

BEHAVIORAL HEALTH ADVISORY BOARD
General Meeting
Monday, November 19, 2018, 1:00 – 3:30 p.m.
Ventura County Behavioral Health
1911 Williams Drive, Training Room • Oxnard, CA 93036

AGENDA

- I. Call to Order and Pledge of Allegiance
- II. Approval of the Agenda – **ACTION**
- III. Approval of the October 15, 2018 Minutes – **ACTION**
- IV. Welcome and Introductions
- V. Public Comments (3 min. per speaker)
- VI. Recognitions
 - A. Anne Sippi Clinics
 - B. Rhonda Fleisher of VCBH Older Adult Program
 - C. Brandy Martin of VCBH Older Adult Program
 - D. Michael White, VCBH Safety Officer
- VII. Chair's Report (5 min.)
 - A. CALBHB/C Quarterly Meeting
 - B. Conference Call for Board/Commission Chairs and Member Supervisors – Southern Region
 - C. Certificate of Commendation Presented at the Board of Supervisors Meeting on October 30, 2018
 - D. Events and Announcements – Janis Gardner, Chair Emeritus (5 min.)
- VIII. Board Members Comments and Announcements (3 min. per speaker)
- IX. Presentation: Recovery – Patrick Jeffries, Pacific Clinics Peer Partner (20 min.)
- X. Director's Report – Dr. Sevet Johnson (10 min.)
- XI. Secretary's Report – Kay Wilson-Bolton (5 min.)
- XII. BHAB Committees Reports (5 min. each)
 - A. Adult Services Committee – Nancy Borchard and Gane Brooking, Co-Chairs
 - B. Prevention Committee – Janis Gardner, Chair
 - C. Transitional Age Youth (TAY) Committee – Cmdr. Ron Nelson, Chair
 - D. Youth & Family Committee – Denise Nielsen, Chair
- XIII. New Business
 - A. Appoint Member At Large to a Six-Month Term (5 min) – **ACTION**
 - B. Suggested Amendment to the BHAB to Increase the Number of Members by One (for a Total of 22 Members), with the New Position Designated for a Member of the Sheriff's Office (10 min.) - **ACTION**
 - C. Status of the Managed Care Workgroup (5 min.) – **ACTION**
 - D. "A Positive Approach to Treatment" – Discussion of the Draft Document (10 min.)
 - E. Pre-Trial Diversion for Mental Health Clients (AB 1810) – Public Defender's Office (20 min.) – **ACTION**
 - F. Feasibility of Bringing the Inpatient Psychiatric Unit (IPU) Under the Authority of Ventura County Behavioral Health (VCBH) Rather Than Ventura County Medical Center (VCMC) (15 min.)
 - G. Ventura County Plan to Prevent and End Homelessness (10 min.)

Members of the public making oral presentations to the Board in connection with one or more agenda or non-agenda items at a single meeting are limited to a cumulative total time not to exceed (5) minutes for all of their oral presentations at such meeting unless otherwise provided. The entire public comment period is limited to no more than (20) minutes total for all speakers. NOTE: The Chair may limit the number or duration of speakers on a matter. In compliance with the Americans With Disabilities Act, if you need special assistance to participate in this meeting, please contact Behavioral Health Administration at (805) 981-6830. Reasonable advance notification of the need for accommodation prior to the meeting (48 hours advance notice is preferable) will enable us to make reasonable arrangements to ensure accessibility to this meeting.

XIV. Old Business

- A. Update on the Adult Crisis Stabilization Unit (CSU) – Daniel Powell, Mental Health Operations Supervisor Inpatient Unit (10 min.)
- B. Future Presentations
- C. Future Recognitions

XV. Contracts – **ACTION**

- A. Board of Supervisors Approved Agreements – October 9, 2018
 - 1. Mental Health Services: Interface Children and Family Services, Idea Engineering, Inc., and Evalcorp Agreements
- B. Board of Supervisors Approved Agreements – October 16, 2018
 - 1. Alcohol and Drug Program and Mental Health Services: Gold Coast Health Plan (GCHP) Memorandum of Agreement (MOA)
- C. Board of Supervisors Approved Agreements – October 30, 2018
 - 1. Alcohol and Drug Program Services – DMC-ODS Standard Agreement
 - 2. Mental Health Services: California Department of Rehabilitation (DOR) and Pathpoint Office Space License Agreements
 - 3. Mental Health Services: Senior Planning Elder Care Services (SPECTS) Agreement

XVI. Public Comments (3 min. each)

XVII. Adjourn

Next Meeting: Monday, January 28, 2019

Behavioral Health Advisory Board

A POSITIVE APPROACH TO DEFINING BEHAVIORAL HEALTH TREATMENT

Draft 1

Discussed during the BHAB Executive meeting on 11/13/18

Individuals with Behavioral Health conditions have a medical illness that requires treatment. The treating provider is responsible for working with the client to help manage that condition in such a way as to enable the individual to live a normal life or as close to a normal life as possible depending upon the degree and limitations of the condition.

If we think about Behavioral Health issues in this way, stigma is removed and the person receiving treatment for his/her condition is the same as an individual receiving treatment as a person with diabetes or asthma. When treating diabetes or asthma the healthcare provider is managing the condition with the goal of providing that person with the ability to live a normal life or as close to a normal life as possible.

Our society must learn to view Behavioral Health conditions and individuals experiencing them in a positive way, thereby removing stigma.

A POSITIVE APPROACH TO DEFINING BEHAVIORAL HEALTH TREATMENT

Draft 2

Both drafts for discussion at the General meeting on 11/19/18

People with mental illness have a medical condition that requires treatment. The treating provider is responsible for working with the client to help manage the condition in such a way as to enable the individual to live a happy, fulfilling and productive life.

If we think about Behavioral Health issues in this way, stigma is removed and the person receiving treatment for his/her illness is the same as a person receiving treatment for diabetes or asthma. When treating diabetes or asthma the healthcare provider is managing the condition with the goal of providing that person with the ability to live a normal life or as close to a normal life as possible depending upon the degree and limitation of the condition.

Our society must learn to view Behavioral Health conditions and individuals experiencing them in a positive way, thereby removing stigma.

VENTURA COUNTY REGIONAL PLAN TO ADDRESS HOMELESSNESS

VENTURA COUNTY CONTINUUM OF CARE ALLIANCE

WHY DEVELOP A NEW PLAN?

- Clearly articulate regional strategies & educate community and partners
- Describe current system; successes and challenges
- Identify areas of focus to develop a comprehensive crisis response system
- Identify proven practices and programs to invest local, state and federal resources
- Use document to conduct annual review and update of plan
- *Requirement for State funding

STAKEHOLDER INPUT

- Community Task Forces
- Cities/County
- Education
- Healthcare
- Social Services Agencies
- Criminal Justice
- Business Community
- Faith Community
- Homeless Service Providers
- Housing Developers/Real Estate/Landlords
- Philanthropic Groups
- Persons Experiencing Homelessness

SUBPOPULATIONS

- Families with children
- Unaccompanied youth
- Persons fleeing domestic violence
- Seniors
- Veterans
- Persons with disabilities
- Persons with serious mental illness
- Persons with substance use disorders
- Persons with chronic health conditions
- Persons with criminal justice history

CORE COMPONENTS

- Homeless Management Information System
- Pathways to Home, Coordinated Entry System
- Housing First/Low Barrier Programs & Services
- Data-Driven Decisions
- Create Sustainable & Effective Programs & Interventions

STRATEGY I

- ❖ **Develop A Comprehensive Crisis Response System**
 - Homeless Prevention targeted at those most likely to become homeless
 - Divert people from shelter whenever possible
 - Provide coordinated entry & access to homeless persons & families
 - Create access & points of entry countywide
 - Increase emergency housing options across the county
 - Enhance outreach efforts
 - Housing Navigation Services to assist with quickly connecting to housing assistance & other services

STRATEGY 2

❖ **Increase Affordable Housing Opportunities for Households Who Are Homeless or At-Risk of Homelessness**

- Housing Location efforts to build partnerships with landlords
- Leverage funding opportunities to increase supply of supportive housing for persons with disabilities including serious mental illness & substance use disorders
- Partnerships with affordable housing providers/Public Housing Authorities
- Share data with jurisdictions to help informed decision making in proposing/approving new housing.

