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H3 Housing Meeting

August 1st, 2017
1:00-3:00pm
2425 Bisso Lane, Concord

Presenters: Lavonna Martin, H3 Director, Jenny Robbins, H3 Housing and Services Administrator, Dana Ewing, H3 Program Evaluator, Emily Parmenter, Public Health, Steve Blum, H3 Supportive Housing Manager, Jaime Jenett, Policy and Planning Manager, and Juliana Pooley, CE Program Manager

MINUTES

Agenda item: No Place like Home (NPLH) Technical Assistance Submission Update

Presentation by Lavonna Martin, Director of Health, Housing and Homeless Services

Discussion: The State of California passed a law several years ago called the No Place like Home Initiative which provides funding at the state level to develop housing for people with severe and persistent mental illness. There will be several notice of funding coming out in the near future regarding NPLH.

- **Technical assistance** funding pot- Contra Costa was eligible for **$150,000**
- **Non-competitive** pot of money that all communities are eligible for. Contra Costa is expected to receive **$7 million** from that pot.
- **Competitive** pot of money that we as a community have the ability to apply for to build housing in Contra Costa for individuals with severe and persistent mental illnesses. The funding that's available will be dispersed within the next year so we have time to apply; the application does not come out until winter 2018.

However, there are technical assistance funds that are available today to help communities like Contra Costa to compete for other funding; competitive and non-competitive. The NPLH initiative is a collaborate effort between

H3, behavioral health, and the department of conservation development. Together we've been attending meetings over the past year for the NPLH initiative and each department has been reporting out its findings. Over the past few months, in these meetings we've been talking about the technical assistance funds and asking you all how we could best use that funding.

There are a number of ways we could use that funding; we (H3, BH, and DCP) have settled on 2 specific areas we want to focus our funding on:

1. **Creating a housing needs assessment**- That will help us as a community decide where our needs are in terms of permanent supportive housing in regards to supporting SMI population the NPLH initiative is intended to serve. That's our target population but we will also be using additional funding to better understand the needs of other populations in our community.
2. **Alignment around Coordinated Entry**- We are starting Phase 2 of our CE process. The state is requiring us to fill these units through coordinated entry. With that being said, we are creating the best path to identifying those individuals that are most vulnerable.

The $150,000 is for both goals but our first priority is the housing assessment. If all 150,000 are needed for the needs assessment then we will look at securing other funding for priority number 2.

Action: Technical Assistance Applications are due **September 30th**. Our application is done and is expected to be submitted by September 1st. We'll be looking to start drafting an RFP come early September.

Agenda item: Point-In-Time (PIT) Count Report Out

Presentation by Jenny Robbins, H3 Housing and Services Administrator and Dana Ewing, H3 Program Evaluator

Discussion: Every year, Contra Costa conducts a Point-In-Time count survey (as required by HUD) to better understand what is the need for housing and housing resources in our community. We gather data on the folks who are experiencing homelessness, whether they're sheltered or unsheltered and gather data and information from agencies who receive HUD funding and through our HMIS data system to collect this information. We also go to agencies and places that people who are experiencing homelessness are most likely to visit such as; food pantries, drop in centers, etc. We train volunteers to go out every year and collect this data through surveys.

We just finalized all of our results from the most recent Point-In-Time count. This isn't necessarily scientific, this is data collected on one specific night in January.

This year…..

- 1607 people were experiencing homelessness the night of the count
- 30% of those folks were first time homeless
- 43% were sheltered

- 57% were unsheltered (people living outside, in cars, places not meant for human habitation).

When conducting these surveys we want to know more about the population we're surveying; whether they are using substances, if they have mental health conditions, chronically homeless, victims of domestic violence, veterans, how many are families, how many minors, and transition aged youth. All of these categories are **self-reported**. We predict that these numbers are **higher** due to reluctance to self-report certain information due to **stigma**.

More results….

- 99 veterans were identified/surveyed which made up 9% of the population surveyed.
- Of those 99 veterans, 86% had been homeless for 12 months or longer.
- These numbers have significantly decreased due to the **Built for Zero** campaign, intending to end veteran homelessness.

This year we really wanted to get a sense of who's **at-risk** for homelessness.

- We found that 23% of the folks we surveyed at community sites such as libraries and food pantries weren't in fact homeless but were at imminent risk for homelessness (includes people couch surfing, hotel/motel, living with another person with a housing voucher) meaning they were at risk of losing their housing within two weeks.
- 27% were housed and not at imminent risk of losing their housing.

