Point-In-Time: Housing as Healthcare

Friday, April 10, 2026 @ Gold Coast Transit District Conference Room

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- Kimberlee Albers, Ventura County Homelessness Solutions Director
- Sara Sanchez & Courtney Lubell, Ventura County Behavioral Health
- Rick Schroeder, Many Mansions
- David Tovar Gold Coast Health Plan
- Jason Meek, Turning Point Foundation

[James Mason] I am the Chair of the HOME Board and I'm also a Community and Economic Development Director for the City of Santa Paula. So glad you came here this morning, we're excited to hear what our panel has to say, and please be engaged. We have cards here, so please write down questions and we'll take questions at the very end of this. Please hand the cards in at the end, so we'll be able to capture some of these things. And maybe some questions that didn't get answered, we'll be able to respond and be able to put this on our website. But thank you for coming, participate, engage, and we're looking forward to what's happening next.

[Karen Fraser, HOME Ex.Dir.] You will be getting a copy of the slides afterwards, as well as a summary of key points and action items afterwards. We are going to just go ahead and start with Kimberlee.

[Kimberlee Albers] All right, is the mic on? Everybody can hear me? Yes. Okay, great. If you don't know me, I am Kimberlee Albers, I am in the County Executive Office with County of Ventura, with Housing and Homelessness Solutions. Those are actually positions, the Housing Solutions Director and Homelessness Solutions Director, that were created by the Board of Supervisors a couple of years ago. I'm just really excited to be in this role and serving the County of Ventura. Today, I was asked to share about our recent point in time count that happened in January, and the results have recently come out. The count is done every year; the County staff lead that effort with 400 volunteers on behalf of the Continuum of Care.

Our office at the County serves as the administrative entity for the Continuum of Care. Sometimes everyone's not sure exactly what the relationship is. We have our Continuum of Care Board Chair, Dawn Dyer, here as well this morning. So with that, I'm going to dive into some data.

I think it's exciting to have a Board of Supervisors and a Continuum of Care Board that are super engaged and very focused on really making these numbers mean something. Every number that you see here is a person, right, with a very unique story of how they wound up experiencing homelessness. And so, of course, we're thrilled this morning to share again that we've had a 28% decrease in the overall number of people experiencing homelessness since 2023. When you see those continual declines, as well as across most populations, we're going to see some of that data. But 11.8% between just 2025 and 2026, and even a larger increase or decrease in the unsheltered population.

So when we're counting people experiencing homelessness, we're talking about those who are living in shelters, like emergency shelters and traditional housing, as well as those that are living outdoors or in a place not meant for human habitation. So we've had a 15% decrease in unsheltered homelessness between 2025, 2026, and a 34% decrease since 2023. We want to keep that progress going.

We usually show this heat map, because sometimes there's perception that homelessness is only in one area of the county. As you can see, besides the forests and where it's not inhabitable, we really have people experiencing homelessness throughout the geography of the county.

So why do we think the number's going down? You know, we feel very confident that the investments that many in this room have made and the developments that have come on board are really the reason that you're seeing these decreases. We've had 297 new permanent supportive housing units dedicated to people experiencing homelessness that opened in calendar year 2024 and 2025, really in that period that you're seeing those declines. Also, the County and Continuum of Care have been investing in homelessness prevention to make sure we're expanding rental assistance and landlord incentive programs so that people are being caught before they fall out into homelessness. Also, there's been some really amazing newer resources to be focused on veteran and youth subpopulations.

And homelessness is one of those things, when you see those additional resources, the numbers show it. We're really excited to see those veteran and youth populations go down as well, which we'll talk a little bit more. And six of our cities went after encampment resolution funding from the state, $41 million in awards. Some of those projects are just starting, but Oxnard has completed their encampment resolution grant, housing around 48 individuals, and sheltering many more. Thousand Oaks opened the Thrive Grove Navigation Center with encampment resolution funding, along with County and City Partnership. Ojai, Fillmore, and Ventura also still have projects that are rolling out with encampment resolution funding. So, we're really seeing those decreases across many of our demographics.

Chronic homelessness means someone who's been experiencing homelessness for at least 12 months but also has a permanent disabling condition. You can see that there is a very steady decrease in chronic homelessness as well, where we know that permanent supportive housing is almost always needed. When we open those permanent supportive housing beds, chronic homelessness goes down.

There are decreases across all age ranges that we track, which is also really exciting, because you'll hear from other communities how senior populations in homelessness are spiking. We've seen still significant decreases in that population as well. It's no coincidence since we had a large senior project open just before the point in time count in Rancho Sierra. You're going to hear more from Many Mansions later today. So again, we talked about those two subpopulations where we've seen really significant decreases, particularly in the unsheltered population. I just want to show those as models of how we can continue to make progress across all populations.

Look at all those partners, right? It takes a village to make sure that we have a very wide reach and a 69% decrease in the number of unsheltered veterans between that same three-year period. We have about 30 unhoused veterans that are still on what we call a “by-name list”. This means instead of us saying, there are this many veterans homeless we're down to, it's Mark and Sue and Joe, and these are their needs, and this is the type of housing that are needed. And that's how we get closer and closer to having what we call “functional zero”, where there is housing available when someone falls into homelessness. We've had amazing projects like Ventura Springs and Dolores Huerta Gardens open, and the Veterans One Team Collaborative, represented by those partners that you're seeing on the screen, meet regularly to figure out how to make sure that every veteran is going to have a place to be sheltered or housed.

Same strategy, right, with youth homelessness, and same types of results. Look at that 65% decrease in the number of transitional age youths that were living unsheltered between 2023 and 2026. Casa Pacifica and Mesa Farm received home key funds to build transitional housing for this specific population. Again, you see this collaboration of partners in order to really make a difference. They meet regularly, looking at youth by name and looking at how we're going to address those that still remain homeless. Of course, there are a lot of folks in transitional housing still, and we need to still find permanent housing for them. So, there is still a need for additional permanent supportive housing.

The cities want to know how it's going in their city, and so we don't have all the numbers up because this slide can get pretty crowded, but I think what we're really excited about is for the most part, you're seeing those declines across all cities, so it's not like people are just moving between cities. I think in 2024, there were some little bit of up and downs with the cities, and so then it unfortunately makes people start pointing fingers, maybe so-and-so is bringing homeless to our city. But seeing these declines really across the cities is exciting, and goes against the myth that that if you offer services and housing, they will come. What you see is communities like Oxnard and Ventura that have invested heavily in housing and shelter and services, is where we're seeing those steepest declines. And Thousand Oaks, after really struggling for that number to move, with the opening of Thrive Grove, saw a 46% drop in homelessness in year one. It is really, really exciting. So that's the news we want to share with the community. It isn't, you know, if you have a shelter, more people will come, right. Our shelters are serving people who grew up here, who are part of our community.

Some good news and bad news on this next slide. The green line is those amazing investments in permanent housing, with lots of resources through COVID and other things that created this really incredible trajectory going from 791 permanent units up to 1,523 since 2022.

You also had COVID investments that peaked interim shelter housing beds. That was a lot of your motel programs like Project RoomKey and the Encampment Resolution funding I mentioned. Those resources are gone, right. Millions and millions were invested in motel rooms that weren't ours, that we hadn't built or that we haven't been able to purchase. And so now those beds are offline. We've lost over almost 400 beds over the last three years. And so we really want to think about where we go from here to continue the progress on unsheltered homelessness. We're going to have to figure out how to have a place for people to go. Behavioral health bridge housing and some other programs helped the interim shelter decline be not even steeper because they brought on interim housing beds like the Vagabond in Ventura. We didn't lose these beds to interim housing because behavioral health was able to take that on. So even with that happening, we still see this steep decrease in the red line.

And then the blue line really fluctuates based on the resources we have dedicated to what's called rapid rehousing, which is short- and medium-term rental assistance.

For the purposes of this discussion, I wanted to share a little bit about what we see when we're looking at the populations experiencing homelessness when we ask questions about health disorder, right? This morning is about looking at housing as healthcare, and you're going to hear from so many great partners about that. But I just wanted to give a little bit of what's going on there.

So we, again, see those significant decreases across all populations, the chronically homeless adults, families with chronic homelessness, those with chronic health conditions, those with developmental disabilities, those with mental health problems, and those with a physical disability, as well as those with substance use issues, justice issues, and domestic violence.

We’ve talked a little bit about prevention and how much progress has been made there. So here you're actually seeing where those investments and how many people were actually served by those dollars when we had those dollars to invest. There is more money on the way to United Way to keep up those prevention efforts, as they are starting an eviction prevention program right now. When we had our Continuum of Care board meeting earlier this week, Dawn pointed out so many reasons why people fall into homelessness. That blue or green box shows some of the reasons why they are approaching United Way for help. This gives us a good list to really see how we can take on those things to make sure people are not falling into homelessness.

The county continues to implement these plans. And so sometimes we pass a strategic plan and it's a binder on a shelf, right? Not the case here. Our team and many of the providers are living this every single day. We go back to our board of supervisors every six months. We're with the continuum of care board giving them actual real progress on each of these action steps.

Trying to stay on schedule, I do want to underline some of the things we've already talked about, and the progress. So, again, 688 new units since the plan was adopted. Those are both those 297 permanent supportive housing units that we have already talked about and the affordable units for low-income populations.

There has been a streamline of recently completed projects coming online; Rancho Sierra, Casa de Carmen in Oxnard, and Valentine Road finishing their final phases very recently. But the other piece is that we do not anticipate another bed opening new for the rest of 2026 and likely into mid-2027. So that, when you've had as many beds as we've had coming online, you have that drop in interim, and now you have a gap in any new, permanent housing. We're feeling that already, and we'll be really feeling it over the next 15 months.

Then we expect a little bit of a surge in 2027. Some projects are under construction, like our Home Key Plus project on Lewis Road. Aspire Apartments recently received their tax credits; this is a Many Mansions project. Camino de Salud just broke ground in Ojai. But after that 2027 surge, the number dedicated to people that are experiencing homelessness goes down dramatically. In fact, in 2028, we're projecting that maybe it might be as low as only 28 new units over the whole year as we see resources go down. And there is uncertainty for developers, right?