STRATEGY 3

❖ **Create & Provide Wrap-Around Services to Keep Households Housed**

- Home-based case management services
- Access to behavioral health services
- Access to substance use treatment and support services
- Access to healthcare services
- Access to education and employment services
- Access to other services needed to maintain housing

STRATEGY 4

❖ **Create Opportunities for Homeless Persons/Families to Obtain Sustainable Income**

- Partner with education/workforce programs to increase meaningful and sustainable employment opportunities for people experiencing or at-risk of homelessness
- Increase connection to SSI Outreach, Access & Recovery (SOAR) program to increase the number of persons with serious mental illness & other disabilities are able to access Social Security benefits and Medicaid.

STRATEGY 5

❖ **Community Outreach & Education**

- Share data, best practices and proven practices with CoC partners
- Share data, best practices and success stories through community engagement
- Broaden membership of CoC
- Use social media, press releases and CoC website to disseminate information
- Solicit input from community on strategic goals and performance
- Facilitate humanizing homelessness to promote compassion/empathy

STRATEGY 6

❖ **Cross-System Integration**

- Work across public & private systems of care to ensure ending homelessness is a shared priority
- Foster high-level coordination among government entities on the issue of homelessness
- Increase data sharing among systems of care
- Assess and prioritize efficiency and effectiveness across impacted systems

STRATEGY 7

❖ **Capacity Building**

- Ensure a strong system capable of meeting strategic goals and locally adopted system performance thresholds (in alignment with State/Federal funding)
- Increase bed coverage & data quality in Homeless Management Information System (HMIS) in order to identify gaps
- Facilitate training opportunities and technical assistance to all homeless service providers

FEEDBACK

- What do you like?
- What else should we consider?
- Other thoughts?

NEXT STEPS

- Use draft plan and integrate strategies
- Share Draft 2 with stakeholders
- Use month of December to gather feedback
- Present updated Draft to CoC Board for approval—January 9, 2019

Ventura County Plan to Prevent and End Homelessness

Introduction

Homelessness looks different for different households, and people become homeless for many varied reasons. In Ventura County's expensive housing market, a single event, like an unanticipated medical bill, a death in the family, a missed paycheck, or a costly car repair can cause a household to lose housing. Safe, stable, and affordable housing is key to the wellbeing of our residents and community. Households living outside, in shelters, cars, campgrounds, temporary or overcrowded shared housing situations, transitional housing, motels, or in housing that is unsafe or unsanitary are considered homeless. Families with children, unaccompanied youth, seniors, persons with serious mental illness or substance use disorders, veterans, and those fleeing or attempting to flee domestic violence or dating violence comprise those who are homeless in Ventura County.

This strategic plan is borne of the belief that preventing and ending homelessness requires a unified and strategic response. Although established systems and programs to address homelessness exist in our community, we are recommitting to carrying out and expanding solutions to help our most vulnerable residents – and the whole community – to succeed and thrive.

History

In 2006, Ventura County adopted a 10 Year Plan to Prevent and End Homelessness. The plan set forth an ambitious agenda for ending homelessness by 2016. Significant strides have been made since the adoption of the 10 Year Plan with an emphasis on greater collaboration and maximizing existing resources through implementation of Pathways to Home, the local coordinated entry system. Significant investments have been made in Homeless Prevention and Rapid Re-Housing programs through commitment from the Board of Supervisors to provide local funding in addition to the resources through State and Federal programs. Progress has been made towards the goal of ending veteran homelessness, improving collaboration among youth-focused services and implementing low barrier, housing first programs throughout the Continuum of Care partner agencies and programs. Behavioral Health and Healthcare focused programs have been implemented including outreach efforts through the RISE and PATH programs of Ventura County Behavioral Health and the Healthcare for the Homeless and Whole Person Care programs of the Health Care Agency including expansion of outreach efforts and recuperative care beds.

While much has been accomplished, homelessness in Ventura County remains a persistent challenge. The 2018 Point in Time Count found there are an estimated 1300 people experiencing homelessness on any given night. The 2018 count showed the first significant increase in homelessness in Ventura County in 8 years. An overall 12.8% increase from the 2017 count with an increase of nearly 24% in unsheltered persons has heightened the awareness of community stakeholders and leaders to a place where a refreshed strategy is needed. The Ventura County Continuum of Care is developing this regional strategy with input from stakeholders including local jurisdictions, homeless service providers, affordable housing developers and supportive housing providers, county service agencies, law enforcement, faith-based partners, the business community, advocates, persons who are currently or formerly homeless and many others focused on homeless subpopulations.

This plan focuses on creating a crisis response system that is organized around the goal of helping all people who are without shelter quickly return to housing. The 10 year plan included recommendations of creating new shelter programs and housing inventory but resources were not made available to reach those goals. With new funding available and a local commitment, comes an opportunity to invest in best practices and proven solutions to prevent and end homelessness for individuals and families.

Who is Homeless in Ventura County?

Each year the Ventura County Continuum of Care conducts the Point in Time Homeless Count and survey with the goal to survey and count each person who was homeless on one night in January. This activity assists with evaluating trends and gaining a better understanding of the needs of the population who meet the United States Housing and Urban Development (HUD) definition of homelessness (sleeping in places not meant for human habitation or staying in an emergency shelter or transitional housing program).

In 2018, there were 1,299 adults and children who were homeless during the Point in Time Count and Survey. Of the 1,299 persons counted, 821 or 63.2% were unsheltered and 478 or 36.8% were sheltered. The 2018 count accounted for the first significant increase in the annual count in several years with an overall increase of nearly 13% and a significant increase in the overall unsheltered population, rising nearly 26% from the 2017 count.

During the 17-18 Federal Fiscal Year, 2,309 unduplicated persons requested assistance from the Ventura County Continuum of Care partners.

The number of people who are at-risk of homelessness is significant in Ventura County's high cost/low vacancy housing market. The United States Census Bureau noted that 9.9% or approximately 84,000 of the 854,223 residents of the county were living below the poverty level as reported in the 2017 American Community Survey. These persons are at-risk of homelessness because of the cost of housing relative to their household income.

Other program data to help us evaluate the number of people who are homeless and at-risk of homelessness comes from Ventura County healthcare and education providers who use a broader definition of homelessness which includes individuals and families who are temporarily staying with family or friends including being doubled up or couch surfing. In 2017, The County of Ventura Healthcare for the Homeless reported 14,521 persons enrolled that meet the Health Resources & Services Administration (HRSA) definition of homeless (includes doubled up and at-risk persons). Of this number, 4,456 or 30% of persons were literally homeless (on the streets, emergency shelter or transitional housing).

Ventura County Office of Education also tracks the number of homeless students through a broader definition of homelessness set by the federal Department of Education. Data collected in the 2017 school year showed 4,400 students temporarily doubled-up or at-risk of homelessness, 569 or 13% of students met the HUD definition of homelessness. This data includes all public K-12 schools in Ventura County.

Vision and Guiding Principles

This plan lays out the strategies to effectively prevent and end homelessness in Ventura County. The Ventura County Continuum of Care's vision is that homelessness is rare, brief and non-recurring.

- **Rare:** Whenever possible, the homeless crisis response system will prevent vulnerable individuals and families from falling into homelessness.
- **Brief:** The system will be in place to ensure that any household experiencing homelessness returns to as housing as quickly as possible striving to accomplish this within 30 days or less.
- **Non-recurring:** Individuals and families assisted by the crisis response system will not return to homelessness

Ventura County Continuum of Care Guiding Principles:

- *Collaboration and Coordination:* Invest in evidence-based, results-driven and client-focused systems of support that integrate practices, procedures, and services within and across public and private agencies, programs, and policies.
- *Housing First:* People experiencing homelessness require very affordable and permanent housing solutions as quickly as possible and then services as needed.
- *Strength Based:* Start with and build upon the skills, strengths, and positive characteristics of each person.
- *Trauma Informed:* Homelessness is a complex, high-risk and individualized condition, not a character trait. Recognize that most people experiencing homelessness have experienced trauma, and build relationships, responses, and services on that knowledge.
- *Harm Reduction:* Seek to reduce the effects of risky behavior in the short-term and eliminate its effects in the long-term.

