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, April 21st, 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
(Gregory House): Kim Watts
(CFS): Robert Boyack, Anthony Lazarro, Hannah Michnya
(CCH): Zoe Lewis
(Gov's Office): Emma Grochowsky, Cheryl Bellisario
(Radical Hale): Kara England
(Hale Kipa): Deborah Smith
(HMSA): Desiree Vea
(C&C): Ailina Laborte
(IHS): Minda Golez
(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, Alex Dale
(VA): Lindsey Kaumeheiwa, Art Minor

Topics	Discussion	Outcome
I. Welcome/ Introductions	Meeting called to order at 10:01am	
II. Meeting Minutes	Minutes approved at 10:06am by Zoe Lewis, seconded by Deborah Smith	Minutes Approved
III. Resource/Policy Updates a. Announcements b. EHV	**III. Resource/Policy Updates** **a. Announcements** **Laura**: City has rec'd notices from HUD on expenditures, working on exit plans. Some clients were connecting to shelter expecting to return to homelessness, but that is not the intent. Working closely with clients for positive outcomes, extending leases up until Sept. on a month to month basis as long as they are compliant with the program. Any concerns, please reach out to me. **b. EHV**	

	Laura: HPHA rec'd 2-month extension to the end of April. Has been a very difficult program to work on obtaining all 27 documents for their clients. Feb 28th was the deadline but we were able to extend. Trying to remove barriers. EHV team is working hard on completing inspections, and with LEP support completing up to 17 inspections a day. Will be working on the City vouchers upcoming (soft opening). **Morgan:** For the City, the assessment is open in HMIS. Any questions can be directed to the HMIS team and documents are available on the PIC website. Encouraging providers to move ahead on collecting documents for their clients. Do not hesitate to apply your clients as it does not follow the same prioritizations as CES referrals. It will come down to first come first serve when documents are all completed so we want providers to take advantage of this as much as they can. Any questions on docs, contact EHV team at ehv@partnersincareoahu.org. **Kara:** Working w/ 3 elderly clients and 1 page of docs involves checking accts. Some clients have online banking (Chime); does not having a bank acct. disqualify you? **Laura:** It does not disqualify you. EHV needs to know they do not have a checking acct. If a client does not have work for example, the client will have to attest and provide proof that this is the case, including statements, award letters from SSI, etc.	
c. Steadfast Program Changes	**c. Steadfast Program Changes** **Darrell:** There has been an administrative change w/ Steadfast regarding the McKinney funding, and can allow for beds within the group homes for CoC/CES referrals. The agency admin changes will reflect Steadfast Housing sites & will be operating under new management. New management will utilize HMIS to record program entry & CES to request referrals for new vacancies as they occur. This change in administration will not be affecting those currently residing in program. The following sites will be operating under new management. **Effective April 1st 2022**, SHDC will not be managing the **Kaukama** & **Ahukini** group homes. **Kaukama** will be managed by **Hale Na'o Pono** & **Ahukini** by **Mental Health Kokua**. **Komo Mai** is in a pending status and Steadfast will determine continued mgmt. of this site or if it will be redistributed to another housing agency.	
d. Create milestones for assessing COVID risk factors as part of prioritization	**d. Creating milestones for COVID risk factors as part of prioritization** **Morgan:** CES wants to discuss revisiting the plan to keep or modify the COVID risk factor prioritization. **Michael:** If we hit certain targets regarding active cases, perhaps motioning to slowly remove the prioritization, but just as importantly regarding new waves getting insight on clear directions lateraling up/down depending on the influx or reduction in cases. Open to any suggestions, or thoughts.	**COVID PRIORITIZATION**: At the next NNL meeting, go through those who are prioritized & see if they still need to be prioritized. CES to propose a couple of options for the Covid prioritization plan.

