# PARTNERS IN CARE

*Oahu's Continuum of Care*

***Our mission is to eliminate homelessness through open and inclusive participation and the coordination of integrated responses.***

**PIC CES Oversight Meeting Minutes**
September 21st, 2023, 10AM – 11:30AM

**Attendees:**

PIC: Sara Ironhill, Laura Thielen, Morgan Esarey, Julia Wolfson, Brandie Morales, Brynn Miranda, Aubrey Pellicano, Joshua Fuentes, Joshua Roach, Berta Maldonado, Michael Kleiber, David Wilkie

AlohaCare: Rhea Nuguid
Alternative Structures International: Desiree Caminos
Child & Family Services: Jessica Oda
CORE: Jenny Neal
Domestic Violence Action Center: Lydia Abajo
EPIC Ohana: Chassidy Shino
HMSA: Desiree Vea
IHS: Connie Mitchell, Margaret Sane-Gasetoto
Kalihi Palama Health Center: Kekoa Miller, Chambree Eyestone, Mahealani Vega, Cassy Rodrigues, Lisa Higa
Mana Pono Holomua: Angel Heath
MHK: Kaycee DeSouza
Office of Homelessness and Housing Solutions: Sarielyn Curtis, Lindsay Pacheco
Queens: Danny Cheng, Tiffany Mukai
United Healthcare: Roddy Marengo, Camille Simon
US Vets: Macy Sevaaetasi
VA: Art Minor

| Discussion | Next Steps |
|---|---|
| **I. Welcome / Introductions**<br>Safety Story, challenges, gaps?<br><br>• Challenge: Angel: a lot of work to be done and not enough workers or funding<br>• Chambree: concerns about lack of ADA units, extremely vulnerable clients in units, concerns about the CES referral process. People are dying in their units. Not a good outcome for anyone.<br>• Danny: where is the gap?<br>• Chambree: Our program doesn't require that the client is connected to CCS. We would like to require it, but it is not within our contract. Clients are getting referred to our agency for independent living and at times they're connected to only an outreach person, and that support goes away once housed.<br>• Laura: We have a lack of appropriately trained individuals, lack of accountability. Housing first isn't truly housing first if the lack of wrap around support isn't there.<br>• Kaycee DeSouza: we're experiencing this at Mauna Kea and Mahani House. We are linking clients up to get 1157 done, referring to psych, making sure they have outside support because we don't have CM support within Safe Haven. We need CM services to do the things they need to do.<br>• Connie: These clients shouldn't be going into independent living, and we need to be more sure about how we're referring. If the person doesn't look like they're able to do it, 1147 should be done so we know the level of care. Need to bring in DHS/foster homes/DOH etc. This is a crisis. | CES to include gaps in services for medically fragile/highly vulnerable households on October oversight agenda.<br><br>CES/PIC to work on scheduling meeting with DOH/DHS<br><br>CES to meet with KPHC and AUW re: case management |

| | |
|---|---|
| • Chambree: There is tension because we see these clients directly and it comes down to accountability. We feel we've lost control of the process. When we unassign referrals we need to do our due diligence, but we feel our concerns aren't taken seriously. I don't know how the scoring is or how people get referred. Is there any additional screening process we can add at the beginning of that referral?<br>• Morgan: prioritization hasn't changed in years, and we may need to revisit that.<br>• Laura: Encourage audience to join VI workgroup.<br>• Follow ups with respective parties to take place after oversight. This discussion was tabled until the October meeting.<br><br>Announcements:<br>• Interest form shared for 3 VI workgroups focusing on policy review, assessment review/development, and evaluation<br>• Encourage agencies to request Agency Analysis role in HMIS Clarity in order to access CES features | |
| **II. Meeting Minutes**<br>Motion to approve August 2023 minutes by Danny Cheng, seconded by Angel | |