Methodology

The Ventura County Plan to Prevent and End Homelessness was created by combining three primary activities:

- Establishing core requirements and core components to prevent and end local homelessness;
- Using core requirements and core components to shape recommendations to prevent and end local homelessness;
- Implementing the locally shaped recommendations with new and existing federal, state, and local funding opportunities.

A. Establishing core requirements and core components to prevent and end local homelessness

Core Requirements

The Ventura County Continuum of Care has adopted the following core requirements for all publicly funded programs serving homeless individuals and families, which is consistent with federal and state legislative requirements:

1. Participating in the Homeless Management Information System

The local Homeless Management Information System (HMIS) is the primary repository for client level data for consumers of homeless services in the County of Ventura. The HMIS allows the Continuum of Care to analyze data from within the homeless system and evaluate essential information related to the provision and assessment of services provided within all levels of the Continuum of Care, including outreach and prevention, emergency shelters, transitional housing and permanent supportive housing. This system allows service providers to submit direct referrals in a more efficient manner, improving access to housing and services.

2. Participating in the Coordinated Entry System

Pathways to Home is the Ventura County Continuum of Care's Coordinated Entry System. This system allows individuals and families to access services needed to move them out of a state of homelessness as quickly as possible. Pathways to Home includes a client-focused approach to minimize the complexity and challenges associated with accessing multiple programs to avoid or exit homelessness. Service providers within the VC CoC work collaboratively to coordinate services and information with the intent to provide the most effective and efficient client services.

3. Implementing a Housing First Approach

Housing First is a low barrier approach that consists of the following elements:

- people experiencing homelessness can achieve stability in permanent housing, regardless of their service needs or challenges, if provided with appropriate levels of services;
- barriers are removed that have hindered homeless persons from **obtaining** housing which include
 - too little income or no income;
 - active or history of substance use;
 - criminal record, with exceptions for state-mandated restrictions; and
 - history of having been or currently a victim of domestic violence (e.g., lack of a protective order, period of separation from abuser, or law enforcement involvement).
- barriers are removed that have hindered homeless persons from **maintaining** housing which include
 - Failure to participate in supportive services;
 - Failure to make progress on a service plan;

- Loss of income or failure to improve income; and
- Fleeing domestic violence.

All privately funded programs are encouraged to adopt the core requirements.

Core Components

Core components are based upon a range of evidence-based, best, and promising practices that have been used to help solve local homelessness in other communities.

- **Evidence-based practices** are founded on the integration of research results with clinical expertise, which helps professionals make decisions on proven results and not on personal experience or anecdote.
 - Examples include **permanent supportive housing** and **Housing First**, which are described below.
- **Best practices** are methods or techniques that have been generally accepted as superior to alternatives because they produce results which are superior to those achieved by other means. These practices are not considered evidence-based because not enough rigorous research has shown them to be effective, which may yet happen.
 - Examples include **street outreach and engagement**, **housing navigation**, and **rapid rehousing**, which are described below.
- **Promising practices** are methods or techniques that have the potential to effectively address issues of concern in a community. They are solutions or approaches that are new, innovative and “startup” in nature and may not have been sufficiently tested, but still hold promise and potential. These practices can warrant additional research and testing to eventually become best practices.
 - Examples include **coordinated entry system**, **low barrier shelter**, and **housing search**, which are described below.

Core components include:

1. Street Outreach and Engagement

- **Outreach** to individuals in a Housing Crisis; begins the initial steps for building personal connections, assessing immediate needs with a basic needs assessment, and working to identify and overcome to improve health status, social support network and address their housing crisis. Outreach to members of the community can also serve as a means of educating them about the components of a Housing Crisis, ways in which to support community members living on the streets and the programs that serve those individuals.

- **Engagement** is continued multiple contacts with individuals living on the street, continued attempts to develop and establish a rapport that leads to a trusting relationship to facilitate the development of a Housing plan as well as addressing their medical, mental health and service needs. The process begins after the initial street outreach contact, when individuals in a Housing Crisis are identified. Engagement periods can be as short as one or two contacts or may take years including hundreds of contacts. Staff who provide the engagement services are aware that refusals of contacts can rapidly shift and that initial rejections can eventually lead to acceptance of services and development of a housing plan. It is important that the community, agencies or government policies and resources recognize the length of time that may be needed for regular and persistent contact to result in active engagement and progress towards creation of a housing plan.

2. Housing Search

Housing search uses Housing Locators who, with support from a wide-range of community members, find housing options for street outreach workers to engage homeless persons. Engaging a wide-range of community representatives in housing search activities with the leadership of Housing Locators results in an increase of affordable housing opportunities, thus freeing street outreach workers to concentrate on developing the relationships necessary to motivate homeless persons to obtain and maintain the housing.

3. Housing Navigation

Housing Navigation focuses on helping homeless households develop a housing plan, address the barriers identified during the plan or regular navigation activities, and assisting the household with acquiring documentation and completing forms required for housing. Navigation includes attending property owner meetings and setting appointments and assisting with completing paperwork needed around housing applications. Navigation also involves the securing of housing through inspections, utility startups and actual move in into housing. Each housing navigator provides services until a linkage with an assigned long-term case manager occurs once the individual is residing in their housing. Thus, navigation differs from active case management in that the primary focus is assisting the individual with obtaining their housing whereas case management is long term and ongoing and helps the household maintain their housing once achieved.

4. Low Barrier Shelter

Low barrier shelter is temporary housing that is in contrast with shelters and transitional housing programs that have “housing-ready models” in which residents must address various issues (e.g., substance abuse) that led to their episode(s) of homelessness prior to entering permanent

housing. Thus, treatment and compliance is required in exchange for help with obtaining permanent housing in 'housing-ready models'.

In low barrier shelter, however, there are no preconditions such as sobriety or medication compliance. A Housing First approach is embraced and anyone facing a housing crisis is offered immediate and low barrier access. Residents work with housing navigators to move into permanent housing as quickly as possible and receive home-based supportive services including substance use treatment services if agreed upon and needed.

5. Rapid Re-housing

Rapid Re-Housing is an intervention that connects families and individuals experiencing homelessness to permanent housing through a tailored package of assistance that may include the use of time-limited financial assistance and targeted supportive services. Rapid Re-Housing programs assist individuals and families living on the streets or in emergency shelters solve the practical and immediate challenges to obtaining permanent housing. The primary focus of the program is to help a household find housing as quickly as possible and receive case management for stabilization purposes. This is a trauma-informed approach that supports households in their own housing which can allow children to remain in school, adults can maintain or more easily obtain employment and families can easily stay together.

6. Permanent Supportive Housing

Permanent supportive housing is an evidence-based housing intervention for persons who have a qualifying disabling condition and need of subsidized housing for which they pay no more than 30% of their adjusted monthly income. Services are provided on-site and off-site. The type of services depends on the needs and the will of the residents. Services may be short-term, sporadic, or ongoing indefinitely. Supportive services may include education, emergency assistance, employment, health care, mental health care, substance use counseling and treatment, transportation and trauma care.

7. Home-based Case Management

Home-based case management focuses on helping persons with maintaining their housing after obtaining their housing by providing a balanced approach that helps clients receive necessary on-site and off-site supportive services but does not evict clients for failure to participate in supportive services; failure to make progress on a service plan; loss of income or failure to improve income which is consistent with a Housing First approach.

B. Using core requirements and core components to shape recommendations to prevent and end local homelessness

Recommendations shaped by core requirements and components include:

1. Implementing a homeless prevention approach that will help ensure that those individuals and families most likely to become homeless do not become homeless.

The approach focuses on providing limited cash assistance and a wide-range of free or low cost supportive services and supplies to those households most likely to become homeless. The approach also focuses on providing a wide-range of free and low cost supportive services and supplies to those households less likely to become homeless but in need of such services and supplies.

Households At-Risk of Homelessness

Households most likely to become homeless will receive appropriate cash assistance. Such assistance may include:

- rental and utility assistance;
- utility deposits;
- security deposits;
- move-in costs;
- legal fees;
- transportation; and
- credit repair costs.

