San Bernardino County Homeless Partnership
West Valley HPN/Regional Steering Committee

Wednesday, November 15, 2023 • 10:00 a.m. to 11:30 a.m.
(please note change in day and time)

Hosted by the City of Rancho Cucamonga - Please Join Us at
RC City Hall – Tri-Communities Room
10500 Civic Center Drive, Rancho Cucamonga 91730
or
By Zoom Video Conference:
https://us02web.zoom.us/j/85194946723?pwd=TUh0cHZGM1JEZ0I3S1I3YXFEUnAvQT09
Meeting ID: 851 9494 6723- Password: 183200
Dial in +1 669 900 6833 - One tap mobile +16699006833,,89595982006# US (San Jose)

Prior to the West Valley RSC Meeting, please join us for a live virtual viewing of the

HMIS Kickoff Meeting
9:00 – 10:00am
Microsoft Teams meeting
Click here to join the meeting
Meeting ID: 244 969 596 341 Passcode: MuGfT2

RSC MEETING AGENDA

OPENING REMARKS	PRESENTER
A. Call to Order B. Welcome and Introductions *Public comment and participation is available and welcomed during all agenda items*	Erika Lewis-Huntley Don Smith
REPORTS & UPDATES	
C. Interagency Council on Homelessness D. Homeless Provider Network E. Office of Homeless Services F. State and Federal Updates G. Regional City & Service Provider Partners	Erika Lewis-Huntley Don Smith OHS staff RSC Committee Members
PRESENTATIONS / DISCUSSION ITEMS	
H. Preparing for the SBC&C CoC 2024 Point-in-Time Count – January 25th, 2024 *I. Updates on the West Valley Regional CES Access Hub* *a. CES Regional Working Group* *J. Presentation on Proposed Changes to the San Bernardino City & County Continuum of Care Governance Charter*	Erika Lewis-Huntley Pastors Donald & Ethel Rucker Dr. Patricia Leslie Hub for Urban Initiatives
CLOSING	
K. Additional Public Comment (2 mins) L. Adjournment	Don Smith Erika Lewis-Huntley

Next Regulalry Scheduled Meeting: West Valley Regional Steering Committee
Wednesday, December 13, 2023, 9:00am – 11:00am
Rancho Cucamonga City Hall – Tri-Communities Room & by Zoom Video Conference

Mission Statement
The Mission of the San Bernardino County Homeless Partnership is to provide a system of care that is inclusive, well planned, coordinated and evaluated and is accessible to all who are homeless and those at-risk of becoming homeless.

THE SAN BERNARDINO COUNTY HOMELESS PARTNERSHIP MEETING FACILITY IS ACCESSIBLE TO PERSONS WITH DISABILITIES. IF ASSISTIVE LISTENING DEVICES OR OTHER AUXILIARY AIDS OR SERVICES ARE NEEDED IN ORDER TO PARTICIPATE IN THE PUBLIC MEETING, REQUESTS SHOULD BE MADE THROUGH THE OFFICE OF HOMELESS SERVICES AT LEAST THREE (3) BUSINESS DAYS PRIOR TO THE PARTNERSHIP MEETING. THE OFFICE OF HOMELESS SERVICES TELEPHONE NUMBER IS (909) 501-0610 AND THE OFFICE IS LOCATED AT 560 E. HOSPITALITY LANE SUITE 200 SAN BERNARDINO, CA 92408. http://www.sbchp.sbcounty.gov/ AGENDA AND SUPPORTING DOCUMENTATION CAN BE OBTAINED AT 560 E. HOSPITALITY LANE SUITE 200 SAN BERNARDINO, CA 92408 OR BY EMAIL: HOMELESSRFP@HSS.SBCOUNTY.GOV .

Item # 5

REPORT ON THE GOVERNANCE AD HOC COMMITTEE

OCTOBER 25, 2023

INTRODUCTION

- Consultants' Report
- Activities of the Ad Hoc Governance Committee
- Summary and Highlights
- Subsequent Information, Listening Sessions, Office Hours

HISTORY AND RESPONSIBILITIES

- The Governance Ad Hoc Committee First Meeting February 2023
- Representatives from the ICH, service organizations, cities, county departments, and other stakeholders.
- Review HUD CoC Governance Requirements
- Review current Structures and Charter
- Develop an updated Charter for CoC Consideration

GOALS – PART I

- Engage in a process
- Deliver a Charter that, if implemented, fulfills all requirements and fosters an effective CoC system
- Educate community about best practices
- Deliver a revised Charter for CoC Action
- Prepare for a system that is transparent, readily understood, collaborative, and promotes effectiveness.

GOALS – PART II

In order to effectively implement the responsibilities of the CoC, prepare for a system that is:

- transparent,
- readily understood,
- collaborative, and
- promotes community-wide engagement of stakeholders in partnership.

COMMITTEE PRINCIPLES

- Working Group.
- Consensus oriented.
- Member engaged: thoughtful discussion, in-room 'deliberation'.
- Focus on what is best for the CoC / community not for individual organizations.

OPERATING PRINCIPLES/PROCESSES

- Charter must meet federal regulations but is locally developed and owned.
- Intentional effort to hear all voices.
- Used a Community Survey, Committee Breakout Sessions, and Small Group 'homework'.
- Groups were dynamic, with changes in composition to maximize diversity of thoughts, experience, and relationship building.

OPERATING PRINCIPLES/PROCESSES, CONTINUED

- New Charter focused on the CoC and all its components, no just the Board.
- Existing names/designations were replaced by the HUD terms for various components, leaving room for rebranding or change.
- Ensure the Charter provides clear guidance.
- Charter organized by Chapters for review.

PROCESSES, CONTINUED

- Bi-weekly meetings and 'homework' between sessions.
- Began with information gathering.
- Initially focused on identifying key roles and responsibilities as outlined by HUD regulations.
- Expanded the roles and responsibilities by delegating additional tasks to various components.
- Drafted new Charter Chapters and information.

DATA AND INPUT

- Stakeholder survey.
- Board Matrix analysis.
- Ad Hoc and Membership Orientation to CoC system responsibilities.
- Current Charter alignment.
- Reviewed best practices and Charters from other CoCs.
- Incorporated HUD Regulations and Federal Partner Guidance.
- Committee Member experience and expertise.

PRIORITY PRODUCTS

Roles and responsibilities of each required system component:

- CoC Membership
- CoC Board
- Collaborative Applicant
- HMIS Lead Agency
- Coordinated Entry Lead Entity

PRIORITY PRODUCTS, CONTINUED

- Code of Conduct
- Conflict of Interest
- Principles of Decorum

TRANSITION PLANNING AND OTHER PRODUCTS

Approval of changes will inspire other products.

- Lead Agency MOUs (Collaborative Applicant, HMIS, CES).
- CoC Membership Application and onboarding process.
- Membership tracking – voting privileges, responsibilities.
- 'Report Cards' and Lead Agency Performance Reviews.
- Board Member selection and transition.

KEY CHANGES

A major outcome of the Ad Hoc Committee process was the identification of the roles and responsibilities of each of the HUD-required system structures.

A Chart with the core responsibilities for establishing and operating the CoC identifies three levels of responsibility for the required actions:

- Authority/Oversight
- Lead for Implementation
- Support roles

The Committee reached consensus on these roles, which were then used to draft the Charter Chapters.

SOME KEY CHANGES, CONTINUED

Survey results and Board Matrix review were used to inform changes in Board composition.

- The current seat distribution has 13 seats (68%) government/public; 5 (26%) HPN regional service providers; and 1 (6%) dedicated to persons with lived experience. Of these, 7 (37%) are dedicated to persons in a specific position. This combination represents the public resources well, recognizes an equal number of seats for the regions, and includes a seat dedicated to a Person with as required by HUD. However, the Board candidates primarily are generated outside the general CoC Membership.

KEY CHANGES, CONTINUED

Stakeholder input and experience fostered recommended Board selection changes that:

- broaden the characteristics of persons eligible to be on the Board.
- places more seats by nomination and election by the CoC.
- have approximately one-third of the members in each category.
- formalizes the practice of having the Collaborative Applicant (OHS) act as CoC Secretary.

KEY CHANGES, CONTINUED

Shift and Strengthen the Advisory Role of Public Entities through an Advisory Group.

- If adopted, the Charter changes would reduce the number of Board seats dedicated to cities.
- Cities are important partners who may face different issues and have varying levels of investment.
- A cross- sector advisory group could help focus and respond to those differences.

KEY CHANGES

Survey and member input called for increased clarity in the Governance Charter.

- Chapters are devoted to required components and over-arching policies.
- Although the Charter is required for HUD CoC funding, the role of the Administrative Entity for state homeless funds allocated to the CoC is included.
- New forms, MOUs, and companion documents are being developed to implement the system changes, if approved by the CoC.

FINAL STEPS TIMELINE, PART I

Prior to presentation to CoC for approval:

- Report to Board (October)
- Charter information and Listening Sessions – Regional Meetings (HPN) (November/ December)
- Office Hours and Community Information and Listening Sessions (November/December)
- Update and review final drafts (December)
- CoC Membership Meeting Presentation for Approval (January)

FINAL STEPS TIMELINE, PART II

Upon CoC Approval:

- Call for Nominations (January-February, 6 weeks allowed)
- Call and registration/ confirmation of members (February)
- Establish Advisory Committee, begin Committee Reforms (Feb-March)
- Nominating Committee Report and selection process (March)
- New Member orientation (April)

CLOSING COMMENTS

- The recommended Governance Charter is 'not perfect'.
- It does not satisfy all the individual desires of the members.
- The consensus is that in principle it puts the community in a better position: HUD Compliance, opportunity to enhance CoC Membership participation.
- The Charter and processes will be 'living / breathing' guidance that will be refined over time.

SUMMARY

The Charter is just a document. Benefits for the community will only be realized if there is a willingness to work together in good faith and transparency, looking forward to a vibrant effective system

THANK YOU!

to the

Governance Ad Hoc Committee
The ICH Board
The Service Provider HPN
And Community Stakeholders

Minutes for San Bernardino City & County Homeless Continuum of Care

West Valley Regional Steering Committee Meeting

Wednesday, October 11, 2023, 9:00am – 11:00am
Rancho Cucamonga City Hall – Tri-Communities Conference Room
10500 Civic Center Dr, Rancho Cucamonga, CA 91730
& by Zoom Video Conference

Minutes recorded and transcribed by Bryanna Parker, Service Coordinator, Knowledge Education for Your Success, Inc.

OPENING REMARKS	PRESENTER	ACTION / OUTCOME
Call to Order Welcome and Introductions	Don Smith	• Meeting was called to order at 9:05 am • Roll Call of RSC Committee delegates followed by self-introductions by all meeting attendees
REPORTS & UPDATES		
Interagency Council on Homelessness (ICH) Homeless Provider Network Office of Homeless Services State & Federal Updates	Don Smith	• 5% of the HHAP-4 has been allocated for CES • The allocations for the HHAP 4 funding is based on the 2023 Point in Time Count. • Setting the date for 2024 Point In Time Count: January 25, 2024 • RFP for capacity building activities was released and is due 10/23/2023 • RFP for CoC for regional planning was released. Due 10/30/2023 • HMIS updated policy and procedure manual • CAL ICH is now required to present goals and track unaccompanied women and domestic violence survivors • Please see the RSC Meeting presentation slides attached for more information
Regional City & Service Provider Partners	RSC Committee Members	• City of Rancho Cucamonga: working w/ other cities across the nation in reaching the goal of affordable housing • City of Chino: waiting to onboard Homeless Outreach Coordinator • City of Ontario: has $135,000 in HHAP funding for RRH. Waiting for approval from board of supervisors. Households will have 6 months of this assistance and be able to sustain their rent afterward. • ACLU: governor just signed a policy that eliminates discrimination in housing policies statewide • Family Assistance: mobile showers every Monday, Tuesday and Thursday in San Bernardino); having resource fair October 27th, has room in TAY shelters for 18-25 year olds at 323 west 7th Street, San Bernardino • Hope Service Alliance hosting suicide prevention walk

