildfires, such as air filtration systems, private rooms, space to physically distance, and providing COVID-19 testing onsite.

### ***Qualitative Data Key Findings***

Listed below is a summary of key findings from the qualitative data, organized by the six categories.

1. **Illnesses, Injuries, or Conditions:** Includes difficulties performing activities of daily living (ADLs), blood pressure, cancer, communicable diseases, chronic conditions, diabetes, drug and alcohol use/withdrawal, gastrointestinal, mental health, nutritional deficits, oral health, physical disabilities, seizures, and wound/skin care.
2. **Unmet Needs:** Foundational concepts found throughout the interviews are low barrier and trauma-informed service models, coordination throughout the County and between providers, and issues of access to specific resources and services.
3. **Disasters:** The effects of the Camp Fire continue to impact Butte County as a whole including both its residents and service providers. Camp Fire survivors experience barriers and vulnerabilities when accessing healthcare, housing, and services. Many service providers are at or over their level of capacity for providing services due to the Camp Fire and COVID-19.
4. **Service Model:** Overall, the data points to low barrier, holistic, and trauma-informed services carried out through a health equity lens. Specific approaches include non-congregate shelter options and destigmatizing co-occurring illnesses, injuries, or conditions, such as drug and alcohol use and mental health.
5. **Staff Support:** A trauma-informed approach is key for intentional creation of resources/support for frontline staff and medical providers who experience burnout and secondary trauma in their day-to-day work.
6. **Program Design:** Centers on the administrator/service provider, culture, and eligibility and services. Findings include intentional collaboration, continuous program evaluation and improvement, and flexibility in services.

### ***People with Lived Experience***

It was acknowledged early in the planning process that obtaining the input of individuals with a lived experience of homelessness would be vital. However, due to a number of community factors happening at the time of this process, Butte County and the MRP authors were unable



to receive that input. However, in 2018, the Butte Countywide Homeless Continuum of Care updated its Plan to End Homelessness to address both medical and behavioral health care needs, which was a planning process that was also facilitated by the MRP authors. That effort included focus groups and a survey with individuals experiencing homelessness, specifically on the topic of health needs. Key findings from that input are summarized here:

- There is a consistent problem with a doctor or nurse being able to reach people when they are homeless, to remind them about an appointment or follow up on tests and medication. Establishing and maintaining a relationship with a primary care physician is nearly impossible without case management assistance.
- Having a place to rest and recuperate allows someone with a medical condition to get better and stabilize. Without a safe and stable recuperative place, people are at a very high risk of becoming cyclically dependent upon the services of the hospital emergency room to address health issues.
- Medication storage is essential, especially for medications that need refrigeration. This is impossible when someone is unsheltered and there is no place to have your medication safely stored and administered.
- Preventing health crises would be enhanced by having a case manager or peer support to help with follow up on medications and appointments.
- It is hard to take care of wounds, incisions, or skin conditions when people are living unsheltered. The lack of access to basic hygiene services makes this impossible.

This input from those with lived experience points directly to the outstanding need for medical respite care programs and how such programs could positively impact their lives.

## Quantitative Data

This section describes the methods, data results, and key findings from 11 quantitative datasets. These data focus on medical needs for people experiencing homelessness and their demographics as gleaned from de-identified data sets, in addition to aggregate data.

### Quantitative Methods

Butte County and Housing Tools staff developed and conducted a survey to help identify stakeholders that could share quantitative data with the County. See Appendix A for the “Medical Respite Plan Data Collection Survey”.

### Quantitative Results

In order to identify the greatest needs of those experiencing homelessness in Butte County and in need of medical respite, data trends were determined and consolidated into Table 3 below. Each column identifies specific illness, injuries, or conditions and each row is the data source. An “X” indicates that the specific illness, injury, or condition was found in each dataset. The columns highlighted yellow in the table indicate the greatest healthcare needs identified through this data review.

	Injuries/Wounds	IV medication	Physical disabilities	Surgery	Infectious/Communicable disease	Chronic conditions	Cancer and other long-term illness	Palliative care	Drug and/or alcohol use	Behavioral health conditions	Musculoskeletal conditions
1. Adventist Health Feather River Health Center	X		X		X	X	X		X	X	X
2. CES Demographics			X							X	
3. CES VI-SPDAT			X	X	X	X			X	X	
4. CES Project Roomkey					X						
5. Enloe FY 2Q 2020	X	X				X			X	X	X
6. Enloe FY 2018	X	X				X			X		X
7. Enloe “Medical Respite”	X	X	X			X			X	X	X
8. Butte County Public Health Communicable Disease					X						
9. Ampla MMU initial 6 months	X				X	X			X	X	X
10. Butte County Public Health LGBTQ+ Survey											
11. Camp Fire Collaborative Disaster Case Management											

## **Quantitative Data Details**

### **1. Source: Adventist Health Feather River Health Center (AHRHC)**

**Timeframe:** 2019-2021

**Findings:** AHRHC staff identified 30 individuals as experiencing homelessness who live across Butte County. They were identified as male (14) and female (16), all English speaking and white, average age of 37 with a range of people from age 32 to 81 (30 over the age of 60—63% of all included). A total 24 of the 30 (80%) are Camp Fire survivors and all live with multiple chronic health conditions or illnesses, and 11 of those have acute health concerns on top of what has already been identified. Of the 30 people included, 21 are sheltered and the remaining individuals are living unsheltered (5) or in a vehicle (4). Emergency department (ED) admissions were low, with only 4 admitted to the hospital through the ED or otherwise, 5 had gone to the ED but were not admitted, and the remaining 19 individuals were engaged through clinic services.

**Trends in medical conditions are as follows:** 19 individuals live with mental illness or conditions, 10 have current drug or alcohol use, 8 deal with pain, 7 with musculoskeletal conditions, 6 have hypertension, 4 people are living with diabetes, 4 people use wheelchairs, and 2 people are living with dental abscesses.

**Needs identified:** Support for people who use wheelchairs, incontinence, catheter support, ability to serve people who are obese, Alzheimer's care, multiple sclerosis and rheumatoid arthritis care, lupus care, respiratory therapy, cancer care, oxygen, nebulizer, continuous positive airway pressure (CPAP), incontinence care, and wound care.

