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, March 17th, 2022

Join on your computer or mobile app:
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Or call in (audio only):
+1 689-206-0354,746251232#
Phone Conference ID: 746 251 232#

Attendees:

(AlohaCare): Rhea Nuguid
(ASI): Lokenani Hope
(CFS): Jessica Oda, Anthony Lazarro, Hannah Michnya
(DHS): Madi Silverman
(Gov's Office): Emma Grochowsky, Cheryl Bellisario, Scott Morishige
(Hale Kipa): Deborah Smith
(HMSA): Desiree Vea
(Kaiser): Charisse Solomon
(Keauhou Shelter): Richard Kaai
(PIC): Michael Kleiber, Morgan Esarey, Julia Wolfson, Wallace Engberg, China Moreira, Brynn Miranda, Laura Thielen, Darrell Edelhoff, Joshua Roach, Berta Maldonado
(Queens): Daniel Cheng
(US VETS): Macy Sevaaetasi
(VA): Lindsey Kaumeheiwa, Art Minor

Topics	Discussion	Outcome
I. Welcome/ Introductions	Meeting called to order at 10:05am	
II. Meeting Minutes	Minutes approved at 10:05am by Lindsey Kaumeheiwa, seconded by Richard Kaai	Minutes Approved
III. Resource/Policy Updates a. OHN RRH	**III. Resource/Policy Updates** **a. OHN RRH** **Berta**: OHN: Goal has been reached to house 300 HH's about a few weeks ago, but are continuing to house clients up until end of the month. OHN end date is in Sept. so last month to assist. 9-10 more HH's working on placement at this time, and there has been delays due to unit denials, missing docs. Working to house before end of this month. For program exits, many clients are trying to work on gathering documents, and LL's have developed good working relationships to assist with move-in, even with documents missing. Other programs may not be as lenient, but OHN is working on gathering all supporting docs, finding resources to support this measure. EHV,	

	Sect. 8 has been a resource pathway for clients exiting from OHN. Any suggestions on gathering docs would be helpful! **Morgan**: Do you have a sense of % of clients who can be housed on their own? What assistance is needed where clients are not qualifying for resources? **Berta**: A lot of clients were more PSH level of need than anticipated, so larger group would need case mgmt., some HH's may not be inclined to pursue employment as well. Some clients may just pursue emergency shelter if the term of assistance comes to an end, and some deny mental health services. **Loke**: May be due to volume of HH's served under one contract. Will work on gathering percentages. Don't want to confuse longer term of need regarding cost of living, rather than requiring PSH level of need. Some HH's just need longer term subsidies due to cost of rent, some HH's just do not make enough to self-sustain. **Lindsey**: A lot of Vets want to get into VASH due to lifetime support, especially regarding rise of already high cost of living. **Berta**: HECO also gave out a notice regarding a 10% hike in costs, which could also impact families working with a tight budget and happening around the time OHN is ending. **Richard**: We have about 7 HH's who went into OHN and from the beginning, I saw some of the units the HH's went into were out of reach for the families. We had one couple who was making $388 each and rent was $1400, so they would definitely need more support after OHN ends. One client went into a studio with a similar hindrance, as these HH's may return back to Keauhou if no alternatives can be considered. **Laura**: Original plan was to get HH's through the pandemic. We do not want people to fall back into homelessness and from the beginning we were working on ways to self-sustain (i.e. earning more income for the HH, securing more employment). We are excited to see EHV and HUD awarded the CoC with over $500,000 more than was requested so other resources can still be looked at. We now need to make sure we are matching HH's to supportive services. **Berta**: Our CM's have been working really hard on getting clients a solid exit plan prior to OHN program entry, and this circles back to documentation. EHV is extensive, but not the only program with these requirements. **Richard**: Can HH's be automatically be added in to EHV program? **Laura**: No, but everyone that can be is being considered for the EHV program and eligibility for priority for state EHV's (already leased up as a component for eligibility). City's priority supports literal homeless, former foster, elderly and DV. We are working with SSA, IHS and LASH for access to federal and state docs.	
b. EHV	**b. EHV** **Morgan**: HPHA: Live for six months and accepting refs. There is a deadline to gather docs (3/28/22). The program is asking all applications be submitted within this timeframe. City PHA EHV's are	