CONSENT ITEMS		
No consent items		• No consent calendar items on the agenda.
DISCUSSION ITEMS		
Building on CalAIM's Housing Supports: Strengthening Medi-Cal for People Experiencing Homelessness	Kevin Mahany, Family Assistance Program	• This initiative is to improve access to coordinated care • Documenting in real-time patient medical records and needs. • Hospitals are hiring homeless navigators to follow up with patients • Please see CalAIM presentation slides in the attached for more information
Taking it to the Streets: New Street Medicine Initiatives in San Bernardino County	Eddie Menacho, PA-C Healthcare in Action	• Street medicine and managed care combined helps homeless with whole person care • A needs assessment is conducted with the homeless to determine what they need • Please see HIA presentation slides attached for more information
J. Strengthening Our Regional Partnerships to Facilitate Coordinated Service Delivery and Strategic Resource Alignment	Robert Gipson Health Service Alliance	• Health service alliance will be partnering with Molina Healthcare to have a mobile clinic and in process of getting a grant for another mobile unit
CLOSING		
Public Comment	All attendees	• No additional public comment
Adjournment	Erika Lewis-Huntley	• There being no further business to discuss, the meeting was adjourned at 11:01 am.
Next Meeting	Don Smith	• West Valley Regional Steering Committee Wednesday, November 8, 2023, 9:00am – 11:00am Rancho Cucamonga City Hall – Tri-Communities Room 10500 Civic Center Dr, Rancho Cucamonga, CA 91730

October 11, 2023, Attendees: West Valley Regional Steering Committee Meeting

LAST NAME	FIRST NAME	ORGANIZATION	PHONE NUMBER	EMAIL ADDRESS
Schoenthaler	Cooper	Pair Team	(909)521-1518	cooper@pairteam.com
Ahmed	Omar	Impact Southern California	(909)285-4223	omar@impactsocal.com
Vasquez	Antonio	City of Ontario-Continuum of Care	(909)534-9529	ajvasquez@ontarioca.gov
Capcal	Melanie	Health Service Alliance	(323)401-2569	Mcac00@lasierra.edu
Johnson	Marlandra	Board of Supervisors District 5	(909)387-4099	Marlandra.johnson@bos.sbcounty.gov
Gavilanes	Leticia	City of Montclair	(909)625-9485	lgavilanes@cityofmontclair.org
Franco	Kari	City of Chino Human Service	(909)334-3537	kfranco@cityofchino.org
Manuel	Aziza	United Way	(626)806-5987	azizam@iscuw.org
Gallegos	Diana	Health Service Alliance	(909)464-9675	008064219@coyote.csusb.edu
Espinoza	Claudia	The Artisan's House	(909)714-6117	theartisanshouseorg@gmail.com
Steele	Melanie	Inland SoCal Housing Collective	(909)809-0849	melanie@ischcollective.org
Kratzer	Pamela	Love Chaple Life Changing Ministries/ San Bernardino SCSEP	(909)948-6571	outreach@lovechapellcmc.com
Kwan	Jason	Health Service Alliance	n/a	008062308@coyote.csusb.edu
Johnston	Janet	Morongo Basin ARCH	(760)668-3622	janetjohnstn@earthlink.net
Dixon	Ramel	Inland Housing Solutions		ramel@inlandhousingsolutions.org
Petite	Linda	Inland Counties Legal Services	(951)368-2558	lpetite@icls.org
Harris	Prentice	Chaffey College	(909)652-6596	Prentice.harris@chaffey.edu
Meggs	Robin	Molina Healthcare	(562)951-8388	Robin.meggs@molinahealthcare.com
Komaro	Natalie	City of Ontario	(909)395-2897	nkomaro@ontarioca.gov
Martinez	Pamela	City of Ontario	(909)395-2529	pmartinez@ontarioca.gov
Gipson	Robert	Health Service Alliance	(909)274-0036	rgipson@healthservicealliance.org
Stokes	Morgan	Health Service Alliance	(909)648-3884	004014542@coyote.csusb.edu
Mahany	Kevin	Family Assistance Program	(909)630-6188	kevin@familyassist.org

October 11, 2023, Attendees: West Valley Regional Steering Committee Meeting

LAST NAME	FIRST NAME	ORGANIZATION	PHONE NUMBER	EMAIL ADDRESS
Rucker	Donald	Christian Development Center	(909)367-9093	pastorrucker@gmail.com
Montes	Nicole	Lighthouse Social Service Centers	(951)616-0314	nicolem@lighthouse-ssc.org
Scott	Zazette	Family Assistance Program	(909)908-8053	zazette@familyassist.org
Reyes		Catholic Charities Ontario	(909)906-5980	sreyes@ccsbriv.org
Durham	Paul	SBCSS	(909)388-2715	Paul.durham@sbcss.net
Coleman	Lanea	City of Fontana	(909)350-7617	lcoleman@fontanaca.gov
Swiestra	Elizabeth	Rolling Start	(909)836-5051	eswierstra@rollingstart.com
Aguilera	David	Rolling Start	(951)832-0886	daguilera@rollingstart.com
Parker	Bryanna	Keys Nonprofit	(909)488-0810	bparker@keysnonprofit.org
Davison	Kevin	Inland Valley Hope Partners	(909)391-4882 ext 204	kevnd@inlandvalleyhopepartners.org
Medina	Justis	Family Assistance Program	(909)515-3978	justis@familyassist.org
Lewis-Huntley	Erika	City of RC	(909)774-2008	Erika.lewis-huntley@cityofrc.us
Smith	Don	SBC Pathways to Housing Network	(909)210-0639	DonSmithSolutions@outlook.com

The Solution to Homelessness is Straightforward:
HOUSING!

Building on CalAIM's Housing Supports: Strengthening Medi-Cal for People Experiencing Homelessness

Taking It to the Streets! New Street Medicine Initiatives

Plus,
Updates on CoC activities,
City & Regional Service partners & more

West Valley Regional Steering Committee Meeting
October 11, 2023, 9:00am

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San Bernardino County HOMELESS PARTNERSHIP

San Bernardino County Homeless Partnership
West Valley HPN/Regional Steering Committee

Wednesday, October 11, 2023 • 9:00 a.m. to 11:00 a.m.

Hosted by the City of Rancho Cucamonga - Please Join Us at
RC City Hall – Tri-Communities Room
10500 Civic Center Drive, Rancho Cucamonga 91730
-or-
By Zoom Video Conference:
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Meeting ID: 851 9494 6723- Password: 183200
Dial in +1 669 900 6833 - One tap mobile +16699006833,,89595982006# US (San Jose)

Regional Steering Committee members must attend in person to establish a quorum and vote on Agenda items when applicable

AGENDA

OPENING REMARKS	PRESENTER
A. Call to Order B. Welcome and Introductions *Public comment and participation is available and welcomed during all agenda items*	Erika Lewis-Huntley Don Smith
REPORTS & UPDATES	
C. Interagency Council on Homelessness D. Homeless Provider Network E. Office of Homeless Services F. State and Federal Updates G. Regional City & Service Provider Partners	Erika Lewis-Huntley Don Smith OHS staff RSC Committee Members
PRESENTATIONS / DISCUSSION ITEMS	
H. ***Building on CalAIM's Housing Supports: Strengthening Medi-Cal for People Experiencing Homelessness***	Kevin Mahany Family Assistance Program
I. ***Taking it to the Streets: New Street Medicine Initiatives in San Bernardino County***	Health Services Alliance Healthcare in Action
J. ***Strengthening Our Regional Partnerships to Facilitate Coordinated Service Delivery and Strategic Resource Alignment*** a. Updates on our West Valley Regional CES Access hub b. West Valley Regional "Navigation Center/Supportive Housing Village"	Pastors Donald & Ethel Rucker RSC Committee Members
CLOSING	
K. Additional Public Comment (2 mins) L. Adjournment	Don Smith Erika Lewis-Huntley

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San Bernardino County Homeless Partnership

Item #7

Interagency Council on Homelessness
Administrative Office
560 E. Hospitality Lane Suite 200, San Bernardino, CA 92408-0044
Office: (909) 501-0610

FROM: Regional Representatives to the ICH

SUBJECT: Homeless Housing, Assistance and Prevention Program, Round 4 Grant Funding Allocations

DATE: September 27, 2023

RECOMMENDATIONS

That the San Bernardino City & County Continuum of Care Interagency Council on Homelessness (ICH) adopt the following recommendations for the distribution, implementation, and oversight of the **$4,430,501.22 in Homeless Housing, Assistance and Prevention Program, Round 4** (HHAP-4) grant funding allocated to the San Bernardino City & County Continuum of Care:

1. Approve the distribution of the HHAP-4 CoC funding, as follows:
   a. **$310,135.08** for Administration (7%)
   b. **$443,050.12** for services for homeless youth populations (10%)
   c. **$221,525.06** for CES Regional activities (5%)
   d. **$3,455,790.96** for regional service projects based on 2023 PITC numbers:
      - **$2,094,209.32** Central Valley Region (60.6%)
      - **$739,539.27** Desert Region (21.4%)
      - **$193,524.29** East Valley Region (5.6%)
      - **$65,660.02** Mountain Region (1.9%)
      - **$362,858.06** West Valley Region (10.5%)
2. Authorize the Office of Homeless Services (OHS) to initiate the project funding application and contract execution process.

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San Bernardino County Homeless Partnership

Item #6

Interagency Council on Homelessness
Administrative Office
560 E. Hospitality Lane Suite 200, San Bernardino, CA 92408-0044
Office: (909) 501-0610

FROM: Marcus Dillard, Office of Homeless Services

SUBJECT: Proposed 2024 Point-In-Time Count Date

DATE: September 27, 2023

RECOMMENDATION

Approve the date of January 25, 2024, to conduct the 2024 Point-In-Time Count.

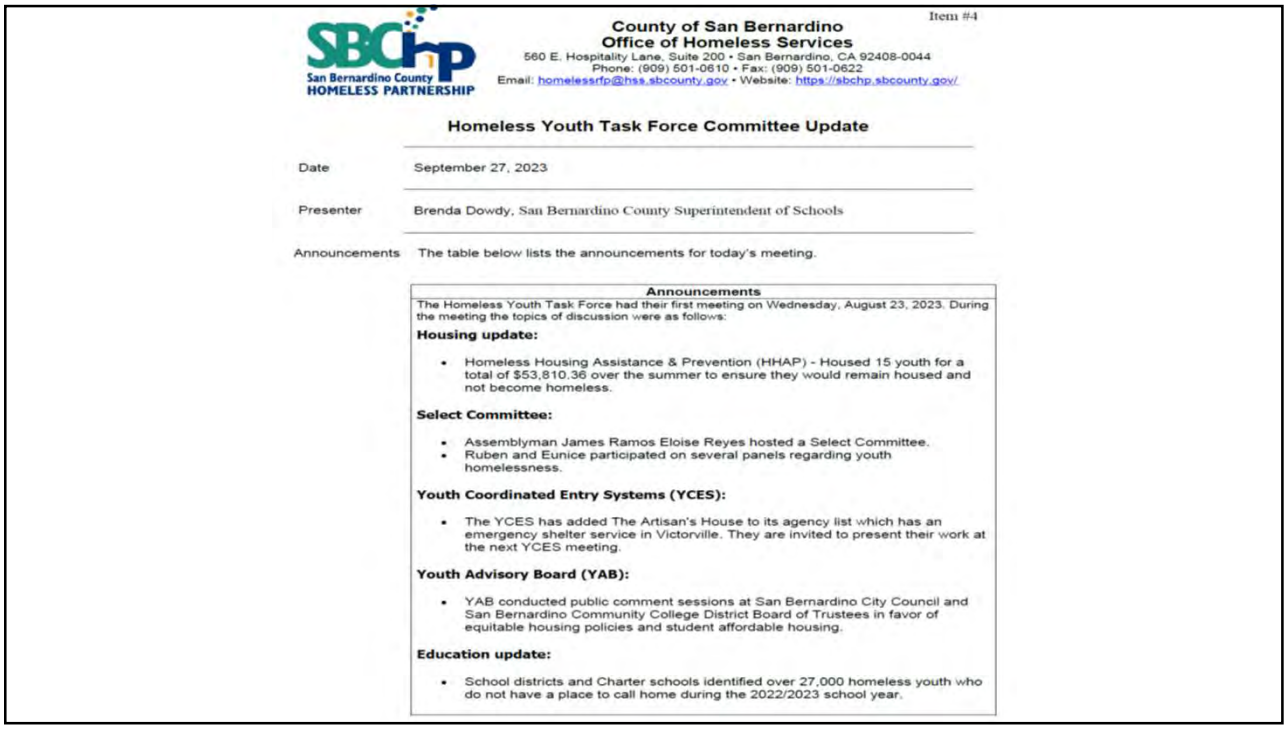
BACKGROUND INFORMATION

In the early 2000s, the U.S. Department of Housing and Urban Development (HUD) began requiring Continuums of Care (CoCs) to conduct a Point-in-Time Count (PITC) of people experiencing homelessness at least every other year as a means of collecting vital data in individual communities.

