MADERA COUNTY DEPARTMENT OF PUBLIC HEALTH

CMSP's Local Indigent Care Needs (LICN) Implementation Plan

June 21, 2021

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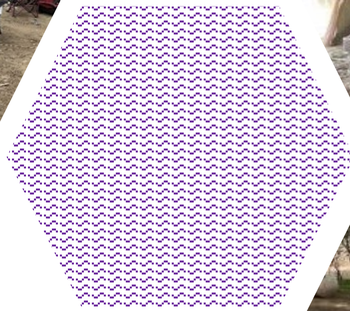

INTRODUCTION

In 2017, the Madera County Department of Public Health (MCDPH) published a countywide community health assessment that revealed homelessness was a major social and econmic problem in Madera County. In 2019, MCDPH applied for and received funding from the County Medical Services Program (CMSP) through the Local Indigent Care Needs grant to conduct a first-time ever health needs assessment focused on access and barriers to care for the homeless population in Madera County.

The results from the Madera County Homeless Health Assessment: Access and Barriers to Care (MCHHA) report along with partner contributions provided insights for this Local Indigent Care Needs (LICN) Implementation Plan. From the assessment, eight proposed interventions were identified: sobering center, respite center, venue-intensive vaccines, crisis stabilization unit, mobile health program, substance use support groups, one-stop-shop, and centralized and quality homeless data. These proposed interventions were presented to stakeholders who were asked to rank each intervention's impact and feasibility. After the ranking, MCDPH reviewed feasibility and impact survey results, excluded existing interventions, identified funding sources, and discussed other key priorities with Madera County's Homeless coordinator and stakeholders. Based upon the discussion, two additional interventions were proposed, rehab center and faith-based housing and support.

After reviewing all the proposed interventions, MCDPH elected to take the lead on the public health focused interventions which include mobile health, one-stop shop, and centralized data. These interventions are the focus of the implementation plan below. The other identified priority interventions will be led by other partners and supported by MCDPH as described in the implementation plan.

MCDPH's goal is to create an implementation plan to address existing gaps in health (physical, oral, and mental) services to improve the overall health of individuals experiencing homelessness in Madera County. The implementation plan is intended to elicit multi-agency collaboration and address upstream social factors affecting health.

The implementation addresses three areas based upon the assessment process:

1. **Mobile Health/One-Stop Shop**
2. **Data Sharing and Data Quality**
3. **Support for other priority interventions**

PROJECT OVERVIEW

Problem:

During the 2020 Point-in-Time count, 390 individuals experiencing homelessness were accounted for in Madera County (95 sheltered and 295 unsheltered). The homeless needs assessment project conducted as part of the LICN's planning grant provided first-time ever insights into the health status of this population. As expected, individuals experiencing homelessness suffer from poor physical and mental health, and substance use. Over 84.5% of individuals experiencing homelessness surveyed had at least one ongoing health or mental health condition. Healthcare access is a big barrier among this population, particularly difficulty obtaining transportation, utilizing traditional healthcare clinic services due to complex healthcare navigation processes, and feeling stigmatized. As a result, over 50% of emergency department (ED) visits in 2019 and 2020 at the Madera Community Hospital among individuals experiencing homelessness were non-urgent and unnecessary visits that can bridged with physical or mental health services specifically tailored to the population. Top three reasons for ED visits among this population were related to substance use, mental/behavioral health

needs, and pain management. 41.8% of survey responders indicated that ED was their usual source of healthcare.

Among individuals experiencing homelessness surveyed, three largest physical needs highlighted were basic health screening such as blood sugar check, weight, blood pressure check (59.7%), dental care (40.4%), and sexually transmitted diseases/HIV services (35.1%). The three largest mental health needs were mental health treatment/management (48.2%), substance use treatment and counseling (35.7%), and substance use support services (33.9%).

Besides physical, oral, and mental health, 32% of those surveyed from the 2020 PIT count, report other social factors affecting health including domestic violence.

Key informant interviews with key organizations that directly serve the homeless population expressed needs for mobile health program to improve healthcare access, one-stop shop to healthcare and mental health services, rehab center, crisis stabilization unit, sobering center, and housing assistance.

Project Theory of Change:

MCDPH proposes increasing the capacity to coordinate and provide healthcare, oral health, and mental health services by developing a new mobile health program focused on the homeless population, improving data sharing capacity, and supporting other homeless-focused initiatives. MCDPH and partners will provide better linkages to care, improve healthcare and behavioral/mental health access, decrease unnecessary ED burden for the local hospital, and ultimately improve overall health of individuals experiencing homelessness.