Hopefully this map will continue to morph. You'll see it often if you come to any of our presentations, because we're always adding to it and then moving things off as they actually become constructed. But definitely, you know, right now we have a lot in the pipeline, but we're very concerned about the pipeline after this group that you're seeing on the screen.

So, I bring good news and cautionary news this morning as we figure out how to continue the progress together. And a lot of that will happen as healthcare becomes one of the primary sources of funding to address homelessness. Thank you.

[Karen Fraser] We now have the awesome duo team of Sarah Sanchez and Courtney Lubell from Behavioral Health.

[Courtney Lubell] Good morning, everybody. I am the manager of Mental Health Services Act, which is about to go away as of June 30th and become the Behavioral Health Services Act. My slides will share about the proposition that passed in March of 2024 and how that shifts the millionaire's tax funding, how our department is now under that new BHSA or Prop 1 law, and what that's going to look like. And then Sarah Sanchez, our Critical Care Navigation Division Chief, will talk more about the specific services and delivery and client engagement aspect.

Proposition 1 was, I think in some ways, not really well understood by California voters at the time. In fact, it only passed by about 24,000 votes, which if you think about a law that passes, that's not a lot, not a big margin in terms of knowing. One of the major tenets within Proposition 1 that I don't think came across clearly enough, but hopefully will be, is one of the benefits that we're going to see, what Kimberlee was alluding to, and is attempting to address a major problem.

Mental Health Services Act, if you're not familiar, is a millionaire's tax, which is 1% of every million. It's a volatile funding source, so it fluctuates year to year. And it's distributed across the entire state of California based on county size. So about 58 counties, right? You have distribution to small counties, medium counties, and large counties. Ventura is considered a large county. However, L.A. is considered a large county too. And you know, they're a super

large county. So it's all relative. But the problem that was really the core of Proposition 1 is we saw too many individuals being unhoused, not having housing and housing support, combined with behavioral health needs or issues.

And that combination was of such a nature that the state wanted, proposed through this proposition, to allocate money towards housing and housing support. So, there is this big problem, and it's not currently being addressed by the Mental Health Services Act sufficiently, how are we going to change it? How are we going to address it?

Proposition 1 consists of changes in funding allocation to services and changes in funding allocation to infrastructure. And it's the combination of those two elements, which is what Prop 1 is attempting to address in terms of the problem I'm speaking about. There's a lot of information on this, so I'm going to focus mostly on the parts that are relevant to our efforts this morning. This is the new allocation of the funding. And you'll see when you start to add up the percentages, the math doesn't math. But I'll explain why.

10% of Proposition 1 comes from the top and goes to the California Department of Public Health for administration. So that's 10% taking it down to 90% of the fund. Then the state got creative and said, well, 100% of that 90% is going to be divided: 35% toward behavioral health services and supports, 35% toward full-service partnerships which is wraparound care and 24-7 treatment teams, and 30% to housing, the newest allocation bucket. Previously, housing did not exist in the Mental Health Services Act funding allocation; it's a new funding allocation. And so that's your 100% of the 90%, right? This is a major investment in terms of taking those dollars.

Now, because funding is volatile year to year, I would say on average we're looking at about 20-ish million a year in the allocation. But that can go up or down depending on the allocation that we get during the year. [Audience member] Is that just for our county? [Courtney Lubell] Just for our county, yes.

The other tricky part throughout the entire funding piece is the suballocations. So within the housing bucket, the 30%, 51% of the funding must be utilized towards those that are chronically homeless. The other challenge is that the housing interventions bucket can't be used for treatment services. It is used for infrastructure support, like interim housing settings, permanent supportive housing settings, and all these things that we need, for sure. But to make this new 30%, you had to take it from something, right? the challenge is that it came out of the current community services and supports under MHSA is about 79%, dropping that funding to a 35% bucket under the BHSA for behavioral health services and supports. So there's going to be this real tension, balance, constant collaboration opportunity to figure out. Sarah and I are now best friends.

At a fundamental level we all know that while we can create the space, if the individual or the families aren't getting the treatment support that they may need, then having the space may only be temporary. They need to really go hand in hand. This is going to be an effort that will be on the front of our minds as we continue to work towards how we make these successful placements and support the individuals to move out of their unhoused situations. Again, the money is shifting here, but we all know it's ultimately not enough for what our counties are going to need. But it is an important focus and an attempt to address the problem.

I'm going to next speak briefly about the Community Health Needs Assessment, which is something that happens every three years, led through the local health jurisdictions, public health, managed care plans, and behavioral health. We go out into the community to do surveys to find out what are the healthcare needs of the community. This year in particular we added questions about housing. So, this is not specific to clients of behavioral health; all community members were outreached into our efforts.

In the end we ended up with a little over 9,000 survey results, which even though our size of our county is pretty

large, the number of hard copy surveys that we were able to get, even though some were partial, this is quite a significant number for this kind of outreach. The Community Health Needs Assessment group did six surveys, six focus groups, and six listening sessions. So, there was a lot.

This report, by the way, is available on vcmatters.org, which is public health's website. You can find the Community Health Needs Assessment, which is like a 300-page report.

The next step we're involved in is the Community Health Implementation Strategy. We take all of the data that we learned from the surveys and the analysis and the focus groups and start to turn it into implementation strategies that can be implemented over the next three years. What I want to focus specifically on are the housing services that came out of the Community Health Needs Assessment survey.

We know the cost of housing is unaffordable and we only see that likely increasing across the state. Long wait lists for trying to get into placements and the inability to move quickly enough to serve the needs for those who need to be housed.

You can't find anything; there are limited numbers. Now, Kimberlee was referencing what's currently going to open up, but also speaking about what it's going to look like in two years? What can we start to do now? That would be the sort of strategic forecasting questions we ask.

And then, of course, there are the eligibility requirements. The ability to get into a space is based on meeting certain eligibility requirements. How can we shift some of those? How do we work in a system that helps make it easier?

And do individuals know where to go to get help. We see this often with behavioral health as well, but that's a different presentation.

So, the last part of my talk is a little bit about, as we move from MHSA to BHSA, we need to do a whole transition and reassessment of our behavioral health continuum of care and add housing to it, because up until now, or up until July 1st, housing has not really been our area, not our house.

In the past we've offered some housing efforts for our full-service partnership clients, the ones who need wraparound care, but otherwise nothing like what we're having to build out now. What is being built out now is really a big, steep climb. Not having had this in our system before is why we've been so appreciative of the collaborations in the housing environment, many of you who are in the audience today.

A new deliverable from the Department of Health Care Services, is to create an integrated plan. The state wants to standardize reporting and have all the counties report out in the same way and speak about how we're going to do housing interventions. That's one section of the integrated plan. So we went out into the community and did 27 key informant interviews, over 50 in-reach presentations, three virtual and six in-person town halls, and 200 surveys. We've made contact with over 1,700 individuals in the stakeholder engagement process. And one of the themes throughout it definitely has been housing.

How are you going to do housing? What does housing look like? And what does this all mean?

We worked with health management associates who came in and did some of the presentations and key informant interviews. They came up with four areas or umbrellas where we need to focus our attention for system coordination and cross-agency collaboration.

Since the resources are reduced, then the need to collaborate should only increase because we all now have a piece of the pie. We can help make a difference if we do it together versus what we try to do individually: access and

quality of care and workforce development and supportive services and interventions. These are just examples, and is not exhaustive, of focus areas specifically in our integrated plan.

So when you see three examples, don't walk out the door and go, that's it, we're done. Under each of the buckets there are three examples of how we look at system coordination, what are we doing related to housing interventions as it relates to system coordination. As Kimberlee point out, Sarah and her team in housing interventions work very closely with the continuum of care. That's an example of cross-agency collaboration. Our work with Gold Coast and David Tovar, and our colleagues at Kaiser Permanente, all making sure the managed care and behavioral health departments are on the same page with transitional rent, for example. That has come online as a new benefit under the CalAIM benefits support structure. Another example, under access and quality of care, is growing our FSP for our TAY, our transitional age youth, as well as making sure we have housing and support for our veterans and our seniors. These are sort of the access and quality of care specifics. All of these are, again, the state mandating under Proposition 1, wanting to see an increased level of system coordination because there's still too much siloing happening within counties.

Within our supportive services and interventions, an example in the integrated plan would be expanding rental subsidies and other new housing initiatives. Sarah will speak about it right now.

[Sarah Sanchez] Thank you for the transition. Well, good morning, everyone. I'm just going to introduce myself again, Sarah Sanchez. I'm the chief over at Critical Care Navigation Services. If you would have told me two years ago that you're going to be knee deep in housing, I would have been, of course, my education is as a family therapist. I'm a licensed therapist, and now I'm learning about housing. Through that process, I've truly had the opportunity to connect with great and passionate partners that are longstanding in the housing realm and willing to share their knowledge and their expertise in the topic. It feels that I've been in this realm about a year or so, going into two.

It's just been amazing the great work that happens. As Courtney was saying, the state is really moving us to work integrated to ensure that we're serving the individual as a whole person and not, as what Courtney was saying, siloed or, you know, having these different resources through different avenues and somewhat of a maze. So, again, building together, honestly, a better tomorrow, right?

I've heard the saying, and it's true, “It's just building a better tomorrow for the individuals that are in most need.” It touches my heart the great work that we're doing.

So, again, thank you, everyone, for the opportunity to talk about what we're doing. I want to start with, come July 1st, our transition from Mental Health Services Act to Behavioral Health Services Act, BHSA. I want to talk about our current efforts and what we're doing now within the housing space.

Most recently we were awarded the BHBH, which is known as the Behavioral Health Bridge Housing Grant. We were awarded approximately $13 million. With that funding, we've had the opportunity to do what I call a trial run of what is going to be expected from us at BHSA. With that we've established some great contracts and great partnerships. As noted by Kimberlee earlier, we currently lease the Vagabond motel in Ventura. Those 80 units, 80 beds that are available to our behavioral health clients. 40 of those are funded through our BHBH grant, and then the other 40 are funded through our MHSA funds. We've seen great progress and great benefit to the clients we serve. Our team is working with them very closely to ensure that while they're residing there, they're receiving the needed supports and the wraparound services to ensure they're getting linked to more permanent housing option. We've already seen great progress through that.

