Medically Vulnerable People (MVP) Interim Housing Program Report

January 20, 2026

2025 Year End Review

FOURTH STREET CLINIC
HOMELESSNESS HURTS. HEALTH CARE HELPS.

the ROAD HOME

shelter the HOMELESS

Why is the MVP program needed?

Number of seniors age 62+ experiencing homelessness continues to be one of the fastest growing demographics

Individuals experiencing homelessness with chronic health conditions is prevalent in overall population

Housing and health care work together to help individuals to prevent a return to homelessness

Health conditions and injury can cause a person to experience homelessness, especially the aging population, and may delay recovery

Address an immediate gap of supportive care for this especially vulnerable population

2025 Year End Updates

2025 Impact Data

- **464 individuals served**, ranging in age from 36 to 83, with an average age of **62**
  - **20% increase** from 2024
- **57 moves** to permanent housing or long-term care
  - **More than double** our 2024 moves
- Ongoing collaboration with **Sandy Police** and **Fire**
- **1,085 referrals** from **78 different providers**

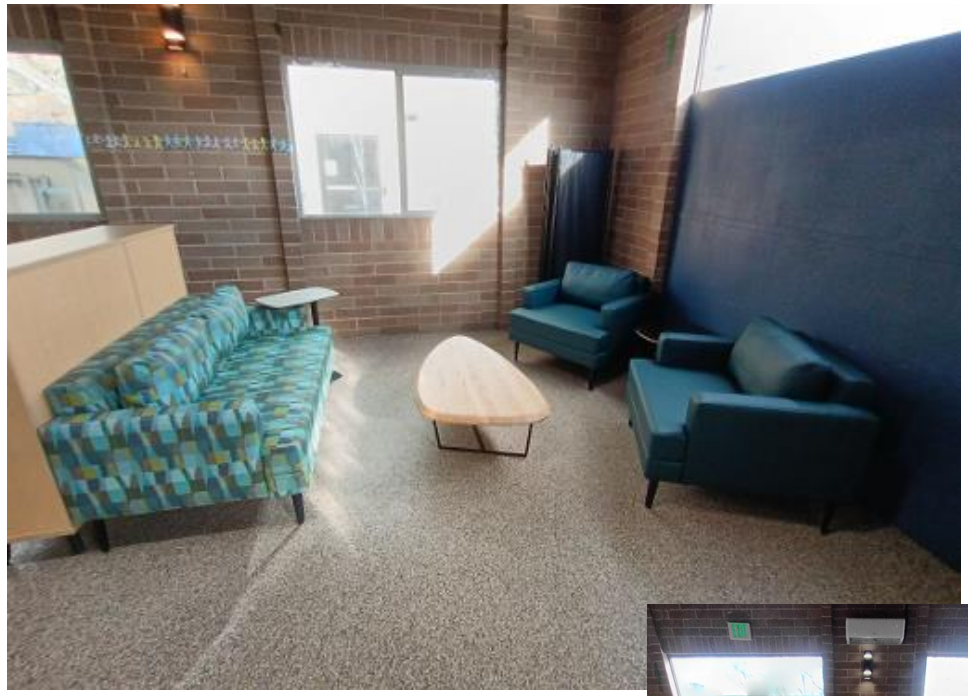
Partnership & Growth Focus

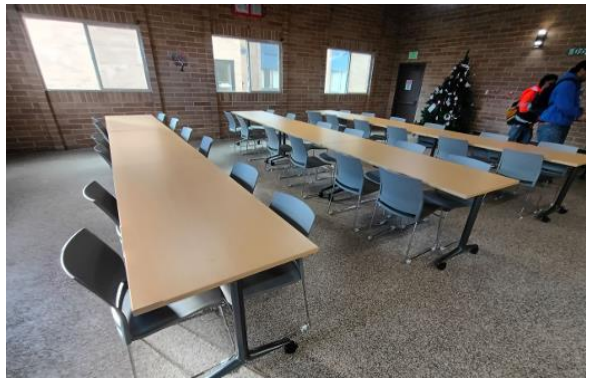
- Ongoing collaboration with **Sandy Police** and **Fire**
  - Safety protocols – continuing to adapt and respond
  - 3 referrals from Sandy Fire; 2 enrolled
- Balance of medical care needs with housing priorities
- Improved intake procedures & pre-admission screenings
- Supporting our senior clients truly takes a community