	Robert: For CFS, we are continuing business as usual. We have adhered to certain procedures during COVID (sanitization of general living spaces, social distancing), but have maintained the same workflow and still have a notification system to allow for tracking cases. Currently no limitations or restrictions for clients gaining access to shelter. **Morgan:** Any contingency plans for other ES operations? **Minda:** We had TQUIK to triage homeless. We have discontinued, but even prior to, have reorganized the shelter and relaxed on masking. In regards to housing and giving priority to clients at higher risk for COVID, it has been any different, working on housing the most vulnerable quicker. Have been running 24-7 throughout the pandemic, and since standards have relaxed, so have we. **Richard:** We relaxed on a lot of procedures and processes in allowing for people to come in, but did not have restrictions for client access prior to, unless a client is feeling ill. Clients do not have to mask but they are available. Staff does mask up for one on one meetings and we have not had an outbreak at Keauhou, we sanitize as much as we can. Waikiki Health Director encouraged masking, both for clients and staff. HHHRC has been sending a lot of people to their sites in Waikiki for those that need access to shelter, where the clients may be coming from. We follow procedure as best as we can and as needed. **Brynn:** If we remove the prioritization, will clients return to their natural priority order? **Morgan:** Yes. We will offer some suggestions on how to implement this policy moving forward into our next meeting. **Laura:** If clients still need to be prioritized on NNL, can we change this if the vulnerabilities are no longer creating an impact? **Morgan:** Yes, we can. **Michael:** Start w/ NNL, check on if it is still necessary. Perhaps this process is already baked in, and perhaps this prioritization is no longer as important, so will gather thoughts from the providers on upcoming meetings. **Richard:** We haven't had any outbreaks or anyone w/ COVID, so risk factors for us have gone way down. 7.1% seems to be the current rate as far as exposure to COVID.	Send out to the group 2 weeks before the next Oversight meeting so we can vote next month.
e. Subpopulation Overviews	**e. Subpopulation Overviews** **Families:** **Brynn:** For the total referrals made in January: there were 42, 25 were to **Rapid Rehousing** (1 to ASI, 6 to IHS ESG, and 18 to OHN RRH), 13 went to **Transitional Housing** (6 to ASI OOOK, 1 to HCAP & 6 to CCH TH). There were referrals made to **PSH**: 2 to State HPHA EHV. Of 42 referrals made, 40% remain active past	

CES time standards, 11 of which were eventually housed or unassigned, but there are 6 that remain active as of today.

There are 3 IHS ESG RRH active referrals, 2 State EHV, and 1 US VETS Housing First PSH. Of the 42 total referrals generated, 20, or 48% have been housed within time standards. 30% were placed into TH, 65% were housed through RRH. 12% of 42 total referrals have been unassigned within the CES time standards.

3 were unassigned from Transitional Housing. 2 of those unassignments were recorded as missing clients, or unable to contact the HH. 1 of those referrals were unassigned due to a change in HH composition and needed a Singles VI to be completed. 2 unassignments occurred from Rapid Rehousing. 1 from IHS ESG was enrolled in another program and another was unassigned from Family Promise OHN because they are missing or unable to be located at the time of the referral.

Singles:

Darrell/China: There were a total of 31 referrals for singles in the month of January; 7 of which remain active, 17 placements occurred, & 7 referrals were unassigned. For PSH: there were 5 referrals made, 1 remains active and 4 placements occurred. The dashboard metrics displays an avg. of 50 days to house for January.

For **US VETS PSH**, 2 referrals w/ avg. of 68 days to house; 1 individual was just housed a week ago, & 1 individual was housed at 61 days. **CCH PSH** had 3 referrals w/ avg. of 31 days to house (all special requests), 1 active referral remaining & awaiting potential placement w/ Artspace Lofts and/or Varsity Circle, which will both become available at end of month. Lots of units were considered but limited responses were rec'd from LL's. **Steadfast Congregate** referrals were completed as well: Of the 3 referrals generated, 2 were housed: 1 was placed within a few weeks & 1 was housed earlier this month due to pending document recovery and income verification from SSI; this client also identifies as Transgender and required a specific site accommodation, so when a vacancy opened up, the program was able to move forward with housing them. There were 4 referrals to **HPHA PH**, 3 remain active and one was unassigned from program due to missing documents.

The majority of the TH referrals made went to **HCAP TH**, 6 placements - 4 placements of the 6 were prioritized down and successfully housed. There is one active referral due to delays to receive a COVID, TB test and program fees and is pending an unassignment. On record, there are 3 unassignments: One missing client, one denial of services, and one case was resolved and secured a place of their own. One unassignment took 68 days due to provider wanting to place a hold on the referral until they rec'd confirmation that client left island and relocated to NY. In **Steadfast's TH** program, one client was housed in January, placement occurred around 20 days.