Another contract we have is with our partners Spirit of Santa Paula. We have eight congregate shelter beds out in

Santa Paula with Spirit of Santa Paula, and they provide the linkage, support, and navigating the different resources. Then we have our partners with Turning Point. At Safe Haven we have four interim shelter beds where the staff works with the residents and closely with our team to ensure that support and resources are provided.

We also have our partnership with various local landlords where we have scattered sites dedicated for families. Through these landlords we have about 15 opportunities to be able to house families in need of support.

Lastly, we have Valentine Permanent Supportive Housing with rental assistance where we have 60 units that we've partnered through our Behavioral Health Bridge Housing Grant. We're at almost maximum capacity with 58 of the 60. So very exciting.

So while we've been able to house many individuals, the need continues to be great. But we are very much excited to be part of that piece, being able to bring interim housing and more permanent settings to our continuum of housing. And again note these housing opportunities and interim shelters are dedicated for individuals with behavioral health components and are either chronically unhoused or at risk of losing their housing.

So what are we doing now? As presented earlier by Courtney, it's that collaboration and delivery of care for the individual … Not only ensuring that individuals get housed, but figuring out how can we ensure that these individuals sustain their housing, are successful in their housing, and the partnership is there.

Toward that delivery of service, we are building up our full-service partnerships dedicated for individuals that are chronically unhoused. It's a team dedicated for individuals with a behavioral health condition as well experiencing homelessness. The support meets individuals where they're at.

Our partners go out to the local encampments at in the river bottoms or out into the community where they engage with individuals, identifying what their need is, not only their behavioral health needs, but their housing needs as well. It is a great team that has been developed and growing. We are expanding our full-service partnership programs with a focus on the needs of the individuals. This has been a great opportunity to expand services specifically to those that aren't housed.

We also have our Wellness on Wheels. Our team is working out of a retrofitted van that allows all-in-one support for outreach events as well as providing services to communities in remote areas where it's difficult for individuals to access care. They partner up with our local Backpack Medicine group and are stationed close by. If individuals want further support, need therapeutic support, resources, they're able to connect with somebody at that time. This program then refers over to our Bridge to Wellness, our full-service partnership.

Everybody may already know about our RISE program, Rapid Integrated Services and Engagement Team. They're dedicated to engage and support individuals as they're navigating, as they're identifying that they may have a behavioral health condition. They also partner with our Backpack Medicine team to go out into the encampments and river bottoms. I actually had the opportunity to be out there with that team to be able to see them working together. Our RISE team is partnered up with local law enforcement on a regular basis. They identify individuals, high utilizers of services, of law enforcement services, those that could benefit from behavioral health referrals. It was very nice to see how they're connecting, knowing individuals by name, and identifying what their resources are. It's our local law enforcement, Ventura County Sheriff's Office. It's the Backpack Medicine team. It's cross-agency partnerships supporting individuals. Again, this speaks to ongoing collaboration and the importance to collaborate.

I bring this up because, again, it goes to where we're working with that individual, being that point person, to be able to identify what their need is, whether we refer them for our services or to other resources; to ensure that

there's a whole person outreach effort and engagement and services.

I want to talk a little bit about BHSA eligibility criteria. So BHSA expands the opportunity for individuals to be served, those that are meeting not only what we've already seen within MHSA, specifically mental health services access criteria, but also now individuals with a moderate to severe substance use disorder. Currently our MHSA funding only allows for individuals with a specialty mental health criteria, but with BHSA, it's going to expand for the substance use disorder individuals. This is a great opportunity for serving all individuals. The priority population with BHSA housing intervention dollars, are those that are chronically homeless, experiencing homelessness, or at risk of homelessness, as well as those involved in the justice system and the child welfare system.

We also look at how to access our services, how to be able to link individuals into services. If individuals are not ready to make that call, our RISE team is available to connect and talk. That referral can be done by community members or professionals that are working with the individual. There is also our 24-7 access line where individuals can call directly. And then, of course, there's our walk-in clinics to be able to access our services. If they are coming into our delivery system, they'll walk away with an appointment to Behavioral Health Clinic for the ongoing care and assessment.

I'm handing it back to Courtney to speak about the work that is happening now, what's being done in regards to BHSA and the housing intervention dollars, how that is going to be utilized, how we foresee to spend the money, and how it’s going into the integrated plan and the overview.

[Courtney Lubell]: Thank you, Sarah. So as I mentioned earlier, we have a deliverable to the state. We met the first milestone of submitting the draft, which includes a draft budget, to the state before the March 31st deadline. You're going to get the opportunity to look at the budget and the dollars rolled up in each section. There's a whole tab on housing and the different types of housing settings that are allowable for utilizing the housing intervention dollars. On April 20th, we'll be presenting at our Behavioral Health Advisory Board, BHAB, the integrated plan information. We'll be closing some of the loops of our community planning process and launching the 30-day public comment window.

So, on April 20th, we'll open for public comments. Individuals can send an email. You'll be given information at the meeting. I will also send Karen an email with information to be able to send out to this specific group about the opportunity to submit a public comment. You'll then be sent to our webpage on our current website, bcdh.gov [I think it used to be just simply .org]. But on it, you go to our community planning subpage, and you'll be able to see where you can access the public comment, and it'll be available starting Monday the 20th.

It'll be open for 30 days, and then it will close at a public hearing at the Behavioral Health Advisory Board on May 18th. So we can accept any public comments via email or verbally at any of those two meetings during that 30-day time. After that we then have the job of synthesizing and summarizing the comments that have come in and integrating them into the integrated plan for submission in June to the state.

It will also go to our Board of Supervisors in the June Board of Supervisors meeting. You may want to attend that as well. As you can see here, this is the timeline we were just talking about.

Oh, let me mention while Karen’s getting the slides ready for David. So the public comment on the integrated plan is a standardized report, but it has a whole section on housing interventions, which gives you more narrative understanding of how we're conceptualizing, utilizing the funding in that way. The budget is supplemental to that, about a rolled-up overview of the dollars. So your public comments are completely welcome, because it's all about community input to help guide and shape future decisions, right? It's not just going into a vacuum. We need your

input. We need to know what the community priorities are, and we need to understand them in relationship to whatever the funding parameters are, because there will be a dynamic tension sometimes between those two. It's important for us to understand what the landscape needs are. So with that in mind, over to you, David.

[David Tovar]: Thank you, Courtney. Thank you, everyone else, for sharing great presentations. My name is David Tovar. I'm with Gold Coast Health Plan. I'm our business strategy manager. You might be like, what is a business strategy manager? I do it all the time. I help lead initiatives at Gold Coast with implementations of new products and services like transitional rent. I also oversee our implementation of justice services, something else Sarah had brought up, as well as any other new CalAIM support.

What I'll try to do is provide a brief overview of who we are at Gold Coast, what CalAIM is, and some of the services that we provide. I'll pass it to Rick for the majority of the talk about transitional rent. The reason why most of us are here is the housing work that we're trying to accomplish through Gold Coast, through behavioral health, and through the county continuum of care. So thank you all for being here. We really appreciate it. I was joking earlier with Sarah that we normally meet at 9 a.m. every Friday with the lead team and others. So this is funny. This is just a new iteration of that.

So at Gold Coast Health Plan, I think the easiest way to explain who we are, if you're not familiar with us, is we're Medi-Cal for Ventura County. We are, quite simply put, a health insurance company, an HMO for Ventura County and by Ventura County. We were actually initiated by the Board of Supervisors about 10 years ago, well 13 years ago, to provide health for us. We have 227,000 members, about one in three Ventura County residents. And the great part about Gold Coast is that we are a health insurance company by Ventura County for Ventura County. The people that we engage with, whether they're through our member services department, whether they're through our provider network, are from here. Most of our employees live here in Ventura County. Like 95%, 96% of our employees live here. I think that really provides an interesting and a really high-touch, high-quality experience. Because our employees, our providers, they're part of our community. For example, my mother-in-law is our member. And so I want to make sure that I provide the best quality of care possible, because I know that her life and her health depends on the service that we provide. It's really important for us to get that through, that we are part of the community. We are an extension of the county's health care system.

And with that, we recognize that we can play a very large role in people's health, whether that's through our traditional healthcare services as well as our new non-traditional services. We've been in this county, this new non-traditional service space for about six years now, and we're really great at contracting with hospitals. We're really good at contracting with clinic systems.

But now that we're branching out into housing, branching out into the justice system, branching out into many other social services, into food, we're recognizing that we need help; we need great partnerships, like with Rick at Many Mansions or Jason at Turning Point Foundation, because they all are the experts in these domains. And so we're going to them consistently and constantly to say, how should we implement this best?

We have our funding sources. We know what we're able to pay for and how we can do that. But the real question is how can we implement that properly, how can we really impact the most lives possible. So I'm just really appreciative of the partnerships that we've built and the thoughtfulness in which they've approached us, because without them, I think we'd be really lost.

So at Gold Coast, we're the payer and the administrator. We build our networks, right? We contract with hospitals. We contract with clinic systems. And now we're contracting with housing providers, with medically supported food

providers, with jails and with others to build a more robust network to engage people, not just in their traditional health needs, but also in the social drivers of health.

We also do oversight and quality. This is a real strong point for us at Gold Coast. We are the number four health plan in California. All right. The only health plans that exceed us are Kaiser for Northern and Southern California and one other local initiative. But, you know, we really are a high quality health plan for Ventura County. And that really is because of our providers. That is because of our network. That is because of the county of Ventura's health care system, Clinicas, Community Memorial Health System and many others who help support health for our members and who, again, are passionate about Ventura County.

And we also we serve as a collaborative partner. We serve as an integrator for local functions. We sit on the continuum of care board. We really seek to engage and to be a strong local integrator. But with the CalAIM and with DHCS's announcement, the Department of Health Care Services announcement of CalAIM back in 2019. Oh, man. What seems like a lifetime ago. You know, it really moved health care from the clinic right to the streets, to the community. And it really was a paradigm shift for us. It was a shift in perception of how we engage people, how we can engage our community in order to provide higher quality care. And so it really made us focus on a whole person care model. Some of you may be familiar with the whole person care team at the county of Ventura.