### **2. Butte County Department of Employment and Social Services (DESS) Coordinated Entry Demographics Data**

**Timeframe:** Data pulled in April 2021

**Findings:** DESS staff pulled data from the Butte County Coordinated Entry System (CES) and the demographics of the 2,026 individuals are represented in these data. Individuals included are from across Butte County and identified themselves as predominantly female (58%), with male (42%), and Trans or Gender Non-Conforming (<1% or 6 people—likely undercount as Trans people may have answered with either their assigned sex at birth or their current gender identity). Average age of the population is 45 with an age range of 17 years old to 87 and the majority of the population (63%) being between the ages 30 to 59 years old. The racial and ethnic makeup of the group loosely follows general trends for the area with an over-representation of people of color— a trend also noted statewide. An estimated 79% of individuals were identified as

White, 13% were identified (ethnically) as Hispanic or Latino, 7% were identified as Black or African American, 5% were identified as two or more races, 4% were identified as Native American or Alaskan Native, 1% were identified as Native Hawaiian or Other Pacific Islander, and 1% were identified as Asian. Veterans represented 5% (97 individuals) of the total population.

**Trends in medical conditions are as follows:** A staggering 61% of individuals (1,242 people) were identified as living with a disabling condition— far higher than rates found in Butte County or California as a whole.

**Needs identified:** Ability to work with a wide range of people, especially seniors. Ability to serve Trans, Gender Non-Conforming, and other people who identify as LGBTQ+, ability to work with communities of color and non-English speaking individuals, ability to work with veterans, ability to work with varied disabling conditions.

### 3. Butte County Coordinated Entry System (HMIS) Data

**Timeframe:** Data pulled in April 2021

**Findings:** DESS staff pulled VI-SPDAT data from the Butte County Coordinated Entry System for families, single adults, and transition age youth who were surveyed using this tool, yielding 229 individual responses.

**Medical Related Trends** reported by individuals or anyone in their family in the past 6 months:

- 61% used a crisis service (defined as sexual assault crisis, mental health crisis, family/intimate violence, distress centers and suicide prevention hotlines),
- 59% are currently homeless in any way caused by a relationship that broke down, an unhealthy or abusive relationship, or because other family or friends caused their family to become evicted,
- 57% ever do things that may be considered to be risky (defined as sex work, unprotected sex, unsafe injection drug use, etc.)
- 50% have any mental health or brain conditions that would make it hard for their family to live independently because help would be needed,
- 44% received services from the emergency department,
- 29% have been attacked or beaten up since becoming homeless,
- 28% threatened to or tried to harm themselves or anyone else in the last year,
- 25% report a mental health issue or concern,
- 22% have any chronic health issue with their liver, kidneys, stomach, lungs or heart,
- 22% avoid getting medical help when not feeling well,
- 16% are interested in space available in a program that specifically assists people that live with HIV or AIDS,

- 15% report their current period of homelessness has been caused by an experience of emotional, physical, psychological, sexual, or other type of abuse, or by any other trauma they or anyone in their family has experienced,
- 14% have been hospitalized as an inpatient,
- 10% have any physical disabilities that would limit the type of housing they could access, or would make it hard to live independently because they would need help,
- 10% have a permanent physical disability that limits their mobility (e.g. uses a wheelchair, has an amputation, is unable to climb stairs),
- 7% report drinking or drug use leading their family being kicked out of an apartment or program where they were staying in the past,
- 4% report drinking or drug use make it difficult for their family to stay housed or afford their housing,
- 4% report a learning disability, developmental disability, or other related disability,
- 4% children in the family who have experienced abuse or trauma in the last 180 days,
- 9 currently pregnant people,
- Insurance status reported: 42% Medicaid, 7% Medicare, 1% VA Medical, 1% Private Insurance, 1% No Insurance

**Needs Identified:** Ability and resources to work with people who have a permanent physical disability, support for people who are pregnant and post birth care, support for children or adults who have experienced abuse or trauma, including emotional, physical, psychological, sexual and other types of abuse, ability to work with people who drink alcohol and/or use drugs, ability and resources to work with people who have a mental health issue or concern, ability and resources to work with people who are living with HIV or AIDS, ability to support individuals who need help with independent living skills, ability to support people with developmental disabilities, ability to work with people who are distrusting of the medical system.

#### 4. Butte County Coordinated Entry System (HMIS) for COVID-19 Screening for Project Roomkey

**Time Period:** 4-3-2020 to 2-13-2021

**Findings:** Most people with COVID-19 identified on one day was five people on 1-25-2021.

**Needs identified:** Ability and resources to work with people impacted by an active COVID-19 exposure or infection. Ability to work with people with co-occurring disorders.

## 5. Enloe Medical Center

**Timeframe:** FY 2Q 2020 (October 2020-December 2020)

**Findings:** Enloe staff shared diagnostic data for 135 individuals experiencing homelessness who received care through their emergency department (90) or inpatient (45) services during that visit and had one of the five most commonly reported diagnoses during that time period. Total number of visits made to Enloe Hospital by people experiencing homelessness during this quarter was 447 individual visits with 267 being unique individuals, and with 28 individuals receiving medical care on more than 3 visits within the 3 month window.

### **Medical Related Trends:**

- 46 (34%) individuals were given a primary diagnosis of hyperglycemia and secondary diagnosis of chest pain and DKA and saw either only the emergency department (ED) (16) or were inpatient (30).
- 24 (18%) individuals were given the primary diagnosis of cellulitis and multiple wound infections with a secondary diagnosis of meth abuse, head injury and medical clearance, and all were seen in the ED.
- 8 individuals were given the primary diagnosis of chronic obstructive pulmonary disease (COPD) with a secondary diagnosis of acute hypoxemia with RVR and meth abuse with all individuals needing inpatient stays.
- 7 individuals had the primary diagnosis of keratoacanthoma of hand with the secondary diagnosis of homeless and alcoholic intoxication and seen either only in the ED (4) or inpatient (3).
- 5 individuals had the primary diagnosis of cellulitis and secondary diagnosis of meth and medical clearance and all cases were only seen in the ED but one needed inpatient care.
- 27% of cases reviewed had meth mentioned in either the primary or secondary diagnosis with indications of injection drug use being prevalent as wound infections and cellulitis diagnosis are also included.

