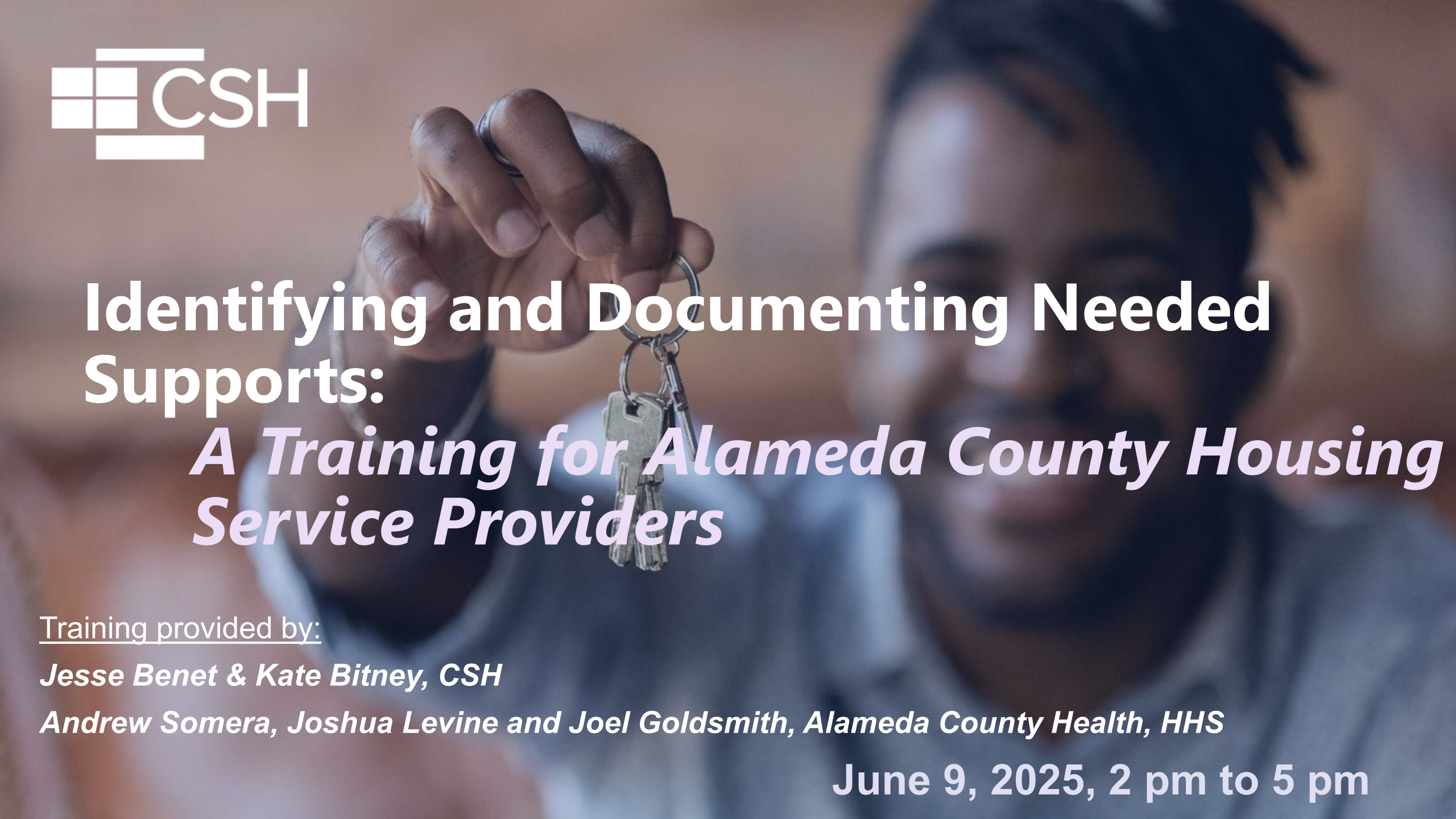


Identifying and Documenting Needed Supports:

A Training for Alameda County Housing Service Providers

Training provided by:

Jesse Benet & Kate Bitney, CSH

Andrew Somera, Joshua Levine and Joel Goldsmith, Alameda County Health, HHS

June 9, 2025, 2 pm to 5 pm

About CSH

CSH is 501c3 nonprofit intermediary organization and CDFI that advances **supportive housing** as an approach to **help people thrive.**

Since our founding in 1991, CSH has distributed more than **$1.7 billion in loans and grants that** has created over **467,000 homes for individuals and families** exiting long-term homelessness.