It really is taking that model and spreading it throughout the community. Really focusing on addressing the root causes of health issues, right. Social drivers of health, such as mental health issues, substance use issues and many others like housing. We're really relying on our core pillars of CalAIM. Most of you have probably heard of enhanced care management or the whole person care program, as well as community supports. But CalAIM is much broader than that.

When we say CalAIM, it's synonymous with Medi-Cal. It is a foundational program that consists of 13 pillars, actually, of many different things like payment reform, like dental reform, but also enhanced care management and community supports. So CalAIM really was a major shift for us in working with new partners in really specifically funding non-medical services that address health needs.

So the real pillar of that, I think, what a lot of people, a lot of our highest touch members engage with, is what's called enhanced care management. I'll go over that briefly and happy to talk with others after this as well about ECM. I also want to shout out one of our ECM providers in the room, which is Conejo Health, who provides amazing care for our members. I think the greatest part about enhanced care management is that it's tailored to the specific population of focus that you work with.

What they do [Conejo Health] is they have an amazing health navigation program that works within our local emergency departments, engages people as they come in and are identified with either a serious mental illness or substance use issue. They're able to connect them quicker and earlier with Ventura County Behavioral Health to ensure that they have that follow up after that emergency department visit. We know that if there's not a follow up within the next seven days, right, and really within the next 72 hours, they're lost and the next time we're going to see them again is in the emergency department. So we want to make sure that they're connected back to care, that then if they're identified as homeless or in-house, right, that we're able to connect them with housing services.

We know if they're in the ER because of uncontrolled diabetes, we connect them with medically supported food to ensure that, we're not just reducing ER stays and ER visits, but that we're supporting their health. Our ECM teams provide comprehensive care coordination through those transitional services.

We have nine different populations of focus, although I highlighted a few on here: adults who are experiencing

homelessness, severe mental illness, or substance use disorders, and those transitioning from a carceral setting, a jail, a state prison, or others. But also those who are high utilizers within our health system, people who visit the ER frequently, as well as children in foster care. We want to make sure that we're providing wraparound services because we know those people are at the highest risk within our community.

Those are the individuals that we're consistently seeing at Turning Point Foundation, right, that Jason and his team are serving. Those are the people consistently showing up in our emergency departments and other places. So we want to make sure that they are supported through Enhanced Care Management, through FSP, at Behavioral Health, and through other avenues so we can help control their health and social issues that may be leading to adverse outcomes.

Each individual in Enhanced Care Management is supported by a lead care manager, a named individual person that is engaging with them in person. Sometimes telephonically, but primarily in person to support their needs with comprehensive care planning and connections to social and health care. I think at the end of it, is look at health outcomes and program goals.

What we see from that is people moving from high utilization, from high need, to lower levels of care. Which is really wonderful to see, not just that they're having better health outcomes, but they're having better life outcomes because of these services.

Secondly, is our expansion to community supports. Community supports, the state originally named in lieu of services, I have no idea what that means, but you can figure it out. We now call them community supports. But really they're in lieu of services because they're in lieu of health care services. We can provide medically supportive food to people with uncontrolled diabetes. They can get their medicine for their A1C and also they can get fresh and healthy food delivered to them to support a healthy diet.

To support medical issues the state has approved 15 community supports. We offer 13 of them at Gold Coast. And if anyone knows a location where we can partner with a sobering center, please let me know. I really want to know and we will work with you. But the only two we don't offer are sobering centers and day rehabilitation.

Otherwise we can offer community supports to people in transitions. Whether that's from a nursing facility to assisted living or assisted living back to the community. We can support with food, whether that's through medically tailored meals or even medically supportive grocery boxes.

We can work on environmental adaptations. If someone has uncontrolled asthma, we can provide HEPA filters and other asthma remediation services to ensure that we can get that back under control. If someone is having difficulty staying at home, we can install grab bars at their house. We have one provider that put in cement ramps for an individual who had mobility issues so that they're able to stay in their home instead of transitioning to a skilled nursing facility. And lastly, we have short-term safety, right, through respite services, through recruitment of care and short-term post-hospitalization housing.

You're probably noticing one thing that's missing from this, which is housing services, right. And so what we're also trying to do is really build a bridge to address these gaps in our homeless services. So we've enlisted a collaborative approach on this by offering four primary homeless service, community supports, housing navigation, housing tenancy and sustaining services, housing deposits, and transitional rent.

We're able to provide time-limited supports to assist people who are facing imminent homelessness within the next 30 days or if they're on the street and have been homeless for the past three years. We're building our new

partnerships with behavioral health even further than we have before and recognizing the challenges that comes with that, but also the great opportunity that we have there as well.

Creating our funding is incredibly challenging. But it has brought our organizations closer together and really has helped us understand where each of us can build a better system for Ventura County. Lastly, we're working on closing the loops, not just on their health care, but on social services, making sure that not just someone was referred for a service, but they actually got that service, right, and that they're able to have recovery because of that.

So with that, I'll provide just a couple fast facts from the services we've rendered to date. We started these CalAIM services in 2022, and so far we've engaged almost 19,000 of our members in them, over 5,000 receiving enhanced care management, and almost 16,500 receiving community supports. That is 5,871 days of housing navigation services. That's 3,500 days of short-term post-hospitalization housing, days in a bed. And 39,000 of recuperative care, again, days in beds.

We've really been able to impact the health and the lives of these individuals, and it's all through our great partnerships, especially those in our new partnership with Many Mansions. Thank you, everyone. Thank you.

[Rick Schroeder]: Thank you, Karen. Thank you, David. I'm Rick Schroeder. I'm president of Many Mansions. A number of our panelists have said their background is in social services or medical or medical insurance, and they've had to learn about housing. Well, my background is in housing, and I've had to learn about insurance, Medi-Cal, social services, behavioral health. I thought a low-income housing tax credit application was complicated, but this far surpasses that. And so I'm going to actually try to bring everything together that we've been talking about, homelessness, behavioral health, housing, social services, Medi-Cal, and discuss these four community supports that David was talking to, that we collectively call the Housing Trio and Transitional Rent.

Many Mansions, as most of you know, is an affordable housing and service provider. We are going to be celebrating our 47th year of existence. We were founded in Thousand Oaks, and we develop affordable housing throughout Ventura County and Los Angeles County and beyond. We provide management and on-site services. So this work that we're now doing with these community supports is a little bit different for us, but as you'll see, quite related to what Many Mansions does. As David was mentioning this CalAIM effort really is trying to address the social determinants of health.

We know that in our housing, in our supportive housing, our affordable housing, we know the importance housing has on health. It's not just housing, but housing with the proper support. So how can we expand that? How can we really help people in the community with health needs, health challenges? Part of that solution is housing. So, we're trying to improve their overall health. We're trying to actually reduce overall health costs. This effort is actually going to reduce the costs overall, and we do that through a collaboration with a lot of people. Enhanced care management and other community supports.

So specifically, as David mentioned, we're going to talk about four of these community supports related directly to housing. The housing transition navigation services, the housing deposits, the tenancy and sustaining system service program, and then the transitional rent. Now, this is only available for those who are eligible for it, so we'll talk a little bit about eligibility as well. First, what they call the Housing Trio. These are the three existing CalAIM system supports that existed prior to this year. The Transitional Rent is a new one that just began in 2026.

The first support is this transition navigation service. That is where the eligible member can receive support to help them find and apply for secure housing. We're talking not just about housing with Many Mansions or Ventura

Housing or other non-profits, although it could include that as well. It's really looking for housing in the private sector as well. There are hundreds of thousands of rental units throughout Ventura County, and many of those units could house this population. But how do you find that housing? How do you find what is available? This is where the service comes in; where many mansions will help the person find the housing.

Housing deposits. One of the big challenges in securing housing is a deposit. You need a security deposit. Maybe you need first month's rent. Maybe you need utility deposits. So again, through this community support, through Medi-Cal, we'll help pay for the security deposits, some setup fees, maybe some things that David mentioned in the particular unit that you need modified. Maybe you need some handicap accessibility. Maybe types of beds that you need. Maybe you need a hospital bed. Other types of things, again, that Medi-Cal will provide and pay for.

The other Housing Trio is this housing tenancy and sustaining services. This is where the eligible member who's found the housing will actually receive ongoing support and help them navigate their relationship with a landlord. Helping them certify, fill out applications, linking them to community services. We're in a community with a number of wonderful nonprofits and social service agencies, but it's hard to know where to go on your own. This is a help for these eligible members who find the housing to also provide other community support for them.

The new program this year is Transitional Rent. So it's not just finding the housing, it's not providing the down payment. Who's going to pay the rent? The transitional rent program, for eligible members, will actually pay for the rent. The rent that will be paid is 110% of the area's fair market rent, which is essentially the Section 8 rent. So it'll pay a very high rent.

It will only pay for six months, though. The member that gets the housing does not have to contribute any of their income toward the rent. Again, for that six-month period Medi-Cal will pay the rent. Many Mansions' role in this is to determine eligibility, coordinate with the landlord, actually funnel the money to pay the rent, and provide these other housing trio services as well.

Who is eligible? As David mentioned, about one-third of the residents in Ventura County are on Gold Coast? One-third. Well, we cannot possibly provide these services for one-third of the county. And so the idea is to provide it to a very targeted group, a targeted population that really desperately does not have many options with respect to housing. I'm not going to go through all the eligibility requirements; I have a whole Many Mansions team that's versed in this.

While very complicated, essentially we're looking at the population that's most vulnerable. Generally, those that have medical conditions, mental health conditions, substance abuse, other conditions that are part of the behavioral health system. Those that are coming from homelessness, maybe chronic homelessness. And those that are coming from incarceration, hospitalization, interim housing, navigation, shelters, things like that.

With those that are part of this, we also develop a "month seven" plan. So let me talk about the month seven plan and some of the challenges that we face with this program. With Transitional Rent eligible members can go to supportive housing provided by Ventura Housing, Many Mansions, Cabrillo, wherever. But our target is for-profit landlords. And the landlords are going to say, well, wait a minute, I don't know if I want this person.

Do they have a security deposit? Yes, we're going to provide a security deposit.

Well, I don't know. They're coming from homelessness. Are they going to have any support? Yes, we're going to provide support. We're going to meet with them. We have case managers. We're going to work with them, et cetera, et cetera.

Then they're going to go, well, who's going to pay the rent? Well, transitional rent; we're going to pay for six months.