Regional Shifts:

- West County made up 24% of the people experiencing homelessness the night of the count
- East County 35%
- Central County 41%
- 20% lost their housing in a county outside of Contra Costa.

Agenda item: Whole Person Care: Community Connect

Presentation by Emily Parmenter, Public Health

Discussion: Whole Person Care is the Medi-Cal waiver program. Contra Costa was awarded a 5 year grant for this program last October totaling to 2 million dollars through 2020 as one of 19 counties across the state to receive this funding. Our goal is to reduce utilization among the Medi-Cal population within the county. We call our program **Community Connect** which is completely interchangeable with **Whole Person Care**.

Our target population would be the high utilizers of Medi-Cal. We have identified all the Medi-Cal recipients in the county and applied a risk-model against that to assign 'points' to the number of hospitalizations, ED visits,

homelessness risk, foster youth on pyschotrophics, 5150 holds, etc. We have a special focus on foster youth on psychtrophic medications.

There are 3 core areas of our program that we receive funding for;

1. Direct services
2. Data projects
3. Sobering centers

Direct Services- Patient care and direct touch. We have two tiers patients can be assigned to;

- Tier 1- is a higher, medically intensive patient; typically a patient with a number of comorbidities, chronic diagnoses, (minimum 4-6 conditions). These are high need folks, high behavioral health and substance users. This tier has room for 4,000 patients who are then managed by a public health nurse, mental health clinical specialist, substance abuse counselor, or community health worker. We received funding through the state per member per month.
- Tier 2 has 10,400 patients. These are patients that have higher social needs. These are individuals primarily managed by community health workers or social workers.

Our teams are multi-disciplinary. Each tier has 4 staffing teams, totaling to 100-150 staff members. **Tier 1** has more medical teams, public health nurses, mental health clinical specialist, social worker, homeless specialist, substance abuse counselor, and a community health worker specialist that make up that team. Each of those team members carries a caseload. **Tier 2** teams have a higher amount of community health workers but are also comprised of the same team members as tier 1.

Updates: All case management across Contra Costa Behavioral Health will be in the electronic health record which will make records available to be sent out to HMIS and community emergency departments. We are implementing a new system called EDY (Emergency Department Information Exchange) in a few weeks which will tells us if our patients are showing up in other county emergency departments.

We also have funding to open a sobering center; short stay, less than 24 hours. We are continuing to look for a site for this center. We are looking at a timeline of 3-5 months.

Agenda item: MHSA Innovations: CBSST Project

Presented by Steve Blum, H3 Supportive Housing Manager

Discussion: MHSA innovations will be submitting two projects approved by the state;

1. Child and adolescent programs with treatment programs.
2. Cognitive Behavior Social Skills Training- (The program I'm going to be talking about, CBSST). The actual project is called CBSST for mental health housing.

a. There's 3 modules;

1) **Cognitive**- like CBT, what beliefs are informing problematic behavior using catch it, check it, and change it.
    a. Catch it- child client is having difficult in school, the belief the child shares with it for the reason behind why the child is having difficulty, "I'm stupid".
    b. Check it- Let's explore this belief and look at the evidence, pros and cons. Is it hear-say or is it evidence?
    c. Change it- after all of the evidence has been reviewed, change it, not necessarily 180 degree because there may be some truth in that belief. With the child example maybe the child believes they are having difficulty in school and wants to do better, which is a lot better than the belief "I'm stupid" which means I'm not even going to try.

When you apply this kind of thinking to adults in a supportive housing program (SHP) you can see where a client could evaluate their own beliefs around a situation that's happening and work to better understand that thinking, make sense of it, and ideally come up with better solutions of how to handle it.

2) **Social skills training**- many times, folks in SHP's lead isolated lives and have often developed routine social skills. Developing goals and role playing we hope will better connect these folks to the community.

3) **Problem Solving**- people develop a long term goal then short term goals and how to achieve those goals. For example, we had an intern use CBSST in our program. The intern was working with a client that had just developed a relationship with an estranged parent. The client was able to form that relationship but was very afraid of using mass transit to visit that parent. The intern worked with the client on taking walks, making sure the client understood the exact stops and changes the client would have to make to get to the next bus, knowing what all was needed from the client in order to transfer buses, and taking practice rides with friends, and was eventually able to make this long bus ride.

