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, June 16th, 2022

Join on your computer or mobile app:
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+1 689-206-0354,746251232#
Phone Conference ID: 746 251 232#

Attendees:

AlohaCare: Rhea Nuguid
CCH: Zoe Lewis
CFS: Robert Boyack, Jessica Oda
Gov's Office: Emma Grochowsky, Cheryl Bellisario, Scott Morishige, Lindsay Apperson
HMSA: Desiree
Ohana: Duke Maele
Queens: Daniel Cheng
IHS: Minda Golez

PIC: Michael Kleiber, Morgan Esarey, Julia Wolfson, Wallace Engberg, China Moreira, Brynn Miranda, Laura Thielen, Darrell Edelhoff, Joshua Roach, Berta Maldonado, Alex Dale
US Vets: Macy
VA: Lindsey Kaumeheiwa, Art Minor
Waikiki Health: Richard Kaai

Kaiser: Charisse

Topics	Discussion	Outcome
I. Welcome/ Introductions	Meeting called to order at 10:00am	
II. Meeting Minutes	Minutes approved at 10:05am by Scott Morishige, seconded by Rhea Nuguid	Minutes Approved
III. Resource/Policy Updates a. OHN RRH	**III. Resource/Policy Updates (Announcements)** **a. OHN RRH** **Morgan**: No new referrals to OHN, may remove from Oversight agenda for CES **Scott:** Do we know if OHN has been extended, the length of extension, and what that may entail? This could impact whether we keep on the agenda. For those that transition off OHN, would also be helpful to keep. **Morgan**: We can keep until program has closed for exit planning, can follow up with Berta and PIC next month.	

b. EHV/HPHA	**b. EHV/HPHA** **Darrell:** Follow up from HPHA meeting: There are 30 open referrals to the City PHA, awaiting a program extension. Total vouchers issued (169) and total leases signed and uploaded (124). **Scott:** On the outreach provider call last week, an issue came up w/ homeless outreach providers that were getting calls from people at-risk to see if they can be connected. Outreach providers are the access points to get them connected to EHV, but they only service literally homeless individuals. Has there been any discussion to redirect at-risk HH's? A few of the at-risk would eventually qualify due to prioritization, but primary issue is access. On EHV page on PIC website, I don't know if it's possible to list the at-risk category to contact specific organizations (i.e. Waimanalo Hx Center, CCH), assuming the organizations are okay with it. There are agencies like HCAP that help with referrals, and get paid to assist with this. Act 57 Eviction Protections would include new potential candidates who are desperate for support; capacity could be a problem further down the line. Would suggest recommending HCAP district office for support as an access point, as their funds allow. **Morgan:** For the at-risk, they are eligible, but there is not a good way to have at-risk clients connect with access points. Catholic Charities has likely received a lot of calls. May have been mentioned on an outreach call that certain agencies may only be assisting clients on the Windward side. Outreach programs may not have the capacity to serve if they are getting inundated with calls. Programs are not paid to apply people for EHV. We could reconnect with the City on this and reach out to HCAP and revisit the concern about provider traffic for at-risk applications. **Zoe:** Is there anyone (with HMIS access) who could be contracted to support this barrier? **Emma:** On the outreach provider meeting, PIC is designated by the PHA's for the administration of EHV, and because they process the applications, capacity was an issue with the EHV team to be the access point for those considered at-risk. **Morgan:** There are currently 3 staff that oversee the 312 EHV's with PIC. We will communicate with the City and EHV about this concern. **Zoe:** I can check with Jillian on this. Dani Gela's clients were requesting support for applying for EHV. Our programs are not paid to assist with this, so the initial reaction is that I'm not sure how we could take this task on, in addition to our current workload.	PIC to reach out to district offices at HCAP to see if they could apply at-risk households Otherwise, need to revisit this with EHV and the City
c. Creating milestones for COVID risk factors as part of prioritization	**c. Creating milestones for COVID risk factors as part of prioritization** **Morgan:** We sent out a word document about the changes. Please review if you get the chance. We want to make sure the policies are understood by all providers. What we agreed upon last month was (**reference the word document for history of COVID protocols**), these prioritizations are now embedded in the	

