PARTNERS IN CARE
Oahu Continuum of Care

Partners in Care is a coalition of Oahu's homeless service providers, government representatives and community stakeholders working together in partnership to end homelessness.

PIC CES Oversight Meeting Minutes
10AM – 11:30AM, January 20th, 2022

Join on your computer or mobile app:
Click here to join the meeting

Or call in (audio only):
+1 689-206-0354,746251232#
Phone Conference ID: 746 251 232#

Attendees:

(AlohaCare): Rhea Nuguid
(CFS): Anthony Lazzaro, Jessica Oda, Robert Boyack, Hannah Michnya
(CCH): Zoe Lewis
(US VETS): Macy Sevaaetasi
(HPO): Ana Piloton
(Radical Hale): Kara
(Family Promise): Joshua Gaoteote
(PIC): Lauren Rojas, Michael Kleiber, Morgan Esarey, Julia Wolfson, Tom McDonald, Wallace Engberg, China Moreira, Brynn Miranda, Laura Thielen, Darrell Edelhoff, Joshua Roach, Berta Maldonado, Alex Dale
(Gov's Office): Emma Grochowsky, Scott Morishige
(Keauhou Shelter): Richard Kaai
(VA): Marc Malate, Art Minor

Topics	Discussion	Outcome
I. Welcome/ Introductions	Meeting called to order at 10:05am	
II. Meeting Minutes	November minutes approved at 10:10am	Minutes Approved
III. Resource/Policy Updates a. OHN RRH b. EHV	**III. Resource/Policy Updates** **a. OHN RRH** **Berta**: 282 HH placed! Minimum of 300 is projected, 741 individuals housed since beginning of OHN, and ending in accepting referrals. First exits from program are also coming up. Rec'd approval to move forward with extending exited HH's up to Sept., who will be able to keep services for a longer period of time while they prepare for the next steps. Several clients have rec'd notifications from Sect. 8 who have transitioned into that resource. Many successes of families of 8-9 also getting housing! March was the beginning of the program and April and May started the kick off! **b. EHV** **Morgan**: EHV has been a long process, working with City to have vouchers available by March, but will see where that lands. HPHA vouchers are for those clients with a move-on strategy from PSH,	

	but the City vouchers will open up to those **experiencing literal homelessness, with consideration given to at-risk, recently homeless HH's, and DV clients.** **Kara**: Question: Income: We try to assist clients with entitlements if they qualify, how does this work w/o income? My clients have medical issues, are within the 50-60 age range and not qualified yet for retirement. How do I get the documentation needed for clients interested in EHV? **Morgan**: Clients are not required to have income for EHV, **but will require proof for a lack of income**. Clients will need to show an income verification. **Julia**: **Bank statements, cash deposits, or any indicator of income should be verified by a statement provided by the client.** **Morgan**: The HMIS team is working on an assessment for EHV's, and like the BNL, the assessment will add them to a separate list for EHV referrals. Big challenge is obtaining documentation and the city's list of required docs is more extensive. So long as client can live independently and have their docs, they would be eligible.	
c. Monitoring Housing First Across Programs	**c. Monitoring Housing First Across Programs** **Laura**: We are hoping to pull providers together to see what their different expectations may be for their own programs **Scott**: Not sure if anyone on oversight has suggestions for training in Housing First, but one idea about monitoring the Housing First approach with CoC programs came up. Trying to figure out how to make Oahu's CoC as competitive as possible. If CoC is going to do a training, may be good to get some input on what they'd want to see in the training. Is any provider able to make a ref. to EHV if client is w/o income? **Morgan**: For the city, the EHV's will allow all four categories in the notice will be eligible and the provider could apply through HMIS (DV would have a separate way of doing this). **Scott**: Any providers can complete the assessment and start referring clients now? **Laura**: We are anticipating the City program will start in **March**, nothing on website in regards to City referrals at this time. As soon as everything is finalized, we will have it on website and can begin referring. Hoping by mid-Feb at the earliest. **Morgan**: We would also do an email blast for all users in HMIS to apply somebody and for those outside of the system who are "at risk" would have to go through HMIS, so we are working to figure that out. **Laura**: We will also do some trainings on the documentation, as verifying proof of nothing can be a challenge **(self-declarations of homelessness, lack of income, etc.)**. The most important thing right now is working on document collection since it is a long process.	