**Needs Identified:** Ability to work with people who drink alcohol and/or use drugs and their associated illnesses and conditions, including wound care and people who use meth or other stimulants, ability to work with people who are distrusting of the medical system.

## 6. Enloe Medical Center

**Timeframe:** January through October 2020

**Findings:** Butte County received aggregate data from Enloe Hospital regarding persons experiencing homelessness (PEH) for 2020; due to the unique circumstances of this

year, the monthly mean of the figures received was used to form a kind of rough, baseline model to compare Enloe's quarterly data moving forward to in order to attempt a measure of impact for the MMU. Orchard Hospital sent similar data as well; their PEH patient population is relatively low, and their current data is not central to the project, but helpful for future planning.

**Medical Related Trends:** The model shows the following:

- Enloe is averaging 340 monthly visits from PEH.
- The monthly averaging for unique patients EH is 142.
- There have been 47 people that have a demonstrated pattern of high recidivism, averaging a visit more than once every 30 days throughout 2020.
- The highest volume consumer at Enloe Hospital has visited 61 times during 2020, an average of more than 6 times per month.

**Needs Identified:** Ability to work with people who have ongoing and unresolved medical care issues.

## 7. Enloe Medical Center "Medical Respite"

**Timeframe:** FY 2018—Data pulled in relation to potential Jesus Center Respite Program target populations.

**Findings:** Reviewed fiscal year 2018 discharges of 63 homeless patients with length of stay >5 days. Of those 63 patients, 10 were excluded due to death or going to jail.

**Medical related trends:** Some of the various diagnoses included cellulitis, sepsis, osteomyelitis, diabetes, chest pain, urinary tract infection (UTI), COPD, pneumonia (PNA), abscess, cardiomyopathy, mandible fracture, and foot ulcer.

- 23 of 63 (36%) patients "seemed appropriate for medical respite." 30 of 63 (48%) patients were not suitable for medical respite.
  - Respite needs identified: Wound care/VACs, IV abscess, daily dressing changes, cellulitis treatment, case management, home health physical and occupational therapy.
  - "Potential risk to placement" was used to opt people out of the model: IV drug use, alcohol, meth, MRSA, people who use wheelchairs

**Needs Identified:** Ability to work with people who are criminalized and discharged into the care of law enforcement, ability to work with a variety of illnesses, wound care and drug and alcohol use.

## 8. Butte County Public Health Communicable Disease Data

**Timeframe:** 2020

**Findings:** Dr. Linda Lewis, Epidemiologist, was able to state that Butte County had 5 active TB cases in 2020 and 1 case was a person experiencing homelessness. She did not provide numbers but did state that Public Health's conditions they were most concerned about regarding the population experiencing homelessness are TB, Hepatitis A, wound botulism, and various STIs at this time.

**Needs Identified:** Ability to work with someone who has an active TB infection, ability to work with BCPH nurses for medical case management and directly observed therapy (DOT), ability to quarantine people with actively transmissible infections.

## 9. Ampla Mobile Medical Unit (MMU)

**Timeframe:** First six months of MMU operation, Starting April 2020

**Findings:** The MMU has operated for approximately six months, accounting for various stoppages and delays. While the technical figure of over 300 served in those six months tells one story, there is a downward trend in patients. Areas served were congregate settings across the County and included Concow, Oroville, and Chico. The population served is overwhelmingly White, with 234 of the 280 people included in the data collection represented below with other groups being less engaged as follows: 21 people identified as Black or African American, 8 people identified as American Indian or Alaska Native, 3 people identified as Asian, 3 people identified as more than one race, and 1 person identified as Native Hawaiian or Pacific Islander. Of the 280 people identified in this data set, it is important to note that 142 of those individuals were housed.

### Medical Related Trends:

- Insurance trends:
  - 66% Managed Medi-Cal
  - 19% Medicare
  - 6% Private insurance
  - 9% Service provider write off
- 22 individuals vaccinated against the flu
- 57 individuals received COVID-19 testing
- Diagnostic trends:
  - 507 visits for preventative care
  - 91 visits for headache symptoms
  - 89 visits for mental health or addiction related care
  - 71 visits for musculoskeletal conditions



- 47 visits for a skin condition or dermatitis
- 41 visits for COPD, asthma, or other lung conditions
- 39 visits for diabetes care
- 37 visits for hypertension or cardiac conditions
- 26 visits for HIV and/or Hepatitis (A, B, C)
- 23 visits for COVID-19 infections
- 18 visits for stomach GERD or reflux conditions
- 15 visits for urinary or kidney conditions
- 6 visits for injuries or broken bones
- 2 visits for toxins or burns

**Needs Identified:** Ability to work with people of all insurance backgrounds, ability to engage and work with communities of color, ability to work with a wide array of health conditions and acuity, ability to plan for seasonal flu.

## 10. Butte County Public Health LGBTQ+ Health Survey

**Timeframe:** Summer 2018 (of note—Pre-Camp Fire)

**Findings:** Safety and discrimination are ongoing themes in relation to housing for people who identify themselves as LGBTQ+. Respondents are persons 16 and older who have lived in Butte County for the past 6 months and self-identify as LGBTQ+. Approximately 149 individuals responded to the survey and the housing related data was pulled for this analysis.

- 18% (27 people) of respondents indicated, yes, definitely or yes, maybe have been discriminated against because of their gender identity or sexual orientation when seeking housing.
- 15% (23 people) of respondents indicated they feel unsafe, very unsafe, or not very safe expressing their gender identity and sexual orientation in their current housing.
- 15% (22 people) of respondents have been without stable housing at any time within the past year.
- 3% (4 people) of respondents are currently without stable housing and report intolerance of their sexual orientation or gender identity led to not having stable housing.

**Needs Identified:** Ability to serve Trans, Gender Non-Conforming, and other people who identify as LGBTQ+, ability to work with people who are actively discriminated against.