	tiebreakers. A provider will need to go into HMIS and input the COVID risk factor due to age or other medical vulnerabilities. For a member in PSH priority category 1, if two clients have the same VI score, the next tiebreaker, rather than age, would be the COVID risk factor assisting with prioritizing that client ahead. In the event the COVID restrictions are reinstated, anyone within the housing pathway would be prioritized to the top. We really appreciated the conversation from last month and voicing suggestions on what should be done. Any changes to the document? Comments? **Duke:** No questions **Morgan:** We will be putting this into the PnP's soon!	CES to include tiebreaker verbiage on COVID prioritization to CES P&P's
d. Homeless Prevention & Diversion Series	**d. Homeless Prevention and Diversion Series** **Morgan:** We just finished the last of the diversion series trainings, all of the sessions have been recorded. There are slides available on the PIC website, so if anyone missed a session and is interested, check them out. Last meeting was on budgeting and tenancy skills and hearing feedback from Rose and Robert, who assisted with facilitation.	
f. Subpop Overviews	**f. Subpop Overviews** **Families:** **Brynn:** Looking at March, there were a total of 71 referrals made for families, 22 of which went to TH, 10 to ASI OOOK, 10 to KWO and 10 to CCH. 12 to RRH, 2 to ASI HPO RRH, 2 to IHS HPO RRH, and 8 to IHS ESG RRH. 2 families were referred to PSH, which was great as there was a wait for referrals for families. 2 to IHS City HF, and 35 families went to State HPHA EHV. Of the 71 referrals made, a total of 17 were unassigned. 10 of which were unassigned within CES time standards and 7 went past time standards that have since been unassigned. 10 unassigned were from TH, 5 from ASI TH denied resources due to location, one required other resources and another case was resolved. Another HH was unassigned from Ma'ililand due to being housed already. An additional family was unassigned from Onemalu due to needing other resources. 6 unassigned from RRH. 5 from IHS ESG RRH, 2 needed a different resource, 1 pursued EHV, and another required HLOC, such as PSH. 22 active over CES time standards. 8 of which have been housed or unassigned, 14 that still remain are active. Those 10 are with State EHV HPHA, 2 with IHS ESG RRH, 2 with HF PSH and those 2 with City PSH are special requests and coming from BH (Bridge Housing). Some of the barriers including finding units in their specified locations of interest. Another is awaiting a current tenant to vacate before moving in the new HH. Looking at the metrics for March, the avg. number of days to complete intake for PSH was 14 days, and for RRH, 12 referrals took an avg. of 7 days, and for TH and avg. of 5 days to complete intake. The number of days to unassign metrics data for families - it took an avg. number of days (28) for RRH, which is a bit over time standard. For TH, an avg of a day. For PH, there was a -2-day	

indication, which has been resolved on the active referral sheet with support from Wallace. Looking at avg. number of days to house for families: for RRH - 48 days, that avg. is within time standard and the avg. number of days to house for EHV was 34 days, and TH an avg. of 9 days.

Singles:

China/Darrell: For March singles, there were (out of a total of 48 referrals) 29 made to PH EHV (State HPHA), 17 were active outside of time standards, 11 were housed within time standards, 1 client resolved due to having been reported as deceased.

For PSH, the 4 referrals completed were to IHS, 1 to MHK, and 10 to Steadfast Congregate and 1 to SHDC HUP TH. Of the 16 PSH referrals, 17 were active OTS, 2 housed within time standards and 7 were unassigned. 1 was not housing ready, 1 recommended for Safe Haven, 2 reported as incarcerated, 1 required a HLOC, 1 considered for PSH (independent housing) and 1 was missing.