Then landlords are going to say, six months? What about the seventh month? So in the eligibility, the people that we're focusing on right now, and this is where the Behavioral Health Services Act comes in. We're going to target people that actually may qualify for ongoing rental support. As was mentioned, the Behavioral Health Services Act will have money to help pay rental subsidies. So these are the people that we want to be in this program so when the transitional rent period is done, they can then transition and the Behavioral Health money will continue to pay the rent. So they're not evicted after six months; they will have ongoing rental support and ongoing permanent housing.

We're working through all this now. It's very difficult to convince landlords, but we're hoping, we're optimistic that landlords will allow that. And there may be some areas where there's master leasing, where we're creating more housing. We don't necessarily have a lot of housing in the pipeline in the future. But again, through this type of support, we're hopeful that more housing will in fact be created for this particular population.

The people that we're looking at have to be qualified through Gold Coast. They send us referrals. We do our own eligibility. Then we work with a person looking for the housing, looking for landlords where they can go. It's a very difficult process. But we must have to have a plan, a plan as to how they're going to support the rent after month six.

It doesn't necessarily have to be behavioral health. Maybe in that six-month period, they can get a job. They can maybe reunify with the family. They can get other types of support. So there's other ways that they can continue the support and continue the housing. But we have to come up with it, with them before they're allowed to draw on the money for transitional rent.

The key then is to provide that ongoing support, to work with the eligible member, to work with all of our partners. As David mentioned, one person is assigned to them, right? So we have one person, one point of contact that will help coordinate all these various community supports for them.

We know that many of the treatments and supports are very difficult to provide for someone that's out on the street. When we have stable housing, that's where they can receive the counseling and the medical support and the meals and all these different things that they could access and provide to help improve their lives. What this whole effort will be, and I think this whole panel is discussing, we're going to increase the amount of available housing that's available for the most vulnerable population.

It's going to infuse the county with additional money, through rental subsidies and the other types of support. We hope that through this integrated approach, we will have better outcomes. People will retain their housing. They will not slip back into homelessness. They will become active members of the community. They will enter the job market. They may reunify with their family. Many great things can come out of this.

The key is early intervention. It's not just necessarily for those that are chronically homeless, but maybe those that are slipping into homelessness. We hope to expand the program that might be included. And it provides more stability, especially financial stability. People can really clear up a lot of problems. Again, with the Transitional Rent Program, they're not devoting income to rent for six months. They can use money, if they have money, to help cover a lot of other problems and address other issues that they may have.

So with that, I think that's the end of my presentation. I'll be happy to answer any questions later. I think that we

have a whole Many Mansions team here that can also answer questions.

[Jason Meek]: Wow, I am exhausted. That is a lot of amazing work. I can appreciate the mental energy and the dedication and just the unyielding desire to make things work the best they can within the confines of giving resources. So hang in there; we'll get through this. I promise.

My name is Jason Meek. I'm the executive director of Turning Point Foundation. Turning Point is a community behavioral health organization, which falls under the umbrella of behavioral health. It's also a lot of the dynamics that result from some acute symptomology. Why this work remains urgent, not necessarily just important, but urgent, is mental illness and homelessness frequently overlap, making recovery harder without a stable place to live. So, we're here for housing and health.

And the anchor to that in many ways is housing. This isn't new information. This has been around for a while. But I think more than anything, we're realizing just how true that is. Some of the common causes for the difficulty accessing housing is affordable housing shortages. And we're working on that.

Cost of living is certainly outpacing wages. And that has never been truer than those on fixed incomes. Trauma, domestic violence, veterans' mental health, limited employment options can certainly deepen housing risk. But it's not just so much the limiting of employment. It literally is the cost of wage not tracking well with the cost of living. People typically require treatment together with income support and housing assistance simultaneously.

This matters. The timing of things matter. We can't always treat things in silos. If we do, we are certainly fixing one to shorten up the quality of help on the other. It really does matter that when we do a robust assessment, which we do, we understand the person in totality. We find individuals where they are, certainly, but then we reverse engineer their life as to how they've gotten here. And then we develop a plan accordingly.

We've been around since 1988. Most people shun the word “reactive”. But the fact of the matter is you have to see an issue in order to address it. We've gotten better at forecasting, certainly. But reactive isn't always a bad term. In the business world, yes, catastrophic. In the behavioral health world and health world, yes, it's an issue because it's far better to have measures to meet the need prior to the crisis. But the fact of the matter is we do have to get a clearer picture of what the issues are in order to provide an absolutely individualized and robust treatment modality, inclusive of housing.

We are a learning organization in many ways. We're constantly using the latest evidence-based practices. And not just in terms of behavioral health and treatment modalities, but also the learning curve that we're all going through in terms of housing and policy. That affects the way we treat.

Our housing continuum is broken into different areas; different settings meet different needs. From immediate safety to long-term supportive housing. Some individuals just need to be stabilized and maybe then go back to their home or place of residence. Some individuals may never have a residence of their own. I think it's important to note that many of our individuals have become experts at survival and becoming homeless. Which is kind of circular thinking in many ways. They have found ways to really successfully navigate being on the streets.

But have we done a good job keeping people in housing? We can help attain it, certainly; we can help get people into housing. But those supportive services are incredibly important. Keeping people successfully housed is a key element. Not just for recidivism, but for one's self-efficacy. For one's belief in their self that they can do something. If one ends up in a house, finally, being able to say: I finally made it; I'm finally safe and stable and connected.

And then if I lose that housing, that has catastrophic implications to their ability to think, a] that they deserved it in

the first place, or b] that they can maintain it going forward. It's similar to having multiple evictions. Now your level of trust in yourself and landlords have now been shrunk at best.

So we do have transitional housing for veterans. We have an emergency shelter called Safe Haven. That is a term grandfathered in from years and years ago which simply means it's a shelter for those with mental health issues. We also have adult residential care and we have licensed care for those that are experiencing some of the co-occurring mental health and physical health associated with their age. These are licensed programs. These are programs to where we've removed the fear of housing insecurity.

We serve three meals and two snacks a day. So, I'm sure we eliminated food insecurity on that one. It's a very, very good program. The culture really matters in many of these programs, especially in housing and when it's permanent and supportive. This is their house; this is their home. You need to settle in and then have a say in how things run. So, the beautification in a lot of these programs really matters too. It definitely correlates with self-worth. I don't know if you've seen these properties. They're amazing, very dignified. Very nice living arrangements.

We also have permanent supportive housing. It's permanent housing, but the supportive piece is crucial to the ongoing maintenance of that housing. We have mental health, wellness, and recovery supports. We have a wellness center, which is kind of a broad name, meaning empowerment more than anything. The person has a say in not only understanding their symptomology and some of their triggers, but they also get to develop plans unique to their needs on how to mitigate those triggers and some of their symptomology in an environment that's stigma-free.

I know most of us would never tolerate anyway in terms of negative connotations or stigma towards our folks. But this environment is unique in that it's largely peer. Individuals that are the experts in behavioral health because they have lived experience. They have a wonderful, uncanny ability to be honest on how treatment and care is received.

I've said this time and time again with my staff, I always come up with these wonderful researched ideas. And I think I know the latest best practice. And there's nothing like having an individual that receives those services to be able to tell me, well, you know, Jason, this would be more palatable this way. Maybe you can deliver it better that way. When I was in treatment or seeking treatment, this is what helped me connect to a menu of options instead of being so much on a prescriptive level.

We do have "RISE". And if you want to know what that acronym means, please refer to Sarah. It is very crucial for the individuals that have difficulty accessing treatment and care. It's incredibly difficult, especially with transportation issues to some of our clinics. I love and admire the staff that work there; those are very difficult jobs. But at times they can be overcrowded, right? They can be, and I don't want to use the word chaotic, but can be perceived in this way. If someone has experienced a high level of anxiety or maybe some internal stimuli or some symptoms from behavioral health, it's kind of hard to sit there and wait for treatment or even to know how to fill out the forms to get benefits.

So it is a wonderful program. Our mobile wellness, where we take the care to the people where they're at. Transportation is huge. Now we know more than ever how costly that is, just in terms of fuel. But also a lot of individuals have diagnosis that prohibits them from driving in the first place. So that freedom has already been removed. So, now we have the ability to go to them. And in the pie that is the human being of a hundred different slices, those with mental illness are almost as one piece of that hundred-piece pie. And what we're looking for with our peer services in mobile wellness is how to get the other 99% of them.

How do they engage in what makes the rest of them, the whole person? How to do so as a partner, not prescriptive? How to hear what they need and co-author if they allow us that dignity to help them create a plan that is meaningful

to them? How to engage in a community, again, in a way that makes them feel like this is mine?

I've often heard that, especially in child welfare, that individuals get adopted out or they're put in foster care where there's wonderful individuals that take care of them. But one of my professors, actually, on my dissertation committee, did a wonderful TED talk that said it's not just the adoption, it's the claiming. These are individuals. We're claiming them. They are worthy. We're on equal footing. They're not a burden. They're absolutely an intricate and viable partner to our community as a whole.

We also have delved into the legal system in terms of Proposition 47, which is a legal reclassification. It's incredible in many ways. What it does is take certain crimes that would be deemed a felony and drop them to misdemeanor. That is significant in terms of life barriers or mitigating barriers. But that's not just an easy thing. The treatment has to be broad and wide.

You see these Venn diagrams, especially the one on the first slide where there's three. Realistically, if we were to be accurate on Venn diagrams, what really goes on would cover the page in circles. Mental health, substance abuse care, housing employment, mentorship, supportive groups, education … all these things are the very cornerstone to build one's path to maintaining their freedom.

Some individuals have been institutionalized, and we have to unpack that. And to do so we have to ask the right questions and certainly do a heck of a lot of listening, active listening. So far, we have some really good numbers. We're waiting for the end of the year to hopefully present some of the successes in that arena, long overdue in my biased opinion. Mounting research substantiates that when housing and behavioral health are in the same unit, integrated care, there are better mental health outcomes. There's a multitude of reasons for that, and I'll give you just a few.