	Morgan: Regarding Housing First, may be great for CES to be involved, providers may also wish to share their insights. Who can we send these suggestions to? **Scott**: I thought the Planning Committee was scheduling the training? **Laura**: Can send the inquiries to me. We can set up a meeting initially through the Planning Committee. **Tom**: Treatment First, then Housing has been a big challenge for providers (SMI, active substance abuse, etc.)	
d. CCH FAC closing or moving?	**d. CCH FAC closing or moving?** **Morgan**: Notification of program closures: VOM closed in November or December, so lot of individual beds no longer being used for ES, as the land belongs to DHHL. FAC belongs to Parks and Rec., and these closures have impacted homeless persons. **Alex**: Program closure was 11/22. **Laura**: Although we do not ask about the reason for closures, CES is continuing to work on making sure that programs are moving clients to appropriate settings but can be a challenge due to the lack of resources. **Ana**: **FAC will be moving from Kakaako to another location, info to be provided in the future as it becomes available.** Intakes stopped in December, with the goal to permanently house currently enrolled HH's. **Scott**: Regarding resources in the community, update on NOFO scoring? About 200 beds for PSH in AUW consolidated grant that is potentially at risk. Question about resources and planning for the future - there is such a deficit in the community, HH's becoming evicted, elderly adults…we have such limited inventory, any updates on this discussion? **Laura**: No updates on awards coming down pipeline. Legacy HF program IHS, KP, and SHDC, between Tier 1 and Tier 2, 100% Tier 1 funding will be rec'd. Another portion in Tier 2 **may not** be funded, which can affect the number of vouchers available in the system. **Consolidated grant is first grant available April 1st**, hoping to get the award notice ASAP. We have been working weekly with grantees to move forward clients that were appropriate for PSH; we have put it in Planning for next year's NOFA. Have not received a lot of providers applying for PSH, so will be working on encouraging providers to apply for PSH awards. **Scott**: Mark Chandler had mentioned that consolidated grant can take non-CH people. Thoughts on how this may impact the system/allowing flexibility to not have all units prioritized for CH clients? From a provider perspective, clients may have acute level needs that are not chronically homeless. Not sure if any discussion has happened yet regarding this. **Laura**: Yes, it has. We do have the ability to not have CH as mandatory for CoC NOFO applications. CH has been a priority for HUD in the last decade and are more prone to award folks who	

	stipulate that they will be focusing on CH. Our CoC does not have to make that priority, but also recognize that CES oversight has been crucial in addressing the special requests that can support non-CH folks into PSH. **Scott**: Family Promise had to reduce shelter capacity recently due to not being able to continue lease with Waikiki Vista, for community awareness? **Joshua**: We had to cut capacity in half, had two floors in Vista bldg., but only renewed lease for one floor, while renting out other floor to students. No updates aside from this. **Scott**: How long was lease extended for? **Joshua**: We have that one floor until May. We are looking for other options for ES right now. Wants to thank Brynn and CES for helping transitioning families out of the ES.	
e. Integrating HOPWA programs into CES	**e. Integrating HOPWA programs into CES** **Morgan**: This is a topic that was discussed some time ago, haven't been doing referrals into these programs, with exception to Gregory House TH program. We may revisit this conversation as we didn't have the data to make referrals before. If anyone is interested in the convo regarding this integration, let CES know! We will set up a meeting for programs in general to have this discussion.	
Oversight Dashboard Discussion	**Oversight Dashboard Discussion:** **Morgan:** If on PIC website and go to CES, go to Oversight Reports, you will be able to follow along on the computer. **Wallace:** It is a very different change to how we look into CES referrals. With this dashboard, really shifted focus to how the referrals are doing within CES data time standards according to P & P's. A client is supposed to have an intake or be unassigned within 14 days, and a client is supposed to be housed within 30 (transitional), 60 (rapid rehousing/permanent supportive housing), or 90 days (veteran subpop). When we look at referrals, they will be a bit delayed due to those time standards, so we are not making referrals look like they are not moving on target. At the top of dashboard, you can select subpop, and click on the graphs to further filter. Clicking on more metrics will open up other elements of the dashboard. The referral tracker updates continuously. We need to look at how effective referrals are moving through the system with respect to these time standards. The referrals are broken down by month with an asterisk, in that they are active within time standards. The whole dashboard is clickable and you can reference this for all subpopulations.	

Emma: What data field is pulling for those housed? Programs may have different ways for enrolling someone, so this could mean there are variations. How is this all captured?

Wallace: CES can verify move in date and on the second page of the dashboard we are looking at date of ref assignment to date of HMIS intake, which also includes the housing component.

Morgan: We verify the move in was recorded and the referral workflow has been completed, but are not verifying the move in date specifically.