## 11. Camp Fire Collaborative Disaster Case Management Data

**Timeframe:** May 2021

**Findings:** Respondents represented agencies who provide Disaster Case Management (DCM) in concert with the Camp Fire Collaborative. All 1,248 individuals receiving DCM are considered survivors of the Camp Fire. Over half (58%) of disaster survivors receiving DCM are receiving those services through Butte County DESS.

- 45 disaster survivors who are experiencing homelessness and have medical issues were identified by six of the seven DCM agencies.
- A minimum of 4% (approximately 45 people) of all survivors receiving DCM services from the seven agencies are experiencing homelessness and have medical issues.
- 58% (723) of disaster survivors receiving DCM are being served by Butte County DESS.
- 1,248 disaster survivors have open cases with any of the DCM agencies as of May 2021.

**Needs Identified:** Ability to serve disaster survivors who are experiencing homelessness and medical issues.

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## VIII. Scope of Care and Range of Services Needed

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**Background:** The care and services provided in a medical respite setting fall across a range of scenarios. While the ideal vision is to fully address the full range of health conditions and needs, the reality is that local resources will determine what conditions can be treated and what supporting services can be offered. It is important to remember that at a minimum, a program should offer basic nursing care for injuries and non-infectious illnesses. And while they are helpful, the extension of shelter services to allow people to stay and rest continuously over a 24-hour period (not subject to the shelter’s usual overnight operation hours) does not meet the definition of medical respite care if there are not active nursing supports in place.

The services listed below reflect the full range of potential services that have been found to be helpful in medical respite programs.

### **Clinical Care:**

Appropriate levels of nursing care and patient education to address:

- Medication assistance (reconciliation, dosing, set up, storage)
- Injuries/wounds (cellulitis, etc.)
- Physical disabilities
- Recovery from surgery and other medical procedures (including childbirth)
- Infectious/communicable diseases (TB, STIs, Hepatitis A and C, HIV, wound botulism)
- Stabilizing chronic health conditions, (diabetes, high blood pressure, COPD, pain management, etc.)
- Long-term and/or terminal illnesses (cancer)
- Palliative care
- Immediate oral health and nutritional issues

### **Supportive Services:**

It is anticipated that most supportive services in medical respite care programs will be provided by existing programs in the community which have a partnership formed with the medical respite provider(s). However, because successful referral and entrance to the respite program, the client’s follow-through with health directives, and a safe exit are very dependent on a structured case management and care coordination function, this service should be designed into any medical respite program. Supportive services include, but are not limited to:

- Case management and care coordination
- Establishing or strengthening a primary care provider relationship
- Drug and alcohol support services

- Transportation to pharmacy and medical appointments
- Meals/showers/laundry and assistance with activities of daily living
- Personal property storage
- Referrals to other services, including shelters and/or housing navigation

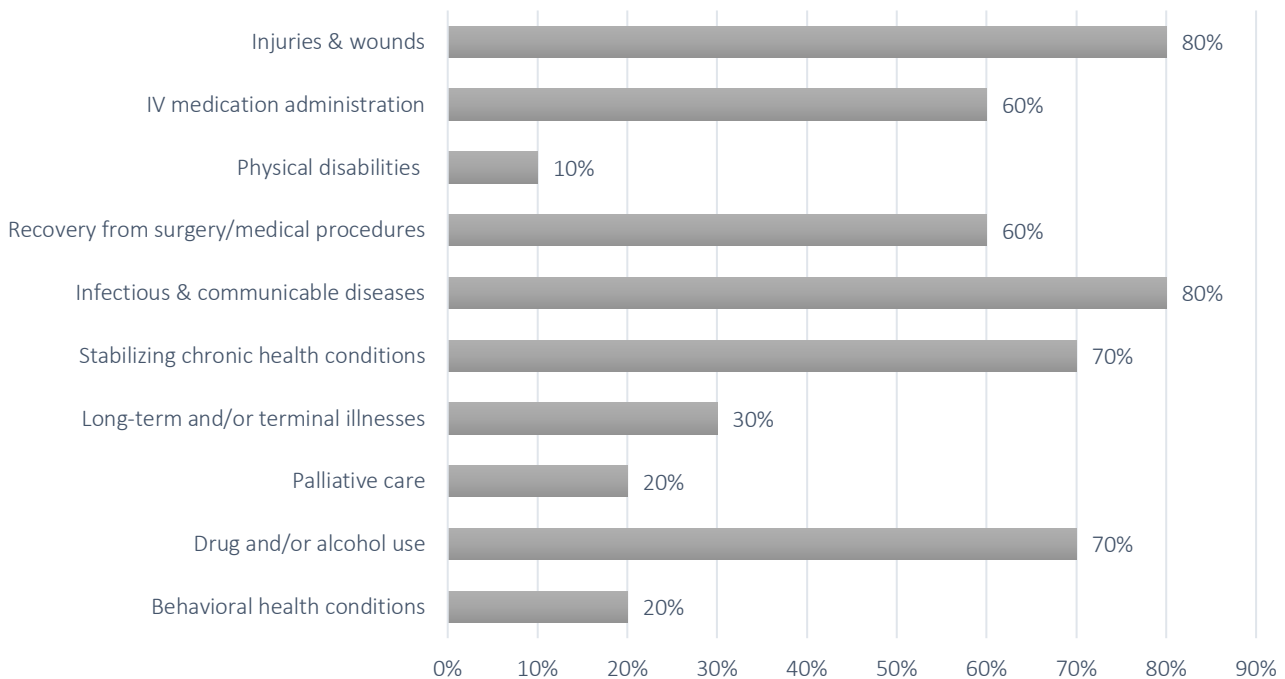
**Specialty Referrals:**

Because of the complex health care conditions likely to be encountered, specialty referral partnerships are needed. Typical specialty care needs include:

- Behavioral health services
- Dental care
- Ophthalmology
- Podiatry
- Dermatology

**Input:** Community Coalition members responded to a poll on scope of care that was launched live during the fourth meeting on May 18, 2021. Both the poll and aggregated responses are provided below.