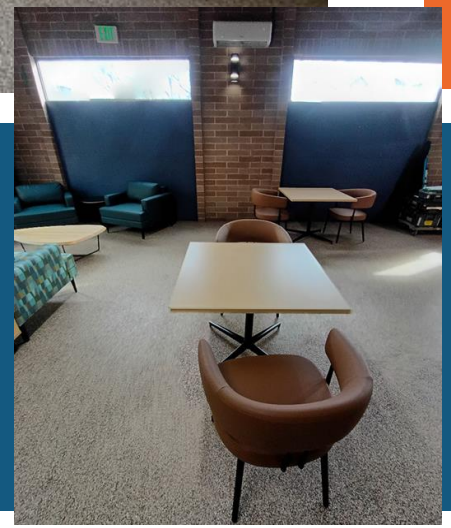
2025 Vision - Updates

- Senior Homelessness Task Force
  - Identified critical system gaps and brought together multiple groups to address and direct resources
- Additional strategic partnerships
  - Continuing work with senior housing partners; seeking opportunities for ongoing shared housing support
- More facility improvements
- Increase positive client health and housing outcomes

Client Successes







Community Engagement

Volunteerism

- Throughout 2025, we had **266 volunteers** serving **678 hours**!
- There are several ways to get involved at MVP:
  - Group activities with clients
  - Donation drives for specific needs
  - Meal delivery for lunch and dinner
- **Email volunteer@theroadhome.org for more info**

Fourth Street Clinic Patient Care Overview

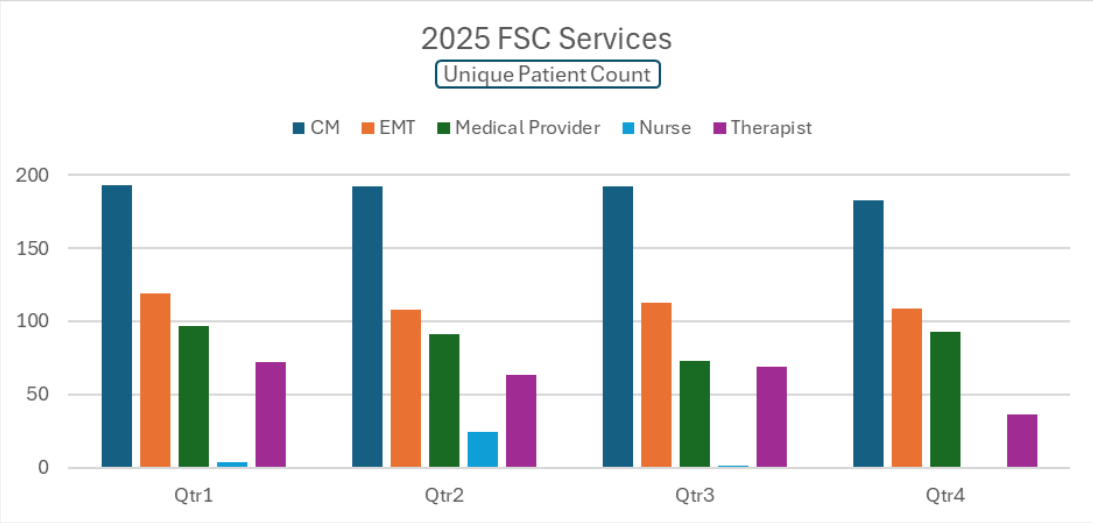
2024

- Onsite Provider – 1 day per week
- Mobile – 1 day per week
- Nursing Services
- Behavioral Health Services
- Medical Case Management
- Transportation Support
- EMT Services – M-F 6am – 12am
- Diabetic Care
- Medication Delivery & Reconciliation
- Vaccine Clinics
- Point of Care Labs
- Specialty Services onsite
  - Home Health
  - Physical Therapy
  - Oxygen Monitoring

2025 Additions

- Onsite Provider – up to 2 days per week
- Lab pick-ups through ARUP
- Onsite durable medical equipment
- Behavioral health groups
- Finished Exam Room 2 - equipment installed
- Specialty Services & Programming
  - Occupational Therapy Student Rotation
  - Community Garden