A wide-range of free or low cost supportive services and supplies include:

- clothing;
- educational assistance;
- employment services;
- food;
- health care;
- household equipment and furniture;
- household supplies;
- hygienic supplies;
- mental health care;
- public assistance;
- school supplies; and
- substance use counseling and treatment.

Households most likely to become homeless will be identified by using the characteristics of the local sheltered population as the criteria for determining if a household is likely to become homeless and should receive prevention assistance. Such information is available through the Homeless Management Information System (HMIS). Characteristics will likely include:

- history of homelessness including number of, and length of, previous homeless episodes;
- very low-income household;
- disabilities in household;
- employment status of adults.

Households less likely to become homeless will receive the wide-range of free or low-cost services and supplies noted above when needed.

2. Expanding street outreach and engagement

Expand street outreach and engagement to all areas of the county to ensure that outreach workers engage persons living in highly visible homeless encampments. Such visible persons are often the most vulnerable who have been languishing on the streets and prone to injury and death.

Outreach workers should be full-time and dedicated solely to outreach and engagement ideally assigned to the same community for extended periods of time. Outreach includes building a personal connection with the individuals, assessing their immediate needs with a basic needs assessment, and working to identify barriers that the individual must address and overcome in order to improve health status, social support network and address their housing crisis. Engagement involves multiple contacts with individuals living on the street.

Outreach and engagement also involves collaborating with outreach workers who may not be full-time and dedicated solely to outreach and engagement. Collaboration will also include cross-training.

Outreach and engagement also includes responding to community requests for street outreach intervention from local government including law enforcement, businesses, civic groups, service groups, and neighbors.

3. Promoting Housing Search

Hire Housing Locators, with support from a wide-range of community members, will focus on finding various housing options for street outreach workers to engage homeless persons. Housing Locators engaging a wide-range of community representatives in housing search activities will result in an increase of affordable housing opportunities. This will allow street outreach workers to concentrate on developing relationships with homeless persons, and in particular chronically homeless persons, to connect with appropriate housing.

Housing Locators will help create and coordinate a Housing Search Task Force that will be made up of a wide-range of community representatives that are committed to identifying and

recruiting potential providers of affordable housing for people who are experiencing homelessness. Task Force members will include representatives from:

- Civic groups;
- Faith communities;
- For-profit corporations;
- Local government;
- Real Estate/Landlord groups;
- Non-profit agencies.

Together, Task Force representatives will identify and recruit potential providers of affordable housing for persons experiencing homelessness such as

- property owners;
- property managers;
- residential care providers,
- affordable housing developers;
- affordable housing operators;
- single room occupancy corporations; and
- permanent supportive housing providers.

Types of affordable housing for persons who are experiencing homelessness will include:

- Scattered site housing which includes individual apartment units throughout the community;
- Single-site housing which includes apartment buildings;
- Set-aside housing which includes a designated number or set of apartments within a larger apartment building;
- Shared housing that provides a household with a private bedroom and shared living space that includes bathrooms, kitchen, dining area, and other living spaces.

4. Augmenting housing navigation

Augmenting housing navigation will include hiring full-time Housing Navigators that are solely dedicated to housing navigation, which means focusing on helping homeless households with developing a housing plan, addressing the barriers identified during the plan or during regular navigation activities, and assisting the household with acquiring documentation and completing forms required for housing. Navigation will also include attending property owner meetings and setting appointments and assisting with completing paperwork needed around housing applications. Navigation will also involve the securing of housing through inspections, utility startups, and actual move in into housing.

5. Increasing the number of low barrier emergency shelter beds

Low barrier emergency shelter is temporary housing in contrast to shelters and transitional housing programs that have “housing-ready models” in which residents must address various issues (e.g., substance abuse) that led to their episode(s) of homelessness prior to obtaining permanent housing. Thus, treatment and compliance is required in exchange for help with obtaining permanent housing. In low barrier emergency shelter, however, there are no preconditions such as sobriety. Residents work with housing navigators (as noted below) to move into permanent housing as quickly as possible and receive home-based supportive services including substance abuse services if agreed upon and needed.

6. Augmenting Rapid Rehousing assistance

Augmenting Rapid Rehousing assistance will help more families and individuals who are not chronically homeless obtain permanent housing immediately and to stabilize themselves as soon as possible. Such households have not been living on the streets for years with physical disabling conditions such as serious mental illness, substance use disorders, and/or chronic physical illness. They have lived independently in permanent housing in the past and need temporary assistance for several months instead of years. They may need short-term rental assistance (six months or less) and longer-term non-monetary assistance to prevent the loss of their housing such as free or low-cost clothing, food, health care, household supplies, and transportation.

7. Increasing the number of permanent supportive housing units

More permanent supportive housing is needed for persons who have a disabling condition and in need of subsidized housing for which they pay no more than 30% of their adjusted monthly income. Supportive housing is the best practice solution for persons with serious and persistent mental illness, substance use disorders and other disabilities. Services will be provided on-site and off-site. The type of services will depend on the needs and the will of the residents. Services may be short-term, sporadic, or ongoing indefinitely and be focused on helping residents maintain their housing. Supportive services may include education, emergency assistance, employment, health care, mental health care, substance use counseling and treatment, and trauma care.

8. Ensuring home-based case management

Home-based case management helps ensure that previously homeless individuals and families receive case management after rapid rehousing assistance ends and ensure that there are enough case managers to provide case management for all households in permanent supportive housing units.

C. Implementing the locally shaped recommendations with new and existing federal, state, and local funding opportunities.

Local recommendations will be shaped by integrating the core requirements and components described above into new and existing federal, state, and local funding opportunities.

Appendix A consists of multiple federal and state funding sources from the Homelessness Task Force Report: Tools and Resources for Cities and Counties. Not all counties and cities are eligible for every funding source. Collaborating with eligible recipients, however, can help ensure the submission of competitive proposals.

There are several new state funding opportunities because of recently passed legislation. They include four opportunities that are described more fully in Appendix B.

The four state funding opportunities include:

State Funding Opportunity	Amount Available for Ventura	Eligible Activities
No Place Like Home Program	\$1,566,826	Permanent supportive rental housing for people with serious mental illness, who are homeless, chronically homeless, or at-risk of chronic homelessness
Housing for a Healthy California	TBD	Pay for the cost of permanently housing homeless individuals on Medi-Cal who receive services through the Whole Person Care pilot program, Health Homes, or some other county controlled funding source
Homeless Emergency Aid Program (HEAP)	\$4,831,856	Established for the purpose of providing localities with one-time flexible block grant funds to address their immediate and emergency homelessness challenges. A minimum of 5% is dedicated to serve homeless youth up to age 24. City and County jurisdictions must adopt a resolution declaring a shelter crisis to be eligible for funding.
California Emergency Solutions and Housing (CESH) Program	\$701,401	Rental assistance and housing relocation and stabilization services to ensure housing affordability to people experiencing homelessness or at risk of homelessness. Rental assistance provided pursuant to this paragraph shall not exceed 48 months for each assisted household and rent payments shall not exceed two times the current HUD fair market rent for the local area, as

determined pursuant to Part 888 of Title 24 of the Code of Federal Regulations.

Operating subsidies in the form of 15-year capitalized operating reserves for new and existing affordable permanent housing units for homeless individuals and families.

Flexible housing subsidy funds for local programs that establish or support the provision of rental subsidies in permanent housing to assist homeless individuals and families. Funds used for purposes of this paragraph may support rental assistance, bridge subsidies to property owners waiting for approval from another permanent rental subsidy source, vacancy payments, or project-based rent or operating reserves.

Operating support for emergency housing interventions, including, but not limited to, the following:

(A) **Navigation centers** that provide temporary room and board and case managers who work to connect homeless individuals and families to income, public benefits, health services, permanent housing, or other shelter.

(B) **Street outreach services** to connect unsheltered homeless individuals and families to temporary or permanent housing.

(C) **Shelter diversion**, including, but not limited to, homelessness prevention activities, and other necessary service integration activities to connect individuals and families to alternate housing arrangements, services, and financial assistance.

