CCICH GENERAL MEMBERSHIP MEETING

APRIL 17, 2015, 10:00 - 12:00 PM
<table>
<thead>
<tr>
<th>AGENDA ITEM</th>
<th>PRESENTER</th>
<th>DESIRED OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Welcome and Introductions</td>
<td>Teri House, CCICH Chair</td>
<td>Call to order.</td>
</tr>
<tr>
<td>2. Community Updates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. 4 C’s: Complex</td>
<td>Esmeralda Okendo, John Muir</td>
<td>Share information on 4 C’s: John Muir’s new case management program, Health Care</td>
</tr>
<tr>
<td>Community Care</td>
<td></td>
<td>for the Homeless, the Multi-Faith Action Coalition Shelter and Housing Task Force,</td>
</tr>
<tr>
<td>Coordination</td>
<td></td>
<td>the SSVF Community Plan, and other community updates.</td>
</tr>
<tr>
<td>b. Health Care for the Homeless</td>
<td>Alvin Silva, Rachael Birch, HCH</td>
<td></td>
</tr>
<tr>
<td>c. Multi-Faith ACTION</td>
<td>Doug Leich, Multi-Faith ACTION Coalition</td>
<td></td>
</tr>
<tr>
<td>Coalition</td>
<td>Elsa Zavala, SHELTER, Inc.</td>
<td></td>
</tr>
<tr>
<td>d. SSVF Community Plan</td>
<td></td>
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</tr>
<tr>
<td>3. PIT/HIC Data Release</td>
<td>Dana Ewing, Homeless Program; Josh Jacobs,</td>
<td>Present findings from the 2015 Point-in-Time Count and Housing Inventory Survey.</td>
</tr>
<tr>
<td></td>
<td>HomeBase</td>
<td></td>
</tr>
<tr>
<td>5. Behavioral Health Integration</td>
<td>Lavonna Martin, Homeless Services Chief;</td>
<td>Share the current status of the Contra Costa Behavioral Health integration</td>
</tr>
<tr>
<td>Update</td>
<td>Amanda Stempson, HomeBase</td>
<td>process</td>
</tr>
<tr>
<td>Update</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Nuts &amp; Bolts</td>
<td>All</td>
<td>Share community announcements.</td>
</tr>
<tr>
<td>8. Pin it</td>
<td>All</td>
<td>Future items of discussion/scheduling to be considered by the CCICH Exec. Board</td>
</tr>
</tbody>
</table>
2. COMMUNITY UPDATES

A. 4 C’s: Complex Community Care Coordination

B. Health Care for the Homeless

C. Multi-Faith ACTION Coalition

D. SSVF Community Plan
A. 4 C’S: COMPLEX COMMUNITY CARE COORDINATION

Esmeralda Okendo, John Muir

Update on John Muir Medical Center’s new case management program.
Complex Community Care Coordination (CCCC)

A Community Health Improvement Program

Esmeralda Okendo, MSW
Maggie Jefferson, LVN
What is the CCCC Program?

• A free and voluntary intensive outpatient case management program that targets the high utilizers of the Emergency Department

• Provides support and resources to vulnerable populations to improve their health and overall wellbeing
Vulnerable Populations Served

Those who may be:

- Low income
- Uninsured or Underinsured
- Frail elderly
- Socially isolated or have poor social supports
- Experiencing language or cultural barriers
- Struggling with substance use issues
- Experiencing mental illness
- Unable to access transportation or food
- Disabled
Goals of the CCCC Program

• Reduce ED visits and inpatient days within the first 6 months after the client is enrolled and engaged in the program

• Empower clients to improve their quality of life by:
  Improving their housing situation
  Improving their healthcare
  Obtaining reliable transportation
  Improving their mental health
  Reducing the impact of substance use
Our Approach

• We are client centered

• We believe in the clients right to self determination

• We accept and promote Harm Reduction

• We engage in Motivational Interviewing
Referral Criteria

• 6 or more ED visits/Hospitalizations in the past 6 months

• At least 3 items total from any of the following categories:

  Unmanaged chronic medical condition(s)
  • CHF
  • COPD
  • Diabetes
  • Chronic Pain
  • Renal Disease
  • Hypertension
Referral Criteria

Unmanaged Mental Health Issues
- Depression
- Anxiety
- PTSD
- Bipolar Disorder
- Schizophrenia