Finally, for RRH assignments, there were a total of 8 referrals made, 2 remain active, 4 placements occurred and there were 2 unassignments. For **ASI HPO RRH**, 1 client was housed within 29 days and was also prioritized down. **Family Promise OHN** had 2

	placements with an avg. of 50 days to house & 2 unassignments: one resolved case due to securing housing and one unassignment due to requiring a different resource and unassigned within a few weeks. **IHS ESG RRH** assignments were clients who were prioritized down to lesser services. One placement occurred of the three refs generated, two of which remain active at 92 days and are still going through housing navigation, & one is receiving support from LEP.	
Prioritizing clients down for resources	**Prioritizing clients down for resources** **Minda:** My team mentioned the referrals they are receiving are a lot higher on the priority category. The PH programs will be opening up, they have been full due to a holding pattern and unsure about funding, but have rec'd and offered a bit more than anticipated. We were also busy working on getting clients support through the EHV's, which will offer some pukas. **Morgan:** Perhaps something we can further address regarding the threshold for prioritizing clients down, so that housing programs are not working primarily with the most vulnerable clients outside of their priority category if they need more support. **Youth:** **Morgan:** No referrals are active at this time, but 4 were made to RRH, 2 to RYSE YHDP, and 1 unassignment was made due to client denial of services. That client wanted to pursue PSH and is working to receive CCS coverage. 4 referrals were made to TH, 3 to Hale Kipa TLP and 1 to RYSE. Of the 3 referrals to HK, all three were unassigned due to client denying the location. **DV:** **Robert:** We had a total of 7 referrals to the DV system; 6 to RRH and 1 to TH for January. One TH to WIN and housed within time standards. Of the 6, 3 went to CFS, and 2 of which remain active. 1 HH applied for several units and was denied due to no income/employment. 1 referral was made to LEP, and will know the outcome of the referral status on Friday when we meet. 1 CFS referral was housed within 33 days and the other 3 were made to WIN. 1 was housed within 41 days. One unassigned due to requiring a different resource, which required longer-term RRH. One was unassigned within 19 days due to resolving their own housing. Avg of 10 days to complete intake for referrals generated to DV. **Veterans:** **Michael:** For January, CES jumped up on the number of referrals made. Vet programs have doubled with referral requests. Still, a number that are active within time standard. We only have one client that was missing regarding their unassignment, which means that providers are taking the time to locate the Vet before processing an unassignment. For Jan. time standards, GPD assignments take place the day of, Vets arrive on site and typically get assessed on site following their placement. These referrals can happen really quickly with the Vet providers. For PSH, this has happened a few times, but there have been some referrals	

	that occurred quickly. VASH may have been working with a client already, but is not as frequent as with GPD. **Mayor's Challenge and BFZ:** there is a monthly report for Vets appearing on the BNL concerning in and outflow. For end of March, 175 Vets, which is lowest number of Vets on the BNL since we have been working with Nate French w/ BFZ. This drop in homeless vets is great to see. A quarter of these Vets are in shelter, 88 of the total number for March '22 are chronically homeless. The CH Vet numbers have been fairly consistent. There were a number of clients who are inactive and no longer meet the BNL criteria, meaning they have resolved their cases in a matter of ways. We had an inflow of 15, which is pretty consistent, about half of which are new to homelessness, and half are reemerging.	
New Business	**New Business:** **Morgan:** One of the outcomes of the prevention meeting is regarding the diversion series. PIC is in collaboration with the Gov's Coordinator's office & will be putting on a diversion series starting around 5/18/22. This will kind of tie in to the Lunch & Learns, and will also target non-homeless service providers who have encountered individuals who may be at risk of facing homelessness. There is not widespread knowledge on what resources are available for those who are at risk, so we are opening a discussion on how to best divert these clients, and knowing what is out there - including long term rental subsidies & remaining in good standing with Sect. 8 so subsidies are not compromised. **LEP** will also discuss how to find rental units, identify tips on what property mgmt. may look for in an applicant, especially for clients in an unpredictable circumstance or who may seek support through an employment-based program. Tenancy skills will be covered in this series, as well as what support can be provided to keep a client in a unit rather than becoming homeless. **CES Oversight Committee Refinement:** **Laura:** We are at the stage of working on committee development. Working w/ Sharon S. and Heather P. for finalized recommendations for Strategic Alignment, but if anyone has suggestions please let myself or anyone from the Advisory Board know. **Anything that hasn't been discussed? Please send the CES team an email!** **Morgan:** We are going to bring up a VI-SPDAT workgroup in relation to concerns with the VI. Will be addressed during Data and Planning committees. Also, of all the youth on NNL, all clients have been referred or recommended for PSH. All youth who have CCS who have also been recommended for PSH have been referred.	
Meeting Adjourned	Meeting adjourned at 11:11am NEXT MEETING: Thursday, May 19th, 2022, 10am – 11:30am	