**Chart 1: Which of the following illnesses, injuries, or conditions do you think should be the focus of the County’s initial efforts for medical respite? (n=10, multiple choice)**



**Discussion:** Based upon the results of the qualitative and quantitative data analysis, as well as the input from the Community Coalition, the scope of care and services provided in any initial programs should include:

- Clinical care for injuries/wounds, infectious and communicable diseases, chronic conditions, musculoskeletal conditions, and post-surgical/childbirth support
- Support from and referral to behavioral health and drug/alcohol services, as mental health and substance use issues are frequently co-occurring conditions for those experiencing homelessness
- Case management and care coordination to help clients overcome barriers to completing prescribed care and to connect to primary care provider for long-term support
- A trauma-informed, health equity approach to services. Meeting clients “where they are” and addressing how to eliminate or mitigate barriers to participation is needed in order to meet the objectives of improving the health and housing outcomes of the individuals served in medical respite care, with concurrent reductions in the utilization of both emergency and in-patient hospital care

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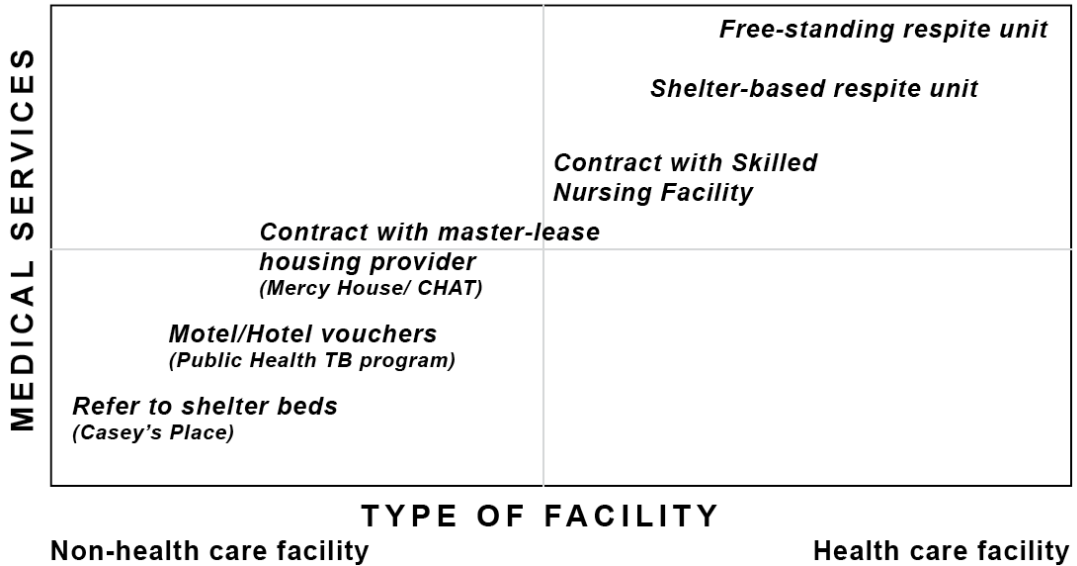
## IX. Potential Models

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**Background:** The characteristics of the medical respite care model implemented are significantly shaped by the type of facility that is used. There are a number of factors to be considered, such as location, size, configuration, physical accessibility and cost, relative to the services that will be provided. The most commonly used models are described below, followed by an axis chart (Figure 1) that illustrates the level of medical services provided compared to the type of facility. The existing community efforts that were described earlier are also plotted on this axis for reference.

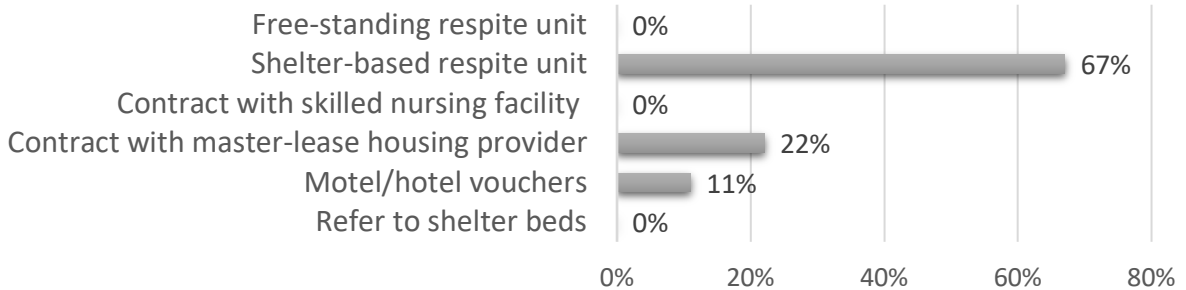
- **Freestanding:** A freestanding unit is devoted entirely to providing medical respite care in a separate facility that is leased or owned. This model provides the highest level of medical support services and is the most expensive.
- **Shelter-based:** An area set aside within an existing shelter where guests have access to nursing care and other supports. Many medical respite programs begin in shelters.
- **Combined model:** Medical respite beds are made available in a shelter for guests to use while they are waiting for entrance into a freestanding facility and/or after staying at a freestanding facility. The combined model addresses situations where the need is greater than any one facility can handle and guests with the most acute needs can be prioritized at the location with the most intensive medical services.
- **Motel/hotel vouchers:** Motel or hotel rooms are either directly rented or a service provider who already provides motel vouchers is engaged. Medical and social services staff then make “home visits” to the guests and arrange for transportation and meals. This is typically a lower level of service and less expensive.
- **Skilled nursing or residential care facilities:** This model is used when funding for other models, or the capacity to bill for medical respite care, cannot be achieved. This would typically be a partnership between a hospital/clinic and a skilled nursing facility or residential care facility. Not all people needing medical respite care are appropriate for this type of placement, but it can fill a niche for some individuals.