Appendix A

Homelessness Task Force Report: Tools and Resources for Cities and Counties

Federal and State Funding Sources:

Shelters and Prevention	Emergency Solutions Grant (ESG): ESG is a HUD program grant administered by the California Department of Housing and Community Development (HCD). ESG provides funding to help improve the quality of existing emergency shelters for the homeless, make additional shelters available, meet the costs of operating shelters, provides street outreach and helps prevent homelessness. The program also provides short-term homelessness prevention assistance to persons at imminent risk of losing their housing due to eviction, foreclosure or utility shutoffs. The State of California runs an Emergency Solutions Grant Program.	Metropolitan cities, urban counties, territories and state
Housing	HOME Investment Partnerships Program (HOME): HOME is a HUD program that provides formula grants to states and units of local government used by communities – often in partnership with local nonprofit groups – to fund a wide range of activities that build, buy and/or rehabilitate affordable housing for rent or homeownership or provide direct rental assistance to low-income people.	State and local and communities, including cities and counties
Housing Case Management	HUD Continuum of Care Program: This program is designed to promote communitywide commitment to the goal of ending homelessness; provide funding for efforts by nonprofit providers and state and local governments to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families and communities by homelessness; promote access to and effect utilization of mainstream programs by homeless individuals and families; effectively manage, promote and utilize the coordinated entry system and optimize self-sufficiency among individuals and families experiencing homelessness.	State and local governments, nonprofit organizations
Housing	Community Development Block Grants (CDBG): CDBG is a flexible program that provides communities with resources to address a wide range of unique community development needs. Among these needs is low barrier shelter.	Counties with fewer than 200,000 residents in unincorporated areas and cities with fewer than 50,000 residents that do not participate in the U.S.

		(HUD) Community Development Block Grant (CDBG) entitlement program
Housing, Families, Seniors and Disabilities	Section 8 Housing Choice Vouchers: This housing program targets low-income families, seniors and those with disabilities by providing a direct housing subsidy to landlords, with the enrollee paying any difference in cost.	Local public housing agencies
Veterans Case Management Housing	HUD-Veterans Affairs Supportive Housing (VASH) vouchers: This program combines Housing Choice Voucher (HCV) rental assistance with case management and clinical services provided by the U.S. Department of Veteran Affairs (VA), for disabled veterans who are homeless.	Local public housing agencies
Veterans, Families and Prevention	U.S. Department of Veterans Affairs' Supportive Services for Veteran Families (SSVF): This nationwide program is intended primarily to serve individuals experiencing crisis homelessness. It provides temporary financial assistance and a range of other flexible services geared toward preventing homelessness among those at risk and rapidly stabilizing in permanent housing those who do become homeless. It is important to note that, despite its name, the program serves both families with children and individual veterans.	Private nonprofit organizations and consumer cooperatives who can provide supportive services to eligible populations
Veterans Prevention Housing	Veterans Housing and Homelessness Prevention Program (VHHP): The purpose of VHHP is the acquisition, construction, rehabilitation and preservation of affordable multifamily housing for veterans and their families to allow veterans to access and maintain housing stability.	Sponsors and borrowing entities may be organized on a for-profit or not for-profit basis. Any public agency or private entity capable of entering into a contract is eligible to apply.
Behavioral Health	Substance Abuse and Mental Health Services Administration (SAMHSA) Grants: These are federal block grant funds available through the Center for Substance Abuse Prevention, the Center for Substance Abuse Treatment and the Center for Mental Health Services to support local programs for substance use disorders and mental illness.	County mental health plans
Health	Medicaid/Medi-Cal: Medi-Cal is California's Medicaid program. Medi-Cal is a public health insurance program financed by the state and federal governments that provides health care services for low-income individuals, including: <ul style="list-style-type: none"> • Families with children; • Seniors; • Persons with disabilities; • Foster youth; • Pregnant women; and • Low-income people with specific diseases such as tuberculosis, breast cancer or HIV/AIDS. In California, counties have a unique perspective on the Medi-Cal program. County welfare departments determine eligibility for the Medi-Cal program, and county behavioral health departments act as the health plan provider for Medi-Cal. California counties do not, however, have a share of cost for the Medi-Cal program. Counties can leverage their unique position within the Medi-Cal program to	California Department of Health Care Services (administered by counties in California)

	conduct outreach to help eligible homeless individuals receive Medi-Cal services.	
Families Prevention Employment	Temporary Assistance for Needy Families (TANF)/CalWORKs: Operated by local county welfare departments, CalWORKs provides families in need with a combination of financial assistance and work opportunities to help them become more financially independent. This program also offers housing support and case management for those at-risk of homelessness.	State and tribal agencies (administered by counties in California)
Families Food	CalFRESH: CalFRESH, formerly known as Supplemental Nutrition Assistance Program (SNAP), is a federally mandated, state-supervised, and county-operated government program that provides monthly food benefits to help low-income households purchase the food they need to maintain adequate nutritional levels. While CalFresh benefits generally cannot be used to purchase hot or prepared food, the CalFresh Restaurant Meals Program allows homeless, disabled and adults age 60 and older to use their Electronic Benefits Transfer (EBT) at select restaurants in some counties. Some individuals also qualify for SNAP employment and training benefits. Children who live in households that receive CalFresh or SNAP benefits are eligible to receive free school meals, including free summertime meals.	State and tribal agencies (administered by counties in California)
Families	Promoting Safe and Stable Families (PSSF): Funded through Title IV-B funding, PSSF is a program to develop a coordinated and integrated service system that builds on the strengths of families and communities.	Child welfare agencies and eligible Indian tribes
Families, Housing and Case Management	CalWORKs Housing Support Program: This program targets CalWORKs homeless families or those at risk for homelessness. Major components include housing identification, rent and moving assistance, and case management and services.	Counties
Seniors and Housing	Section 202: Supportive Housing for Elderly: This program provides grants for supportive housing for the elderly who are very low-income and at least 62 years old.	Private nonprofit organizations and nonprofit consumer cooperatives
Youth	McKinney-Vento grants: The State of California receives a limited amount of federal funding to support efforts to address the needs of homeless students, which is sub-granted to local education agencies (LEAs) such as school districts and can support collaborative projects. Each school district is required to have a McKinney-Vento liaison. LEAs are also mandated to comply with objectives outlined in the State of California's Every Student Succeeds Act (ESSA) plan, www.cde.ca.gov/re/es/ .	Local education agencies
Youth	Local Control Funding Formula/Local Control Accountability Plans (LCFF/LCAP): The State of California's funding formula for local school districts to meet outlined objectives, particularly related to priority populations (i.e., English-language learners, foster youth and low-income youth) must now also specifically address the needs of homeless students. LCAPs are developed by school districts but may present opportunities for collaboration. Some school districts combine their objectives to serve homeless students with those designed to serve foster youth. LCAPs are available on school district websites.	School districts
Youth and Food	CalFresh: Homeless youth not living with parents/guardians or "under parental control" may be eligible for CalFresh benefits. There is no age requirement to apply for benefits, no need to supply a permanent address, and a school identification card is sufficient for identification requirements.	Individuals