Reduces financial stress. So earlier it was said that some of our folks are high utilizers of the emergency department. That is absolutely true. Those that are unhoused and have a mental health diagnosis spend four times more on average, and spend four days longer in treatment that otherwise could have been mitigated had treatment been offered in a place that they could reach, namely where they are, where they live. It causes greater housing stability and safety, fewer crises. And this isn't uncommon given the fact that one in five Americans have some form of mental health diagnosis, more commonly now than ever. Anxiety or depression can turn into medical conditions really quick.

Now you have these core modalities going, a lot that could have been mitigated, and it is only costly to the county and individuals that don't have health insurance. It's costly to their health, their exposure. The long-term function and quality of care with integrated health models matter, to those of you that are of the financial persuasion, and it also matters to those of you that are more of the human condition. The bottom line is it does benefit folks and this is what we hope to continually accomplish.

I'm up here not saying we need to do a ton of things different by any means. We just want to do more of the successes that we do have. Engagement with our outreach team. You know, it is quite a lot to ask an individual that is having acute symptoms, maybe psychosis, maybe delusional thinking, maybe paranoia, to ask that individual to a] have the insight [which sometimes in mental health diagnoses, a lack of insight is a pretty common symptom] that they have an illness, b] all of a sudden know where to get help, and c] have the transportation to get there.

We do spend a great deal of time reviewing point-in-time count and understanding where the majority of the folks are that are in highest need and put together treatment teams and outreach teams in a way that is palatable to those individuals.

Another thing has to do with reachability. It's a funny word. We need individuals that have the ability to connect with people where they are in the language in which they speak. In some of our programs, we have different populations. Some are English-speaking, some are Spanish-speaking. We also have a large population of Mixteco. And obviously, you wouldn't send me to an encampment of a Mixteco population to try to connect. I don't have that dialect and so I don't have the ability to connect on that level. In many ways, they probably see me as law enforcement and want nothing to do with me. Just simply how I look. I certainly don't blame them for that. But it is important that we connect with people where they are in a way that, again, is meaningful and palatable to them. So we do try to assign the appropriate staff to the appropriate people that can connect.

Regardless, if we do have the right treatment and the right resources, if they are not able to engage with us for fear or lack of understanding, that will fall on the service provider. And that's something that we are continually trying to mitigate.

Of course, we also link housing services. We pair that with behavioral health, substance abuse, and daily living supports. Many individuals have become successful at being homeless. And I don't mean that in a negative connotation. It's incredibly resourceful to do that. But it sometimes doesn't translate. So it is incumbent upon us to be able to provide those connections and new skill sets.

Stabilization: it is one thing to house a person, it is quite another to keep that house maintained. One individual particularly sticks with me. He had housing from us but kept sleeping on the balcony. So we just kept asking, is there something we can do? Can we make your apartment more homely and conducive to what feels good to you? It was just too enclosed, so where can we help on that? So, we've started doing pretty intensive therapies to help with some of those phobias.

These things are very real. That's why supportive housing is incredibly important in the maintenance of that housing. The funding gap, you're going to hear that from any provider, not just a community service provider. It happens at a county, state level all the time too. You're required to not necessarily do less or more, but certainly do differently. You have to operate within the confines of your resources, and that's where collaboration comes in.

We could certainly exist without our collaborators, but we wouldn't exist at this capacity without our collaborators, that's for sure. Procedural friction. We have new programs. It happens; there's a learning curve, referrals, eligibility rules, documentation, billing requirements. And all these things can certainly slow placement. Duplication is also an issue, and a tightened housing market. I've got to say, it's incredible hearing those numbers on what's been done. For sure. That's a huge dent; many counties are not experiencing that same level of success, unfortunately.

What would help? Stabilized funding. Wow, what's that? Stabilized funding. Multi-year, flexible funding. Wow, I'm really asking for it. Multi-year, for sure, for one obvious reason, is that it's predictable. The last thing you want to do is get a safe house, hire some staff to address your new program and your new housing unit, and then a year later have to worry about layoffs or displacing people. That is just unacceptable on our end, but sometimes it's an unfortunate result.

Multi-year funding and flexible, that's always nice. Just to maintain wraparound services. Housing and homelessness is certainly not one symptom. It is a byproduct of multiple things going on.

Simplify access. Sounds like that's being worked on constantly. Again, in this county it's pretty incredible. I can tell you, as one who spends a lot of time at the state level, Sacramento and multiple boards [we'll call them think tanks …. mostly just a lot of coffee]. But what are we doing? Kidding aside, there's some wonderful people. I can tell you, there's not a lot of counties that have I wouldn't say motivation, but they're certainly not putting their value on the

highest tier of simplifying services and integrating cooperation. This county is doing a pretty exceptional job.

Expanding unit supply. Same thing. We are doing a very good job thus far; very impressive over the last three years, anyway.

Coordinated accountability. Oh, that one. When everybody's accountable, hopefully work not just gets accomplished, but it gets accomplished in a way that it's verifiable, and everybody understands each other's roles, and it's in a way that is dignified. Accountability is not a scary word. It's an assurance. That's all it is. It's not a scary word. It's not punitive. It just simply means we all are ensuring each other that things are handled properly.

Faster placement equals stronger retention. Putting all this together, kind of a-day-in-the-life-of what it is to be a service provider to those that are experiencing homelessness and behavioral health symptoms, whether discharged from a hospital or a jail or simply lost their place for whatever reason. Prop 1 can be incredibly instrumental in this regard, and we're looking forward to the rollout. There are always growing pains, but we're definitely looking forward to how that can help build capacity for housing, length, and treatment. It's very important.

Integrated care has been substantiated over and over. There's mounds of evidence. They've been doing it in medical models for a long time, but not so much in housing and behavioral health in a way they can really benefit. To sum all of this up, housing homelessness is certainly not in a vacuum, and it's not one-dimensional. Most of the time it's not even two-dimensional. It is not just socioeconomics. It could be behavioral health issues as well. We can see that it is not an uncommon practice now for individuals that are working two and three jobs and having anxiety and losing their ability to feel like tomorrow's going to be any better and collapsing. So we're there as a safety net, and that's an amazing thing. I really am hopeful, even more so now being on the panel today and hearing all the amazing work that's going on, that that's going to get better, and that's evidenced.

We saw a lot of minus signs on reductions today. That was incredibly impressive. I can say that other counties are not sharing those same successes, but I wish them well. I really do. Hopefully Ventura will be the great replicator, right, where individuals can look to it and say, wow, their model is working. Very impressive.

Anyway, I appreciate your time listening to my rantings on this. And I will leave you with this, just kind of an unfun fact. A recent study, I believe 2024 in the University of Pennsylvania, found that individuals that are homeless experiencing mental illness, maybe some accompanying substance abuse, have a life reduction now of 30 years. Thirty years. The median range is between 42 and 52 years old. That's precisely what we're all working on and is precisely what keeps my lens focused on this. I mean, it's much bigger than just a person dealing with the cold or dealing with maybe some of the negative stigma on the street. It's potentially lethal.

At a minimal, life reduces. And another part of that, people sometimes misinterpret these individuals on the street as violent or substance users. Many of the stats that came out highlight heart attack as one of the leading causes of death. Substance abuse is certainly out there. But it is lack of medical treatment and follow-up being on the street.

Oh, and another part of that I think is noteworthy… they are 15 times more likely to be assaulted or hurt than to actually be the one doing the assault. I just think that that's worthy of note to at least frame our individuals and whether they're dignified and worthy of our care and treatment. I am deeply appreciative of those that are around me today and optimistic as a result.

So anyway, thank you for your time. I really appreciate it. And if you have any questions when that time comes, I'll be more than happy. Thank you.

[Audience]: What are we doing to create and sustain board and care?

[Sarah Sanchez]: I can touch upon that. That's a very good question. Currently we have, I don't have the numbers right off the top of my head here, current boarding cares and residential care facilities for the elderly. So we contract with various providers and actually Turning Point oversees and operates, is it two of our boarding cares? Three, thank you. So the goal is really to expand these.

What I didn't touch upon is with BHSA housing intervention dollars, boarding cares are now under housing. So when we talk about 30% of our BHSA funding going into housing specifically, we do need to note that many of the current contracts in place are considered to go under housing. So, it's not necessarily there's no commitment already, there is. These boarding cares are so crucial for our community and for individuals we serve. So the goal is to expand, but the ability to have boarding cares it's quite difficult in the county. But yeah, our goal is continuing to expand just the different levels of housing opportunities for individuals because not everybody's going to meet one specific area within housing.

[Audience, Dawn Dyer]: Thank you, great presentation. Really appreciate bringing the housing and healthcare together. I also want to acknowledge our host, Gold Coast Transit, because transportation is also a critical piece of that network of providing services to people who are unhoused. The question that I have is how will changes to federal funding priorities impact BHSA? I'm sure everybody in this room is aware but there's been a shift at the federal level away from the housing first model, which this all seems to be based upon. So curious how that might impact BHSA going forward.

[Kimberlee Albers]: Maybe I'll just start a little bit on federal challenges and then the good news is, right, the Behavioral Health Services Act is state funding. So that's the good news to that question. I think what we're seeing at the federal level, right, is mostly uncertainty and litigation, right?

So policies are put forward and then they're challenged in court and so we all are reacting and then we're pausing and then we're reacting again when the next injunction comes over and that's the kind of uncertainty, right, that doesn't help developers feel certain to move forward. I think there's uncertainty about vouchers, right? That's when, if you told me what's the one thing the state could step in and do that would make the biggest difference right now, it would be having a state-funded voucher rental subsidy pool so that we aren't completely dependent on federal dollars to make sure that people who are housed stay housed.

But those policy shifts in saying, we don't believe in (and this is HUD, not Kimberlee), we don't want to fund more permanent housing, we want to fund transitional housing; we don't want you doing housing first, we want you to do something different. Those kind of shifts on a four-year cycle, right, can be very, very challenging for providers to implement. But even though I still wish the state would invest in vouchers, we're grateful, right, that we have Prop 1 to fill some of the gap; we're grateful that we have the Medi-Cal waiver, right, to have Cal-AIM and other pieces so that healthcare can step in. Those aren't our traditional sources, and they serve a certain population, they serve the person, not the project.

Unless we have federal and state dollars that support projects, it's very hard to operate a shelter if you're getting benefits for each person. So transitional rent can pay for someone in a shelter, but they pay for that person, they don't pay to run the shelter. So coming up with a bed-night cost and how to bill it and have month seven funded, right, all of these things are just creating so much change with how the federal government approaches us as well as the actual policies.