HUD requires a sheltered PITC be conducted annually and only requires the unsheltered portion of the count every other year. However, many CoCs including ours, include unsheltered people in their annual counts as a way to gather more accurate data and provide better services.

Nationwide all PITCs are conducted the last 10 days of January, due to HUD policy, but generally the results of the data are submitted and published a few months later. Planning activities for the PITC must begin months prior as these projects require a lot of time and manpower.

4



Item #4

County of San Bernardino
Office of Homeless Services
560 E. Hospitality Lane, Suite 200 • San Bernardino, CA 92408-0044
Phone: (909) 501-0610 • Fax: (909) 501-0622
Email: homelessrfp@hss.sbcounty.gov • Website: https://sbchp.sbcounty.gov/

Homeless Youth Task Force Committee Update

Date	September 27, 2023
Presenter	Brenda Dowdy, San Bernardino County Superintendent of Schools
Announcements	The table below lists the announcements for today's meeting.

Announcements

The Homeless Youth Task Force had their first meeting on Wednesday, August 23, 2023. During the meeting the topics of discussion were as follows:

Housing update:

- Homeless Housing Assistance & Prevention (HHAP) - Housed 15 youth for a total of $53,810.36 over the summer to ensure they would remain housed and not become homeless.

Select Committee:

- Assemblyman James Ramos Eloise Reyes hosted a Select Committee.
- Ruben and Eunice participated on several panels regarding youth homelessness.

Youth Coordinated Entry Systems (YCES):

- The YCES has added The Artisan's House to its agency list which has an emergency shelter service in Victorville. They are invited to present their work at the next YCES meeting.

Youth Advisory Board (YAB):

- YAB conducted public comment sessions at San Bernardino City Council and San Bernardino Community College District Board of Trustees in favor of equitable housing policies and student affordable housing.

Education update:

- School districts and Charter schools identified over 27,000 homeless youth who do not have a place to call home during the 2022/2023 school year.

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HMIS Policies and Procedures Manual - UPDATED

We are pleased to inform you we have updated the HMIS Policies and Procedures Manual with the intention to streamline data collection, reporting procedures, accuracy, security of the system, and align with the latest HUD standards.

Key changes to the attached policy include:

- Clearer data entry guidelines to maintain data consistency and accuracy.
- Improved data security measures to safeguard sensitive information.
- Updated reporting protocols to comply with regulatory requirements.
- Additional guidance on user roles and responsibilities within the HMIS.

For convenience, we have attached a copy of the updated HMIS Policies and Procedures Manual to this email. The Document is also available on the Homeless Partnership Website Resources – Homeless Partnership (sbcounty.gov).

We appreciate your cooperation and prompt adherence to the updated HMIS Policies and Procedures Manual. The effective date is today, August 04, 2024, and we kindly request that you carefully review the document and begin implementation.

If you have any questions or require further clarification regarding the updates, please contact us via the HMIS helpdesk at dbh-hmishelpdesk@hss.sbcounty.gov.

Please note, HUD recently released updated HMIS standards which will be effective October 2023, the HMIS team is carefully reviewing the standards and will notify the agencies of any changes that impact how you collect and manage data.

Thank you for your continued dedication to our shared mission. Together, we can make a significant impact in addressing homelessness and improving the lives of those most in need.

Thank you,
Your HMIS Team

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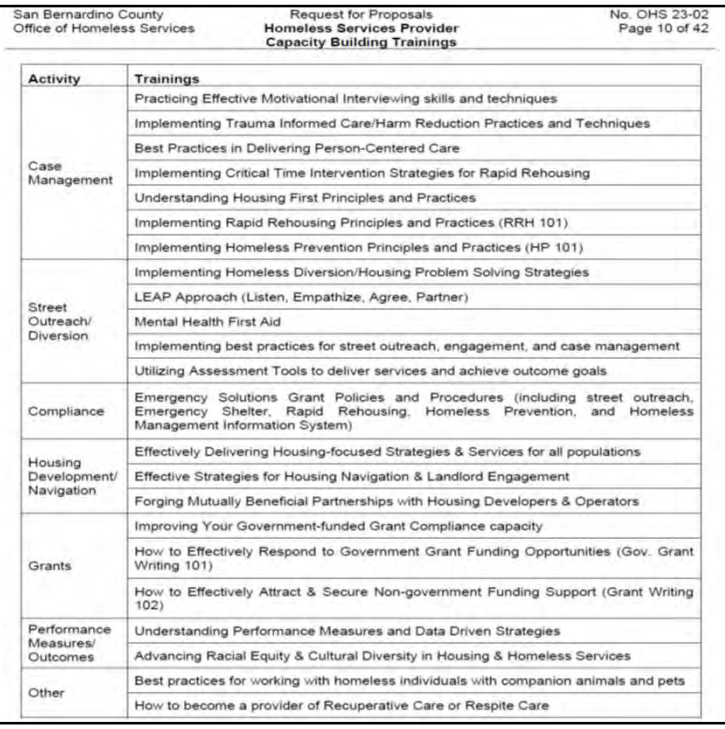
Request for Proposal – Capacity Building Services

The San Bernardino County Office of Homeless Services, the designated Administrative Entity of the San Bernardino City and County Continuum of Care (CoC), is seeking Proposals from interested and qualified Proposers to enhance homeless services coordination through education and capacity building programs.

The requested workshop and training activities are aimed at providing education, guidance, and support to our CoC partners – including service provider staff and supervisors, CoC leaders, city and county officials and staff, community service advocates and other stakeholders – on topics related to improving and enhancing our homelessness response system. Please refer to the attached Request for Proposals for submission guidelines and deadlines.

Proposals are due Monday, October 23, 2023 by 4 p.m. (Local Time) and must be submitted electronically via email to the mailbox: HomelessRFP@hss.sbcounty.gov



San Bernardino County Office of Homeless Services | Request for Proposals **Homeless Services Provider Capacity Building Trainings** | No. OHS 23-02 Page 10 of 42

Activity	Trainings
Case Management	Practicing Effective Motivational Interviewing skills and techniques
	Implementing Trauma Informed Care/Harm Reduction Practices and Techniques
	Best Practices in Delivering Person-Centered Care
	Implementing Critical Time Intervention Strategies for Rapid Rehousing
	Understanding Housing First Principles and Practices
	Implementing Rapid Rehousing Principles and Practices (RRH 101)
	Implementing Homeless Prevention Principles and Practices (HP 101)
Street Outreach/ Diversion	Implementing Homeless Diversion/Housing Problem Solving Strategies
	LEAP Approach (Listen, Empathize, Agree, Partner)
	Mental Health First Aid
	Implementing best practices for street outreach, engagement, and case management
	Utilizing Assessment Tools to deliver services and achieve outcome goals
Compliance	Emergency Solutions Grant Policies and Procedures (including street outreach, Emergency Shelter, Rapid Rehousing, Homeless Prevention, and Homeless Management Information System)
Housing Development/ Navigation	Effectively Delivering Housing-focused Strategies & Services for all populations
	Effective Strategies for Housing Navigation & Landlord Engagement
	Forging Mutually Beneficial Partnerships with Housing Developers & Operators
Grants	Improving Your Government-funded Grant Compliance capacity
	How to Effectively Respond to Government Grant Funding Opportunities (Gov. Grant Writing 101)
	How to Effectively Attract & Secure Non-government Funding Support (Grant Writing 102)
Performance Measures/ Outcomes	Understanding Performance Measures and Data Driven Strategies
	Advancing Racial Equity & Cultural Diversity in Housing & Homeless Services
Other	Best practices for working with homeless individuals with companion animals and pets
	How to become a provider of Recuperative Care or Respite Care

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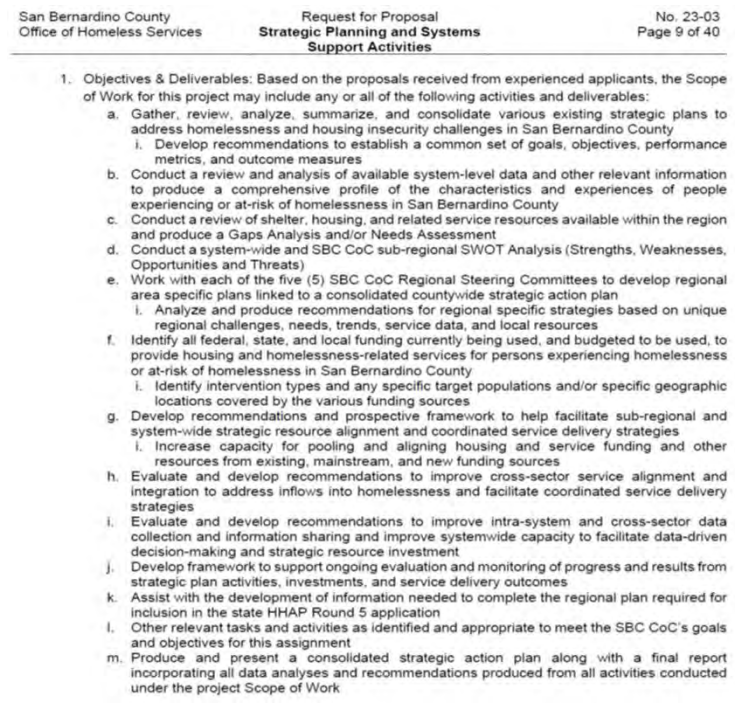
Request for Proposal – CoC Strategic Planning

The San Bernardino County Office of Homeless Services, the designated Administrative Entity of the San Bernardino City and County Continuum of Care (CoC), is seeking Proposals from experienced vendors to conduct a comprehensive evaluation of the homelessness response system in San Bernardino County and facilitate strategic planning activities designed to strengthen regional partnerships, improve service delivery coordination, and enable strategic alignment of resources.

The project Scope of Work will be determined based on a review of the proposed work plans received from experienced vendors designed to meet a broad set of objectives outlined below. Work product from this effort will be used to inform, or perhaps complete, the Regional Plan that will be required as part of the HHAP Round 5 application.

Proposals are due Monday, October 30, 2023, by 4 p.m. (Local Time) and must be submitted electronically via email to the mailbox: HomelessRFP@hss.sbcounty.gov



San Bernardino County Office of Homeless Services | Request for Proposal **Strategic Planning and Systems Support Activities** | No. 23-03 Page 9 of 40

1. Objectives & Deliverables: Based on the proposals received from experienced applicants, the Scope of Work for this project may include any or all of the following activities and deliverables:
   a. Gather, review, analyze, summarize, and consolidate various existing strategic plans to address homelessness and housing insecurity challenges in San Bernardino County
      i. Develop recommendations to establish a common set of goals, objectives, performance metrics, and outcome measures
   b. Conduct a review and analysis of available system-level data and other relevant information to produce a comprehensive profile of the characteristics and experiences of people experiencing or at-risk of homelessness in San Bernardino County
   c. Conduct a review of shelter, housing, and related service resources available within the region and produce a Gaps Analysis and/or Needs Assessment
   d. Conduct a system-wide and SBC CoC sub-regional SWOT Analysis (Strengths, Weaknesses, Opportunities and Threats)
   e. Work with each of the five (5) SBC CoC Regional Steering Committees to develop regional area specific plans linked to a consolidated countywide strategic action plan
      i. Analyze and produce recommendations for regional specific strategies based on unique regional challenges, needs, trends, service data, and local resources
   f. Identify all federal, state, and local funding currently being used, and budgeted to be used, to provide housing and homelessness-related services for persons experiencing homelessness or at-risk of homelessness in San Bernardino County
      i. Identify intervention types and any specific target populations and/or specific geographic locations covered by the various funding sources
   g. Develop recommendations and prospective framework to help facilitate sub-regional and system-wide strategic resource alignment and coordinated service delivery strategies
      i. Increase capacity for pooling and aligning housing and service funding and other resources from existing, mainstream, and new funding sources
   h. Evaluate and develop recommendations to improve cross-sector service alignment and integration to address inflows into homelessness and facilitate coordinated service delivery strategies
   i. Evaluate and develop recommendations to improve intra-system and cross-sector data collection and information sharing and improve systemwide capacity to facilitate data-driven decision-making and strategic resource investment
   j. Develop framework to support ongoing evaluation and monitoring of progress and results from strategic plan activities, investments, and service delivery outcomes
   k. Assist with the development of information needed to complete the regional plan required for inclusion in the state HHAP Round 5 application
   l. Other relevant tasks and activities as identified and appropriate to meet the SBC CoC's goals and objectives for this assignment
   m. Produce and present a consolidated strategic action plan along with a final report incorporating all data analyses and recommendations produced from all activities conducted under the project Scope of Work

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REPORT/RECOMMENDATION TO THE BOARD OF SUPERVISORS
OF SAN BERNARDINO COUNTY
AND RECORD OF ACTION
October 3, 2023

SUBJECT
Establish Homelessness Ad Hoc Committee

RECOMMENDATION(S)
Establish a Homelessness Ad Hoc Committee consisting of Fourth District Supervisor Curt Hagman and Fifth District Supervisor Joe Baca, Jr. to identify the root causes of homelessness in San Bernardino County and provide policy recommendations to the Board of Supervisors.
(Presenter: Dawn Rowe, Chair and Third District Supervisor, 387-4855)

COUNTY AND CHIEF EXECUTIVE OFFICER GOALS & OBJECTIVES
Promote the Countywide Vision.
Improve County Government Operations.
Operate in a Fiscally Responsible and Business-Like Manner.