Laura: Because this is open to public, under referral unassignment reason, can we add “client denied services?” May help clarify for anyone from the public, is an important metric in that client choice is considered.

Wallace: Yes, we can do this. Roughly 60% of clients assigned end up getting unassigned outside of time standards and around 20% receive placement outside of time standards. Second page of dashboard looks at average number of days for all programs to conduct intake, unassign and house referred clients.

For housing across every program & across every referral (for the entire year), the avg. is 47 days to house. Two-month cut off was not included as we are only requiring two weeks to facilitate intake, so only includes a two-week cut off. Avg. days to house is only looking at housed date within time standards. We have avg. median number of days to complete intake, we used median because data can be far-reaching and scattered, so we can have a client that’s 1 day to intake and another with a more extensive time to have intake completed.

We can see **for the whole year of 2021, it took an avg. of 20 days over 195 referrals and the time standard is 14. For families we have 12 days, veterans is 10 days and youth is 14 days to intake.** This can be adjusted to look at specific months as well. The red bar that is on display in avg. days to house, indicates the standard for the subpop. Example: veteran avg for PSH was 135 days to house for 229 individuals, but time standard indicates 90 days.

Scott: Can you clarify what the "PH" is? I think it's Kauhale Kamaile, but not sure. I was interested in how referrals are made for that category of program.

Wallace: Yes, OPH (Other Permanent Housing) program is Kauhale Kamaile. May be the only OPH program.

Emma: It's super helpful to see the average # of days to house broken down by program type/subpopulation.

Scott: Is there existing BH (Bridge Housing) CES refers to now?

Morgan: It is in TH, we did this with VOM and occasionally can do with ASI or KWO TH. If program has a vacancy, they can utilize units for BH. The challenge has been over time, “how do we use Bridge?”

Scott: I am interested in a way CES can work with LEP to include those who may not be up next for a referral or into units? I'm wondering if bridge could be used for veterans -- since it seems like the veteran PSH and RRH have the longer timeframes to house

	Tom: Kauhale was used to prioritize the vulnerable and targeted CH, paired with some sort of permanent voucher. Kamaile were paired w/ RRH, and to optimize, there should be a pairing. **Scott**: it sounds like Kauhale Kewalo is similar to the Punawai building/Steadfast units that have to be paired with a voucher. **Wallace**: Any questions, please feel free to reach out.	
Subpop Workgroups	**Subpop Workgroups:** **Julia**: The next youth sub meeting will be on **Feb 3rd at 10am-11am** regarding a recap on incoming EHV's and aligning youth who are appropriate for that resource, in addition to goals for the youth in the new year, including stakeholders and other providers. **Morgan**: Brynn will be assisting in setting up a Family subcommittee. This hasn't been set, but let our team know if you are interested in joining. **Joshua**: Interested in the family subcommittee. **Jessica**: For DV, we have a workgroup tomorrow with HMIS and repurpose to train a separate program. This will take place once a month, on every 3rd Friday. Will sent the notifications to HMIS due to using another database, but working out the kinks of this. **Kara**: Interested in the 3rd Friday meeting. **Michael**: Regarding Vets subpop, we are reaching the bottom for VASH referrals, but no other updates aside from this.	
New Business a. BNL discussion regarding BNL access by CM's and outreach:	**New Business:** **a. BNL discussion regarding BNL access by CM's and outreach:** **Scott**: We are thinking for outreach providers, shelter providers and CM's if they have access to run a report to see who is on the BNL. For frontline providers, wondering if this would be helpful. **Morgan**: We do want providers to be able to see more CES navigation, but maybe more specific to client's being CH, the prioritization matrix was built to assist with this as well. **Laura**: One of the possible cons that may be surmountable: Very important to know as much info as possible, but having access can lead to misinformation in that it isn't a typical waitlist. **Michael**: You can check to verify whether a client is on the BNL if they have an active VI. Some of the questions are also being captured on the Number Next list and providers have access to this if they have completed CES training. **Scott**: I'd defer to providers, Laura brings up a valid point in that you do not want to give people false hope. **Morgan**: Could suggest to build something more user friendly for outreach providers through HMIS?	

	Michael: Regarding CES/HMIS integration, I am trying to fold the NNL into HMIS so that there is a CES navigation dashboard available for providers. **Laura**: May want to get providers some iPads to conduct outreach and assist with BNL lookups/pulls.	
Meeting Adjourned	Meeting adjourned at 11:35am NEXT MEETING: Thursday, February 17th, 2022, 10am – 11:30am	