Key Partners:

Most critical organizational partners for the project include Madera County Behavioral Health, Madera County Department of Social Services, Community Action Partnership of Madera County, Madera Community Hospital, Camarena Health, Valley Children's Healthcare, and other healthcare networks, CalVIVA managed care, Madera Rescue Mission, Madera Police Department, Madera County Sheriff's Office. Key coalitions include Live Well Madera County which now includes a workgroup focused on homelessness called Homeless Solutions; Homeless Connect, and Housing for the Homeless.

ACTION PLAN

Goal 1: Increase access to health care among individuals experiencing homelessness by expanding mobile health and linkages to services for sexually transmitted diseases, HIV and other communicable diseases; relevant immunizations (including COVID); oral health services; mental health services; health screenings and education; and social support programs such as Medi-Cal, WIC and other support services.

Key Activities	Timeline	Key Personnel Responsible
1. Identify and/or hire key staff such as a mobile health lead to establish a mobile services team to operate a mobile clinic and promote department services.	Sept 2021-Dec 2021	Program Manager
2. Assess and coordinate with other mobile health services to fill in service gaps and leverage a one-stop shop approach to reach homeless populations.	Sept 2021 – Aug 2024	Program Manager, Health Education Coordinator
3. Develop a centralized event database and identify a community partner point of contact to coordinate and promote mobile events.	September 2021 – March 2022	Program Manager
4. Implement mobile services based upon data and needs of homeless population.	Sept 2021 – Aug 2024	Program Manager, Health Education Coordinator
5. Explore the feasibility of telehealth to diagnose, prescribe and perform other services.	Sept 2022 – Aug 2023	Program Manager, Health Education Coordinator
6. Implement telehealth if feasible.	Sept 2023 – Aug 2024	Program Manager, Health Education Coordinator
7. Support onboarding, enrollment, and training of identified services and partners into Unite Us, an electronic platform that allows for electronic referrals among enrolled partners.	Sept 2021- Dec 2021	Health Education Coordinator
8. Facilitate and implement bi-directional linkages and referrals to and from appropriate health and support and social services using Unite Us platform.	Jan 2022-Aug 2024	Health Education Coordinator
9. Develop tools and to assess effectiveness of mobile health program and health care linkages. Collect data and conduct program evaluation.	Jan 2022-Aug 2024	Epidemiologist/ Health Education Coordinator
10. Provide Motivational Interviewing (MI) and other appropriate training to mobile van team and other relevant staff providing	Jan 2022 – June 2022 (and as needed)	Program Manager, Health Education Coordinator

services to individuals experiencing homelessness.		

Goal 2: Expand homeless-focused data availability and quality across Madera County agencies.

Key Activities	Timeline	Key Personnel Responsible
1. Assess homeless-focused data gaps compared to best practices.	Sept 2021-Dec 2021	Epidemiologist
2. Obtain or develop standardized tools and data points in conjunction with partners.	Jan 2022-Sept 2022	Epidemiologist
3. Explore and initiate data sharing methodology (i.e., data sharing portal, MOUs) that provide access to all partnered agencies providing homeless-focused services.	Sept 2022-Aug 2023	Epidemiologist
4. Develop and publish data visualization dashboard to present countywide homeless-focused data to partners and the community	Sept 2023-Aug 2024	Epidemiologist/Public Information Officer (PIO)

Goal 3: Collaborate and support other community initiatives focused on improving the health and well-being of the homeless population in Madera County. Interventions may include crisis stabilization center, sobering center, rehab center & faith-based housing.

Key Activities	Timeline	Key Personnel Responsible
1. Attend and/or host stakeholder meetings including Live Well Madera County, Homeless Connect, and Housing the Homeless.	Sept 2021-Aug 2024	Program Manager, Health Education Coordinator, Epidemiologist
2. Conduct research and provide data to inform partner initiatives as needed.	Sept 2021-Aug 2024	Epidemiologist
3. Assist in the implementation of partner initiatives through the purchase of supplies, equipment, and renovation as appropriate.	Sept 2021-Aug 2024	Program Manager, Health Education Coordinator, Epidemiologist
4. Promote services of MCDPH and partners through on-the-ground in-person outreach with community-based organizations and various communication channels such as flyers, radio, and social media.	Sept 2021-Aug 2024	PIO