FINANCIAL IMPACT
Approval of this action will not require the use of additional Discretionary General Funding (Net County Cost).

BACKGROUND INFORMATION
The 2023 San Bernardino County Point in Time Count (PITC) states that 4,195 residents reported experiencing homelessness, with 2,976 being unsheltered. These results showed that homelessness numbers have steadily risen since 2017 and increased by approximately 26%, compared to 2022. Homelessness can have a significant impact on communities and the health of individuals. Common effects on health are physical health problems, mental health conditions, substance abuse, and infectious disease.

The Chair of the Board of Supervisors (Board) recommends that a Homelessness Ad Hoc Committee (Committee) consisting of two Supervisors be established to research, review, and recommend policy to the Board to address homelessness in the county. The Chair recommends the appointment of Supervisor Curt Hagman and Supervisor Joe Baca, Jr. to the Committee. Changes to the appointment of Supervisors on this committee will require Board approval. The Committee would work with County staff to investigate the root causes of homelessness specific to this County and present its findings, as well as policy recommendations, to the Board at public hearings or meetings for public comment and input prior to implementation.

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SAN BERNARDINO COUNTY

San Bernardino County Housing Development Fund Guidelines

1. **Purpose**
   On March 28, 2023, the San Bernardino County Board of Supervisors approved the County Homeless Initiatives Spending Plan to direct $72,700,000 for a multi-faceted approach for the Homeless Strategic Action Plan. The Homeless Initiatives Spending Plan allocated $20 million of funding to establish a housing development grant fund to accelerate the production of new housing units to address and prevent homelessness. An additional $20 million dollars in funding is pending approval of the Fiscal Year 2023-2024 Recommended Budget. The Development Fund is designed to provide gap funding to support projects currently underway in cities and communities.

2. **Goals of the San Bernardino County Housing Development Grant Fund**
   The Fund has three primary goals: 1) to advance County-City partnerships; 2) accelerate affordable housing production; and 3) to initiate strategic sheltering investments that will increase the capacity of the homeless system of care. The Fund is designed as gap funding which will leverage local, State and Federal funds to the fullest extent possible.

3. **Organization & Oversight**
   The San Bernardino County Board of Supervisors provides oversight to the Development Fund and serves as the decision-making body. Staff from the Department of Community Development and Housing (CDH) will process all applications and make funding recommendations to the Board of Supervisors based on established funding priorities and project readiness. The Board of Supervisors will review funding requests through the regular agenda of the Board of Supervisors. CDH staff will be made available to provide consultation and technical assistance to applicants and awardees.

4. **Types of Projects**
   Development Funds are available, but not limited to, the following type of projects:
   - Emergency shelters which are defined as any facility, the primary purpose of which is to provide a temporary shelter for the homeless in general or for specific populations of the homeless and which does not require occupants to sign leases or occupancy agreements. Non-congregate emergency shelter is an eligible component provided that it is a fixed, permanent site.
   - Permanent Supportive Housing
   - Affordable Housing targeted to 80% AMI or below
   - Other projects that meet the goals and priorities of these Guidelines.

SAN BERNARDINO COUNTY

6. **Priorities**
   The Development Fund will prioritize projects that:
   - Produce interim housing beds, permanent supportive housing units and affordable housing units
   - Provide a restricted use period or affordability restrictions; shelters/interim housing restricted for a minimum of 15 years and affordable housing 20 years
   - Leverage other funding to the maximum extent feasible

7. **Terms**
   Development Fund monies are generally available in the form of a forgivable loan. Fund disbursement and terms will vary by project to meet the needs of the project, availability of financing, financing method, development configuration and organizational capacity of the developer, as determined by staff and the Board of Supervisors.

8. **Funding Amounts**
   The Development Fund will issue awards in the amounts of $100,000-$5,000,000 per project depending on funds available, type of project, beds/units created and the use of leveraged funds.

9. **Funded Activities/Activities Eligible for Funding**
   Any cost associated with the new construction, acquisition or rehabilitation of shelters, permanent supportive housing and affordable housing. The Development Fund may provide funding for the following types of activities:
   - Seed/Catalyst funds for very early costs to initiate or expedite project development (such as feasibility analysis or community planning)
   - Land or property acquisition for new development
   - Predevelopment (architecture, engineering/soils, environmental reports, financial consultants, etc.)
   - Construction (site preparation, construction, materials)
   - Rehabilitation activities to renovate existing rental units or
   - Conversion of market rate housing, or non-residential buildings, to deed restricted affordable housing
   - Any other activity that helps to address program goals and priorities of increasing affordable housing as reflected by ordinances and resolutions established by the Board of Supervisors.
   - Administrative, operating, and programmatic costs are not eligible for funding.

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Regionally Coordinated
Homeless Housing, Assistance and Prevention Program
ROUND 5

B. Purpose And Program Objectives

HHAP-5 is established for the purpose of organizing and deploying the full array of homelessness programs and resources comprehensively and effectively, and to sustain existing federal, state, and local investments towards long-term sustainability of housing and supportive services. (HSC §§ 50232(a) and 50236(a).) To accomplish these goals, HHAP-5 requires applicants to create and implement Regionally Coordinated Homelessness Action Plans.

In order to successfully reduce homelessness through this funding, Cal ICH also expects applicants to:

- Foster robust regional collaboration and strategic partnerships aimed at fortifying the homeless services and housing delivery system. This should be achieved through the formulation of data-driven and cross-system plans designed to allocate resources in alignment with the state's priorities for homeless housing solutions. This means implementing strategies that create and sustain regional partnerships and emphasize permanent housing solutions.
- Ensure the long-term sustainability of housing and supportive services, by strategically pairing these funds with other local, state, and federal resources to effectively reduce and ultimately end homelessness. Applicants are encouraged to follow the guidance provided in "Putting the Funding Pieces Together: Guide to Strategic Uses of New and Recent State and Federal Funds to Prevent and End Homelessness".
- Demonstrate sufficient resources dedicated to long-term permanent housing solutions, including capital and operating costs.
- Demonstrate a commitment to address racial disproportionality in homeless populations and achieve equitable provision of services and outcomes for Black, Native and Indigenous, Latinx, Asian, Pacific Islanders and other People of Color who are disproportionately impacted by homelessness.
- Establish a mechanism for people with lived experience of homelessness to have meaningful and purposeful opportunities to inform and shape all levels of planning and implementation, including through opportunities to hire people with lived experience.
- Fund projects that provide housing and services that are Housing First compliant, per HSC section 50234(f), and delivered in a low barrier, trauma informed, and culturally responsive manner. Individuals and families assisted with these funds must not be required to receive treatment or perform any other prerequisite activities as a condition for receiving interim or permanent housing, or other services for which these funds are used. Housing First should be adopted within the entire local homelessness response system, including outreach and interim housing, short-term interventions like rapid re-housing, and longer-term interventions like supportive housing.
- Cal ICH strongly encourages applicants to prioritize the use of HHAP funds to assist people to remain in or move into safe, stable, permanent housing. HHAP funding should be housing-focused -- either funding permanent housing interventions directly or, if used for interim housing or street outreach, have clear pathways to connect people to permanent housing options.

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Regionally Coordinated
Homeless Housing, Assistance and Prevention Program
ROUND 5

Regionally Coordinated Homelessness Action Plans (Regional Plans)

The new feature of HHAP 5, which is a product of continued conversations at the state level on accountability, is the regional plan. As directed in the trailer bill, the state must issue the HHAP 5 application by September 30, 2023, after which, jurisdictions will have 180 days to work together to craft a regional plan (with regions defined at the county level) and submit a joint application for HHAP funding. Every big city, county, and CoC will have the ability to keep their HHAP 5 base allocation, although the trailer bill gives the option for applicants in a region to create a regional fiscal agent. This regional plan process will replace the HHAP 3 and HHAP 4 goal setting process, and the performance metrics outlined in HHAP 3 and HHAP 4 are being eliminated.

The HHAP 5 regional plans are required by statute to do the following:

- Identify roles and responsibilities for each entity within the region, including smaller, non-HHAP grantee jurisdictions that choose to participate in the planning;
- Outline recent system performance metrics, including metrics related to racial disparities;
- Identify all federal, state, and local funds being utilized to meet the performance metrics;
- Describe actions that each region will take to limit inflow into homelessness from institutions such as jails and hospitals;
- Describe how each region will leverage an array of state and federal resources to end homelessness and provide sufficient wrap around services;
- Describe actions being taken to ensure greater equity in homeless services outcomes/

Entities crafting the plans are required to hold at least three public meetings before submitting the plans, and must invite an array of stakeholders to these meetings, including people with lived experience of homelessness, service providers, Medi-Cal Managed Care Plans, and others. The plan must result in a signed memorandum of understanding (MOU) between the HHAP grantees within the region.

III. ELIGIBLE USES

While the eligible uses for HHAP-5 remain largely unchanged from previous rounds, the HHAP-5 statute reorganizes eligible uses into three main buckets: (1) costs that support permanent housing; (2) costs that support interim housing; and (3) costs that support service provision and systems support. This change represents a strategic alignment aimed at amplifying the focus on regional coordination, permanent housing, sustainability, and person-centered services. The overarching objective of HHAP funds remains unwavering – to effectively address and end people's experiences of homelessness.

A. State Priorities for HHAP-5 Funding

Pursuant to HSC section 50236, HHAP-5 is intended to sustain existing federal, state, and local investments towards long-term sustainability of housing and supportive services. To achieve this, applicants shall develop data-driven plans which fund the state's priorities to:

- Sustain existing investments towards long-term sustainability of housing and supportive services; and
- Prioritize permanent housing solutions.

Additionally, pursuant to HSC section 50236(c) grantees may not use any HHAP-5 dollars on any new interim housing solutions unless they are given written permission from Cal ICH. Before proposing to use HHAP-5 resources to fund new interim housing solutions, the applicant must demonstrate that the region has dedicated sufficient resources from other sources to long-term permanent housing solutions, including capital and operating costs. (See Section *III.C.4 "Limitations on New Interim Housing Solutions"* below for additional information about the limitation of HHAP dollars on interim housing solutions.)

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Regionally Coordinated
Homeless Housing, Assistance and Prevention Program
ROUND 5

C. Eligible Use Changes under HHAP-5

1. Eligible Population Change for Prevention and Shelter Diversion Services– At Risk of Homelessness

Prior rounds of HHAP restricted the eligible population for HHAP prevention and shelter diversion services to people experiencing homelessness or at imminent risk of experiencing homelessness. HHAP-5 statute modifies the eligible population to also include people at risk of experiencing homelessness so long as households with incomes at or below 30 percent of the area median income, who pay more than 50 percent of their income in housing costs, and who meet criteria for being at highest risk of homelessness through data-informed criteria are prioritized. Consistent with HHAP-3 and HHAP-4, those who are at imminent risk of homelessness, as defined in Section 578.3 of Title 24 of the Code of Federal Regulations, are still eligible for prevention and shelter diversion services.