Youth and Food	<p>USDA school nutrition programs: These programs include school breakfast, school lunch, summer meals and after-school meal programs and provide free meals to students with income below the federal poverty level. Homeless students may be easily enrolled into the school lunch and breakfast programs through McKinney-Vento liaisons. In areas with significant numbers of homeless students and challenges getting to school, cities and counties can encourage school districts to implement or expand Breakfast in the Classroom or other Second Chance Breakfast programs. Summer meal and after-school meal programs are drop-in programs that present opportunities to avoid any stigma associated with accessing school meal programs. These programs also provide jobs to community members. Many high-poverty schools are eligible to participate in the Community Eligibility Provision, www.frac.org/community-eligibility, which enables schools to provide free breakfast and lunch to all students without requiring household applications.</p>	Individuals
Youth	<p>Homeless Youth and Exploitation Program: This program, administered by the Governor's Office of Emergency Services, addresses the various needs of homeless youth including housing, outreach, signing up for available public benefits, employment training and educational support.</p>	Nonprofit organizations
Law Enforcement Behavioral Health Housing	<p>Proposition 47 (Year): Prop. 47 was a voter-approved initiative to enact the Safe Neighborhoods and Schools Act that is administered by the Board of State and Community Corrections (BSCC). The act includes a grant program aimed at supporting mental health treatment, substance abuse treatment and diversion programs for people in the criminal justice system, with an emphasis on programs that reduce recidivism of people convicted of less serious crimes.</p>	Local public agencies
Law Enforcement Prevention Housing Behavioral Health	<p>Law Enforcement Assisted Diversion (LEAD) Grant: This \$15 million grant, administered by BSCC, allows law enforcement officers to redirect people suspected of committing low-level offenses to community-based services rather than to jail, addressing underlying factors that drive criminal justice contact. The program focuses on providing substance use and mental health treatment and housing.</p>	Cities and counties
Law Enforcement	<p>AB 109 Funding: Police officers may often serve as an initial point of contact with homeless individuals and families. Law enforcement agencies are implementing many new tools to help reduce incarceration of homeless individuals and connect them to services. Counties have used their AB 109 public safety realignment funding to help provide temporary and transitional housing for AB 109 offenders and individuals involved in the local criminal justice system. This typically is part of a comprehensive case management plan for the offender.</p>	Counties
Case Management	<p>Medi-Cal Whole Person Care Pilots: In 2016, Medi-Cal began funding 25 Whole Person Care Pilots designed to improve coordination of health, behavioral health and social services at the local level. The Whole Person Care Pilots are being conducted as part of the Medi-Cal 2020 Waiver, which will allow participating counties and the City of Sacramento to coordinate health, behavioral health and social services in a patient-centered manner aiming to improve beneficiary health and well-being through a more effective and efficient use of resources. The pilots will work toward supporting the</p>	Counties and one city

<p>integration of care for a vulnerable group of Medi-Cal beneficiaries — who have been identified as high-frequency users of multiple systems and continue to have poor health outcomes — with the goal of providing comprehensive coordinated care for the beneficiary, leading to better health outcomes. Some counties view these pilots as a way to help more homeless individuals achieve better health outcomes.</p>	
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Appendix B

Summary of Selected California Legislation Providing Funding for Homelessness

Homeless Emergency Aid Program (HEAP)

1. Estimated funds for Ventura CoC: \$4,831,856
2. Administered by Administrative entity which means the CoC collaborative applicant pursuant to CoC Interim Rule Section 578.3 of Title 24 of the Code of Federal Regulations
3. purpose is to provide localities with flexible block grant funds to address their immediate and emergency homelessness challenges
4. Round 1 NOFA will be released by September 5 and applications due by the end of the year
 - Awards made no later than January, 2019
 - Not less than 50 percent of program funds shall be contractually obligated by January 1, 2020.
 - One hundred percent of program funds shall be contractually obligated by June 30, 2021. Any funds not expended by that date shall be returned to the agency and revert to the General Fund.
5. Round 2 NOFA will be released by February 15, 2019
 - Awards made by May 2019
6. Declaration of Emergency Shelter Crisis:
 - A county may only declare a shelter crisis in the unincorporated areas of the county.
 - Each city within a county must declare a shelter crisis within the geographic boundary of its jurisdiction to be eligible for funds.
 - The County acting as an administrative entity may **not** declare a blanket shelter crisis for the entire county and all its jurisdictions.

California Emergency Solutions and Housing Program

The California Emergency Solutions and Housing Program was established recently by *California Senate Bill 850 Housing* (SB 850), which requires 50% of the funds collected under *Senate Bill 2 Building and Jobs Act* (SB 2) on and after January 1, 2018, and before December 31, 2018, to the California Department of Housing and Community Development (HCD) for the California Emergency Solutions and Housing Program. Year 1 breakdown of funds from SB 2 includes \$57.5 million for the California Emergency Solutions and Housing Program.

1. Estimated funds for Ventura CoC: \$701,401

Round 1: non-competitive: AE (CoC) applies - NOFA in August

Round 2: competitive for remaining dollars not awarded in Round 1 - NOFA in early 2019

Requirements include:

2. Applicant needs to be an administrative entity designated by the Continuum of Care;
3. Qualified subrecipients need to carry out eligible activities (project selection process must avoid conflicts of interest);
4. Prioritized assistance to homeless households over households at risk of homelessness is required;
5. Emergency housing interventions are limited to no more than 40 percent of funds;
6. Operational Coordinated Entry System (CES) is required;
7. Operational Homeless Management Information System (HMIS) is required;
8. Commitment to Housing First is required;
9. Numeric goals and performance measures must be described in application to HCD;
10. Action plan not required but encouraged (funds may be used to develop plan);
11. Funds may only be requested for eligible activities (as listed below);
12. Project selection process must be documented;
13. Funding request to HCD must be based on an assigned allocation (as quoted below);
14. Match is not a requirement.

Funds can be used for one or more of the following eligible activities:

(1) Rental assistance and housing relocation and stabilization services to ensure housing affordability to people experiencing homelessness or at risk of homelessness. Rental assistance provided pursuant to this paragraph shall not exceed 48 months for each assisted household and rent payments shall not exceed two times the current HUD fair market rent for the local area, as determined pursuant to Part 888 of Title 24 of the Code of Federal Regulations.

(2) Operating subsidies in the form of 15-year capitalized operating reserves for new and existing affordable permanent housing units for homeless individuals and families.

(3) Flexible housing subsidy funds for local programs that establish or support the provision of rental subsidies in permanent housing to assist homeless individuals and families. Funds used for purposes of this paragraph may support rental assistance, bridge subsidies to property owners waiting for approval from another permanent rental subsidy source, vacancy payments, or project-based rent or operating reserves.

(4) Operating support for emergency housing interventions, including, but not limited to, the following:

(A) Navigation centers that provide temporary room and board and case managers who work to connect homeless individuals and families to income, public benefits, health services, permanent housing, or other shelter.

(B) Street outreach services to connect unsheltered homeless individuals and families to temporary or permanent housing.

(C) Shelter diversion, including, but not limited to, homelessness prevention activities, and other necessary service integration activities to connect individuals and families to alternate housing arrangements, services, and financial assistance.

(5) Systems support for activities necessary to maintain a comprehensive homeless services and housing delivery system, including CES, data, and HMIS reporting, and homelessness planning activities.

(6) To develop or update a CES system pursuant to subparagraph (B) of paragraph (3) of subdivision (a) of Section 50490.3, or to develop a plan addressing actions to be taken within the Continuum of Care service area to address homelessness pursuant to subdivision (b) of Section 50490.3.

Administrative entities cannot “use more than 40 percent of any funds . . . in a fiscal year for operating support for emergency housing interventions as described in paragraph (4) of subdivision (a), as noted in 50490.4 (6f). Paragraph (4) states

“Operating support for emergency housing interventions, including, but not limited to, the following:

(A) Navigation centers that provide temporary room and board and case managers who work to connect homeless individuals and families to income, public benefits, health services, permanent housing, or other shelter.

(B) Street outreach services to connect unsheltered homeless individuals and families to temporary or permanent housing.

(C) Shelter diversion, including, but not limited to, homelessness prevention activities, and other necessary service integration activities to connect individuals and families to alternate housing arrangements, services, and financial assistance.”

No Place Like Home Program

1. An initial Notice of Funding Availability (NOFA) will be issued by the Department of Housing and Community Development (HCD) prior to November and will make awards by the end of the calendar year depending on voter approval of AB 1827, Committee on Budget, No Place Like Home Act of 2018.

2. The initial NOFA will provide \$200 million through a noncompetitive over-the-counter process.
 - Non-competitive estimated amount for Ventura County: \$1,566,826

3. Background Information

- a. Last fall, the Legislature passed and the Governor signed a package of bills referred to as the 2017 Legislative Housing Package that will provide hundreds of millions of dollars during the next several months for various activities to help prevent and end homelessness in California. It is anticipated that an additional \$2 billion for permanent supportive housing for persons living with serious mental illness will be distributed by the end of the year pending voter approval.
- b. AB 1827, Committee on Budget. No Place Like Home Act of 2018, which was approved by the Governor on June 27, 2018, submits the No Place Like Home Act of 2018 to the voters for the November 6, 2018 statewide general election.