**Figure 1: Axis of Medical Respite Services**

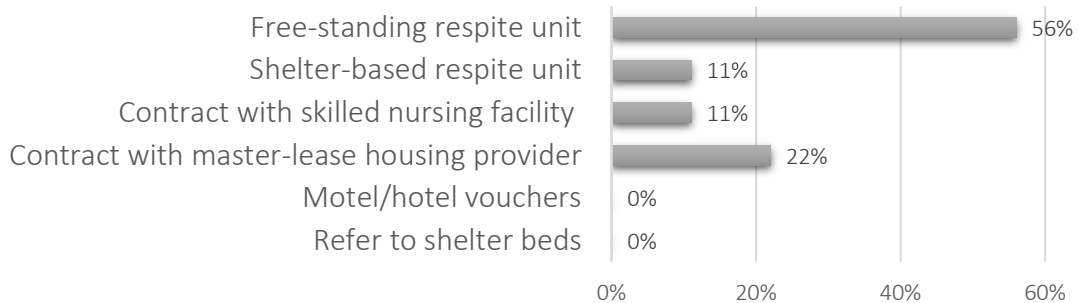


**Input:** Community Coalition members responded to two polls on models that were launched live during the fourth meeting on May 18, 2021. Both the polls and aggregated responses are provided below.

**Chart 2: Which of the following types of facilities do you think should be the focus of the County’s initial efforts for medical respite? (n=9, single choice)**



**Chart 3: Beyond the initial efforts, what do you think is the ideal facility for the County to pursue, given the needs that exist in our community? (n=9, single choice)**



**Discussion:** In discussing where initial efforts should be focused, the consensus of the Community Coalition was to consider “low hanging fruit” in terms of ease and cost of implementation, with an eye also towards effective housing models that already exist in the community. The majority of stakeholders concurred that initial efforts should be focused on utilizing existing shelters, where feasible and appropriate. During the discussion it was noted that some individuals may not feel comfortable using these shelter-based respite programs if the shelter service model has been a barrier to accessing services in the past. The other model that many found attractive is a master-lease contract housing provider, similar to the Mercy House program operated by CHAT. It was also noted that residential care facilities with home health services may also be a good option to further explore, as it allows the person more independence and freedom while receiving necessary support. The long-term vision was definitively noted to be freestanding respite units, located in both North and South County. The freestanding model is clearly recognized by experts as the ideal model, as it provides the freedom to customize the environment to maximize the conditions for medical care and recuperation, along with the ability to effectively integrate other support services and control policies and procedures that best serve the needs of the guests. This model does involve a greater level of cost and planning, however, and therefore will very likely take more time to implement.



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## X. Costs and Available Financial Resources

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### Costs:

As the County and its partners look to the implementation of medical respite care services, project budgets will need to plan for the following costs, at a minimum:

- Facility rent, lease or purchase
- Utilities
- Insurance
- Licensing fees
- Staffing
- Supplies for staff
- Fixtures: beds, guest and medication storage, laundry equipment, durable medical equipment, etc.
- Disposable medical supplies
- Meals
- Transportation

### Available Financial Resources:

There are a number of known financial resources available to support the operation of medical respite programs. This list is current as of the drafting of this MRP. Other resources and/or flexibility in utilizing supporting resources are a likely possibility in the future, given the increased state and national focus on addressing and eliminating homelessness.

**Whole Person Care:** The Butte County Department of Employment and Social Services, Housing and Homelessness Branch, has secured a \$1 million, 5-year grant under the Whole Person Care program, available through the State Department of Health Care Services. The overarching goal of the Whole Person Care program is the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. This funding will allow the County to integrate care for Medi-Cal beneficiaries experiencing homelessness who have been identified as high-volume users of multiple systems and continue to have poor health outcomes.

**CMSP LICN Implementation Grant:** Grantees who have received a CMSP LICN Planning Grant, such as Butte County, are eligible to apply for an implementation grant of \$500,000 per year for 3 years (\$1.5 million in total). The principal goals of the LICN program are to:

- Promote timely delivery of necessary medical, behavioral health and support services to locally identified target populations;

- Link these populations to other community resources and support; and
- Improve overall health outcomes for these target populations.

Funded services are to address care management, disease management and continuity of care, with homeless adults and individuals with chronic health and behavioral health conditions as an identified target population.

**Cal AIM:** The State Department of Health Care Services (DHCS) has developed a framework that encompasses a broad-based delivery system, program and payment reform across the Medi-Cal program, called CalAIM (California Advancing and Innovating Medi-Cal). CalAIM's purpose is to leverage Medicaid as a tool to help address many of the complex challenges facing California's most vulnerable residents, such as homelessness, behavioral health care access, children with complex medical conditions, the growing number of justice involved populations who have significant clinical needs, and the growing aging population.

One of CalAIM's goals is to build capacity in a clinically-linked housing continuum for California's homeless population, including housing transition navigation services, housing deposits, housing tenancy and sustaining services, short-term post hospitalization housing, recuperative care for inpatient transitions and day habilitation programs. This would mean expanded opportunities to bill Medi-Cal for services related to Whole Person Care and Enhanced Care Management within a medical respite setting.

CalAIM implementation was originally scheduled to begin in January 2021, but was delayed due the impact of the COVID-19 public health emergency. As a result, DHCS is proposing a new CalAIM start date of January 1, 2022.

**National Institute for Medical Respite Care:** In February 2021, the National Institute for Medical Respite Care, in partnership with the CDC Foundation, awarded \$1.6 million in grants to nine existing and emerging medical respite programs across the country. While it is unknown if this will be an ongoing funding opportunity, it will be worthwhile for the County and its partners to stay engaged with the parent organization, the National Health Care for the Homeless Council, in order to receive updates on future funding opportunities.

**Sierra Health Foundation, Responsive Grants Program:** The Sierra Health Foundation awards annual funding through their Responsive Grants Program in support of community-driven efforts to improve health, promote access and reduce health inequity throughout their 26-county funding region in Northern California.

## XI. Community Stakeholders

Below are tables of community stakeholders operating in Butte County, their services, and their potential role(s) in the medical respite program. Though the authors have attempted to create a comprehensive list compiled by staff at Butte County, Housing Tools, the Steering Committee, and the Community Coalition, there may be unintentional omissions. This list should be thought of as living and dynamic, with future adjustments as new organizations are established, or other organizations expand or contract their services. Stakeholders are listed according to where their services are generally provided: countywide, or solely within the communities of Chico, Gridley and Biggs, Oroville, and The Ridge (Magalia and Paradise).