I was at a HUD convening recently and I'm the enemy, right, in those meetings. I'm the homelessness industrial complex that … (you know, I'm not going to repeat it because I don't want anyone to hear it, but it was awful). I

mean, I had a woman crying in that room as a service provider, feeling attacked, personally attacked. It is a different environment today, and thank you for acknowledging that, but the good news is we do have some state programs like HomeKey, BHSA, CalAIM, that should have less impact from federal funds.

[Sarah Sanchez]: Yes, and BHSA dollars, as noted by Kimberlee and Courtney, is on the state level, but that fluctuates depending upon the revenue that comes in. BHSA is still, as a requirement, is a housing-first model, so we're ensuring that we're aligning that with our priorities.

[Kimberlee Albers]: But that means funding can't be layered with federal funds, right? So we're usually talking about braided funding. You have to put it all together. If the state's saying you must do housing first and the feds wind up saying permanently, you can't do housing first, how do we put federal and state funds together, which has always been the case to make these projects happen?

[Sarah Sanchez]: And I do want to note, that's also crucial because the funding is reallocated. It's not necessarily new funding coming in for BHSA, but reallocation. What does that mean? That means now there's funding for housing, but not that it's limiting direct clinical services, it's just revisiting and thinking outside the box, leveraging the different partners. The community supports on the managed care plan side is working together collaboratively so we're not duplicating efforts and ensuring that we're supporting the individual. It's a lot of thinking outside the box of what traditionally has been done over the years.

[David Tovar]: I can add to that also. So with last year's HR1, the BPP, that initiated a 10% cut overall to CMS, which we'll see within our Medicaid Medi-Cal program. We're starting to see that already throughout the state. One initiative that we'll start rolling in next year is to ensure that people sign up twice a year for Medi-Cal. Currently, it's once a year. We're already seeing our member list drop. At the beginning of the year or late last year, we were at about 250,000 members, and now we've already dropped to 227,000 members. We have one of the lowest drops of enrollment throughout the state. Other managed care plans have seen drops of up to 15% already.

So that means layoffs of staff reductions in the payments to providers. Typically, the individuals that we're seeing fall off are our highest need, those with the highest risk. What's going to end up happening is, those people will present to a hospital emergency department and the care will be uncompensated, putting our entire healthcare system at risk. We already know that hospitals like the Ventura County Medical Center primarily serve our Medicaid population, and because now that care will be uncompensated, they will not have reimbursement.

It really will put a lot of risk within our system, not just our system, but the entire Medicaid system overall, whether you're in Arkansas or California, it will make a tremendous impact. I think there is some good news there, that we do have many of these services already under waiver authority. A waiver authority is basically saying, the Centers for Medicaid and Medicare Services allow for exceptions for California to certain things. But our waiver authority is up this year. And so the Department of Healthcare Services is submitting a reauthorization for many of these services. Much of them we can continue providing.

However, some of the services will transition and change, primarily around recuperative care and short-term post-hospitalization housing. Those do need waiver authority to continue. The massive problem, just like Housing First, CMS really hates room and board services … really, really hates them.

So while we're anticipating what CMS comes out with in terms of the renewed waiver, we're hopeful, because we have seen Utah come out with a similar waiver for continued recuperative care. There's no current risk to transitional rent because that was approved last year. But we might see some changes. One large change is it will probably be with recuperative care, and we're hopeful. But also, we're anxious about what that outcome might be.

[Kimberlee Albers]: I was handed a question when I was standing outside. It was, how was the homeless count impacted by the encampment in Simi being removed weeks before the count? And should there be a note in the report?

I would just say that our methodology is that we're trying to cover the entire geographic area. That's why we enlist the help of 400 volunteers. So the premise in any count is there's going to be movement of the population. As long as we're covering the geography, the hope would be that anyone that was displaced from that encampment, where they would have been potentially easier to count when they were all in one place, but the fact that our methodology still covers the entire geography. The hope would be that they would have been counted in their new location at places like Samaritan Center. After the volunteers go out for the count, we actually still send out law enforcement with staff to try and make sure any areas that we thought were an encampment or people who were residing in an encampment were not counted. We do go back out in the days following the count to try and make sure we're consistent. So we wouldn't have a note in the report because there always are changes. But I do realize in Simi, your most significant encampment was displaced in those days; the hope would be that those folks were counted at other locations.

[Audience]: Hi, my name is Tammy (Duff) with Gables House, and looking at the gaps that we're going to be having, I just want you guys to know that we do have beds, and we are for women and children, transitional and emergency, and we would love for anyone you know to call and do a phone interview. We try to keep women from slipping into homelessness. It's a very safe place, and building up. Thank you.

[Karen Fraser]: Tammy, is there an age limit or restrictions on the minor children that come with the woman?

[Audience: Tammy Duff]: So we are one of the only facilities that allow boys over the age of 10. We take them usually about up to 14, but women or girls all the way up to 18 is fine. But women, when the boys start becoming like men, then no, because we're in one large house, but we can house up to like 30 women and children, so.

[Audience]: Hello everyone, my name is Aran Tanchum. My company's called Moonrise Living. I'm working to start new transitional living residences in Ventura County. My question for anyone, is there a particular part of the county, or are there locations that need these services the most? Are there particular demographics that need services like these the most? Thank you.

[Kimberlee Albers]: I think there's a great need for all types of housing. And I think sober living is part one of the things also that can be compensated with the Behavioral Health Services Act Housing Intervention funding. So, finding the right location with the right ordinances, et cetera. I'm sure it would be welcome anywhere.

[Sarah Sanchez]: I guess I do have to plug in. We have a recent request for a proposal that was rolled out in regards to recovery housing, sber living that will do an interim stay for up to 12 months. So very much interested in providers that can provide that for our individuals. We serve with a dual diagnosis or a substance use only diagnosis.

[Kimberlee Albers]: That's one of the emphasis we see within some of the new HUD policies as well is a shift potentially towards recovery housing. There may be more resources in that area, but that would go take away from other resources that currently support permanent housing.

[Audience]: Hi, I'm Sandy Sage from the Conejo Family Health. Thank you for the shout out, David. I appreciate it. I had a question about transitional housing and the housing trio. When it says referral, is that going through the community supports? How would that be set for eligible members, potentially eligible members?

[David Tovar]: I think it goes first to Gold Coast. Well, it just depends, but we have no wrong door policy. So it could

go to the provider. It could go to an ECF, right? It can go to us. I mean, typically we'd like it to come in to us so we can triage and send it appropriately, check if they're already connected with care with another provider. But of course, CalAIM is one of the largest premises there, right? There's no wrong door and closing the loop on that. So really it could go to us. It can go to them. It can go to behavioral health, but Sarah doesn't want that.

[Sarah Sanchez]: It's not our benefit.

[David Tovar]: Absolutely. But that's what we're seeing. There's no wrong door. It will go to other partners. But of course we do have our community supports referral form as well as a transitional referral form where individuals can just call our member services line as well.

[Audience, Linda Braunschweiger]: Thank you. I have a follow up on that. For a long time, 211 was the place we were to send everybody for coordinated entry. I didn't hear that brought up at all. So I'm wondering, is that still where we send people? Is that still the source to connect you all to the client?

[David Tovar]: So 211 is a great resource that you can absolutely send people to. They're actually an ECM provider. Interface is actually an ECM provider as well. And so they would be able to connect people, absolutely. However, they would be an intermediary. So you could go to 211. Or you could come directly to us. Again, no wrong door. I like that philosophy.

[Audience]: But I guess maybe the continuum care folks could talk about it. Because I know there were a number of years where everybody was saying, put them first at 211. Get them at 211. But I haven't heard that.

[David Tovar]: Not particularly the case with our Gold Coast County services. But absolutely, 211 is next. For other homeless services. Absolutely.

[Sarah Sanchez]: But for the HMIS, I know Gold Coast, right? They're contracted providers on the community supports. Navigates and supports individuals into entering them into, individuals into HMIS system. So I think historically, please let me know if I'm speaking out of turn, historically, I think it was less HMIS licensed users that could be supported. It was a lot of navigating to go through this entryway. But now, I know on our end, we're working with individuals and building our capacity to support the individual we serve into that HMIS system.

[Kimberlee Albers]: I think what you've heard today, right? Is that housing as healthcare is complicated. Yeah. And so, the notion that someone could call 211 and somehow be helped navigating the Medi-Cal system, along with housing and homelessness resources, right? This would be more and more challenging, the more layers that we're going through. So 211 is always a good place. If you don't know a specific resource, if you don't have the access line number, if you're looking for that specific resource. We still fund 211 from the continuum and the county, and it's a vital resource, as David mentioned. But it's just going to be so general in nature, where all this work has become so specific, right? That these doors are, as Jason said it well, no wrong door in theory, right? But is the 211 operator really going to be able to help you navigate the system? Mostly, they're going to give you another phone number from probably one of the people on the panel, right? And or the CES hotline, homeless services, I think Jillian is here today.

And then that's going to be another call for the person. So I think that there's work to be done for all of these new ways that we're delivering services. It's a revolution in the way we deliver services, right? When the whole funding structure changes, the way we deliver services changes. And so we're still figuring out how do we really make that accessible to the client? If you are talking to a client, the best thing is to be connected to a service provider, because the service provider is going to help navigate you through these complicated systems.

It's just not usually going to be the person who's that wide group of resources. We have nice trio pamphlets to show all the different resources that the 211 operator is relying on. But it's even hard to keep that up to date. That's how fast things are changing.

[Rick Schroeder]: I just want to add to that, to your question. I think back in the day when we were really focusing everybody to 211, we were working on building up the coordinated entry system and our HMIS, record keeping, if you will. And through county staff at Continuum of Care, they've done a really good job of bringing our providers on board.

Gold Coast and our other many managers are all hooked into that HMIS system. So when people enter the system through any of these portals, they're going to end up in that coordinated entry system, which is, I think back to what you're talking about, Linda, we were still trying to build that framework within the county, and we had a lot of service providers who were not really adept at and fully utilizing the HMIS system. For any providers in the room, just another shout out, our funding is so precarious right now, and data quality is going to be one of the key factors for us moving forward to be able to retain funding. So it's super important if your team is not fully trained on how to use the CES system, please reach out to Kimberlee and the county and get some training. It's available, and we'd love to bring you up to speed so everybody on your team feels comfortable using the system.