Our clients may also be experiencing issues with roommates, neighbors, and property managers in their SHP which often lead to evictions or 5150's. If people develop problem solving skills they can significantly reduce those issues. CBSST really works at a ground level, giving clients real life skills like problem solving to reduce such incidences from occurring.

How we want to implement CBSST is by having 3 teams;

- 2 teams in mental health, with a mental health specialist and a community support worker
- 1 team in supportive housing that will work in all of the SHPs, shelters (Cali House).
- Our service delivery for both teams will be that we go in the field, meaning, we go to the clients, not the other way around. These two teams can act as a mediation service as a problem solving agent, for example, if a client is having problems with their landlord, the team can help the client develop a strategy where the team is actually there with the client when the client has a conversation with the landlord.

Outcomes- we want to know are we reducing 5150s, should there be 5150s, and most importantly are we reducing evictions. CBSST can help reach our overall behavioral health goal of getting people to live lives independent of us and moving forward how they want to.

Updates: This is a project that is in the proposal stage. If the state approves, then it will be funded.

Agenda item: NOFA update

Presented by Jaime Jenett, Policy and Planning Manager

Discussion:

- HUD- Department of Housing and Urban Development
- NOFA- Notice of Funding Availability
- HUD is at the top, then each community has a Continuum of Care (CoC) the umbrella that HUD is looking at for funding. The council on homelessness is an advisory board of supervisors that is directly connected to HUD funded projects. Non HUD funded projects also fall under the CoC. The projects submit their applications for funding from HUD to the council on homelessness. The council on homelessness decides what priority these projects get. HUD decides what projects get funding, then that money goes directly to the projects not through the council. HUD looks to the council to make decisions but ultimately HUD decides what projects get funded. HUD focuses on projects that look to end homelessness for all people, creating a systematic response to homelessness, strategically allocating and using resources (are projects being smart about how they're using their funding), using a housing-first approach. Projects that don't have a lot of rules and regulations (low barriers) about their programs/get into housing is what HUD is looking for.

Last year, HUD funded…..

- Permanent supportive housing which is housing plus services and awarded them $11 million.
- Rapid Re-Housing- nearly half a million went to rapid re-housing, short term rental assistance plus short term services to help people get back into housing,
- Coordinated Entry at $1.2 million, getting people access to multiple systems of care
- HMIS (homeless management information system)
- CoC planning
- Last year we received around $13 million from HUD
- This year we're looking at about $14 million.

Tier 1- Renewals; been funded before, pretty sure we're going to get the money again

Tier 2- National competition; this is not for sure money

Timeline- The council on homelessness will propose their recommendations on **September 7th, 2017**. Our office compiles everything and sends it all to HUD and that is happening on **September 28th, 2017**.

Agenda item: Coordinated Entry Updates

Presented by Juliana Pooley, CE Program Manager

Discussion:

Updates: Since our last meeting in May- part of our Phase 1 goals is to streamline how on the ground assessment and case management is being delivered through different providers. In June we offered a variety of VI-SPDAT trainings which were a success, we were able to train and capture almost all of the providers. This was the first of several trainings that we are going to be rolling out. We want feedback on possible trainings you have found helpful in the past or want more training on.

Our coordinated entry policy and procedures has been officially signed by our council on homelessness. It is available online, it is a working document which means there will be ongoing adjustments as our system expands.

Since our roll out in February, as of July, we've double the amount of CORE teams we have. We started with 3 teams and now we have 6. These are the outreach teams that are out in the field offering services to individuals and families experiencing homelessness.

Looking forward- our HMIS system is being migrated to a new system. We've had several trainings on this for providers to learn the new system. If you still need training, let us know.

Expansions- Prevention Diversion Services; we are trying to expand what it looks like to be at-risk of homelessness and how can we help stabilize and connect those individuals to appropriate services that would be the best fit before they experience homelessness. RFP to come.

Care center services in East County.

Update: Our website has been updated. The 'Get Help' section has been added. The 'council on homelessness' tab lists when and where the upcoming meetings are happening. 'Tools for Partners' has all of the HMIS documents if you're a provider. In 'trainings and tools' we're posting materials like materials from the VI-SPDAT training, bedbug protocol, if you're looking for those things they are now easier to find. 'Coordinated Entry' has a two-page overview of what CE is if you're trying to explain it to somebody. Our policies and procedures is on there. 'Data reports' is where you can find the Point-In-Time count, annual report, HUD reporting, etc. 'H3 programs' just has a brief explanation of each of the county programs.