Social Barriers to Care
- No identified PCP
- Homeless or at risk of homelessness
- Unreliable transportation
- Underinsured/Uninsured
- Substance Use (Dependency, Addiction, Treatment)
- Lack of a support system
- Medication Access/Management
The Process

Engagement

• Telephone Calls
• Home Visits
• Inpatient/ED visits
• Letters
• Assist with transportation to Medical or Mental Health appointments
• Meet with potential clients in the community
The Process

Initial Visit

• Complete consents to participate in program
• Complete a psychosocial assessment
• Discuss client’s needs and identify goals to improve their health and overall wellbeing
• Collectively create a care plan based on client’s goals
  – Goals may change throughout the case management process
Intensive Case Management Begins

Case manager and client begin working together to achieve their goals by:

• Telephonic or face to face weekly contact
• Appointment Accompaniments
• Assisting with applications for government benefits (i.e. SSI, SSDI, CalFresh, CalWorks)
• Assisting with applications for health insurance
• Referring to community resources (IHSS, Rotacare Clinics, para transit, Mobile Health clinic etc.)
• Home Visits
• Appointment Reminders
Intensive Case Management Begins

• Supportive counseling
• Short term assistance with transportation to medical appointments
• Assisting with communication with PCP, MD specialists, mental health providers
• Scheduling appointments
• Picking up and delivering prescriptions
• Collaborating with other community agencies
Challenges Within Case Management

- Loss of contact
- Client unwilling or unable to follow through
- Scarce resources
- Client chooses to withdraw before goals have been achieved
- Client dies
- Client’s health status may change
- Client does not want to be discharged from the program
Graduation from Program

- Case manager has the conversation about graduation from the program at the beginning of the case management process
- Average length of stay in CCCC program is 6-9 months
- Celebrate successes with clients when they have achieved their goals
- Provide warm hand offs to less intense programs: CCHP case management, medical home, mental health case managers
Case Presentation

• Demographics

  • 47 year old twice divorced Caucasian male

  • Receives General Assistance

  • Basic Adult Care
Case Presentation

Medical History
- Underinsured
- Hypertension
- Hepatitis C
- Migraines
- Aortic Stenosis
- Degenerative Disk Disease
- Endocarditis with abscess
- History of open surgical repair of aortic root and valve

Social History
- Lived with elderly mother
- Most of adult life in prison
- History of severe child abuse
- PTSD
- History of 5150 d/t suicidal ideation
- Depressive Disorder with psychotic features
- Severe Anxiety
- Agoraphobia
- Substance Abuse
  - Methamphetamines
Interventions Used with David

- Appointment accompaniments
- Referrals to crisis line, mental health access line
- Supportive counseling
- Motivational interviewing
- Collaborated with other providers (medical home, LCSW, PCP, substance abuse counselors)
- Reflective listening
- Assisted with transportation to treatment center
- Advocated for client
- Assisted with filling out forms for SSI application
- Assisted client in keeping his housing
- Helped with getting client’s GA and food stamps reinstated after completing the drug treatment program
Successes From David

- Completed substance abuse treatment program
- Has been clean and sober since December 19, 2013
- Has become a sponsor for other men in recovery
- Has been receiving routine health care
- Completely off narcotics
- Receiving mental treatment from psychiatrist and therapist
- Has made friends
- Learning to interact with peers
- Attends the Putnam Clubhouse
- Able to navigate public transportation
- Moving out of state to start a new life
- At the point in his life where he is actually feeling loved
- Appropriately utilized supportive people
Questions

Comments
B. HEALTH CARE FOR THE HOMELESS UPDATE

Alvin Silva & Rachael Birch, HCH

Update on HCH program developments.
## 2014 Homeless Health Coverage

<table>
<thead>
<tr>
<th>Coverage</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured</td>
<td>28.3%</td>
<td>16.7%</td>
<td>11.4%</td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>46.9%</td>
<td>63%</td>
<td>71.8%</td>
</tr>
<tr>
<td>Medicare</td>
<td>6.2%</td>
<td>13.5%</td>
<td>11.2%</td>
</tr>
</tbody>
</table>
Accessibility
Clinic hours/location posted in a public place.