[Courtney Lubell]: I just want to speak to one of the last points that you just made. There are two sort of higher level elements here. Whereas the system is under a radical shift or shifts. And it's due to these shifts in funding and shifts in structure that, to those of you who invested your Friday morning to come here and be a part of this conversation, how do we improve and clarify roles and responsibilities in the system collaboration, in our partnerships, right? How do we then educate our community members about how to get the support and care that they need when it's a complex system? It's not a single point of entry, it's multiple points of entry. How do the partners know what's what in the system? I think this is going to be an ongoing opportunity and an ongoing challenge, both for our community members who need help and for the organizations that are attempting to create opportunities to serve.

The second thing that has been referenced, and I just want to reemphasize it, is braided funding is going to be more the reality than it is even now, and it's already a complex thing, right? But from the little organizations to the bigger entities, everybody's going to need to be looking for how to fund and maintain the services through multiple funding streams, because it won't be one house, right? It won't be one stream that goes this way.

So how do we become better at finding the funding opportunities, taking advantage of those streams, and utilizing data to apply for specialty grants, even if they're very small in amount. This is all about your sustainability planning as part of overall strategies. Because we do see what's coming. I mean, we don't see what it's going to look like, but we know in 2028 and beyond, as things leave through HR1 and other things start to happen, that we can see two years down the line it's going to get even tighter and more complex. What can we do now to start to address what we think is coming down the line?

[Audience]: Is there a list of numbers and services with all these changes? Like, do you guys have something that we would have access to with the name of the person, the name of the organization with their numbers so that we can access those things? A resource page.

[Karen Fraser]: I put one together a couple years ago when we had a similar panel here. I put together a matrix spreadsheet of all the different providers, services, and what they do, whether it's permanent supportive housing all the way down to shelter and stuff. I would love to be able to expand on that and be able to keep it current.

[David Tovar]: This is one thing we're working on at Gold Coast and I know the county has supported it as well as

our community information exchange, right? So a digital platform that wouldn't have to be regularly up dated in paper. Where individuals and organizations can directly refer and again, close that loop on those referrals and see how, if it was accepted, declined, or transitioned to another place. That's where the VNet? has already rolled out, right? And we're working on it.

[Courtney Lubell]: I think opportunities like what HOME has put together with today's conversation and panel, thank you for all of your efforts in that Karen. How do you create opportunities for continual convening and conversation that leads towards decision-making and action?

[Audience]: Hi, I'm Vanessa Rauschenberger. I'm the general manager here at Gold Coast Transit. It is a pleasure to have you guys. I just want to thank you guys for your work on the RISE program. A few years ago, we had reached out to the county to talk about some of the challenges we're having at our transit centers and have been very responsive.

I hear from our road supervisors that they are often referring people and talking to people. I want to ask if you have any thoughts on, or any other information or programs that you would like our bus operators to know about? Because we have 200 bus operators who interact with the community daily. And we have a monthly safety meeting where we talk about community resources that they can refer their riders to. They're very friendly and close and, you know, with their riders. They see their regulars. And so they know probably very deeply about what's going on in their lives. We like to provide that.

So if there's any partnership ideas that you want to share with me that we can pass along to our eyes on the street, we'd be happy to share that. And then also just on a bigger level, we really appreciate the partnership in housing and with healthcare. We want to try to shape our services to connect people to those. So if anyone ever would like to bring a group here, get a behind-the-scenes tour of how we operate, talk more about partnership ideas, please reach out to me. My card, I'll have a card out there. And also today, if anybody has time after today wants to talk to me or ask any questions, I'm available.

[Karen Fraser]: Any other questions? Ok, I have one. Jason, you have said, and I loved your quote, different settings meet different needs. Right? In talking about braided funding, sometimes the funding comes with restrictions and limitations, say they get six months and then you have to pass them on to the next level of housing. So how does that work? What do we need? Where is our gap? Are all the different types of housing being funded and met? Or is some being dropped? What needs to be done in that regard?

[Kimberlee Albers]: I'll just share. I think we showed you that red line that I was concerned about, right? We've got this great green line going and we do still have a number of permanent supportive housing units coming on in 2027. But we’re concerned after that, very concerned, right? We've essentially lost 400 interim housing beds. Even though those were emergency, they were never going to be forever. But when you have them for five years, you feel the loss, right? It doesn't matter if they were emergency, you still feel it. And so we want to make sure that we have a flow through our shelters by continuing permanent housing because a bed can be available by an opening or a new bed, right?

So we need availability and openings in our interim housing, but we also will need more beds. And we don't want to continue to invest in motel rooms that we spend millions of dollars on and don't have a bed when the hotel room payment stops, right? We want to build something to where we have it long term.

I think there's lots of gaps. Jason highlighted that as well. But I would say for me right now, for service providers on the street doing this work, they cannot find a bed for someone now while they're waiting for permanent housing.

And there's an opportunity because some of the smaller groups like Samaritan Center and Faith-Based and Gabriel's are trying to get into that space. It won't be 150 bed shelter, but it will be a necessary 20 beds in this area. You know, a little bit of it.

[Jason Meek]: Can I add a little more context in terms of our position on that? As funding changes, it's very important that you have a thorough understanding of what that looks like. And discharge planning, of course, starts on day one, obviously, but things in the world of behavioral health, things materialize in different directions.

But it is that continuity of information between service providers that can make this at least a safety net with a landing. The end result is always permanent housing, right? And it's very difficult with the lack of inventory, but if we do a better job on our end and others to make sure that we understand the funding, we collaborate, discharge starts, literally planning starts on day one and you understand the resources in which you're operating within. That's about what all you can do at that point. We've done a lot of creative things on housing. Hopefully there's no fire inspectors in here. Just kidding …I'm kidding.

People can land safely in the course of that transition, you know? And it is, it's not just stabilizing. You really have to be forward thinking. But you can do none of that if you're not ahead of new policy and new funding sources that are coming out. Kim had brought up a couple of times how this enhances things. But there is a counterbalance to that, to where it is a reduction potential in other areas. So if you are focusing now by removing permanent housing to do transitional, because transitional might be the need now or vice versa. Again, it really comes to that continual understanding of the resources out there, what you can do internally and who you can source some of that stuff out collaboratively and immediate.

And it has to be immediate. We're in flux and we're going to probably see some of that in the next couple of months here, how that's going to wash out. But again, with some of these shelters, at least we can have a safety net while we're trying to get some money into either transitional or permanent housing. But it's very complex.

[Rick Schroeder]: I would only add though, you know, Kimberlee had mentioned that we've come a long way in terms of the number of permanent supportive housing in the county. A lot has come online in the last couple of years. But I don't think the future is very bright for more permanent supportive housing. I think although there's been some changes, there's more tax credit financing available. I think there's a growing concern that future permanent supportive housing projects will not be successful because there will not be the money for the necessary services.

We're also seeing a lot of the tax credit investors starting to shy away from permanent supportive housing with the perception that these properties, once they're developed, they're just too difficult. The operating costs go way up, there's vandalism, there's high security concerns. We just don't want to finance these types of projects anymore. You're seeing a lot more developers, for-profit and non-profit, really just doing a lot more affordable housing for families or individuals, and maybe a higher income amount, even though the state still prioritizes a lot of the extremely low-income supportive housing. I think there's going to be a difficulty with developing more. I know even from Many Mansion standpoint, we'd have to think long and hard to do another big supportive housing property without any assurances that there's going to be money for services.

But I'm glad to see Proposition 1, and maybe when that works out, that will provide that source. But right now, I'm not so sure that the future's so good.

[Kimberlee Albers]: Uncertainty again, right? The theme.

[Audience] I have one very specific question. Not too many of you would be able to help me with this, but here is the difficult population: senior, mental health issues, physical health issues, and dementia. What do we do with these folks? They're on a limited or very small income with no family. How do we do it? That's a growing segment.

[Kimberlee Albers]: I'll just share that I think that there are limitations to permanent supportive housing, and I think probably everyone in the room would agree that we're stretching those limits. It was never meant to be serving someone with that high level of need. Yet we continually prioritize people with the highest level of need into an intervention that was never meant to be … a boarding care usually doesn't have clinical staff on site. I think we have to think about what is the level of care after PSH for someone who's in permanent supportive housing and needs to go to a higher level of care, or someone who shouldn't start in permanent supportive housing and risk the kind of failures that Jason described, right? Because we put them in the wrong place.

So someone with those high of needs, I think we really want to think about the boarding care network and assisted living facilities and Medi-Cal supported assisted living, those types of things. And not think that getting them to the top of the PSH list is going to be the answer for someone like you described.

[David Tovar]: But that's specifically the population we're working with within our justice services programs that have spent 40 years in Chowchilla or another state prison. Now they're exiting incarceration, they're 72 years old with cancer, dementia, former substance use issue, and their family has since passed, or they're no longer in contact with them, but they're not self-sustaining. So we're connecting them, again, with our enhanced care management providers, but also working on a transition of care to probably a skilled nursing facility or another appropriate level of care.

Unfortunately, it's just incredibly complex and difficult situation, and we are going to see many more of that, people of that complexity just continuing on. It's difficult.

[Jason Meek]: It'd have to be, realistically, risk mitigation. Typically what they'll do is assess the highest risk factor, and in this case it would be medical, and you would probably fall under grade disability, inability to effectively care for oneself. So it would be more of a licensed skilled nursing, memory care, one of those types of facilities. Supportive housing wouldn't have the human capital to deal with that level of healthcare issues on top of that in a safe, in a safe manner. But great question. Unfortunately, that is rising, that population.

[David Tovar]: And we'll see that more and more as there's more compassion, regardless of specifically from state penitentiaries. We're going to encounter that a lot more.

[Karen Fraser]: We did have a stop here at 10.30, so I do appreciate you all coming and super appreciate the panel for speaking and presenting. Thank you. Thank you.

If you have any questions now, on your cards that weren't answered or whatever, just leave them on the table out here. If you come up with additional questions, email them to me and I'm going to reach out to the panel and try to get them answered.