**III. Sub-populations Overview**

a. Youth

- In 2019, there were 46 referrals made. At this time there were only 2 youth housing programs, one through IHS and one through RYSE, and they were both RRH programs.
- In 2020, there were 64 referrals made. In 2020, Hale Kipa launched their Transitional Living Program for youth ages 18-21 as well as their Housing First PSH program. 2020 was also the year that the YHDP (Youth Homeless Dem Program) grant was awarded to RYSE, Hale Kipa/Waikiki Health, and HHHRC and this brought in a wide array of programs to make the youth system more well-rounded and better meet needs of youth (mobile crisis outreach, guide on the side peer support, a joint TH/RRH, PSH that prioritizes youth with severe mental illness and CCS coverage). In Nov 2020, CES referred the first 7 youth households into the new RYSE YHDP housing projects. CES did not start referring until the last quarter/closer to the end of the year, but we still saw that increase in referrals and placements.
- In 2021, there were 76 referrals made. You'll see another jump here. This is the first year since 2019 that placements were greater than unassignments. We could possibly attribute this to the new supportive services and housing options that came online from Hale Kipa and YHDP. By Jan 1 2021, there were 7 total housing programs available within the youth system, compared to only 2 programs in 2019 limited to RRH.
- In 2022, there were 71 referrals made. A tiny bit of a decrease in # of referrals made, likely because youth placed into housing in 2021 were still taking up those beds in 2022 but I'd have to dig a bit deeper to confirm that. Although there was a slight decrease in # of referrals made, the system still saw that placements were greater than unassignments.
- So far in 2023, there have been 71 referrals made. As of today, there are 10 active referrals with at least 3 projected to be housed next week. Hoping to see more placements in the coming months as additional youth programs have come online this year - one being the RYSE Manu O Ku program which is permanent supportive housing. RYSE/ASI/AZ have also worked hard in recent months to amend their contract for their Kauhale Kewalo project so it is now officially dedicated to youth and going through CES. CES is meeting with them tomorrow to discuss how to best prioritize for this resource. RYSE has recently opened a clean and sober home called Apapane, it is a pilot and privately funded. Referrals do not go through CES but it's just one more place for youth to stabilize who are trying to focus on sobriety.
- The takeaways from this data might be self-explanatory, but it turns out that adding more money and a variety of resources to a system usually results in an increase of people served and placed into housing! RYSE and others are really tackling the work and applying for funding to continue adding even more resources into the system. Youth providers are doing an incredible job at thinking outside of the box and offering creative and supportive housing options to their youth.

CAMHD/AMHD data, how many youth lose coverage due to aging out?

b. Domestic Violence

- Most common unassignments are resolved case, these are specifically households housed outside of CES or moved outside of the CoC. Second most common reason is client denied services.
- 49% of referrals were active outside of time standards.
- TH/RRH - days to intake an unassign are a bit above time standard, days to unassign for TH is under time standards and for RRH is a bit above. Days to house are both within time standards.
- There is a need for more RRH within DV.
- Connie – where is eligibility and how are people referred?
- Jess- access points are DVAC PACT WIN CFS.
- Jess: VI questions identify if someone could be eligible for DV. They can stay outside of the system if comfortable with info being shared in HMIS. Mainstream access points might try to connect them with a DV access point.
- Connie: can the referrals be broken down by where they're coming from?
- Danny: we see DV a lot in the ER. The institution wants to take the next step and need to figure out how to link them up in real time to meet solutions.

Work on displaying where DV housing referrals originated (shelter, non-DV system, etc.)

c. Veterans

- Michael spoke with VASH about their targets, they have targets similar to ours, but we look for vets to be housed within 90 days of their *referral*. For vets the