Primary Concerns:
Housing/Shelter
Dental Care
Eye Care
Taking Better Care of Myself
Food
Depression/Anxiety
Employment
Weight
Reasons for missed appointments or lack of medical care:
I forget my appointments
Clinic location is inconvenient
Other things are more important
Dental services at our Respite Clinic in Concord beginning in July/August 2015 and open to general homeless community by the end of the year

Mobile dental services available summer 2015
HCH Education and Activity Program

- County-wide classes and activity programs including
  - Dental Education
  - Health Education (Diabetes, Hypertension)
  - Cancer Support Groups
  - Exercise/Yoga
  - Mindfulness/Stress Reduction
  - Meditation

We need your help!
HCH Focus in 2015

- Health Care Maintenance:
  - Screenings for cervical, breast and colorectal cancer
  - Immunizations
  - Dental Services
  - Depression & Substance Abuse Screenings

- Increasing access to Medical and Behavioral Health Services

- Establishing Medical Homes and Primary Care Physicians

- Increasing appointment compliance rates

- Reducing barriers to care by providing accessible and culturally-sensitive services in non-traditional settings.
C. MULTI-FAITH ACTION COALITION

Doug Leech, MFAC

Update on the Shelter and Housing Task Force and other MFAC activities.
Imagine the Collective Power & Impact of a Unified Faith Community

Multi-faith ACTION Coalition
We are Advocates & Communities Taking Initiative 4 Our Neighbors
Multi-Faith ACTION (Advocates & Communities Taking Initiative 4 Our Neighbors) Coalition

✧ Hundreds of Clergy, Ministers & Lay Leaders
✧ Over 50 faith institutions
✧ Representing More than 26,000 congregants
What Does Multi-Faith ACTION Do?

- Research Concerns
- Develop Long Term Solutions
- Build Relationships
- Take Action
- Reflect & Evaluate
How Are We Organized?

- Congregations
  - Multi-Faith ACTION Coalition
    - Housing / Shelter
    - Food Security
    - Jobs & Economic Security
    - Education
    - Health
  - Research/Data and ACTION: Direct Service, Advocacy, Lobbying

Steering Committee
- Budget & Planning
- Approval of Action
- Communications, PR
Poverty in Contra Costa County

- 131,800 people live below the federal poverty line
  - 38,000 are children
- Nearly 50,000 live in extreme poverty (less than $11,746/year for family of 4)

2014 Annual Income Comparison (2 adults & 2 children)

- Federal Poverty Line: $23,850
- CA Minimum Wage (2 jobs): $37,440
- Self Sufficiency Income: $71,711

86% of households living below the self-sufficiency standard have 1 or more workers
Housing and Shelter Task Force

- 8,252 homeless individuals
- On any given night 4000 homeless
- Almost 30% were youth < 18
- Almost 60% reported a disability
- Almost 132,000 people live below federal poverty line in CCC

Zero: 2016
Emergency Shelters
Point In Time Count

2014 SB391 – California Homes and Jobs Act
Strengthen Housing Element Laws
2015 AB 35 and AB 1335
Affordable Housing Week
Concord Naval Weapons Station
Food Security Task Force

- 1 in 6 people are at risk of being hungry
- 33% CCFB clients choose food vs rent
- 42% eligible not enrolled
- -> $96M into the Economy
- 53% CalFresh Cases have earned or wouldn’t be expected to earn income

Cal Fresh
- Help with Increasing Enrollment - Schools, Faith Institutions & Cities – Mayor & County Proclamation
- SB1002 – CalFresh and Medi-Cal enrollment alignment
- Increased number of County CalFresh eligibility workers

Nutrition

Access To Food
Health Task Force

- Poverty ≈ poorer health ≈ shorter life expectancy
- Lower Education ≈ poorer health ≈ shorter life expectancy
- 40,000 People Visit DMC ER

- Connect to Care
- ACA/ Cover CA Enrollment
- Doctor’s Medical Center
- Health Care for Undocumented
Jobs and Economic Security Task Force

- 26% of households – below self-sufficiency standard
- Of households below, 86% have at least one worker
- Single Mothers are 2x as likely to fall below standard
- $27/hr for family of three
D. SSVF COMMUNITY PLAN

Elsa Zavala, SHELTER, Inc.