2. Additional HMIS funding

Per HSC section 50236(f), the Council may authorize applicants to allocate an additional one percent of funds to cover expenses associated with HMIS. Related costs include HMIS licenses, training, system operating costs, and costs associated with carrying out related activities. The funds should be transferred to the HMIS lead entity by the grantee for related costs as per the agreement.

3. One Percent Planning Allocation

Per HSC section 50234(a)(1), not more than one percent of HHAP-5 funding shall be available to applicants for the purpose of planning for and preparing the Regionally Coordinated Homelessness Action Plans. This funding shall be provided on a reimbursement basis and will be disbursed along with applicant's approved HHAP-5 base allocation. As a reminder, applicants may also use previous rounds of HHAP dollars to support this regional collaboration, under the eligible use of "Systems Support." Applicants that do not have any available funds to cover this planning period may request an advance of this one percent in a form and manner determined by Cal ICH.

Because the most recently available PIT is currently 2022 data, the calculation for the planning allocation funding will be based on the 2022 PIT data.

4. Limitations on New Interim Housing Solutions

Per HSC section 50236(a) and outlined above under *State Priorities for HHAP-5 Funding*, HHAP Round 5 is intended to sustain existing federal, state, and local investments towards long-term sustainability of housing and supportive services. To achieve this, applicants shall develop data-driven plans which fund the state's priorities to:

- Sustain existing investments towards long-term sustainability of housing and supportive services; and
- Prioritize permanent housing solutions.

Before proposing to use HHAP-5 resources to fund new interim housing solutions, the region must demonstrate that they have dedicated sufficient resources (both financial resources and policy actions) from other sources to long-term permanent housing solutions, including capital and operating costs. (HSC § 50236(c).)

In reviewing whether a region has dedicated sufficient resources from other sources to long term permanent housing solutions, Cal ICH will evaluate resources and actions related to reducing and ending homelessness. Specific scoring criteria will be provided in subsequent guidance.

Status on Financial Resources for each eligible applicant in the region:

- Document the total amount of funds that the region has received in federal, state, and local dollars to prevent and end homelessness, as described in the Action Plan Section: Utilization of Local, State, and Federal Funds to End Homelessness.
- Of the housing and homelessness funding available to the region, what percentage is dedicated to permanent housing solutions and what percentage is dedicated to interim housing solutions?
- Describe the impact your proposed use of HHAP-5 dollars would have on the above percentages.

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CHCF Issue Brief

JULY 2023

Making CalAIM Work for Older Adults Experiencing Homelessness

Among the growing population experiencing homelessness in California and nationally, older adults — defined here as age 50 or older — are the fastest-growing segment.[1] The circumstances that trigger homelessness in older adults are often different than those for younger people, and older adults experiencing homelessness are often at risk for worse health outcomes, including much higher mortality than their younger counterparts.[2] Unfortunately, experts believe this problem has not peaked, and this older population is expected to continue to grow unless action is taken.[3]

California's current Medi-Cal reform effort — known as CalAIM (California Advancing and Innovating Medi-Cal) — offers new opportunities to help the growing number of people experiencing homelessness, including older adults.[4] Specific CalAIM initiatives with the potential to address homelessness include Enhanced Care Management (ECM), Community Supports, the Justice-Involved Initiative, and the institutional long-term care carve-in.[5] These initiatives can empower Medi-Cal managed care plans (MCPs), community-based organizations (CBOs), and long-term care facilities to coordinate activities that address homelessness among Medi-Cal enrollees over age 50, especially when these programs are closely aligned with the existing housing and homelessness systems of care.

Drawing from literature reviews, expert interviews, and examples from other states, this brief provides an overview of California's population of older adults experiencing homelessness, describes CalAIM

Fast Facts on Older Adult Homelessness

Older adults are becoming homeless at higher rates than other age groups in California and nationally.

- Nationally, adults age 50 or older are one of the fastest-growing segments of people experiencing homelessness, and their numbers are expected to triple by 2030.[6]
- California has a high number of older people having their first episode of homelessness. One study of older adults experiencing homelessness in Alameda County found that nearly half of the study participants faced their first episode of homelessness after age 50.[7]
- Between 2017 and 2021, California's population age 55 or older grew by 7%, but the number of people 55 or older who sought homelessness services increased by 84%.[8]

Older adults experiencing homelessness can have grave health outcomes.

- Older adults experiencing homelessness often acquire geriatric and medical conditions that lead to cognitive decline and decreased functional abilities at rates on par with housed counterparts who are 20 years older. Older adults who are homeless are also more likely than their younger counterparts to have disabilities that require assistance with activities of daily living.[9]
- People who are homeless after age 50 are 3.5 times more likely to die within four to five years than other adults, and die at a faster rate than the under-50 homeless population.[10]

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Building on CalAIM's Housing Supports - Strengthening Medi-Cal for People Experiencing Homelessness

While the health care system cannot by itself solve homelessness, it has a crucial role to play in providing access to services critical to the welfare of people experiencing homelessness. Across the state, organizations and communities help people exit homelessness every day. But the story behind each success is often a long journey through layers of administrative barriers and siloed programs. Navigating access to meaningful care by people experiencing homelessness, who are already facing trauma and struggles to survive, requires a person-centered approach to care.

This paper, from the Corporation for Supportive Housing, rests on a foundation of extensive research and examines the successes, challenges, and opportunities in providing person-centered care to people experiencing homelessness. **In Part 1**, the authors describe in detail how homelessness undermines a person's health. When people live outdoors or without reliable shelter, existing health issues are made worse, and people develop new ones. Californians experiencing homelessness die in large numbers from causes directly related to their lack of housing. Homelessness cuts lives short: People experiencing homelessness die on average 20 to 30 years younger than their housed counterparts. Homelessness also exacerbates existing racial health disparities, with Black and American Indian / Alaska Native people being significantly more likely to experience homelessness. Decades of racism in housing and institutional policies contribute to these disparities, leading to untreated chronic health conditions and other behavioral and physical health problems that contribute to chronic patterns of homelessness and early mortality.

The primary driver of homelessness is a lack of affordable housing. **Part 2** describes opportunities in CalAIM, in the Providing Access and Transforming Health (PATH) initiative, and in the Home and Community-Based Services Spending Plan to fund housing support services that connect people to housing and help keep people stably housed. This section also includes explanations of CalAIM's Enhanced Care Management benefit (PDF) and Community Supports (PDF), seven of which specifically focus on people experiencing homelessness.

Despite the promise of CalAIM and related programs, CalAIM's impact has been limited to date. **Part 3** describes the challenges providers and managed care plans face in implementing CalAIM and the provision of housing support services. Health care and social service providers offering services under CalAIM must navigate differing reimbursement rates — which may not be enough — and differing requirements set by each managed care plan, even among plans operating in the same county. Managed care plans may not know how best to identify and reach people experiencing homelessness, and to connect people to housing and housing support services. Meanwhile, people who are unhoused must still find and access the care and services they need by navigating complex systems of care and fragmented provider networks.

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Building on CalAIM's Housing Supports - Strengthening Medi-Cal for People Experiencing Homelessness

Recommendations

The substantial research cited in this report highlights the need for a well-designed Med-Cal benefit for housing support services that would make the integration of housing and support services funding possible and sustainable. The report offers these seven recommendations California policymakers can take now to implement Medi-Cal housing supports and achieve person-centered care for people experiencing homelessness:

1. Seek federal approval by the end of 2024 for a housing support services Medi-Cal benefit to provide a comprehensive range of services to all Medi-Cal members experiencing homelessness.
2. Set provider rates that adequately support housing-related services, covering the full costs of evidence-based programs.
3. Fund evidence-based homeless outreach and engagement strategies through sustainable funding sources.
4. Build the capacity of community-based organizations to implement housing-related services.
5. Develop a plan for integrating inter-agency health and housing policies, aligning funding models and resources effectively.
6. Establish equity benchmarks to address health disparities and reset eligibility criteria based on need.
7. Create a process for referrals that begins with the homeless response system, allowing for smoother access to housing support services.

These recommendations can help advance our health care system toward evidence-based, comprehensive, person-centered care that can help people with the most complex needs find and access housing, obtain needed care, stabilize, and thrive.

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California's Potential to Address Homelessness

In responding to homelessness and its health ramifications in California, the Department of Health Care Services (DHCS) is taking a leading role (described in detail in Part 2 of this report) through the following programs and initiatives:

- California Advancing and Innovating Medi-Cal (CalAIM)
- Providing Access and Transforming Health (PATH)
- Home and Community-Based Services (HCBS) Spending Plan

Importantly, state leaders are working to make Medi-Cal an integral component in solving homelessness through bridging two major systems — housing and health care — with a goal of creating a person-centered approach to receiving care. A person-centered approach seeks to accommodate the unique needs of the person, rather than requiring the person to accommodate the way the system operates (Figure 1). In a person-centered approach, the person drives their care, and systems coordinate to meet the person's needs.

This report provides research findings and background on the current system, opportunities, and challenges associated with integrating housing and health care systems, and specific recommendations for creating a housing support services benefit that does the following:

- Reliably funds evidence-based services to help people access housing and remain stably housed.
- Coordinates and aligns with housing and homeless response systems.
- Includes people with lived experience in all aspects and components of the health care sector, including policymaking, program design, delivery system, service delivery, financing, and research.
- Increases access to people with the greatest barriers to receiving care.

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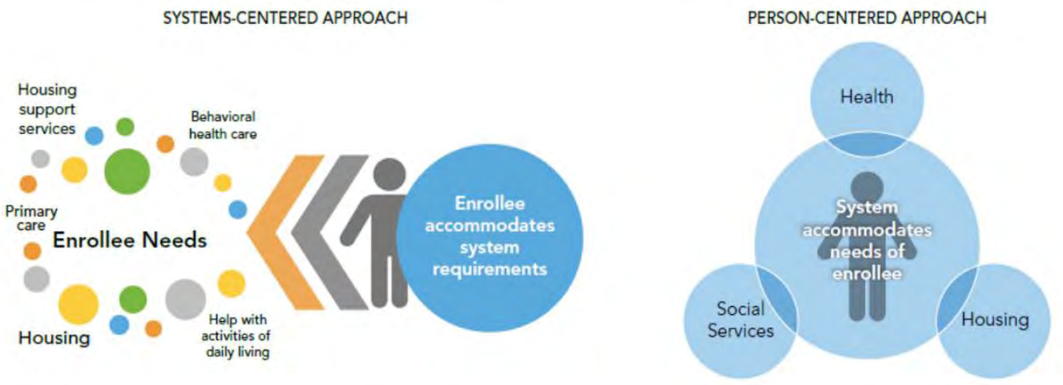
Figure 1. Current Systems-Centered Approach to Care vs. Person-Centered Approach to Care



Sources: *What Is People-Centered Care?*, World Health Organization, YouTube video, June 21, 2017; and "Person-Centered Care," Centers for Medicare & Medicaid Services.

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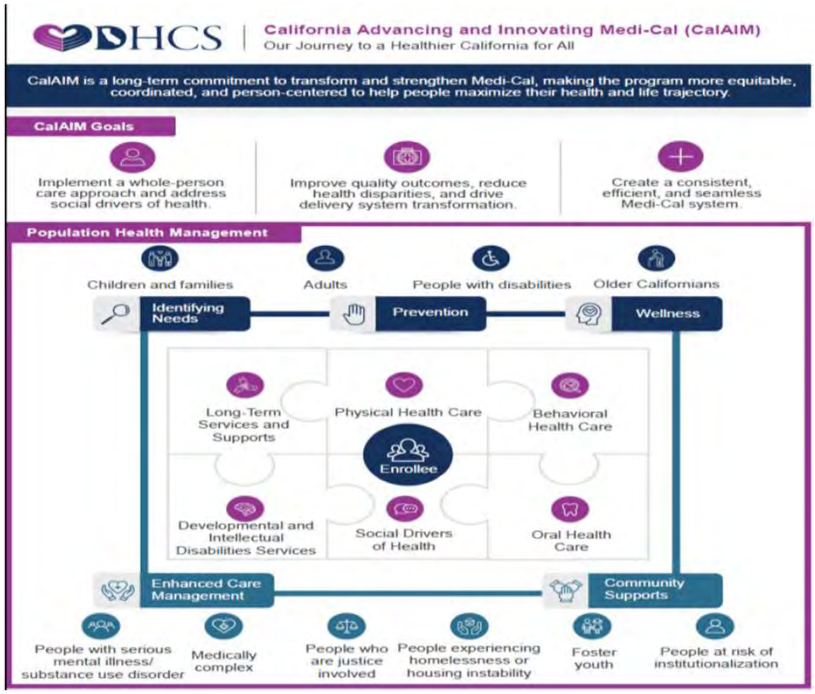

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The Issue

Over 161,000 people are experiencing homelessness in California on any given night.