CSH

csh.org

What We Do

CSH takes action through our three lines of business.

Policy & Advocacy

We promote concrete policies and strategies that advance more supportive housing development.

Community Investment

We are a CDFI and invest resources to increase availability and sustainability of quality, affordable housing aligned with services.

Strengthening the Field

We provide training, technical assistance and thought leadership to the housing and services sectors.

CSH

Welcome & Introduction

Please enter your name, role and organization in the chat!

Please make sure your mic is muted!

Today's Training

Housekeeping: Our time today

- **Module 1:** The Cal-Aim and Alameda County Landscape (2 to 3 pm)
- **Module 2:** Digging In: Housing Support Plans & Documentation meeting Medicaid Standards (3:15 to 5 pm)

Is there one thing about Housing Support Plans that you'd like to know or learn about today that would help make your job easier in the day to day?

Alameda County Health Role / Overview

Housing Community Supports is part of **Alameda County Health's Housing & Homeless Services** division.

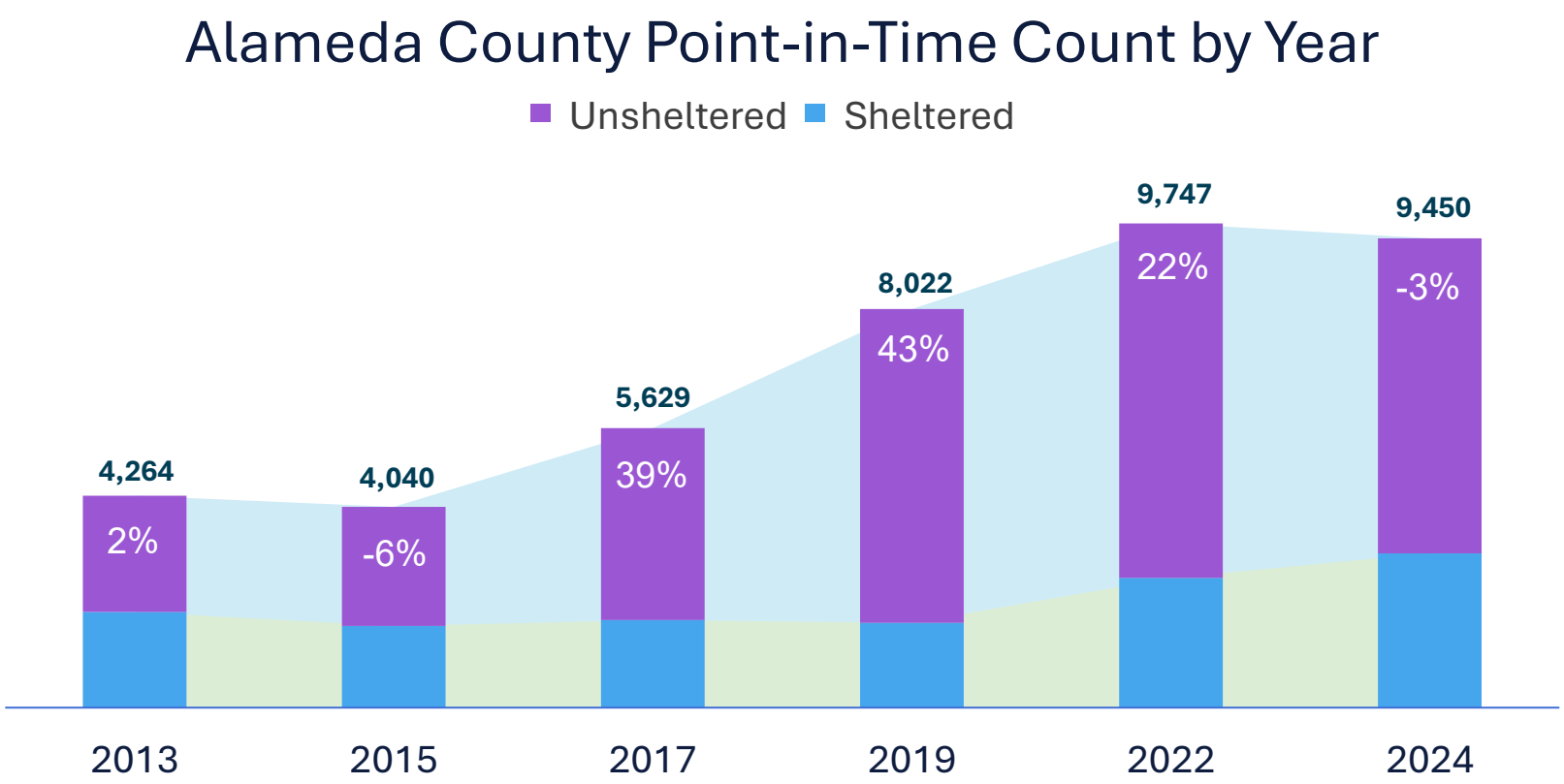
Together with our contractors, we:

- Coordinate housing-related Medi-Cal services (CalAIM Community Supports)
- Align health and housing goals to reduce homelessness
- Manage provider contracts and ensure service quality
- Partner across systems to improve outcomes for vulnerable populations

Our shared mission: Improve health and housing outcomes for people experiencing or at risk of homelessness.

Countywide Snapshot on Homelessness

- **9,450** people were estimated to be experiencing homelessness in the 2024 PIT Count.
- For the first time since 2013, **overall homelessness declined slightly** (3% from 2022)
- **Unsheltered homelessness declined significantly** (down 11% since 2022). **6,343** people were estimated to be living unsheltered in 2024.
- **3,107** people were sheltered, a 19% increase from 2022.



Home Together 2026 Community Plan Objectives

1 Prevent homelessness for our residents

1. Address racial disparities in mainstream/upstream systems to prevent racially disproportionate inflow into homelessness
2. Focus resources for prevention on people most likely to lose their homes
3. Rapidly resolve episodes of homelessness through Housing Problem Solving
4. Prevent racially disproportionate returns to homelessness

2 Connect people to shelter and needed resources

1. Expand access in key neighborhoods and continue improvements to Coordinated Entry
2. Lower programmatic barriers to crisis services such as prevention, problem solving, and shelter
3. Prevent discharge from mainstream systems to homelessness
4. Significantly increase the availability of shelter, especially non-congregate models, to serve vulnerable adults and families with children and to reduce unsheltered homelessness
5. Provide accessible behavioral health services to people with serious mental illness or substance use needs and who are unsheltered, in shelter, or in supportive housing programs

3 Increase housing solutions

1. Add units and subsidies for supportive housing, including new models for frail/older adults
2. Create dedicated affordable housing subsidies for people who do not need intensive services
3. Create shallow subsidies for those who can exit or avoid homelessness with more limited assistance
4. Add new slots of rapid rehousing for those who can pay full rent over time
5. Ensure new housing funding is distributed across the county according to need
6. Reduce entry barriers to housing and ensure racial equity in referrals and placements

4 Strengthen coordination, communication and capacity

1. Use data to improve outcomes and track racial equity impacts
2. Improve messaging and information availability
3. Build infrastructure to support and monitor new and expanded programs

Alameda County HCS Hub Model

In compliance with Department of Health Care Services (DHCS),
Alameda Alliance contracts with
Alameda County Health as HCS Intermediary

Alameda County Health contracts with
Community-based partners (contractors) for Housing Community Supports
(for services provided to Medi-Cal managed care members and others not enrolled with AAH)

Community-based partners (currently 24) providing
Housing Community Support Services
(Housing Navigation, Tenancy Sustaining Services, Housing Deposits)

Alameda County Health

AC Health Housing Community Supports Provider Network: 24 Contractors

1. Abode Services
2. Bay Area Community Services (BACS)
3. Building Futures with Women and Children (BFWC)
4. Building Opportunities for Self-Sufficiency (BOSS)
5. City of Fremont Human Services Department (Fremont Family Resource Center)
6. Cardea
7. Covenant House California
8. East Bay Asian Local Development Corporation (EBALDC)
9. East Bay Innovations (EBI)
10. East Oakland Community Project (EOCP)
11. Five Keys Schools and Programs
12. Fred Finch Youth Center
13. Housing Consortium of the East Bay (HCEB)
14. Insight Housing (formerly BFHP)
15. La Familia Counseling Service
16. Larkin Street Youth Services
17. LifeLong Medical Care
18. Life Skills Training and Educational Programs (LifeSTEPS)
19. Operation Dignity
20. Roots Community Health Center
21. Satellite Affordable Housing Associates (SAHA) Family Services
22. St. Mary's Center
23. Tiburcio Vasquez Health Center, Inc
24. Women's Daytime Drop-in Center (WDDC)