FSC Patient Care Overview 2025

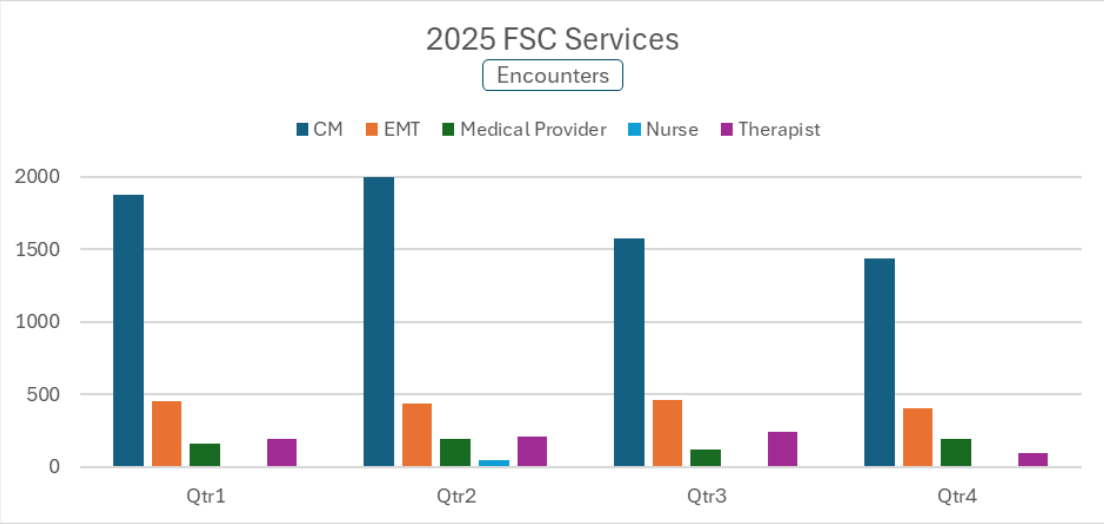


Total Patients

- 2024 = 339
- 2025 = 418

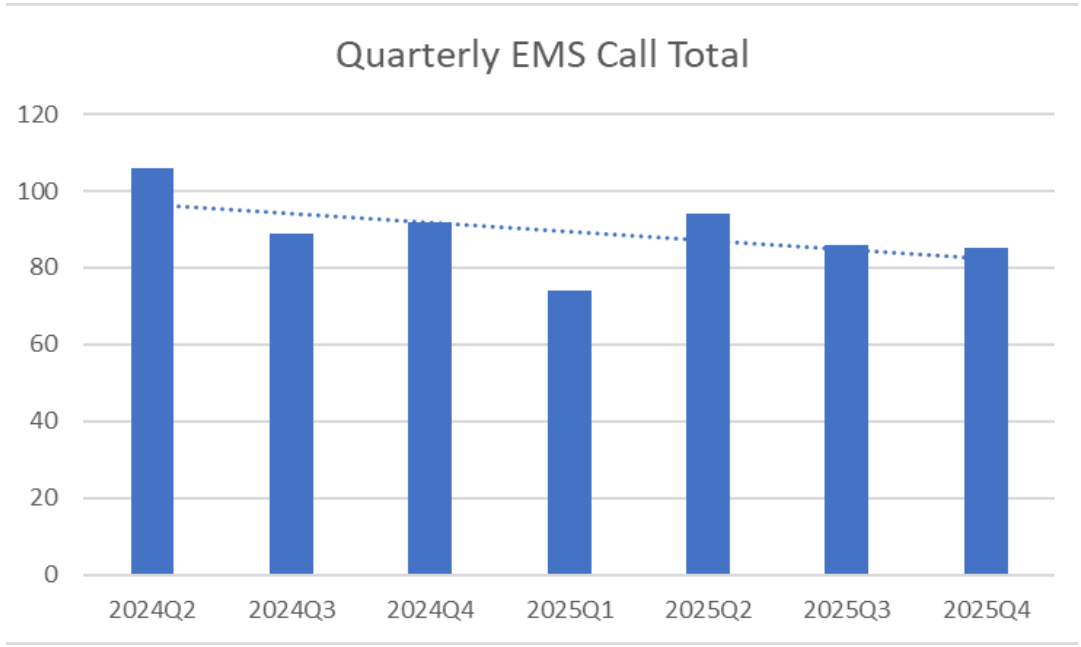
Total Patient Encounters

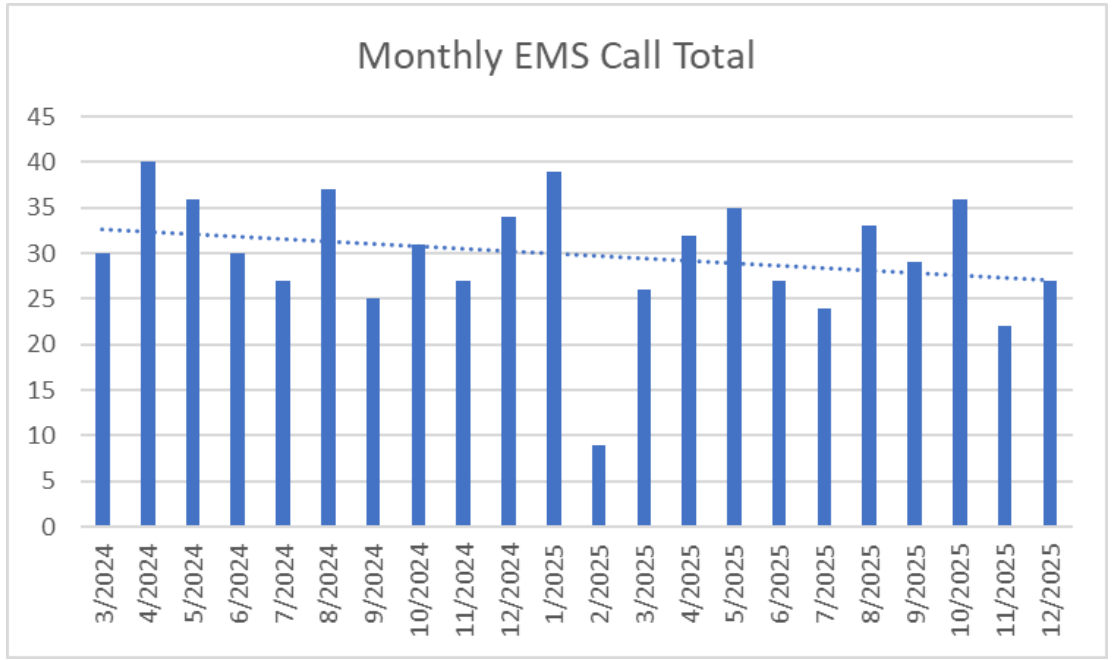
- 2024 = 6,148
- 2025 = 10,153



Fourth Street Clinic EMS Calls 2024-2025

- Data gathered from TRH incident reports
- Sustained decrease in EMS calls, trending downward over time
- Month to month comparison, decreasing across most months over time
- 293 patients served through 1,754 encounters





Fourth Street Clinic - 2025 Achievements

- Delivered high value, coordinated care to **418 patients**
- **Enhanced and refined** our medical model
  - Added onsite provider day (goal is 2 days per week)
  - Trialed the support of Occupational Therapy Students (U of U)
  - Continued to provide specialized supports: diabetes management, medication delivery, specialty referrals, transportation, lab services, med recs, DME
- **Increased engagement** in behavioral health services
  - 2024 = 135 visits for 63 unique patients
  - 2025 = 749 visits for 161 unique patients
  - Added behavioral health supports to the Mobile Clinic

Fourth Street Clinic - 2026 Goals

Certification through the National Institute for Medical Respite Care

- Kickoff in January 2026
- Guidance, resources, technical assistance, and peer connections
- Enhance quality initiatives and patient outcomes
- Further refine our service delivery model at MVP

FSC – Success Story

Patient Example – Male, 57

Challenges:

- Active substance use disorder with medical instability
- Severe malnutrition and underweight
- No reliable access to clothing or hygiene
- History of violent assault resulting in:
  - Broken jaw
  - Traumatic brain injury (TBI)
  - Multiple skull, cheekbone, and orbital fractures
- Hospitalized at University of Utah Hospital, including coma
- Discharged to the street without supports
- Continued substance use after discharge
- No coordinated medical follow-up or recovery supports

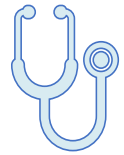
9 chronic conditions

Services Provided:

- Referred to MVP from Weigand Center for urgent medical and social needs
- Engaged by MVP referral team
- Admitted to MVP and enrolled in Respite Waiver due to medical complexity
- Comprehensive medical and psychosocial assessment
- Interdisciplinary care (MCMs, EMTs, providers, BH)
- Medication management and adherence support
- Coordination of primary and specialty care
- Ongoing monitoring of complex conditions
- FSC coordinated medical transportation
- Safe, stable medical respite for recovery

Outcomes:

- Consistent, coordinated medical care
- Stabilization of complex conditions
- Increased engagement in care and follow-up
- Reduced barriers through medical transportation
- Greater ability to focus on recovery
- Increased trust in providers
- Improved dignity, hope, and motivation
- MVP = a critical pathway to stabilization and addiction care



FSC - Success Story

Patient Example – Female, 60

Challenges:

- Chronic pain that significantly limited daily functioning
- Unmanaged pain with physical and emotional distress
- Difficulty engaging in care due to instability
- Housing insecurity limiting long-term planning
- Elevated stress affecting overall health

7 chronic conditions

Services Provided:

- Enrolled in MVP with Medical Case Manager
- Medical and psychosocial assessment
- Coordinated, patient-centered pain plan
- MCM–provider collaboration
- Medication oversight and follow-up
- Support understanding treatment options and care expectations
- In-house behavioral health support
- Housing navigation and referrals
- Assistance with applications and documentation
- Ongoing advocacy during stabilization

Outcomes:

- Improved pain control
- Increased engagement in medical and behavioral health care
- Better daily functioning and well-being
- Reduced stress and greater emotional stability
- Successful placement into housing
- Increased independence and ability to maintain health
- Transition from crisis to stability

Shelter the Homeless

Facility and Security Updates

- Security camera additions to blind spots
- Courtyard: ADA door functions & landscaping improvements
- Community room HVAC and weatherproofing upgrades
- Roof replacement
- New sprinkler system & sod at entrance and courtyard
- Emergency Preparedness Kit

Upcoming 2026

- Lobby Entrance – security and ADA upgrades
- Office configuration to support programming
- Upgrade electrical and HVAC systems throughout building
- Repaint client rooms

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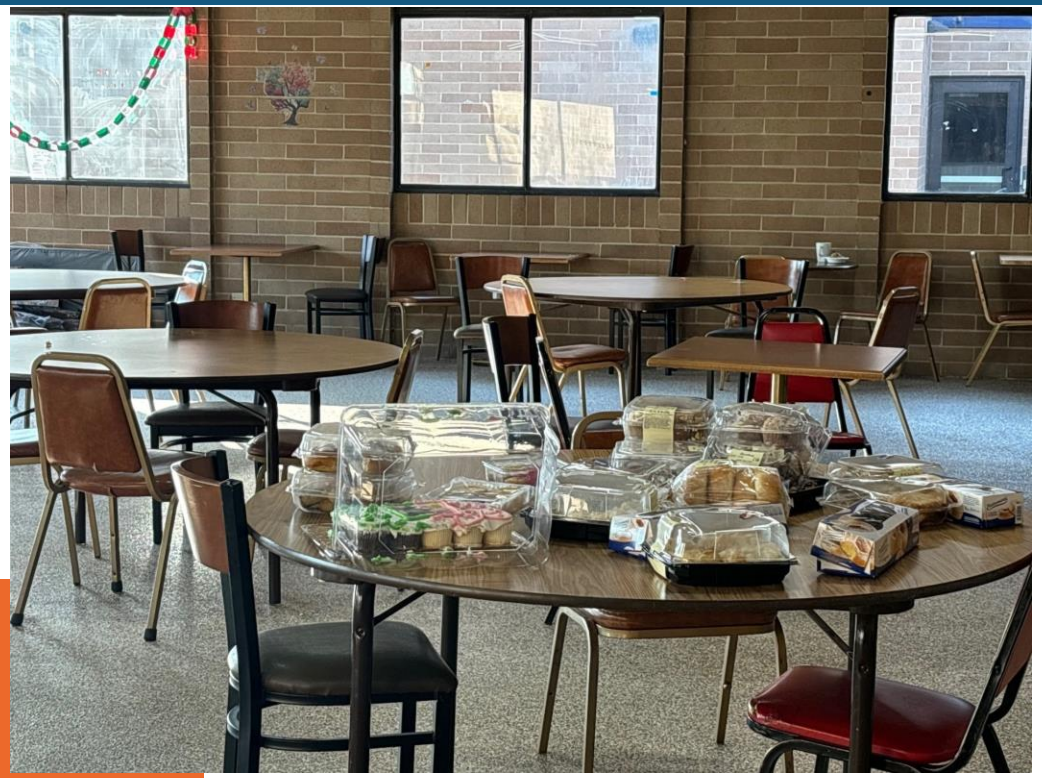