*Update on the Supportive Services for Veteran Families Community Plan.*
CONTRA COSTA COUNTY
Community Plan: Homeless Veterans

- a personal necessity
- a community need
- a federal funding requirement
**GOAL:** Eliminate Veteran Homelessness by 2016

**TRENDS**

- 48% decline in veteran homelessness in the last 3 years
- +20% rise in 1 and 2 bedroom apartment rents in each of the previous two years
### Point-in-Time: 2013

<table>
<thead>
<tr>
<th>Household (HH) Type</th>
<th>All Homeless Veterans</th>
<th></th>
<th></th>
<th></th>
<th>Chronic Homeless Veterans</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sheltered</td>
<td>Unsheltered</td>
<td>TOTAL</td>
<td>Sheltered</td>
<td>Unsheltered</td>
<td>TOTAL</td>
<td>Sheltered</td>
</tr>
<tr>
<td>HH w/out Children</td>
<td>51</td>
<td>75</td>
<td>126</td>
<td>13</td>
<td>48</td>
<td>61</td>
<td>13</td>
</tr>
<tr>
<td>HH w/children</td>
<td>9</td>
<td>3</td>
<td>12</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL HOUSEHOLDS</td>
<td>60</td>
<td>78</td>
<td>138</td>
<td>15</td>
<td>49</td>
<td>64</td>
<td>15</td>
</tr>
<tr>
<td>% of TOTAL Households</td>
<td>43%</td>
<td>57%</td>
<td></td>
<td>23%</td>
<td>77%</td>
<td></td>
<td>23%</td>
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</table>
## Supportive Services for Homeless Veterans (SSVF)
### Contra Costa County Projections FY 2014-15

<table>
<thead>
<tr>
<th>Agency Name</th>
<th>Grant Amount</th>
<th>Households Assisted: Prevention (estimated)</th>
<th>Households Assisted: Rapid Re-Housing (estimated)</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>SHELTER, Inc.</td>
<td>$861,532</td>
<td>112</td>
<td>168</td>
<td>280</td>
</tr>
<tr>
<td>Berkeley Food &amp; Housing</td>
<td>$200,000</td>
<td>24</td>
<td>56</td>
<td>80</td>
</tr>
<tr>
<td>East Bay Community Recovery Project</td>
<td>$316,240</td>
<td>21</td>
<td>49</td>
<td>70</td>
</tr>
<tr>
<td>TOTAL SERVED</td>
<td>$1,377,772</td>
<td>157</td>
<td>273</td>
<td>430</td>
</tr>
</tbody>
</table>

| TOTAL SCREENED                              |              |                                             |                                                  | 330   |
| (+20% ineligible)                           |              |                                             |                                                  |       |

| TOTAL POPULATION                            |              |                                             |                                                  | 380   |
| (estimate another +20% not seen?)           |              |                                             |                                                  |       |
Contra Costa County

2015 HOMELESS VETERAN POPULATION PROJECTION

Served by Rapid Re-Housing (RRH)

<table>
<thead>
<tr>
<th>Household (HH) Type</th>
<th>Annual Unduplicated Homeless Veteran Households</th>
<th>Estimated # of Needing RRH (a)</th>
<th>Projected # Assisted with SSVF RRH (b)</th>
<th>Projected # to be Assisted with other RRH (c)</th>
<th>Gap (a-(b+c))</th>
<th>% Unserved (estimate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HH without Children</td>
<td>342</td>
<td>274</td>
<td>246</td>
<td>14</td>
<td>14</td>
<td>4.1%</td>
</tr>
<tr>
<td>HHHH with Children</td>
<td>38</td>
<td>34</td>
<td>27</td>
<td>4</td>
<td>3</td>
<td>7.9%</td>
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<tr>
<td>TOTAL:</td>
<td>380</td>
<td>308</td>
<td>273</td>
<td>18</td>
<td>17</td>
<td>4.5%</td>
</tr>
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</table>
Coordinate distribution of program outreach materials
Finalize template for coordinated referral form
Implement coordinated assessment tool (VI-SPIDAT)
Master tracking list for all identified homeless veterans
Formalize inter-agency veterans service coordination
Integrate with Zero:2016 Campaign, CofC, VA system, etc.
3. PIT/HIC DATA RELEASE

Josh Jacobs, HomeBase; Dana Ewing, Homeless Program

Present findings from the 2015 Point-in-Time Count and Housing Inventory Survey.
METHODOLOGY: SHELTERED POINT-IN-TIME COUNT

Household Categories:
- Households with at least one adult and one child
- Households without children
- Households with only children (including one-child households and multi-child households)
- Youth households (including parenting youth and unaccompanied youth)