Alameda County Health

Agency	Housing Community Supports: Primary Activities
Alameda Alliance for Health	• Authorizes HCS services for AAH members • Co-designs and co-presents trainings with Alameda County Health (AC Health) • Processes and pays claims submitted by AC Health for eligible services to enrolled members • Contractual oversight of HCS intermediary, convenes in-person CS trainings • Provides clarity and guidance on operational policies & procedures

Alameda County Health	• **Matches clients to contractors using Coordinated Entry prioritization**
	• Vets and onboards new HCS contractors (including credentialing)
	• Provides program and contractor performance oversight
	• Coordinates and prepares comprehensive authorization requests for AAH
	• Manages and reconciles invoicing and claims process with AAH
	  • Extract data from Homeless Management Information System (HMIS)
	  • Ongoing data matching against member eligibility files
	• Disburses payments to contractors for **all eligible clients served** through braided funding, including AAH- authorized services

Providers/ Contractors	• **Build relationships with participants to support in housing journey** • Obtain informed participant consent to enroll • Perform outreach and engagement • **Co-develop individualized Housing Support Plans** • Documentation of services and progress in HMIS

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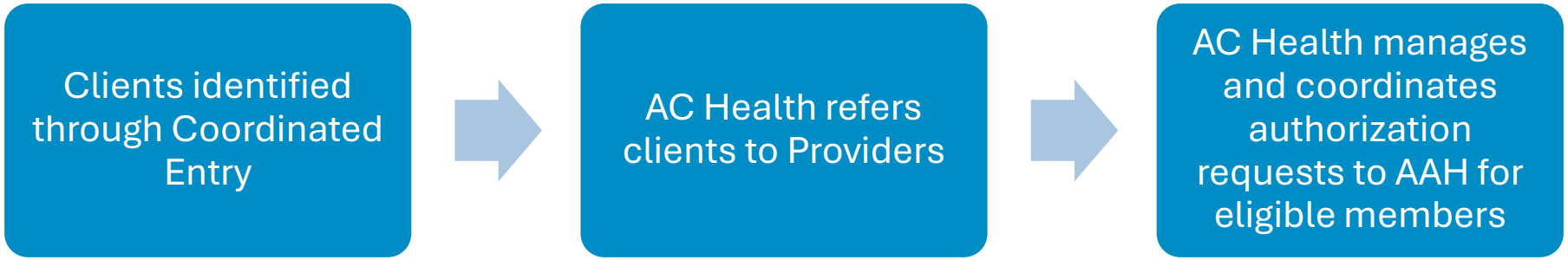
Housing Community Supports Workflow



- AC Health assigns clients prioritized for Housing Community Supports through Coordinated Entry to Housing Providers (regardless of Medi-Cal enrollment)

- Housing providers provide outreach and enrollment and enter data into HMIS
  - Case Notes in HMIS
  - Currently: HSP on paper and TSS extension in HMIS
  - In process: HN and TSS HSP's in HMIS (Pending July 1)

- AC Health extracts new enrollments from HMIS, matches data to MCP eligibility (SHIE) to determine who is enrolled with Alameda Alliance and prepares comprehensive request to AAH for authorizations.