California accounts for **more than half** of all unsheltered people in the U.S.

By far the largest racial gap in populations experiencing homelessness, people who are Black make up 39 percent of California's homeless population as compared to only 13 percent of the state's general population.

People experiencing homelessness have **mortality rates 4 to 10 times higher** than the general population. They also experience more frequent and longer hospital stays, and are three times more likely to be readmitted.

The unsheltered also experience **higher rates of diabetes, hypertension, and HIV** in comparison with the general population.

CalAIM includes a strong focus on addressing the challenges facing these individuals through Enhanced Care Management and Community Supports. It also provides funding for community-based organizations and other entities to expand capacity to better service these individuals through the Providing Access and Transforming Health (PATH) initiative.

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Faces of CalAIM: Meet Mary

Mary has been living on and off the streets in the Central Valley for decades. She has uncontrolled hypertension and has struggled with severe anxiety throughout most of her adult life. She's had short stays with relatives, bounced in-and-out of shelters, and has had countless trips to the emergency department. With CalAIM, Mary will have an Enhanced Care Manager who will go out into the streets to provide ongoing, high-touch care management. This includes coordinating health care and social services to ensure she can stay compliant with her medication regime and nutrition plan. It also ensures her access to treatment for her anxiety disorder, and to Community Supports so she can secure stable housing. Before CalAIM, Mary fell through the cracks in a siloed and fragmented system. Now, she has hope and a foundation for a better life.

Key CalAIM Initiatives to Address Homelessness or Housing Instability

Enhanced Care Management and Community Supports are ambitious reforms to address Medi-Cal enrollees' needs through coordinated and community-based whole person care. Community-based Enhanced Care Managers will engage Medi-Cal enrollees experiencing, or at risk of, homelessness to help them access coordinated health care, housing services, and other services, collectively known as Community Supports.

www.dhcs.ca.gov/CalAIM @CalAIMDHCS @CalAIM_DHCS

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CalAIM initiatives to address homelessness and housing instability will:

Improve access to coordinated health and social services, including housing. Enhanced Care Management will provide high-touch care management – meeting individuals where they are, not waiting for them to show up in clinics – and link enrollees to housing-related Community Supports. People with the biggest barriers to stable housing, such as those re-entering the community from incarceration and former foster care youth, will be reached where they are, including the streets and shelters.

Expand statewide access to housing supports. Currently, not all Medi-Cal enrollees who need community-based housing support are able to access it. CalAIM provides new resources as well as a new community-based approach to address housing instability and improve health equity statewide.

Provide funding for community-based organizations to expand services and programs. California will implement the Providing Access and Transforming Health (PATH) initiative. This initiative will provide funding to community-based organizations, street medicine teams, shelters, interim housing providers, counties, county behavioral health, public hospital systems, and public health departments to expand resources available to populations and communities that have been historically under-resourced and under-served.

Reduce avoidable use of costly health care services. Data from the National Hospital Ambulatory Medical Care Surveys between 2015 and 2018 show a rate of 203 emergency department visits per 100 homeless persons, compared with 42 emergency department visits per 100 non-homeless persons. By transitioning eligible individuals who would otherwise be homeless into permanent housing and helping them maintain that housing, CalAIM can improve health outcomes and reduce the inefficient use of costly and unnecessary medical care (e.g., unnecessary emergency department visits, avoidable readmissions).

Improve whole-person health for Medi-Cal enrollees. Ultimately, CalAIM's goal is to improve the health and well-being of people experiencing homelessness or housing instability. By connecting more Medi-Cal enrollees to safe and stable housing, CalAIM will help mitigate existing chronic health conditions and reduce new health problems associated with homelessness, including those stemming from exposure to communicable diseases and lack of access to clean drinking water, adequate food, and proper sanitation.

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Enhanced Care Management and Community Supports

Medi-Cal Transformation

Enhanced Care Management (ECM) and **Community Supports** are foundational parts of the transformation of Medi-Cal focused on:

- **Breaking down the traditional walls of health care**, extending beyond hospitals and health care settings into communities;
- Introducing **a better way to coordinate care**; and
- Providing **high-need members with in-person care management** where they live.

What this change means for Californians

ECM is a new statewide Medi-Cal benefit available to eligible members with complex needs, including:

- Access to a single Lead Care Manager who provides **comprehensive care management** and coordinates their health and health-related care and services.
- Connections to the quality care they need, **no matter where members seek care** – at the doctor, the dentist, with a social worker, or at a community center.

Community Supports are services that help address members' health-related social needs, help them live healthier lives, and avoid higher, costlier levels of care. These include:

- Support to **secure and maintain housing**.
- Access to **medically tailored meals** to support short term recovery.
- A variety of other community-based services.

These services are available to eligible Medi-Cal members regardless of whether they qualify for ECM services. All Medi-Cal managed care plans (MCPs) are encouraged to offer as many of the 14 pre-approved Community Supports as possible.

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MEDI-CAL TRANSFORMATION: ENHANCED CARE MANAGEMENT

The Issue

Medi-Cal members typically have **several complex health conditions** involving physical, behavioral, and social needs.

Members with complex needs must often engage **several delivery systems to access care**, including primary and specialty care, dental, mental health, substance use disorder treatment, and long-term services and supports.

More than half of Medi-Cal spending is attributed to the **5 percent of members with the highest-cost needs**.

Enhanced Care Management is a statewide Medi-Cal benefit available to select members with complex needs. Enrolled members receive comprehensive care management from a single lead care manager who coordinates all their health and health-related care, including physical, mental, and dental care, and social services. Enhanced Care Management makes it easier for members to get the right care at the right time in the right setting, and receive comprehensive care that goes beyond the doctor's office or hospital.

Enhanced Care Management Highlights

Enhanced Care Management is a statewide Medi-Cal benefit that addresses the clinical and non-clinical needs of the highest-need Medi-Cal members by building trusting relationships with members and providing intensive coordination of health and health-related services. Lead care managers meet members where they are—on the street, in a shelter, in their doctor's office, or at home—to meet their needs. Through Enhanced Care Management, members can also be connected to Community Supports services to help address their health-related social needs, such as access to healthy foods or safe housing to help with recovery from an illness. Enhanced Care Management is available to specific groups (called "Populations of Focus"), including:

Current Populations of Focus (PoF)

	ECM Populations of Focus	Adults	Children & Youth
1a	Individuals Experiencing Homelessness: *Adults without Dependent Children/Youth Living with Them Experiencing Homelessness*	✓	
1b	Individuals Experiencing Homelessness: *Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness*	✓	✓
2	Individuals At Risk for Avoidable Hospital or ED Utilization (*Formerly "High Utilizers"*)	✓	✓
3	Individuals with Serious Mental Health and/or SUD Needs	✓	✓
4	Individuals Transitioning from Incarceration	✓	✓
5	Adults Living in the Community and At Risk for LTC Institutionalization	✓	
6	Adult Nursing Facility Residents Transitioning to the Community	✓	
7	Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition		✓
8	Children and Youth Involved in Child Welfare		✓
9	Individuals with I/DD	✓	✓
10	Pregnant and Postpartum Individuals; Birth Equity Population of Focus	✓	✓

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TRANSFORMATION OF MEDI-CAL: COMMUNITY SUPPORTS

Community Supports are services provided by Medi-Cal managed care plans (MCPs) to address Medi-Cal members' health-related social needs, help them live healthier lives, and avoid higher, costlier levels of care. Members may receive a Community Supports service if they meet the eligibility criteria, and if the MCP determines the Community Supports service is a medically appropriate and cost-effective alternative to services covered under the California Medicaid State Plan.

All MCPs are encouraged to offer as many of the following 14 Community Supports as possible but it may be that not all MCPs will offer the full suite. Members, their caregivers, and providers can contact MCPs directly to learn which Community Supports are offered that members may be eligible to receive and the eligibility requirements for each service.

COMMUNITY SUPPORTS		
	Housing Transition Navigation Services	Members experiencing homelessness or at risk of experiencing homelessness receive help to find, apply for, and secure housing.
	Housing Deposits	Members receive assistance with housing security deposits, utilities set-up fees, first and last month's rent, and first month of utilities. Members can also receive funding for medically-necessary items like air conditioners, heaters, and hospital beds to ensure their new home is safe for move-in.
	Housing Tenancy and Sustaining Services	Members receive support to maintain safe and stable tenancy once housing is secured, such as coordination with landlords to address issues, assistance with the annual housing recertification process, and linkage to community resources to prevent eviction.

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COMMUNITY SUPPORTS		
	Short-Term Post-Hospitalization Housing	Members who do not have a residence, and who have high medical or mental health and substance use disorder needs, receive short-term housing for up to six months to continue their recovery. To receive this support, members must also have been discharged from an inpatient clinical setting, residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care.
	Recuperative Care (Medical Respite)	Members with unstable housing who no longer require hospitalization, but still need to heal from an injury or illness, receive short-term residential care. The residential care includes housing, meals, ongoing monitoring of the member's condition, and other services like coordination of transportation to appointments.
	Respite Services	Short-term relief for caregivers of members. Members may receive caregiver services in their home or in an approved facility on an hourly, daily, or nightly basis as needed.
	Day Habilitation Programs	Members who are experiencing homelessness, are at risk of experiencing homelessness, or formerly experienced homelessness, receive mentoring by a trained caregiver on the self-help, social, and adaptive skills needed to live successfully in the community. These skills include the use of public transportation, cooking, cleaning, managing personal finances, dealing with and responding appropriately to governmental agencies and personnel, and developing and maintaining interpersonal relationships. This support can be provided in a member's home or in an out-of-home, non-facility setting.
	Nursing Facility Transition/ Diversion to Assisted Living Facilities	Members living at home or in a nursing facility are transferred to an assisted living facility to live in their community and avoid institutionalization in a nursing facility, when possible. Assisted living facilities provide services to establish a community facility residence such as support with daily living activities, medication oversight, and 24-hour onsite direct care staff.

COMMUNITY SUPPORTS		
	Community Transition Services/ Nursing Facility Transition to a Home	Members transitioning from a nursing facility to a private residence where they will be responsible for their own expenses, receive funding for set-up services such as security deposits, set-up fees for utilities, and health-related appliances, such as air conditioners, heaters, or hospital beds.
	Personal Care and Homemaker Services	Members who require assistance with Activities of Daily Living or Instrumental Activities of Daily Living receive in-home support such as bathing or feeding, meal preparation, grocery shopping, and accompaniment to medical appointments.
	Environmental Accessibility Adaptations (Home Modifications)	Members receive physical modifications to their home to ensure their health and safety, and allow them to function with greater independence. Home modifications can include ramps and grab-bars, doorway widening for members who use a wheelchair, stair lifts, or making bathrooms wheelchair accessible.
	Medically-Supportive Food/ Medically Tailored Meals	Members receive deliveries of nutritious, prepared meals and healthy groceries to support their health needs. Members also receive vouchers for healthy food and/or nutrition education.
	Sobering Centers	Members who are found to be publicly intoxicated are provided with a short-term, safe, supportive environment in which to become sober. Sobering centers provide services such as medical triage, a temporary bed, meals, substance use education and counseling, and linkage to other health care services.
	Asthma Remediation	Members receive physical modifications to their home to avoid acute asthma episodes due to environmental triggers like mold. Modifications can include filtered vacuums, de-humidifiers, air filters, and ventilation improvements.

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CalAIM Providing Access and Transforming Health Initiative

Providing Access and Transforming Health (PATH) is a five-year, $1.85 billion initiative to build up the capacity and infrastructure of on-the-ground partners, such as community-based organizations (CBOs), public hospitals, county agencies, tribes, and others, to successfully participate in the Medi-Cal delivery system as California widely implements Enhanced Care Management and Community Supports and Justice Involved services under CalAIM.