Age Categories:
- The number of children under age 18
- The number of adults ages 18 to 24
- The number of adults over age 24
METHODOLOGY: SHELTERED POINT-IN-TIME COUNT

Population Data:
- Gender
- Race
- Ethnicity

Subpopulation Data:
- Chronically homeless individuals and families
- Veteran individuals and families
- Chronically homeless veteran individuals and families
- Severely mentally ill persons
- Persons experiencing chronic substance abuse
- Persons with HIV/AIDS
- Victims of domestic violence
METHODOLOGY: UNSHELTERED POINT-IN-TIME COUNT

The 2015 Unsheltered Count combined two strategies to count the homeless population:

**STREET-OUTREACH BASED COUNT:** trained staff went out into encampments and collected survey information from every person they encountered over a three day period.

**SERVICE-SITE BASED COUNT:** trained volunteers went to service sites known to have high concentrations of homeless persons and interviewed persons they encountered.
2015 PIT ENCAMPMENT AND SERVICE SITE MAPS
COMPARISON TO PAST COUNTS

Households with Children

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>At risk</td>
<td>732</td>
<td>956</td>
</tr>
<tr>
<td>Homeless</td>
<td>126</td>
<td>116</td>
</tr>
<tr>
<td>Total</td>
<td>858</td>
<td>1072</td>
</tr>
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</table>
COMPARISON TO PAST COUNTS

Households without Children 2013 and 2015

2015 PIT HOUSEHOLDS

Households with Children: 956 At risk, 116 Homeless
Households without Children: 1583 At risk, 257 Homeless
Total Households: 1215 At risk, 1699 Homeless
## 2015 YOUTH HOUSEHOLDS

<table>
<thead>
<tr>
<th>Category</th>
<th>Sheltered</th>
<th>Unsheltered</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parenting Youth and Children</td>
<td>26</td>
<td>14</td>
<td>40</td>
</tr>
<tr>
<td>Parenting Youth</td>
<td>10</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Children of Parenting Youth</td>
<td>16</td>
<td>9</td>
<td>25</td>
</tr>
<tr>
<td>Unaccompanied Youth</td>
<td>42</td>
<td>84</td>
<td>126</td>
</tr>
<tr>
<td>Children (Under 18)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Young Adults (18 to 24)</td>
<td>42</td>
<td>84</td>
<td>126</td>
</tr>
<tr>
<td>Total Youth</td>
<td>68</td>
<td>98</td>
<td>166</td>
</tr>
</tbody>
</table>
4. ZERO: 2016 LAUNCH

Jennifer Baha, Zero: 2016 Coordinator

Share information regarding the Zero: 2016 campaign launch.
CONTRA COSTA ZERO: 2016

Zero: 2016 is a national campaign coordinated by Community Solutions to house all homeless veterans by the end of 2015, and all people who are chronically homeless by 2016.

Contra Costa has joined 70 other communities across the U.S., all working to quickly and efficiently reduce the number of veterans and chronically homeless people in need of permanent housing solutions.
CONTRA COSTA ZERO: 2016

What Zero Means:

Our housing placement goals to reach Zero in Contra Costa County:

- 218 homeless Veterans
- 628 chronically homeless individuals

We can reach zero by connecting the right people to the right housing, right now.

We can build a way to immediately address the need for permanent housing when it arises in our communities.

How To Make It Happen:

If we concentrate on housing solutions, zero is realistic.

Contra Costa Zero: 2016 is developing strategies for increasing local housing opportunities to achieve zero veteran and chronic homelessness in our county.
## CONTRA COSTA ZERO: 2016

<table>
<thead>
<tr>
<th>Take Down Target</th>
<th>Veterans</th>
<th>Chronically Homeless</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antioch</td>
<td>24</td>
<td>82</td>
</tr>
<tr>
<td>Brentwood</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Clayton</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Concord</td>
<td>31</td>
<td>119</td>
</tr>
<tr>
<td>Town of Danville</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>El Cerrito</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Hercules</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Lafayette</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Martinez</td>
<td>9</td>
<td>38</td>
</tr>
<tr>
<td>Moraga</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Oakley</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Orinda</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Pinole</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Pittsburg</td>
<td>15</td>
<td>44</td>
</tr>
<tr>
<td>Pleasant Hill</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Richmond</td>
<td>31</td>
<td>119</td>
</tr>
<tr>
<td>San Pablo</td>
<td>9</td>
<td>25</td>
</tr>
<tr>
<td>San Ramon</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Walnut Creek</td>
<td>4</td>
<td>19</td>
</tr>
</tbody>
</table>
5. BEHAVIORAL HEALTH INTEGRATION UPDATE

Lavonna Martin, Homeless Services Chief; Amanda Stempson, HomeBase

Share the current status of the Contra Costa Behavioral Health integration process.
THREE PHASES OF BEHAVIORAL HEALTH SYSTEM TRANSFORMATION PROCESS

Phase 1: PLANNING & RESEARCH (2012-2013)
• Systems and process orientation and development.