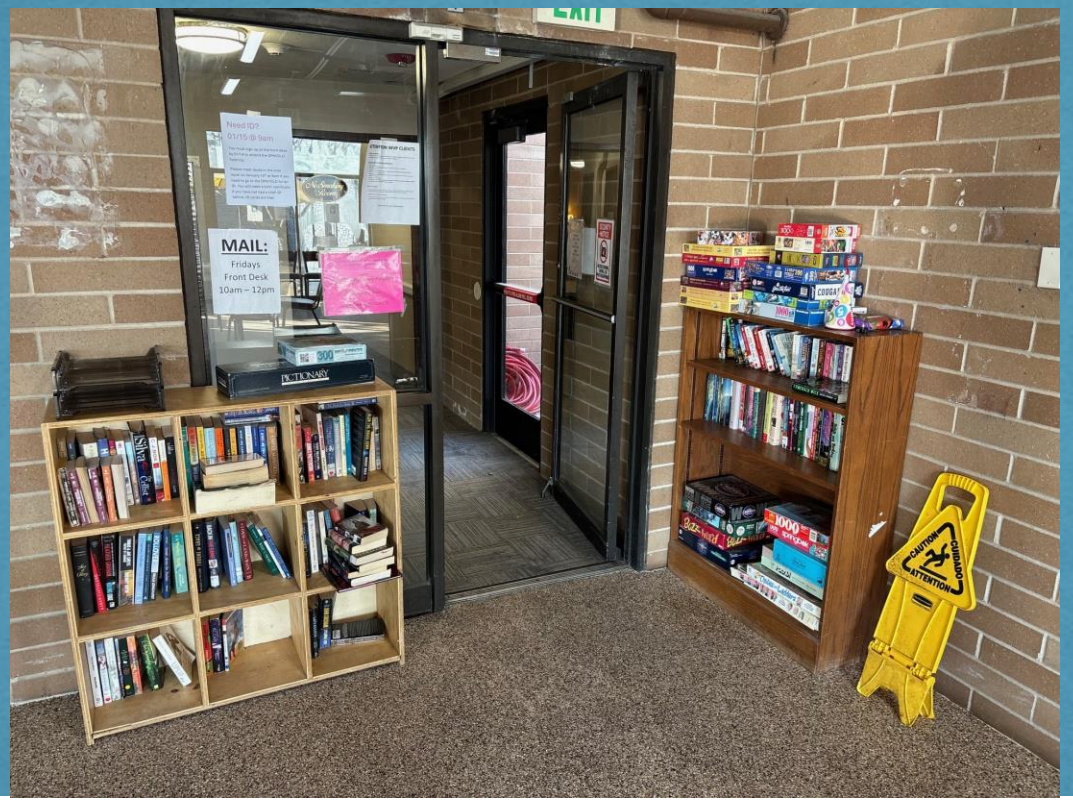
MAIL:
Fridays
Front Desk
10am – 12pm

Fourth Street Clinic Enhancement of Services

Proposed Change to the Memorandum of Understanding
MEMORANDUM OF UNDERSTANDING BETWEEN SHELTER THE HOMELESS, INC. AND SANDY CITY

Section 2: Medical Personnel Staffing Requirement

Current language:
2.1(c) A mobile medical clinic ("MMC") will be on-site at least one day per week.

Replace with:
The MVP health clinic will be staffed up to two times per week. The MVP health clinic will be staffed with (1) a medical provider (i.e., a doctor, physicians' assistant, or nurse practitioner); (2) a medical assistant; and (3) a care coordinator. These medical personnel will provide primary care to the participants in the MVP program including (1) treating a wide range of urgent and non-urgent care needs;(2) performing point-of-care testing (COVID, flu, diabetes, HIV, urinalysis);(3) providing ultrasound services; (4) providing EKG testing; (5) performing standard-vitals testing; (6) performing laboratory blood draws; (7) prescribing needed medications (which can be delivered on a same-day or next-day basis); and (8)making referrals to specialists.

Thank you.

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