Drawing upon the success and lessons learned from the Whole Person Care and Health Homes Pilots, PATH funding will address the gaps in local organizational capacity and infrastructure that exist statewide, enabling these local partners to scale up the services they provide to Medi-Cal beneficiaries.

With resources funded by PATH—such as additional staff, billing systems, and data exchange capabilities—community partners will successfully contract with managed care organizations, bringing their wealth of expertise in community needs to the Medi-Cal delivery system. As PATH funds serve to strengthen capacity statewide, particularly among providers and CBOs that have historically been under-resourced, the initiative will help California advance health equity, address social drivers of health, and move towards an equitable, coordinated, and accessible Medi-Cal system.

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CalAIM Providing Access and Transforming Health Initiative

PATH refers to the following aligned programs and initiatives:

Support for Implementation of Enhanced Care Management and Community Supports. PATH will support the expansion of the capacity and infrastructure needed to implement Enhanced Care Management and Community Supports and increase access to services statewide. This involves four integrated initiatives:

- **Whole Person Care Services and Transition to Managed Care Mitigation Initiative:** PATH will fund services provided by former Whole Person Care Pilot Lead Entities until the services transition to managed care coverage under CalAIM. This funding will end by January 1, 2024.
- **Technical Assistance Initiative:** PATH will provide a virtual "marketplace" that offers hands-on technical support and off-the-shelf resources from vendors to establish the infrastructure needed to implement Enhanced Care Management and Community Supports.
- **Collaborative Planning and Implementation Initiative:** PATH will fund regional collaborative planning and implementation efforts among managed care plans, providers, CBOs, county agencies, public hospitals, tribes, and others to promote readiness for Enhanced Care Management and Community Supports.
- **Capacity and Infrastructure Transition, Expansion, and Development (CITED) Initiative:** PATH will provide direct funding to support the delivery of Enhanced Care Management and Community Supports services. Entities, such as providers, CBOs, county agencies, public hospitals, tribes, and others that are contracted or plan to contract with a managed care plan can apply to receive funding for specific capacity needs to support the transition, expansion, and development of these specific services.

Justice-Involved Capacity Building Program. Starting in 2023, PATH will provide funding to support the implementation of statewide CalAIM justice-involved initiatives. This includes support for the implementation of pre-release Medi-Cal enrollment and suspension processes, as well as the delivery of Medi-Cal services in the 90 days prior to release. This includes:

- **Collaborative planning:** PATH funding will support correctional agencies, county social services departments, county behavioral health agencies, managed care plans, and others so they can jointly design, modify, and launch new processes aimed at increasing enrollment in Medi-Cal and continuous access to care for justice-involved youths and adults.
- **Capacity and Infrastructure:** PATH funding will support correctional agencies, institutions, and other justice-involved stakeholders as they implement pre-release Medi-Cal enrollment and suspension processes.

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ECM & Community Supports Year One Report: Executive Summary

Medi-Cal Enhanced Care Management (ECM) and Community Supports Calendar Year (CY) 2022 Implementation Report
Published August 3, 2023

California has embarked on a multi-year journey to transform Medi-Cal and provide members with more coordinated, person-centered, and equitable care. In 2022, two cornerstones of this journey -- Enhanced Care Management (ECM) and Community Supports -- launched statewide and reached more than 125,000 managed care plan (MCP) members in the first 12 months of implementation.

Enhanced Care Management

- **109,004** MCP members across California received ECM in CY 2022. That number increased by **40%** from the end of Quarter 1 (Q1) to the end of Q4.
- There were an estimated **1,158** contracts with providers of ECM in CY 2022. That number increased by **70%** from the end of Q1 to the end of Q4.

Community Supports

- **36,391** MCP members across California received **80,859** Community Supports services in CY 2022. The number of members served increased by **160%** from the end of Q1 to the end of Q4.
- There were an estimated **1,563** contracts with providers of Community Supports in CY 2022. That number increased by **112%** from the end of Q1 to the end of Q4.

Building on the successes of year one, DHCS and its MCP partners are working to expand access to and utilization of ECM and Community Supports in 2023 and beyond. The first year of these initiatives occurred in the midst of the COVID-19 public health emergency, which caused significant bandwidth constraints across the health sector. DHCS anticipates an acceleration of the work in 2023 and in subsequent years. The major levers of this acceleration will include:

- **Expanding access to services** by launching ECM for additional POFs and increasing the number of available Community Supports services in each county across the state;
- **Refining program operations and policies** to eliminate barriers to provider contracting and service utilization;
- **Providing grant funding and technical assistance** to support providers to implement and expand capacity for ECM and Community Supports through Providing Access and Transforming Health (PATH); and
- **Incentivizing MCPs** to further increase utilization of ECM and Community Supports through the Incentive Payment Program (IPP).

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DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Enhanced Care Management (ECM) Implementation Data from Calendar Year (CY) 2022
This document summarizes ECM uptake in CY 2022 as reported by Medi-Cal Managed Care Plans (MCPs).
All data is subject to change upon resubmission by MCPs.[1]

		Background				Members Who Received ECM in CY 2022[2]									
								Cumulative Members Who Received ECM by End of Each Quarter				By Population of Focus[3,4]			
County	Medi-Cal Managed Care Plan (MCP)	ECM Launch Date	Health Homes Program	Whole Person Care Pilot	Total MCP Members in Average Month of CY 2022	Total Members Who Received ECM in CY 2022	Penetration Rate[5] (% of MCP Members Who Received ECM)	Q1	Q2	Q3	Q4	Individuals Experiencing Homelessness	Individuals At Risk for Avoidable Hospital or ED Utilization	Individuals with Serious Mental Health and/or Substance Use Disorder Needs	Individuals Transitioning from Incarceration[6]
Orange		**1/1/2022**	**Y**	**Y**	**896,576**	**3,275**	**0.4%**	**2,254**	**2,600**	**2,884**	**3,275**	**2,663**	**1,090**	**776**	**0**
	CalOptima				896,339	3,275	0.4%	2,254	2,600	2,884	3,275	2,663	1,090	776	0
Placer		**1/1/2022**	**N**	**Y**	**62,067**	**253**	**0.4%**	**93**	**135**	**210**	**253**	**78**	*	*	*
	Anthem Blue Cross				37,237	125	0.3%	36	57	117	125	32	41	82	<11
	California Health and Wellness Plan				12,709	108	0.8%	45	65	77	108	34	50	64	<11
	Kaiser Permanente				12,106	20	0.2%	12	13	16	20	12	<11	<11	0
Riverside		**1/1/2022**	**Y**	**Y**	**871,139**	**9,234**	**1.1%**	**5,423**	**6,508**	**7,785**	**9,234**	**1,940**	**5,021**	**5,289**	*
	Inland Empire Health Plan				762,761	8,644	1.1%	4,928	5,979	7,229	8,644	1,873	4,552	5,206	296
	Molina Healthcare of California				105,325	592	0.6%	496	530	557	592	67	470	83	<11
Sacramento		**1/1/2022**	**Y**	**Y**	**532,691**	**4,380**	**0.8%**	**2,963**	**3,381**	**3,899**	**4,380**	**1,062**	**2,488**	**1,911**	*
	Aetna Better Health of California				20,197	477	2.4%	273	323	421	477	74	369	342	0
	Anthem Blue Cross				211,416	1,516	0.7%	1,030	1,181	1,398	1,516	270	731	755	<11
	Health Net Community Solutions				129,908	944	0.7%	675	745	781	944	221	613	443	<11
	Kaiser Permanente				113,477	516	0.5%	365	425	483	516	238	182	167	0
	Molina Healthcare of California				57,085	930	1.6%	621	708	819	930	260	595	206	<11
San Bernardino		**1/1/2022**	**Y**	**Y**	**861,941**	**7,728**	**0.9%**	**4,758**	**5,466**	**6,548**	**7,728**	**1,441**	**4,090**	**4,636**	*
	Inland Empire Health Plan				758,474	7,294	1.0%	4,407	5,087	6,147	7,294	1,382	3,741	4,576	44
	Molina Healthcare of California				100,794	435	0.4%	351	379	402	435	59	350	60	<11
San Diego		**1/1/2022**	**Y**	**Y**	**891,851**	**9,435**	**1.1%**	**5,216**	**7,263**	**8,073**	**9,435**	**1,830**	**5,016**	*	*
	Aetna Better Health of California				26,688	484	1.8%	320	358	438	484	48	334	335	0
	Blue Shield of California Promise				121,882	1,619	1.3%	1,083	1,279	1,434	1,619	259	1,142	896	0
	Community Health Group				321,341	3,791	1.2%	925	2,516	2,900	3,791	899	1,007	2,648	<11
	Health Net Community Solutions				86,383	384	0.4%	277	308	339	384	43	234	185	<11
	Kaiser Permanente				64,922	29	0.0%	24	25	26	29	16	19	<11	0
	Molina Healthcare of California				238,624	2,930	1.2%	2,429	2,577	2,694	2,930	459	2,173	479	<11
	United Healthcare Community Plan				29,487	254	0.9%	161	205	248	254	119	118	18	0

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DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Community Supports Implementation Data from Calendar Year (CY) 2022
This document summarizes Community Supports uptake in CY 2022 as reported by Medi-Cal Managed Care Plans (MCPs).
All data is subject to change upon resubmission by MCPs.[1]

County	Medi-Cal Managed Care Plan (MCP)	Background			Community Supports Offered in CY 2022			Community Supports Provided in CY 2022[2]		Members Who Received Community Supports[6,7]																				
											Cumulative Members Who Received Community Supports By End of Each Quarter[4]				By Community Support Service[6]															
		Health Homes Program	Whole Person Care Pilot	Total MCP Members in December 2022	Number of Community Supports Services Offered At Any Point in 2022[3]	Number of Community Supports Services Offered Starting 1/1/22[3]	Number of Community Supports Services Offered Starting 7/1/22[3]	Total Community Supports Services Provided in CY 2022[5]	Overall Utilization Rate (# Services/10K MCP Members)	Total Members Who Received Community Supports in CY 2022	Q1	Q2	Q3	Q4	Housing Transition and Navigation Services	Housing Deposits	Housing Tenancy and Sustaining Services	Short-Term Post-Hospitalization Housing	Recuperative Care	Respite Services	Day Habilitation Programs	Nursing Facility Transition/Diversion to Assisted Living Facilities	Community Transition Services/ Nursing Facility Transition to Home	Personal Care and Homemaker Services	Environmental Accessibility Adaptations	Medically-Supportive Food/ Medically Tailored Meals	Sobering Centers	Asthma Remediation
Sacramento		Y	Y	**532,691**	**14**	**14**	**0**	**4,507**	**85**	**1,992**	*	**1,178**	**1,587**	**1,992**	**1,678**	*	**255**	*	*	*	**0**	**0**	**0**	*	**0**	*	*	*	
	Aetna Better Health of California			20,197	14	14	0	98	49	58	<11	14	26	58	53	<11	0	<11	<11	0	0	0	0	0	0	<11	<11	0	
	Anthem Blue Cross			211,416	12	10	2	1,506	71	687	258	433	589	687	606	30	108	40	37	0	0	NA	NA	0	0	72	<11	<11	
	Health Net Community Solutions			129,908	8	6	2	623	48	359	0	157	240	359	275	<11	30	NA	18	NA	NA	NA	NA	NA	NA	38	32	0	
	Kaiser Permanente			113,477	2	2	0	1,260	111	493	221	310	401	493	449	NA	79	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
	Molina Healthcare of California			57,085	11	8	3	1,020	179	429	157	282	363	429	321	29	39	<11	24	<11	0	NA	NA	<11	NA	76	20	0	
San Benito		N	N	**10,753**	**8**	**6**	**2**	*	*	*	**0**	**0**	*	*	*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	
	Anthem Blue Cross			10,753	8	6	2	<11	*	<11	0	0	<11	<11	<11	0	0	NA	NA	0	NA	NA	NA	0	0	0	NA	0	
San Bernardino		Y	Y	**861,941**	**13**	**11**	**2**	**3,974**	**46**	**1,946**	**363**	**808**	**1,426**	**1,946**	**1,174**	**65**	*	**19**	*	**0**	**0**	**0**	*	*	*	**688**	**0**	**0**	
	Inland Empire Health Plan			758,474	10	10	0	3,782	50	1,832	342	742	1,333	1,832	1,128	65	166	19	115	NA	NA	0	<11	NA	<11	609	NA	0	
	Molina Healthcare of California			100,794	11	8	3	192	19	114	21	66	93	114	46	0	<11	0	<11	0	0	NA	0	<11	NA	79	NA	0	
San Diego		Y	Y	**891,851**	**14**	**14**	**0**	**2,601**	**29**	**1,518**	*	*	**1,121**	**1,518**	**834**	*	*	*	*	**0**	**0**	**75**	*	*	*	*	**0**	*	
	Aetna Better Health of California			26,688	14	14	0	37	14	29	<11	<11	11	29	29	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Blue Shield of California Promise			121,882	12	10	2	720	59	395	123	220	289	395	259	<11	33	<11	50	0	0	NA	NA	15	<11	63	0	0	
	Community Health Group			321,341	14	8	6	374	12	317	69	170	239	317	108	<11	0	0	<11	0	0	75	<11	<11	37	45	0	55	
	Health Net Community Solutions			86,383	8	6	2	52	6	32	0	11	28	32	25	0	<11	NA	<11	NA	NA	NA	NA	NA	0	<11	0	0	
	Kaiser Permanente			64,922	5	4	1	61	9	36	<11	11	15	36	15	NA	<11	NA	0	NA	NA	NA	NA	NA	NA	20	0	NA	
	Molina Healthcare of California			238,624	11	9	2	1,241	52	682	179	325	501	682	374	13	27	NA	11	0	0	NA	0	<11	NA	312	0	<11	
	UnitedHealthcare Community Plan			29,487	7	7	0	116	39	58	<11	33	46	58	53	0	<11	NA	0	0	NA	NA	NA	NA	NA	<11	0	NA	

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Community Supports are services or settings that Managed Care Plans (MCPs) may offer in place of services or settings covered under the Medicaid State Plan. These services should be medically appropriate and cost-effective alternatives.