Phase 2: PROGRAM DESIGN (2013-2015)
• Deep analysis and alignment of policies and practices.

Phase 3: IMPLEMENTATION & CONTINUOUS QUALITY IMPROVEMENT (2014 - Ongoing)
• System transformation through implementation of prioritized strategies.
OVERVIEW OF THE THREE PHASES

Phase 1: Planning & Research (2012-2013)
- Change Agents
- SPIID Teams
- Line Staff Convenings
- Program Managers Roundtable
- Living Room Conversations

- Steering Committee
- Community Participation Plan: Office of Consumer Empowerment conducted focus groups and administered survey to consumers and family members to gather input on system redesign
- Behavioral Health Mgmt. Meetings (Monthly)
- Prioritized strategies for implementing change: low-hanging fruit, core infrastructure

Phase 3: Implementation & Continuous Quality Improvement (2014 - Ongoing)
- SPIID Teams: Expanded to include CBOs, line staff, consumers, family members, Change Agents, Steering Cmte members
- Executive Team:
  - Review, prioritize, and implement common frameworks for behavioral health practices
  - Prioritized Strategies: Program design implemented per Executive Team directives

County Pilot Project Implementation: move forward on low-hanging fruit and core infrastructure strategies concurrently
County Integration Roundtable: reinstated to carry out implementation of prioritized strategies as directed by Executive Team
PHASE 3: IMPLEMENTATION & CONTINUOUS QUALITY IMPROVEMENT (2014 – ONGOING)

- **Executive Team**: with leadership from Mental Health, Alcohol and Other Drug Services, and Homeless Programs, meets weekly and guides the overall BHD integration and planning process.

- **County Integration Roundtable**: consists of program managers and supervisors from all Behavioral Health Division programs. It works collaboratively as an integrated team within County BHD operations, and coordinates on the ground implementation of integration efforts.
FOR MORE INFORMATION

To subscribe to Behavioral Health Connection, the newsletter of the Behavioral Health Division, please visit

http://cchealth.org/bhs/
6. CONCORD NAVAL WEAPONS STATION UPDATE

John Zhuang, HomeBase

Present update on CNWS master developer selection process.
BACKGROUND

U.S. Navy intends to transfer **1,400** acres of **CNWS** to Concord as part of the Concord Reuse Project Area Plan. Concord invited experienced real estate development companies to submit development proposals for **CNWS**. Proposals must dedicate 25% of their total proposed units to affordable housing, a subset of which encompasses housing for the homeless.
RFP APPLICANTS
SunCal is an Irvine, California-based real estate company

- 8+ decades of commercial development experience
- Among the largest real estate development companies in the United States
Lennar Corporation (NYSE: LEN) is a publicly traded Fortune 500 company based in Miami, Florida

- Second largest homebuilder in the United States
- The company has extensive experience with military base redevelopment in California
- Capital and financial background to finance these large-scale projects
Catellus is a privately held development company based in Oakland, California

- 30 years of experience in commercial and residential development
- Background in transforming former military bases and industrial sites into thriving communities
- Subsidiary of Prologis, a global industrial real estate investment company headquartered in San Francisco, California
### PROPOSALS’ HOMELESS HOUSING VISION

<table>
<thead>
<tr>
<th>Company</th>
<th>Units Dedicated to Homeless</th>
<th>Timeline for Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catellus</td>
<td>260</td>
<td>2017</td>
</tr>
<tr>
<td>Lennar</td>
<td>130-260</td>
<td>2021</td>
</tr>
<tr>
<td>SunCal</td>
<td>130-260</td>
<td>TBD</td>
</tr>
</tbody>
</table>
7. NUTS & BOLTS

All members

Share community announcements.
8. PIN IT

All members

*Future items of discussion/scheduling to be considered by the CCICH Exec. Board.*