Would like to see the supply in # of beds

| | |
|---|---|
| national target is to house within 90 days of their *enrollment*. VASH across the nation is missing the target but more recently, we're doing a great job on housing time standards here.<br>• Unassignments last 3 months: missing client is #1 reason among Vets. May have to do with Vets having financial resources that others may not have. #2 client denying services. #3 and #4 are more data issues (enrolled in another program, resolved case). Sometimes have to make blind referrals.<br>• Overview by year: Remarkable consistency – 30% housed yearly is the trend. Unassignment reasons, missing clients is far and away the top reason.<br>• Avg time April – June: in RRH, avg days to intake is exactly on target 14 days, avg days to unassign could be lower, days to house is very good.<br>• VASH has been very quick to bring someone in and either move forward or quickly unassign.<br>• Housing by agency: everything is in green all within time standards to house!<br>• US vets PSH HF – we've heard that there is expanded funding for Vets that has been historically very small maybe 5-6 referrals per year). This is possibly expanding quite a bit and will bring another Vet resource onboard.<br>• # of Vets on BNL has stayed about the same, but number of long stayers has decreased!<br>• Connie: data collected on participants' tenure in Hawaii? We've been seeing a lot more recent arrivals. Is this tracked?<br>• Michael: HMIS collects this, but it's not on the BNL. The VA is aware that there is a cycle around this time of year, vets begin to pop up in Hawaii more regularly through winter, then tends to drop off when it's warmer on mainland. Do you feel there's a larger # of Vets?<br>• Connie: I look at people in general who are from somewhere else.<br>• Danny: Nice to see the demand portion of this. What do we need? Is there a supply that can be applied to these? # of beds. Companion table? Available inventory to show if we're utilizing the resources<br>• Laura: Sometimes there are units available, but they are understaffed, units being repaired, etc. And we should be putting a lot of thought into this now that we're in Clarity.<br>• Connie: Issue of shelter inventory when people are sent to IHS but cannot actually take care of themselves living in a shelter. It's scary to put it all out there because we get abused.<br>d. Singles<br>• Significant decrease in referrals this period, could be due to the Clarity migration which took place in April. Going back to what Danny said, what does inventory look like or is utilization low or staffing shortages? CES will have to dive in further.<br>• Breakdown of numbers on overview page: one housed, one over time standards, 7 unassigned. All 7 didn't meet program eligibility, needed either CCS or AMHD. Typically, when they pop up on the BNL they will be referred without needing CHV or anything. HLOC also comes in, do they need PSH with support in place or do they need something more? If so, what is that?<br>• Most common unassignment reason is program eligibility not met. Noting that in this reporting period there have been 0 RRH referrals for individuals.<br>• If you look further at the 57 referrals, 16 housed and 31 unassigned, 12 needed HLOC (PSH or 24 hr group home). Raises the question of how appropriate is RRH for this subpop? And do we need to look closer at prioritization?<br>• Met time standards/time standards breakdown: mostly on trend. Difficult to get CHV, DVL, verify CCS, staffing shortage, etc.<br>• Danny: overview by year. Worried about this year, looking now compared to 2018 and 2019. Can we look back at those years and see where the referrals are coming from? What happened within those 2 years<br>e. Families<br>• Apr-June, total of 60 referrals. 11% to PSH, 88% TH, and 0 RRH referrals within these 3 months. Of these referrals 35% housed, 60% unassigned, and 5% still active today. All to PSH and all special requests with barriers to housing. Prolonged intake process, special accommodation process, taking time to find units. Working with LEP.<br>• Highest unassignment reason is missing client. 2nd is denied services, remains common and continues to be a barrier for clients unsheltered in places other | available (inventory) compared to demand and referral data. Utilize the HIC |

than Westside. For PSH, only one unassignment for not meeting eligibility for that program.

- Eligibility by year: hoping to speak to this more next time. Looking back over the year unassignment reason most commonly is still denied services. 76% came from TH 21% from RRH.
- Met time standards – of the 60 referrals, 30% unassigned within, 31% housed within __ active
- PSH – taking 26 days on average to do intake. Identified some of those barriers were CM having heavy caseloads and high number assigned to each of them. 100 clients to 2.5 CM. One program asking for extra disability docs on top of a DVL already provided. They ask for this because they want a specific diagnosis, where other programs will take the standard DVL. Days to house looking great.
- Encourage audience to take time to look at the other sections of this dashboard.

| | |
|---|---|
| **IV. Resource/Policy Updates**<br><br>a. CES P&Ps<br>b. Emergency Housing Vouchers (EHVs)<br>i. Hawaii Public Housing Authority (HPHA)<br>ii. City Public Housing Authority (City PHA)<br>c. Program utilization<br>i. PSH program concerns about accepting higher level of care clients and the length of time it takes to house them<br>d. Data Committee<br>a. HMIS agency analysis role – pertinent for NNL access<br>b. In the last couple of months, there have only been 7 duplicates since we switched to Clarity. Huge improvement.<br>e. Planning Committee | |
| **V. New Business**<br><br>a. Coordinated Assessment Workgroup<br>a. VISPDAT feedback survey review<br>b. NAEH: Reimagining a Racially Equitable and Just CES Lab<br>c. CES Oversight Committee Refinement<br>i. Oversight description & role<br>ii. Data Measures to focus on<br>iii. Oversight participation<br>1. Missing stakeholders<br>d. New Sub-populations<br>i. Hospitalized<br>ii. Higher Level of Care<br>iii. Incarcerated<br>iv. Oahu Initiative to End Veteran Homelessness | |
| **VI. Adjourn**<br>Next meeting Thursday, October 19th 10:00-11:00am | |