	going to officially start soon. Can reference the PIC website for more information on the EHV process and the assessment will roll out. **Laura**: The program will at least soft start immediately. Some differences between state and city, regarding docs and workflow. Training should take place within a couple weeks. From there, providers can work on the assessment and start uploading documents into HMIS. By April & May, vouchers can be issued for those who are ready to go. **Morgan**: Consolidated grant was looking initially at losing funding, with programs needing to decrease their workload by 40%, but are now fully funded. Hoping to see an increase in referrals for programs within this grant. **Laura**: Hoping to meet with AUW regarding April 1st. grant contract and trying to prepare for scenarios. There are some capacity issues: for programs that have been funded, most of them have been funded more than requested. Ultimately, we need to be able to spend down this money appropriately and not return much of it, if any. Please work with CoC, subrecipients and providers to connect with CES to complete referrals! This also means that people may stop looking at EHV since funding was restored, but EHV is a more permanent program for housing assistance for those who may not need supportive services that other Housing programs allow.	
c. Subpopulation Overviews	**c. Subpopulation Overviews** **Families:** **Brynn:** I noticed the number of active referrals has dropped compared to previous months, and placement rates within time standards has increased. For the total refs made in December were 43, 24 were to Transitional Housing (11 to ASI, 1 to HCAP and 12 to KWO Onemalu TH), 18 went to RRH (1 to ASI HPO RRH, 1 to HIS HPO RRH & 16 to OHN RRH). No refs were made to PSH, and 1 went to PH to State EHV. Of 43 refs made, only 7% remain active past CES time standards. 23, or 53% have been housed within time standards. 48% were placed into TH, 52% were housed through RRH. 40% of 43 total referrals have been unassigned within the CES time standards. 13 or 76% were unassigned from KWO and ASI Transitional Housing: 6 were unassigned due to needing a different resource - 3 of which needed a different unit size, 1 needed RRH instead of TH, and 1 was on the emergency shelter side of KWO and was close in securing section 8, and short term or shallow RRH may have been more appropriate than TH. 3 were unassigned due to housing program being filled to capacity. 3 were due to declined services - 2 due to location and one declined to go into TH, but was currently working with Brooke to get housed through the Youth Step-Up permanent housing program. 1 was due to being enrolled in another program outside of CES, this family moved to the shelter in Kahalu'u.	

4 or 24% were unassigned from FP OHN RRH:

2 were due to resolved cases - 1 moved to the mainland, 1 was housed already.

1 was due to enrolled in another program - they had section 8

1 was due to declining services - denied 9 units they were shown by the housing program.

Singles:

Darrell/China: The Singles Subpop had a total of 61 referrals, no PSH referrals were filled for the month of December. The majority of the referral activity took place with RRH, specifically OHN with 15 refs and of those 4 were housed, two hold an outstanding active referral status at 85 days.

One of these outstanding cases is pending an unassignment due to limited contact with client, although there is not much information to base why the assignment remained open for as long as it did so our team will have to look further into this case. The other outstanding case is moving forward with a housing application after completing an 1147 following a pre-screening of eligibility for the program.

There were 9 unassignments within the OHN program, 4 clients were reported as missing, 1 resolved case, 1 unassigned due to needing a higher level of care concerning a physical disability that limits her ability to work, but denied completing an 1147 with her health plan. 1 other unassignment was due to client's VI score not meeting the eligibility criteria for OHN following a reassessment of their VI. 10 referrals were completed to SDHC Congregate, w/ 2 resolved cases where client was successfully housed outside of CES, 3 unassignments due to a denial of services, 1 missing client case and two unassigned due to not having the right eligibility criteria specific to AMHD/CCS.

For the additional singles referral activity, there were 28 collective refs to RRH and 27 to TH. Singles TH holds an avg. of 56 days to complete intake which is considerably high. One data point of interest were in regards to time standards for avg. days to house by program type, HCAP holding a higher number of days to house at around 58 days so our team is helping HCAP refine their post-referral workflow to bring this number back down to more appropriate time standards, since intake should be happening around the 14-day mark.

Another area of concern regarding unassignments to TH are that 4 singles referrals were unassigned due to no contact established from POR. China is working with providers on troubleshooting the post-referral process regarding why this occurred, in addition to avg. days to unassign by program, with HSI currently at around 82 days to unassign due primarily to capacity to house, but the program does request for referrals at a rate higher than the program capacity allows. The upside of this referral activity is that three referrals of the five generated for Dec were housed within a two-week timeframe.

Youth:

Morgan: 5 refs were made, 3 to PSH Rycroft Group Home and housed within time standards. 1 ref to Hale Kipa TLP placed within time standards. 1 RRH ASI RYSE collaborative ESG program took about 97 days to house, specifically finding appropriate units and HH has a minor child and reunifying with partner and switching to Family supports.

DV:

Jessica: Of the total refs made: 5 CFS 3 to PACT TH and 1 to WIN RRH, active OTS and in these cases, providers may struggle to get ahold of the clients. Of the 4 unassigned refs, one had a change in HH, one resolved outside of CES and 2 declined services having moved to the mainland.

Veterans:

Michael: Vets from Jan 2021-Dec, almost 800 refs made, 121 remain active. Focusing in Dec., there were 30 refs made, 16 remain active and OTS. Of the unassignments (7), the main reason is cases have been resolved which is a good thing. It can be a data concern if we are not getting this information fast enough confirming resolved cases.

Clients also denying services is a general unassignment reason as well. Going back to larger set, clients who are missing or unable to locate is the primary unassignment reason over the past year and clients declining services, specifically GPD (81). 1 ref was made to VASH in October, 7 to SSVF, so not a lot of ref activity in Oct. with exception to GPD. November, there was a freeze in some refs but RRH grew to 15, TH as well.