Of the 7 referrals active OTS, 2 have been housed, and 3 have been unassigned due to 1 client wanting Shelter + Care PSH, 1 denied resources due to location preference and 1 client's SharePoint referral was not completed in time.

For RRH, we have 1 that went to ASI, and 2 to IHS. 1 referral remains active outside time standard, and 1 client was unassigned due to moving off island to Alaska.

Youth:

Morgan: There were 3 referrals made for this subpop; 2 to ASI RYSE RRH and 1 to YHDP program. 1 was housed within 54 days to YHDP RRH program and to ASI RYSE, 1 was unassigned within 8 days due to client being on Big Island. Another referral was in and out of contact during the referral, and eventually lost contact with outreach provider, leading to an unassignment at 50 days. Youth intakes around 5 days, and one was unassigned at 50 days.

DV:

Jessica: For DV, 8 referrals were made in March; 6 were made to RRH, 3 to WIN and 3 to Child and Family Services. WIN's RRH referrals - 1 remains active: they are on track to be housed after conducting unit search.

1 was unassigned within time standards, the client required a different resource. 1 HH was placed within 52 days. The 3 to CFS - 2 were unassigned outside time standards: 1 due to HP unable to house the client, as they reached program capacity and client returned back to BNL for resources. Another case was unassigned due to being enrolled outside of DV CES. The other CFS referral was housed within time standards. The 2 to TH were housed at PACT and WIN within TS.

Regarding metrics, intake was completed within an avg. of 18 days for March, the clients missed the first scheduled intake, which could have contributed to the avg. For Transitional Housing, intake was avg. at 6 days. For unassignments for RRH, the avg.

	was 40 days due to program capacity. Avg. days to house was at 51 for RRH and for TH, 6 days. **Veterans:** **Michael:** Looking at Vet subpop for March, there was a dip to 38 referrals, in the 50's in the past. We reached a dip in Vets appearing on the BNL, but there were more individuals identified on the BNL for needing resources. Due to time standards, 8% housed (3), 21% were unassigned (8) and 71% OTS. Client denying services was the primary unassignment reason. Most of the unassignments took place with SSVF, and a lot of the open referrals are with GPD or VASH. All of the SSVF assignments for March have reached an outcome of housed/unassigned. 17 referrals made to VASH, 10 to SSVF & split between CCH and US VETS, and 11 referrals were made to GPD. General overview: TS days to complete intake, VASH is at 13 days, SSVF programs are at 18 days and number of days to unassign, 23 days to process VASH unassignments, and 32 days with SSVF, which are reasonable, and 16 days for GPD. For March, the data is fairly similar, 15 days to unassign, 16 days to complete intake for VASH. Only one client was housed with SSVF, none were housed through VASH so the metrics for days to house does not reflect for March. Mayor's Challenge Data: 175 end of March data for Vets that has since gone up, 132 unsheltered, and 43 sheltered. A huge number of CH vets are unsheltered (88). Inflow (15) and outflow (29) breakdown of being inactive clients, newly homeless and clients who returned to housed. 8 veterans were new to homelessness, 1 vet returned from housed, and 6 vets returned from inactive status. Of the people housed in March, it took 166 days to go through the housing process. 122 long stayers that have remained active on the BNL. **Other Subpops:** **Morgan:** We keep up the subpops incarcerated, hospitals, and behavioral health on the agenda for follow-ups. Any updates on the subpops mentioned? **Daniel:** No significant updates or hard deliverables other than ED perspective, we are knee deep in another surge, which puts pressure on hospital on how do we navigate those long-stayers, social determinants, client dispositions and how this intersects with inpatient care? In PIT report, there was a report that Queens did in tandem to PIT, so if anyone is interested in checking into this, please do. Perhaps we can gather more info from the Queen's homeless clients.	
Meeting Adjourned	Meeting adjourned at 11:00am NEXT MEETING: Thursday, July 21st, 2022, 10am – 11:30am	