- Currently, Kaiser members who are prioritized through Coordinated Entry are referred to Kaiser to get assigned a Housing provider

Alameda County Health

Lifecycle of the Authorization Process

HSP Developed by Contractor

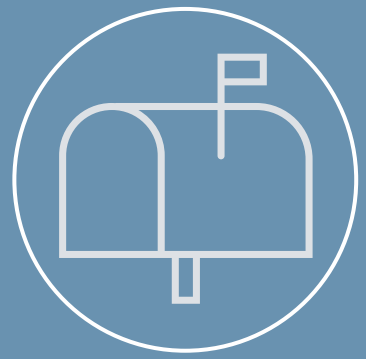
- Contractor documents needs, goals, and services in Housing Support Plan (HSP)
- HSP is submitted to AC Health

Authorization Prepared by AC Health

- AC Health reviews HSP, confirms eligibility, and prepares the full authorization packet
- Includes MCP member status, service type, duration, and rationale

Authorization Submitted to AAH

- AC Health acts on behalf of the network to submit to AAH (MCP)
- Submission includes supporting documentation like HSPs and eligibility checks



AAH Authorization

- MCP reviews, approves denies, or requests more information
- AAH coordinates and provides authorization status files to AC Health

Reauthorization or Extension

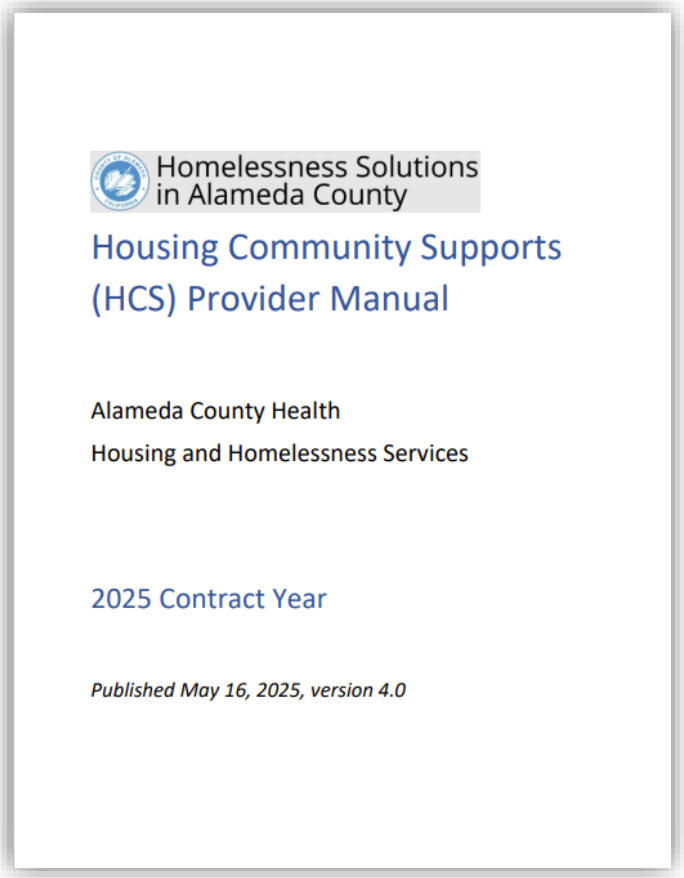
- AC Health monitors eligibility and timelines
- May request updated HSP or other documentation to align with MCP auth and eligibility timelines
  - Triggers repeat of Steps 1-4

Important Reference Documents & links

Alameda County Health
Housing and Homelessness Services

Updated HCS Provider Manual

- Admin Requirements
- Program Policies and Guidelines
- How-To's
- Templates
- Searchable



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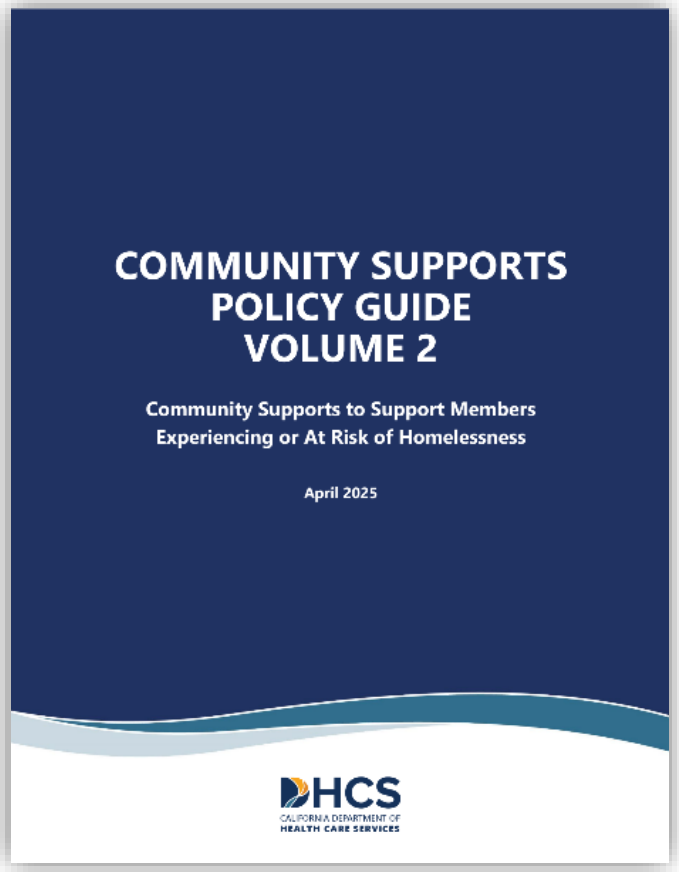