4. Eligible activities

- a. Page 1 of AB 1827, as did SB 1206, notes that the No Place Like Home Program will provide “finance capital costs, including, but not limited to, acquisition, design, construction, rehabilitation, or preservation, and to capitalize operating reserves, of permanent supportive housing for persons living with a severe mental illness.”
- b. As noted on page 53 in the California State Budget 2018-19 budget,

“The Budget places the No Place Like Home program on the November 2018 ballot (Proposition 2) to accelerate the issuance of \$2 billion in bond funds. The bonds will help provide housing for individuals experiencing mental illness who are homeless or at risk of homelessness and will be repaid from the Mental Health Services Fund.

Housing for a Healthy California Program

-Counties must tie rental subsidies to health care services-

1. Assembly Bill 74 (AB 74) Housing required the California Department of Housing and Community Development (HCD) to establish the Housing for a Healthy California Program (HHC Program) on or before January 1, 2019. Funding for the program was made available through California Senate Bill 850 Housing (SB 850).

2. SB 850 requires 50% of the funds collected under *Senate Bill 2 Building and Jobs Act* (SB 2) on and after January 1, 2018, and before December 31, 2018, to HCD for the HHC Program. Year 1 breakdown of funds from SB 2 includes \$57.5 million for the program.
3. The Notice of Funding Availability (NOFA) will be released during the spring, 2019.
4. Funds must be used to address the problem of high costs incurred by health system for homeless persons while living on the streets. Funds must be used to implement a solution that ties rental subsidies to health care service funds included in the final 1115 Medicaid Waiver, which includes the Whole Person Care pilot program and the Health Home Program.
5. Requirements

In order to be eligible for program funding, a county must meet all of the following requirements outlined in AB 74 Section 53592:

“(a) Has identified a source of funding for providing intensive services promoting housing stability. Funding for these services may include, but are not limited to, one or more of the following:

(1) County general funds.

(2) Whole Person Care pilot program funds, to the extent those funds are available or the Whole Person Care program has been renewed.

(3) The Health Home Program.

(4) Other county-controlled funding to provide these services to eligible participants.

(b) Has agreed to contribute funding for projects assisted through federal Housing Trust Fund grants. This assistance may include preferences or set-asides for federally funded, locally administered rental subsidies.

(c) Has designated a process for administering grant funds through agencies administering housing programs.

(d) Agrees to collect and report data, as described in Section 53593, to the department.”

MEMORANDUM

DATE: November 15, 2018
TO: Behavioral Health Advisory Board
FROM: Contracts Administration
SUBJECT: Board of Supervisors Approved September Agreements

Executive Summary

Board of Supervisors Approved Agreements– October 9, 2018

1. Mental Health Services: Interface Children and Family Services, Idea Engineering, Inc., and Evalcorp Agreements.

This item recommended approval of various Mental Health Services Act (MHSA) Innovations category service contracts. These contracts are funded with MHSA funds.

Interface Children and Family Services Agreement - Push Technology Project.

Interface Children and Family Services will be contracted to manage the Push Technology Project. The Push Technology Project is a three-year project that will focus on reducing re-hospitalization rates by using text messaging to offer bridge support and mini-assessments during the first 90 days post-hospitalization. This project will target individuals exiting county inpatient psychiatric hospitals, residential, and crisis stabilization units. The project is designed to increase the quality of mental health services and improve post-discharge outcomes using mobile ecological momentary interventions (EMI). The project represents a change to an existing mental health practice by using EMI to reduce re-hospitalization through repeated mini-assessments and appropriate follow-up during the first 90 days post-hospitalization. Participants will report their mental health status via text message/EMI, receive appointment reminders and can be connected to additional services using 211 services. The project will evaluate participant's satisfaction, value in their recovery, any improvement in first appointment attendance, and re-hospitalization after one year. VCBH recommended approval of the agreement with Interface Children and Family Services for the Push Technology Project, in the amount of \$294,253, effective August 1, 2018 to June 30, 2021.

Idea Engineering, Inc. Agreement– Bartenders as Gate Keepers Project.

Idea Engineering, Inc. will be contracted to manage the Bartenders as Gatekeepers Project. Similar to the Push Technology Project, this is three-year project that will focus on increasing access to services for middle-aged men who may be suffering in silence with suicidal ideations and actions. Ventura County had 93 deaths to suicide in 2017, 40 percent of those were of men of middle age (45 to 64 years of age). Using an evidence-based model, Question Persuade Refer (QPR), the project will train bartenders within our county to recognize the signs of mental distress of those individuals that come into their place of employment. The QPR training will be supported by a targeted outreach campaign for the areas of Ventura, Conejo Valley, Simi Valley and Moorpark, where the highest rates of completed suicides take place. The project will evaluate the effectiveness of the outreach campaign, any increase in the rate of supportive services utilization by middle aged men, and whether bartenders are an appropriate population to target in gatekeeper training. This project will also track any reduction in completed suicide rates of middle-aged men. VCBH recommended approval of the agreement with Idea Engineering Inc. for the Bartenders as Gatekeepers Project, in the amount of \$151,043, effective August 1, 2018 to June 30, 2021.

EVALCORP Agreement – MHSA Innovations Projects Data Collection and Analysis

EVALCORP will be contracted to provide MHSA data collection and analysis services for the Push Technology and Bartenders as Gate Keepers Projects. Through the agreement, EVALCORP will collect data, facilitate meetings between stakeholders and VCBH staff, create and develop data tools, specific to both projects such as, the client history tool, self-report and follow up tool, other data collection forms, including stake holder interview protocols, to recommend best practices for these three-year projects. VCBH recommended approval of the agreement with Evalcorp for data collection and analysis services, in the amount \$87,927, effective August 1, 2018 through June 30, 2021.

Board of Supervisors Approved Agreements – October 16, 2018

1. Alcohol and Drug Program and Mental Health Services: Gold Coast Health Plan (GCHP) Memorandum of Agreement (MOA).

This item recommended approval of the MOA with Gold Coast Health Plan to update mental health services requirements and add new substance use disorder (SUD) service requirements as required by the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver. There is no fiscal impact.

On December 13, 2016, the Board of Supervisors approved an Amended and Restated Memorandum of Understanding between the County of Ventura, on behalf of VCBH, and GCHP regarding the provision of mental health services to clarify and further define the roles and responsibilities with respect to specialty mental health, mental health outpatient, and SUD services. Under the MOU, VCBH provided or arranged for specialty mental health services and SUD services for Medi-Cal eligible

individuals, and GCHP provided or arranged for outpatient mental health services for eligible Medi-Cal individuals. The MOU was extended for the period July 1, 2017 through June 30, 2018.

On December 1, 2018, the Alcohol and Drug Program will begin implementation of its new DMC-ODS Implementation Plan. The new system of service delivery program is expected to demonstrate how organized SUD care increases the success of beneficiaries while decreasing other health care system costs. Key elements of the DMC-ODS Implementation Plan include a continuum of care modeled after the American Society of Addiction Medicine (ASAM) criteria for substance use disorder treatment services, controls to improve care and make efficient use of resources, evidence-based practices, and integration and coordination of other systems of care. Coordination of services between the GCHP and VCBH is an important element of the Plan. As part of the County's "Readiness Review" with the State, the DHCS requested minor revisions to the GCHP MOA to clarify definitions, roles, access, care coordination, and timelines. The proposed MOA also includes care coordination with GCHP through the new 24/7 Beneficiary Access Line scheduled to begin December 1, 2018. In addition to changes required by the DMC-ODS transition of care, VCBH also made modifications to the mental health services definitions, roles, access, and care coordination information. VCBH recommended approval of the GCHP MOA for the service period of July 1, 2018 through June 30, 2019.

Board of Supervisors Approved Agreements – October 30, 2018

1. Alcohol and Drug Program Services – DMC-ODS Standard Agreement.

This item recommends approval of the DMC-ODS Standard Agreement with DHCS for SUD services. This contract is funded with DMC-ODS funds.

On March 8, 2018, the DHCS approved VCBH's request to plan a new system of health care service delivery for Medi-Cal beneficiaries with a SUD. The new service delivery, modeled after the ASAM criteria for SUD treatment services, is now referred to as the DMC-ODS.