COUNTYWIDE			
Community Stakeholder	Type	Services/Description	Potential Role(s)
Anthem Blue Cross	For-profit	Managed health care	Provide funding; Billed to for services
Ampla Health	Non-profit	Medical clinics; Mobile Medical Unit	Provide services to eligible clients; Provide and receive referrals
Butte County Adult Protective Services	Government	Investigation and intervention for adults affected by abuse, neglect, and exploitation	Provide services to eligible clients; Provide and receive referrals
Butte County Department of Behavioral Health	Government	Mental health and drug and alcohol use support services	Provide services to eligible clients; Provide and receive referrals
Butte County Housing and Homeless Services (part of the Department of Employment and Social Services)	Government	Centralize efforts to prevent homelessness and coordinates solutions for supportive housing	Administer medical respite program; Provide funding; Provide and receive referrals
Butte County Department of Public Health	Government	Protect the public through promoting individual, community, and environmental health	Provide services to eligible clients; Provide and receive referrals
Butte-Glenn 211	Non-profit	Phone, text, and online - connect people in need	Provide data on community needs;

		with services that offer help	Provide and receive referrals
California Health & Wellness	For-profit	Managed health care	Provide funding; Billed to for services
Caminar	Non-profit	Prevention, treatment, and recovery services for people with mental health, drug and alcohol, and co-occurring needs	Provide services to eligible clients; Provide and receive referrals
Caring Choices	Non-profit	Disaster, food pantry, HIV/AIDS, and housing assistance services	Provide services to eligible clients; Provide and receive referrals
Catalyst Domestic Violence Services	Non-profit	Reduce the incidence of intimate partner violence through crisis intervention, community education and the promotion of healthy relationships	Provide services to eligible clients; Provide and receive referrals
Far Northern Regional Center	Non-profit	Services and supports to people with developmental disabilities	Provide services to eligible clients; Provide and receive referrals
Housing Authority of the County of Butte	Non-profit public agency	Affordable housing assistance for low-income residents	Provide services to eligible clients; Provide and receive referrals
Northern Valley Harm Reduction Coalition	Community based organization	Opioid overdose prevention, outreach and education, rapid HIV & Hepatitis C testing, syringe disposal, syringe litter reporting line, syringe access through MDs	Provide training to staff; Provide services to eligible clients; Provide and receive referrals
Northern Valley Indian Health	Non-profit; Tribal	Behavioral health, dental, and medical services	Provide services to eligible clients; Provide and receive referrals
Stonewall Alliance Center	Non-profit	LGBTQ+ advocacy, education, resources, and support	Provide training to staff

			Provide services to eligible clients; Provide and receive referrals
United Way of Northern California	Non-profit	Runs and supports programs that focus on health, education, housing, and financial stability	Provide funding; Provide services to eligible clients; Provide and receive referrals

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CHICO			
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Community Stakeholder	Type	Services/Description	Potential Role(s)
California State University, Chico	Education	Higher education institution offering undergraduate and graduate degrees	Collaboration for research, service-learning, or internships
Chico Housing Action Team (CHAT)	Non-profit	Affordable housing master-lease, landlord incentives, and tiny-home programs	Provide services to eligible clients; Provide and receive referrals
City of Chico	Government	Municipal government, includes a community development department	Provide funding; Provide and receive referrals
Enloe Medical Center	Non-profit	298-bed hospital with a Level II trauma center and neonatal intensive care unit and an air ambulance service	Provide funding; Provide services to eligible clients; Provide and receive referrals
Jesus Center	Non-profit, faith-based	Emergency shelter, transitional housing, and vocational training	Provide services to eligible clients; Provide and receive referrals
Safe Space Winter Shelter	Non-profit	Emergency shelter services December to March annually	Provide services to eligible clients; Provide and receive referrals
Shalom Free Clinic	Non-profit	Physical, mental, and behavioral health services for people who are underinsured and uninsured	Provide services to eligible clients; Provide and receive referrals

True North Housing Alliance	Non-profit	Emergency shelter, permanent supportive housing, rapid rehousing, street outreach, and transitional housing	Provide services to eligible clients; Provide and receive referrals
<b>GRIDLEY AND BIGGS</b>			
<b>Community Stakeholder</b>	<b>Type</b>	<b>Services/Description</b>	<b>Potential Role(s)</b>
City of Biggs	Government	Municipal government, includes planning department	Provide funding; Provide and receive referrals
City of Gridley	Government	Municipal government, includes planning department	Provide funding; Provide and receive referrals
Orchard Hospital	Non-profit	45-bed hospital	Provide funding; Provide services to eligible clients; Provide and receive referrals

<b>OROVILLE</b>			
<b>Community Stakeholder</b>	<b>Type</b>	<b>Services/Description</b>	<b>Potential Role(s)</b>
African American Family & Cultural Center	Non-profit	Community-based programs and services	Provide services to eligible clients; Provide and receive referrals
The Elijah House/Sierra Health and Wellness	Non-profit, faith-based	Drug and alcohol support services	Provide services to eligible clients; Provide and receive referrals
Feather River Tribal Health	Non-profit; Tribal	Behavioral health and medical services	Provide services to eligible clients; Provide and receive referrals
Hmong Cultural Center of Butte County	Non-profit	Community-based cultural education, advocacy, support, and services	Provide services to eligible clients; Provide and receive referrals
Oroville Hope Center	Non-profit, faith-based	Clothing, food, and job training services	Provide services to eligible clients; Provide and receive referrals
Oroville Hospital	Non-profit	153-bed hospital	Provide funding;