https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide-Volume-2.pdf

From DCHS slide re Volume 2

Housing Support Plans (HSPs)

What are they, what's required, and how are they created?

When is the Housing support plan required?

As an activity under the Housing Trio

To authorize a member for transitional rent*

*Effective January 1, 2026

Housing Support Plan (HSP) process flow

Member enrolled in services (HN or TSS) by contracted provider

30 days

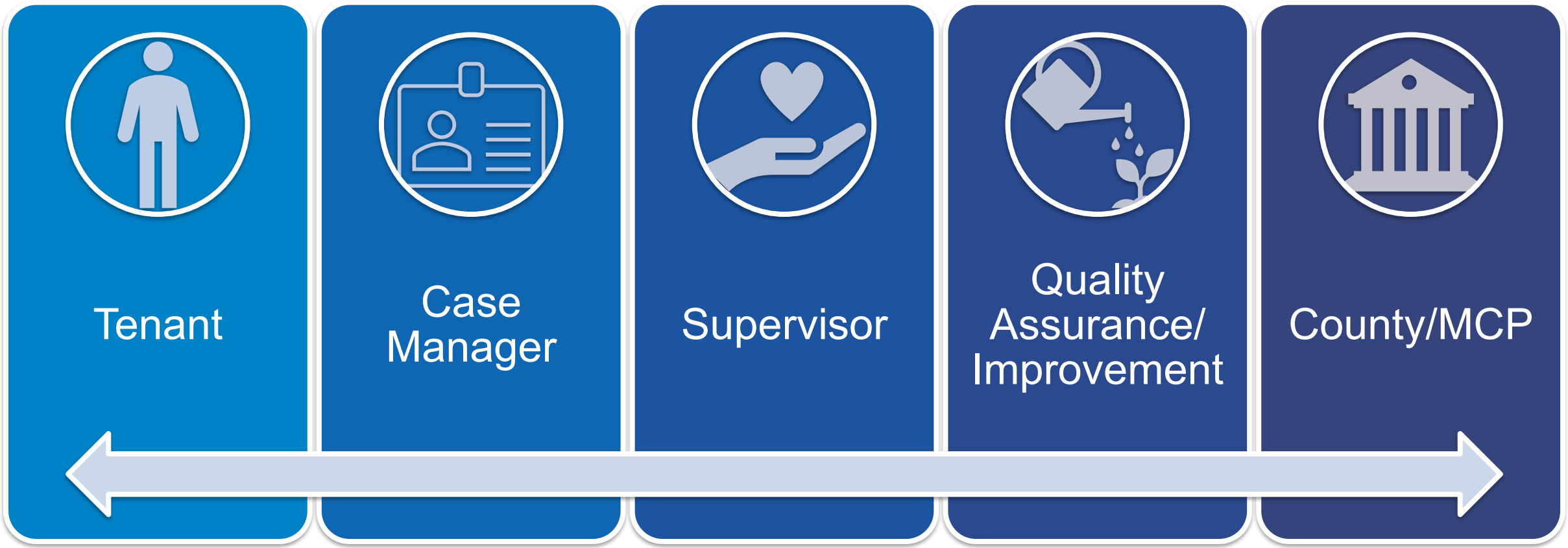
Housing Support Plan due in HMIS

New HSP must be completed at least every 180 days thereafter (TSS 'assessment" is within TSS HSP- no longer separate document)

180 days

Documenting ongoing need for services in the HSP

Who is involved in the documentation process?