In Dec., VASH opened up the referral process and 20 were generated. Around the same time VASH opened up, RRH decreased to 3 refs made. If we focus on the last few months, SSVF resources have experienced higher unassignment rates.

Too many Vets waiting for VASH, not enough refs to SSVF:

Michael: The line for VASH is getting longer, as people decline services to SSVF. SSVF referral could instead be a first step toward getting a VASH referral. Vets who are chronic elderly and women currently receive priority to VASH, and would not need to go through the SSVF pathway first.

Lindsey: VASH opened up elig. to anyone who served any active duty. Following this change, general and OTH discharges were considered. VASH has opened up to everyone and although there is no shortage, SSVF is a great resource; clients could have a shallow subsidy in addition to this resource, which covers 50% FMR.

Special Case Conferencing for PITC:

Lindsey: During PITC, PIC allowed me (Have you ever served in military or had active duty time?) Answering yes to these questions

	allowed for clients to appear on a map following their PITC survey; populate onto a spreadsheet and we case conferenced these Vets for coordinated outreach to follow up on clients who may not be appearing on the BNL. Outreach teams will be out looking for people and clients will be able to get their VI assessments completed if not appearing on BNL. **Laura:** Any ideas for PITC being more effective in your respective areas, let us know so we can integrate these ideas. PITC is just a snapshot. **Danny:** Hoping to report on data captured in the ER within the next few months.	
Subpop Workgroups a. Family Subcommittee	**Subpop Workgroups:** **a. Family Subcommittee:** **Brynn**: On Feb. 24th, we had first CES family sub meeting. Goal was to address gaps and barriers within the family system that providers or families are facing. Another goal was to identify where improvements may be needed within CES in addition to other system issues. The turnout was very high from providers and a lot was brought up. Documents, resource availability inside & outside of CES, homeless MH services, SA treatment availability, coordination of emergency shelter beds, the need for larger inventory for bigger HH sizes, language barriers, other barriers to house regarding Sex Offenders, pets, and arson convictions, including provider data entry concerns. One thing that stuck out was regarding the VI-SPDAT not capturing the severity as a whole, revamping the assessment. **Loke**: My idea of revamping the VI came out of the national alliance to end homelessness conference. Two cities have done this (Austin and Chicago) and have research groups to target gaps in the CoC. Some examples: Substance use (how are people taking substances, frequency of usage) expanding questions, severity of mental health and clients not addressing these concerns to the interviewers. If questions are not being asked correctly, the score will not reflect accurately. **Morgan**: Would it be elaborating on parts of the assessment more? **Loke**: One example I can give is asking about SA and MH: can these issues affect people living independently. Some clients may take offense to the way the questions are perceived and addressed, perhaps changing the language? Some severity statements can help provide more insight into what the VI is not showing, but hoping to have this captured in the initial interview may help with this. When clients admit to these conditions via self-report, we have providers match this information for verification, but the severity statement may contradict this if a disability verification has already been completed. A medical professional may clarify SA for a client for example, but if the consumer does not consent or address these conditions, we cannot make this adjustment on the assessment. **Emma**: Service provider and clinician perspective and consumer insight into their condition may be something worth looking into more. Clients with high level of vulnerability may need long term supports to conditions the clients are not readily aware of.	CES to bring the VI-SPDAT workgroup to other PIC Committee meetings and see if anyone is interested in joining this conversation.

	Morgan: Anyone interested in attending the workgroup to address these points? * (**Lindsey**, **Brynn**, **Emma**, **Berta**, **Macy**) *	
New Business	**New Business:** **Morgan: Diversion Training** series in the CoC may be a point of interest for providers or if it is something that is needed regarding RRH. LASH (eviction diversion programs, who do they serve and how does someone qualify for this support), workforce development programs, public assistance and programs providing ongoing rental subsidies, the realities of budgeting and PIC LEP involvement. Is there a need for this training? We talk about prevention but there is not standardized process within CES for prevention at this time. **Emma:** There is an increased need and clients may be employed but cannot afford rent. Compiling strategies to intervene early is necessary and a lot of questions directed to providers or to CES on how to prevent homelessness, which is abstract. **Laura: Strategic planning**: We really wanted to make sure all committees have a chance to think about what the committees do and how they might change. We don't have a Chair and wanted to meet until after strategic planning and bring someone in who understands the committee's direction. CES is a well-functioning committee and gets out a lot of information out there, enabling provider feedback to housing pathways and suggestions to any changes that can be made are most welcome. **Madi:** Iain De Jong did a great diversion training. **Danny:** Subpopulations to consider a focus on: Heavy CCS behavioral health group and medically fragile, incarcerated homeless population, regular high utilizers who are homeless (as these are common within the hospital system), conduct disorder revolving in and around the jail system with special needs (PO).	CES to add behavioral health, hospitalized, and incarcerated folks to a special sub-pops section of the CES Oversight Agenda next month.
Meeting Adjourned	Meeting adjourned at 11:33am NEXT MEETING: Thursday, April 21st, 2022, 10am – 11:30am	