Beginning January 1, 2022, IEHP began offering 11 DHCS Preapproved Community Supports services. Effective July 1, 2023, 3 additional services were added. Please click on the service for additional details.

Asthma Remediation
Community Transition Services/Nursing Facility Transition to a Home
Home Modifications
Housing Deposits
Housing Tenancy and Sustaining Services
Housing Transition Navigation Services
Medically Supportive Food/Meals/Medically Tailored Meals
Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care
Recuperative Care (Medical Respite)
Short-Term Post-Hospitalization Housing
Sobering Centers (Riverside County)
Day Habilitation
Personal Care and Homemaker Services
Respite Services

IEHP Inland Empire Health Plan

Please return the completed Community Supports Service Provider Assessment (PDF) via email to DGCommunitySupportTeam@iehp.org

IEHP Direct and Delegated Providers can submit referrals for Community Supports via the Provider Portal. For questions on how to submit a referral or more information relating to the above services, Providers can call the Provider Call Center at **(909) 890-2054** or **(866) 223-4347**.

Please continue to direct IEHP Members needing additional information on Community Supports services to IEHP Member Services at **(800) 440-4347**, Monday - Friday, 8am - 5pm. TTY users should call **(800) 718-4347**.

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IEHP
Inland Empire Health Plan

ENHANCED CARE MANAGEMENT

Get the Care You Need

ENHANCED CARE MANAGEMENT (ECM)

You may be contacted if you qualify for Enhanced Care Management (ECM) with Inland Empire Health Plan (IEHP). You can also call IEHP Member Services or talk to your Doctor or clinic staff.

WHEN YOU NEED EXTRA CARE

We understand that certain health conditions like diabetes, hypertension, or substance use disorder can be complex, confusing, and hard to manage in your life. IEHP's ECM offers supportive services to address your whole health–to care for your body and mind.

You may qualify for ECM with IEHP if you meet certain criteria shown under "WHO IS ELIGIBLE?" and need more help with managing your health.

WHO IS ELIGIBLE?

The IEHP ECM is for Members who have:

- Homelessness with complex health and/or behavioral health needs;
- Frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits;
- A serious mental illness or substance use disorder with complex social needs;
- Complex needs and are transitioning from incarceration in Riverside County.

HOW YOUR CARE TEAM CAN HELP YOU

If you qualify for ECM, you will get a care team with a lead care manager that coordinates **no-cost services**, such as primary care, behavioral health, community-based long-term services and supports (LTSS), developmental health, oral health, and social services.

WHO IS ON YOUR CARE TEAM:

- Nurse Care Manager
- Behavioral Health Care Manager
- Care Coordinator
- Community Health Worker

WHAT IEHP'S ECM INCLUDES

If you join ECM, it will not change any benefits you have now. You can keep your Doctors and Providers and get help to:

- Find Doctors and get an appointment for physical, mental, and substance use health needs.
- Keep all your Providers fully informed
- Set up transportation to your Doctor visits
- Get follow-up services after you leave the hospital
- Manage all your medicines
- Get help connecting to local resources such as food or other social services

The ECM services are provided at no cost, and you can join or stop ECM at any time.

SUPPORT WHEN YOU NEED IT

Your care team can support you by phone or in person and may even go to your location. You are not alone with the IEHP ECM. Please call IEHP Member Services at the number below to join or stop ECM.

www.iehp.org | Call IEHP Member Services: 1-800-440-4347 | Monday – Friday 8am – 5pm | TTY users should call 1-800-718-4347

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Flexible Care Choices:

Community Supports

IEHP
Inland Empire Health Plan

Flexible Care Choices: Community Supports

Many Members have used supportive care with Inland Empire Health Plan (IEHP). To learn more, call IEHP Member Services or talk to your Doctor or clinic staff.

What are Community Supports?

Inland Empire Health Plan (IEHP) offers Community Supports, which are special care options. These may be offered (instead of state plan-covered services) to qualified Members at medium to high levels of risk.

Community Supports can help you remain healthy, reduce complications from illnesses, and avoid unnecessary stays in the hospital, nursing facilities, and emergency departments.

You may find that Community Supports with IEHP can help during a transition in housing or care. If you need help managing your health, IEHP's Community Supports might be the right choice.

When you need extra care

Our Community Supports are open to IEHP Members or IEHP DualChoice (HMO D-SNP) Members who need supportive care. Community Supports may nurture your whole health—to care for your body and mind.

Members who could benefit from Community Supports may be:

- Facing times without housing
- Struggling to get food for their loved ones
- Having asthma issues and need changes to their living space

How your care team can help you

If you can be helped by Community Supports, you may get a care team that can assist in identifying your needs. Then the team coordinates **no-cost services**. This includes finding resources for housing, care after leaving the hospital, and dealing with asthma at home.

Who may be on your care team:

- Nurse care manager
- Behavioral health care manager
- Care coordinator
- Community health worker

Support when you need it

Your care team can assist you by phone or in person, and they can even meet you at your location. You are not alone with IEHP's Community Supports.

What Community Supports are offered?

- Asthma Remediation
- Community Transition Services/ Nursing Facility Transition to a Home
- Housing Deposits
- Housing Tenancy & Sustaining Services
- Housing Transition Navigation Services
- Medical Supportive Food/Meals/ Medically Tailored Meals
- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Recuperative Care (Medical Respite)
- Short Term Post-Hospitalization Housing
- Sobering Centers (Riverside County)

IEHP
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iehp.org

IEHP Member Services:
1-800-440-4347
1-800-718-4347 for TTY users
Monday-Friday, 7am-7pm, and Saturday-Sunday, 8am-5pm

Stay connected. Follow us!

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Healthcare In Action

An Innovative Approach To Serving the Unhoused Population

Eddie Menacho, PA-C

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Objectives/Goals

- Understand what defines “Street Medicine”
- Why a “Street Medicine” approach is needed in the I.E
- Learn how Healthcare In Action’s (HIA) model is a unique way to create a sustainable Street Medicine Model
- Learn how HIA approaches serving the unhoused population

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What is Street Medicine?

Street Medicine includes health and social services developed specifically to address the unique needs and circumstances of the unsheltered homeless delivered directly to them in their own environment. The fundamental approach of Street Medicine is to engage people experiencing homelessness exactly where they are and on their own terms to maximally reduce or eliminate barriers to care access and follow-through. Visiting people where they live – in alleyways, under bridges, or within urban encampments – is a necessary strategy to facilitate trust-building with this socially marginalized and highly vulnerable population.

Providing care exactly where they are and on their own terms to maximally reduce or eliminate barriers to care…

Visiting people where they live – in alleyways, under bridges, or within urban encampments –

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A MEMBER ORGANIZATION OF SCAN

We serve patients experiencing homelessness through an innovative **"street medicine"** approach aimed at meeting a person where they are to provide care for a person's comprehensive medical, social, and behavioral needs

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HIA Mission and Vision

▶**Mission**: to improve the lives of people experiencing homelessness through quality holistic care

▶**Vision**: that all people experiencing homelessness have access to quality healthcare that addresses their mental and physical health needs

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Why Now?

News

San Bernardino Declares a State of Emergency Over Homelessness Crisis

KVCR | By Madison Aument
Published February 2, 2023 at 3:56 PM PST

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San Bernardino County

- **Demographics:**
- Size of County: 20,105 mi²
- Population: 2,100,000
- **Homeless Count (2023):**
- Approx. 4,196 (**26% Increase from 2022**)
- 70% Male
- 30% Female

- Reference: https://www.census.gov/quickfacts/riversidecountycalifornia
- https://www.hud.gov/sites/dfiles/CPD/documents/HOME-ARP/ALLOCATIONPLANS/RiversideCAAllocationPlan.pdf

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HIA Model

Street Medicine
Care delivered when, where and how patients want it

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Managed Care
Financial mechanism to create a sustainable delivery system (i.e. CalAIM)

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Sustainable Healthcare Model for Homeless Adults

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Our Approach

Build **relationships** and **trust** by focusing on clients' priorities and needs

Frequent contacts (Integrated Tier System)

Meeting people **where they are:**

- Street Outreach: using a medically equipped van to deliver medical care in locations such as parking lots, encampments, parks, in alleyways, under bridges, etc.

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Street Rounds/Outreach

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Key Roles

Consulting Psychiatrist ------ **Physician Team Leader** ------ **RN/LVN Care Manager**

Primary Care Teamlet

Physician Assistant:
- Acute and chronic medical issues
- Substance use
- Mental health

Clinical Support Partner:
- Supplies and Medications
- Triaging and planning

Care Planner/ Housing Navigator:
- Behavioral health counseling
- Social needs & case management

Peer Navigators:
- Individual with lived experience
- Patient engagement
- Resource Navigation

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Model 1: Subdelegation or Wrap-Around Contract

Clinical Care Services
- Full Scope Primary Care
- Clinical Care Management
- Mental health and substance use care in partnership with the County (for straight Medi-Cal)

Wrap-Around Services*
- Case Management/ Social Work Support
- Housing Navigation
- Transportation to Social Services and Key Appointments
- Longitudinal care (e.g., care transitions, facilities etc.) (Healthcare in Action would NOT be hospitalist of record)

***Note**: HIA's wrap-around services are certified as Enhanced Care Management and Housing Transition Navigation Community Supports Service under CalAIM.

Healthcare in Action

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San Bernardino Team and Structure:

- Lead PA: Eddie Menacho, PA
- Clinical Support Partner: Michael Moreno
- Lead Peer Navigator: Andrea Martinez
- Peer Navigators: Robert Mora, Caleb Brown, Joshua Santana Kristen Malaby
- Other Members:
  - Evely Barajas – Coordinator
  - Sonali Saluja, MD – Medical Director of Care Management
  - Michael Jordan, MSN, MBA – Regional Director of Clinical Operations
  - Francis Angeles - Supervisor Care Management

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Numbers thus far…

- # of Patients Seen: 200
- # of Patients Medically Treated: 174
- # of Patients Enrolled into ECM: 83
- # of Patients Enrolled into CSS: 42
- # of Total Patient Interactions: 990
- # of Patients on LAI: 15

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Vision for the IE

- Create a Homeless Collaboration in the IE (Monthly Calls amongst Street Providers to help serve and locate patients)
- Educate and inform government and public entities about services available (Boston Healthcare for the Homeless)
- Contractual agreements with local hospitals (St. Bernardines/ARMC/Loma Linda) to decrease ER readmission rates and post discharge follow up
- City and state contracts to help expand our teams in the region
- Establishing food programs through state funding

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Questions?

Contact

Edward Menacho, MPAP, PA,C

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