Content of a Housing Support Plan (HSP)

1. Identify the **permanent housing strategy and solution** for the client, **including the payment sources**
2. Identify the **full range of permanent housing supports** that will support the client in sustaining tenancy

What does this look like in your work?
How do you identify these and articulate them in the HSP?

Content of a Housing Support Plan (HSP)

3. Be informed by **Member preferences and needs (person-directed/person-centered)**
4. Be based on a **housing assessment**
5. Be developed in a way that is **culturally appropriate and trauma-informed way**

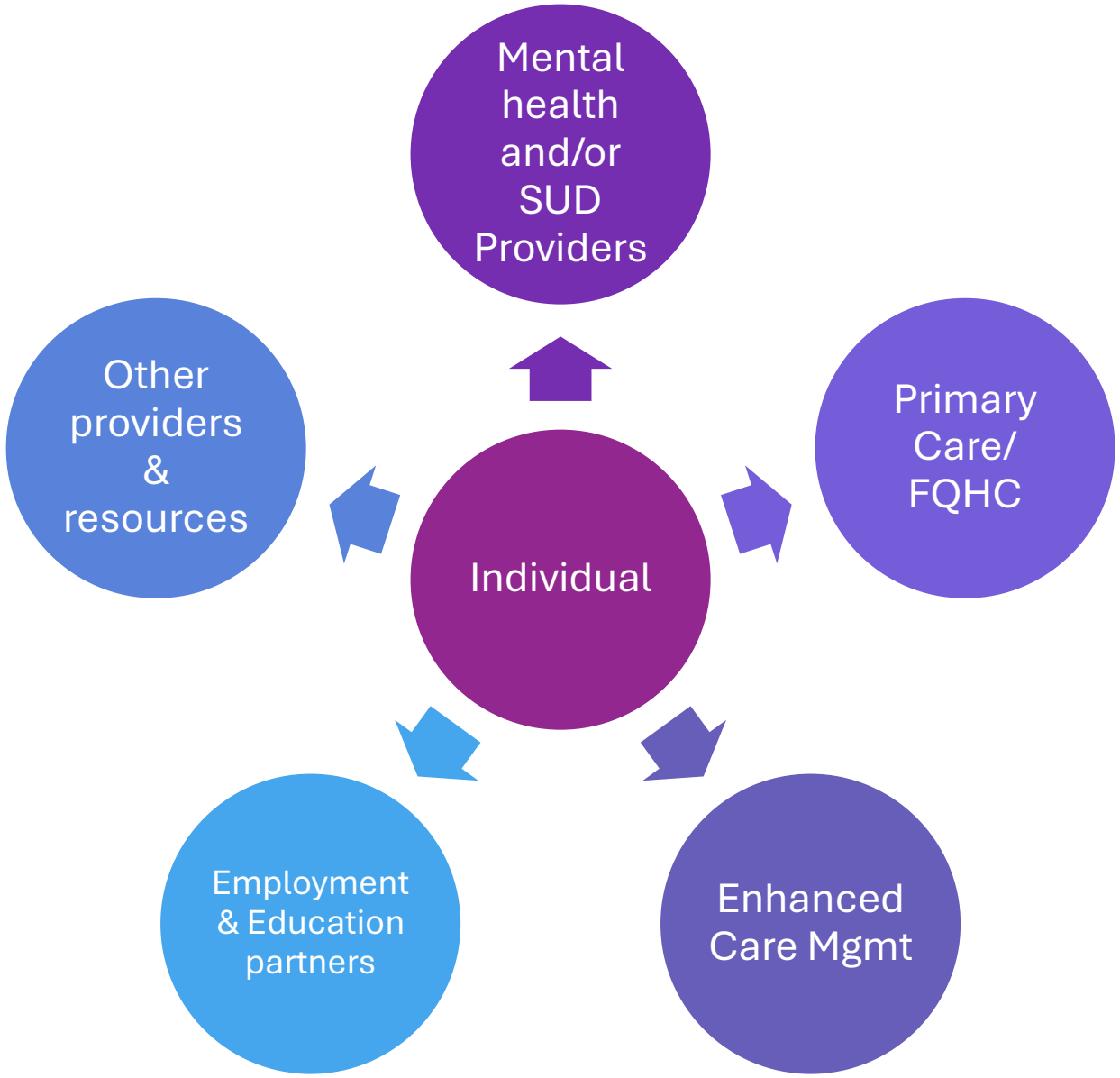
What does this look like in your work?