Throughout the VCBH DMC-ODS program planning process, community input was solicited at a variety of stakeholder forums and committee workgroup meetings to prepare for changes in the way that services would be provided in the future. Essential components of the proposed service delivery plan include: (1) treatment services available to beneficiaries, (2) beneficiary procedures for moving through different levels of the continuum of care, (3) beneficiary access and data collection information, (4) coordination procedures for mental health service beneficiaries with co-occurring disorders, (5) coordination procedures for provision of physical health services, (6) county coordination assistance needs, (7) the availability and accessibility of adequate number and types of service providers in the county, (8) county procedures for timely access to care and service requirements, (9) training options that will be made available to service providers, (10) county technical assistance needs, (11) quality assurance

procedures and oversight, (12) procedures to ensure the county will use evidence-based practices, (13) telehealth services, (14) contracting process and procedures, (15) medication assisted treatment plans, (16) residential services authorization processes, and (17) the mechanism for sharing information and coordinating service delivery for beneficiaries served. Under the DMC-ODS Standard Agreement, VCBH will continue to provide outpatient, intensive outpatient and narcotic treatment services, and will add Drug Medi-Cal adolescent residential treatment, withdrawal management, recovery support services, case management, physician consultation programs, and medication assisted treatment.

The DHCS multi-year DMC-ODS Standard Agreement is the established mechanism for the County to receive federal and state allocated funds for the array of SUD services that will be provided under the new DMC-ODS waiver. The DMC-ODS Standard Agreement specifies the conditions and requirements that VCBH must meet to receive federal and state allocated funds. Specifically, the Agreement details the: (1) program offerings and system access requirements, (2) program integrity requirements, (3) beneficiary protection requirements, (4) data and information submission requirements, (5) approved county proposed rates for all services, (6) revenue and expenditure reporting requirements, (7) funding usage and reimbursement requirements, (8) audit and record requirements, (9) various requirements associated with conducting business with the State of California, (10) information confidentiality and security requirements, (11) privacy and information security provisions (as defined under the Health Insurance Portability and Accountability Act of 1996 and California Information Practices Act) and (12) the Social Security Administration and DHCS Information Exchange Agreement requirements. VCBH recommended approval of the Standard Agreement for DMC-ODS services with the DHCS, in the amount of \$69,558,350, effective December 1, 2018 through June 30, 2021.

2. Mental Health Services: California Department of Rehabilitation (DOR) and Pathpoint Office Space License Agreements

This item recommended approval of the Agreements with: (1) DOR for vocational rehabilitation services for transitional age youth and (2) Pathpoint for a license to occupy office space at VCBH. These services are funded with DOR and Realignment funds.

VCBH requested approval to enter into a cooperative agreement with DOR to provide vocational and supported employment services for TAY served by VCBH. As part of this agreement, VCBH will provide a cash match to draw down federal dollars.

One of DOR's priorities is to expand outreach and services to TAY between the ages of 16 to 25 years of age. Such an investment in programming for Ventura County TAY is vital to teach life readiness skills, promote purpose in life and model recovery and wellness while potentially decreasing dependence on Social Security Disability Insurance in the future.

For this agreement, the Santa Barbara District of the DOR and VCBH will utilize staff and resources to provide vocational rehabilitation services to VCBH consumers who

receive services through the VCBH TAY Program. The TAY clients will have a diagnosis of mental illness, meet DOR and VCBH criteria for services and express motivation to seek employment. DOR will also have a case service agreement directly with Pathpoint to provide the actual job placement and employment supportive services.

The VCBH TAY Program Team will use the following staff to support this program: (1) a full-time Mental Health Associate for providing key vocational assessment services, conducting motivational interviewing to resolve work barriers, identifying supports, and assisting clients in developing the skills and behaviors to achieve success, (2) an Office Assistant to coordinate appointments and referrals, track successful placements and closures, and assist in data sharing between VCBH, DOR and Pathpoint, and (3) a Clinic Administrator III for providing programmatic oversight.

Once a client is referred to DOR from VCBH, DOR staff will determine eligibility, assist the client to develop an Individual Plan for Employment (IPE), provide vocational counseling, and provide service coordination. VCBH will supplement the above services by providing psychiatric inpatient/outpatient treatment, medication monitoring, case management services and skill development services. The intent of these services is twofold: to stabilize the client mental health and to prepare the individual with skills necessary to secure and maintain competitive and successful employment which will lead to self-sufficiency. An important aspect of client recovery is gaining and maintaining employment. The employment supports and services offered to VCBH clients through this program are integral to their recovery process. If the TAY is found eligible, they will be referred to Pathpoint.

The DOR/Pathpoint case service agreement will provide personal, vocational, social adjustment and employment services to assist in the development or re-establishing of skills, attitudes, personal characteristics, interpersonal skills, work behaviors and functional capacities to achieve and maintain positive employment outcomes. These services will address one or more barriers that are preventing a TAY client from successfully completing his or her IPE.

Services will be provided at VCBH in both East and West County. During the term of this multiyear agreement, approximately 475 clients will be served. The agreement will contribute towards assisting clients of VCBH with disabilities to successfully obtain and retain employment, and to develop the ability to live independently in their communities.

The cash match provided by VCBH is \$275,000 annually and will draw down a total of \$1,291,080 in services. VCBH will have a service budget of \$227,015 which leaves a net cost of \$47,985 for the department. This cost will be covered with 1991 Realignment. The remaining service dollars will be allocated between DOR (\$508,040) and Pathpoint (\$556,025). DOR has requested an October 1, 2018 agreement date to coincide with the DOR and Pathpoint agreement that will allow DOR to reimburse Pathpoint for startup activities prior to the services start date of November 1, 2018. With an agreement date of October 1, 2018, and a service start date of November 1, 2018, for the cash match, VCBH service budget, and the total draw down in services, will be prorated for the remaining 8 months of FY 2018-19.

As mentioned above, Pathpoint will be providing personal, vocational, social adjustment and employment services to assist in development or re-establishing of skills, attitudes, personal characteristics, interpersonal skills, work behaviors and functional capacities to achieve and maintain positive employment outcomes for the TAY clients. Pathpoint will be providing services at 1911 Williams Drive in Oxnard to facilitate connecting with a majority of clients in their home clinic. An office space license agreement is required to allow Pathpoint to occupy space at the Williams Drive location. VCBH recommended approval of the: (1) agreement with DOR for the coordination and provision of vocation rehabilitation services for TAY, with an annual cash match of \$275,000, effective October 1, 2018 through June 30, 2021 and (2) office space license agreement that allows Pathpoint to occupy 737.43 square feet of office space at 1911 Williams Drive in Oxnard, in the amount of \$1,555.98 per month, starting November 1, 2018.

3. Mental Health Services: Senior Planning Elder Care Services (SPECS) Agreement.

This item recommended approval of the FY 2018-19 contract with SPECS for temporary staffing. SPECS is the provider formally known as Meditech—a name change occurred and a new contract is needed with the new entity. This agreement is funded with Short Doyle Medi-Cal Federal Financial Participation, Drug Medi-Cal Federal Financial Participation, Realignment, MHSA, and Substance Abuse Prevention and Treatment Block Grant funds.

SPECS provides certified and/or licensed temporary staff to help fill vacant positions due to the difficulty in recruiting qualified and appropriately certified and/or licensed staff. VCBH's vacancy rate ranges between 9% and 17%. VCBH is in need of temporary staff to provide services to its clients. SEPCS will help VCBH to maintain continuous services until permanent VCBH staff can be hired. VCBH will use a variety of temporary staff from SPECS including registered nurses, mental health associates, and licensed marriage and family therapists.

VCBH previously contracted with Meditech to provide the temporary staffing services. On August 10, 2018, SPECS acquired Meditech's assets (including the name Meditech) and took over performance of the contract. Because the contract with the County was not assigned to or assumed by SPECS, it is necessary for the County to enter into a separate contract directly with SPECS. The new SPECS agreement will be effective August 10, 2018 and continue through June 30, 2019. The new agreement contains the same scope of work and agreement maximum as the previous agreement with Meditech. Some of the rates have been adjusted to allow SPECS to provide VCBH with qualified staffing. VCBH recommended approval of the agreement for medical personnel staffing and recruiting services with SPECS, in the amount of \$328,058, effective August 10, 2018 through June 30, 2019.