			Provide services to eligible clients; Provide and receive referrals
Oroville Rescue Mission	Non-profit, faith-based	Emergency shelter, clothing and food distribution, and drug and alcohol support services	Provide services to eligible clients; Provide and receive referrals
Oroville Southside Community Improvement Association	Non-profit	Food distribution, mobile hygiene unit (Haven of Hope on Wheels)	Provide services to eligible clients; Provide and receive referrals
<b>THE RIDGE (MAGALIA and PARADISE)</b>			
<b>Community Stakeholder</b>	<b>Type</b>	<b>Services/Description</b>	<b>Potential Role(s)</b>
Adventist Health – Feather River	Non-profit, faith-based	Behavioral health, dental, and medical services	Provide funding; Provide services to eligible clients; Provide and receive referrals
Magalia Community Church	Non-profit, faith-based	Clothing and food distribution, Camp Fire survivor resource center	Provide services to eligible clients; Provide and receive referrals
Medspire Health	Non-profit	Mobile medical clinic providing non-emergency medical care, emotional wellness support, and health education	Provide services to eligible clients; Provide and receive referrals
Paradise Hope Center	Non-profit, faith-based	Clothing, food, and other basic necessities, and referrals for Camp Fire survivors	Provide services to eligible clients; Provide and receive referrals
Tzu Chi USA (Buddhist Tzu Chi Foundation)	Non-profit, faith-based	Housing support, medical outreach, and disaster case management	Provide services to eligible clients; Provide and receive referrals
Town of Paradise	Government	Municipal government, includes planning department	Provide funding; Provide and receive referrals

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## **XII. Appendices**

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### **Medical Respite Plan Data Collection Survey**

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The Butte County Public Health Department has received a planning grant through the State CMSP program to complete a Medical Respite Plan for individuals experiencing homelessness who are in need of these services. The purpose of this survey is for service providers (e.g. health care, hospitals, housing, homeless services, shelters, etc.) to outline what data they have available to inform the Medical Respite Plan. This data will assist the County in understanding community needs. If you have any questions about this survey you can contact Housing Tools (admin@housing-tools.com) or Kyle Willman, Butte County Public Health (kwillman@buttecounty.net).

1. What is your organization's name?
2. Which communities does your organization serve in Butte County? Please select all that apply.
  - a. Chico
  - b. Biggs/Gridley
  - c. Oroville
  - d. The Ridge (e.g. Paradise, Magalia, Concow, etc.)
  - e. Other, please describe
3. What is your contact information?
  - a. Name
  - b. Title
  - c. Email
  - d. Phone Number
4. What is the contact information for the staff that will provide the data?
  - a. Name
  - b. Title
  - c. Email
  - d. Phone Number
5. Please select from the list below which data variables your organization collects and is willing to provide to Butte County Public Health in a de-identified or aggregated format. The population for this data is people experiencing homelessness.



- Demographics
  - Sheltered or unsheltered
  - City of residency
  - Primary language
  - Age
  - Race
  - Ethnicity
  - Gender identity
  - Sexual orientation
  - Veteran status
- Disabilities or Health Conditions
  - Currently pregnant
  - Physical disabilities
  - Developmental disabilities
  - Mental health conditions
  - Diabetes
  - Cardiac-related
  - Cancer
  - Substance use or disorder (alcohol and licit or illicit drugs)
  - Long-term communicable diseases such as HIV, Hepatitis C, and Tuberculosis
- Hospital Care
  - Health insurance status at time of service
  - Number of visits to the Emergency Room
  - Number of inpatient visits at the hospital
  - Length of inpatient stays at the hospital
  - Discharge location type
  - Discharge orders for home health
  - Discharge orders that include ongoing medication or treatment
  - Primary admitting diagnosis
  - Secondary admitting diagnosis (or co-occurring illnesses)
  - Referrals to specialists, including specialist type
- Other Medical Care (e.g. Community Clinic, Federally Qualified Health Center, Prompt Care, Tribal Health, etc.)
  - Health insurance status at time of service
  - Number of visits to provider
  - Reason for visit (e.g. check-up, wound care, back pain, uncontrolled diabetes, etc.)
  - Referrals to specialists, including specialist type
  - Prescribed medication regimen

6. Are there any data variables not listed above that you think should be included? Please describe.

7. What year(s) do you have data available for these variables? Please select all that apply.
  - a. 2021
  - b. 2020
  - c. 2019
  - d. 2018
  - e. 2017
  - f. 2016
  - g. Other, please describe
  
8. In addition to analyzing the data listed above, Butte County Public Health staff will conduct interviews with interested parties to inform the Medical Respite Plan. Is your organization interested in being interviewed? Please select all that apply.
  - a. I am willing to be interviewed
  - b. My co-worker in a direct service role is willing to be interviewed
  - c. My co-worker in a management role is willing to be interviewed
  - d. A client of my organization is willing to be interviewed
  - e. My organization is not interested in an interview at this time
  - f. Other (please describe)
  
9. Do you have questions or comments?

## **Qualitative Data: Semi-structured Interview Tool**

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### **Introduction Script**

I'm calling to share more about a program Butte County is hoping to put together as well as learn from people like you who can help us understand the needs of our neighbors who are experiencing homelessness. The potential program would offer shelter up to 90 days along with health care for people experiencing homelessness to recover from an injury, illness, or condition. We don't have specifics yet, but the program would include service providers and health care providers. We're talking with people to see if this program could meet needs in the community. Your participation in this conversation is optional and any information you give us will be anonymous. Your honest feedback is appreciated and will be used to create a program that better serves people that need these services. If at any time you don't want to answer a question, you can say "pass" and we can move on. If you have questions at any time you can stop me and I would be happy explain more. You can think of this more as a conversation than an interview. Do you have any questions or concerns before we get started?

### **Questions for Service Providers**

1. In general, what types of illnesses, injuries, or conditions and/or health needs do your clients experiencing homelessness live with?
2. Can you describe any instances where a client was re-admitted to the emergency room soon after their first visit for the same illness, injury, or condition due to incomplete recovery?
3. Can you describe any health services you provide to clients that you didn't expect? (e.g. bathroom care, IV care, medication management, etc.)
4. What health or shelter services are missing that would be helpful to your clients?
5. Do you think your clients would use a program that offers a short-term place to stay and health care to recover from an illness, injury, or condition for up to 90 days? Please explain why or why not.
  - a. What kind of concerns would you have about this type of program? Please describe.
  - b. What would make this program a good fit for your clients? What wouldn't?
6. Have your clients ever avoided health care, procedures, or treatment because they knew they didn't have a place to recover after?
7. Is there anything else you would like to add?