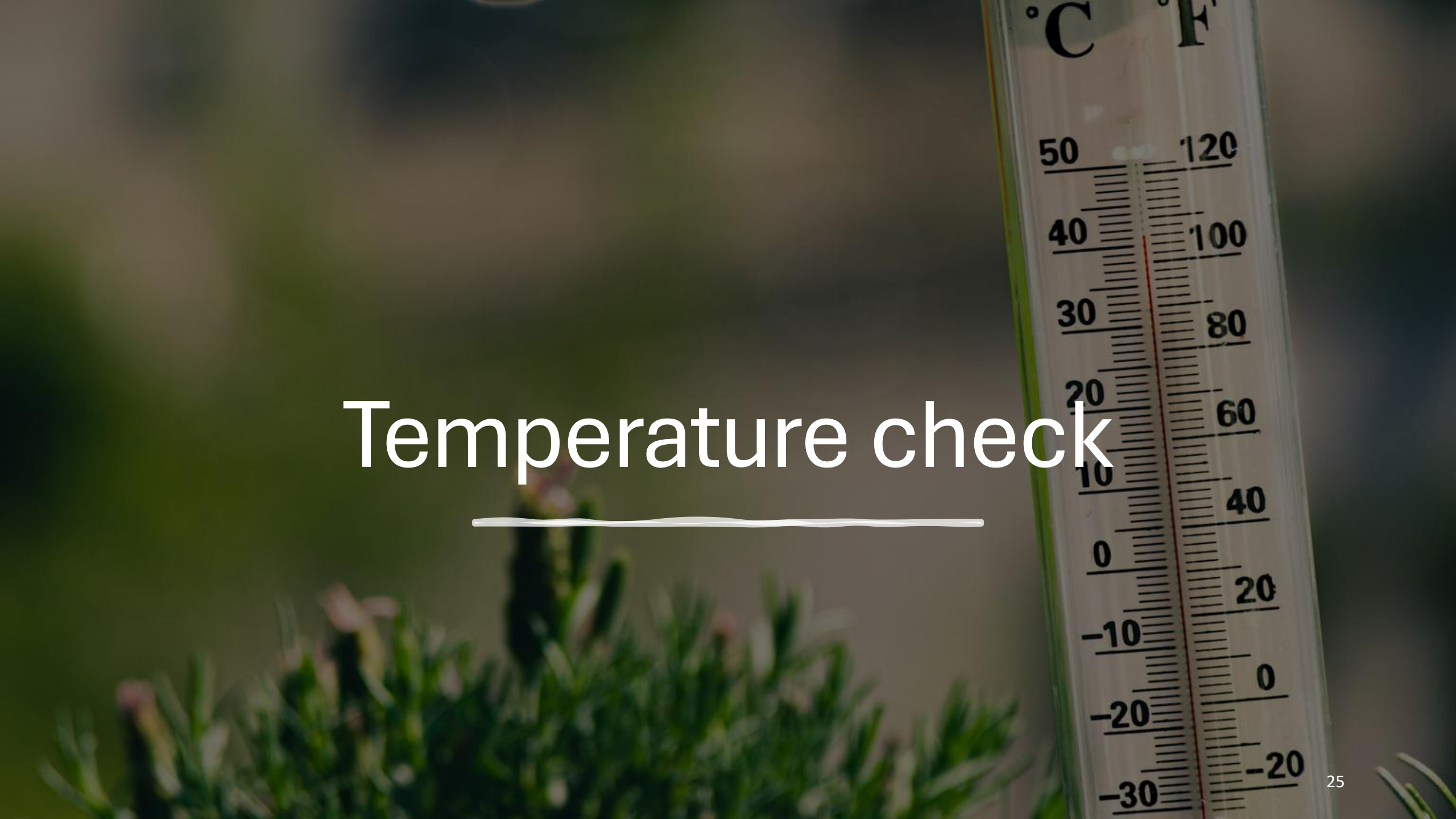
What examples can you share (e.g. what do you ask)?

What kind of information is helpful to gather as you prepare to write a HSP? Who might you want to talk with?

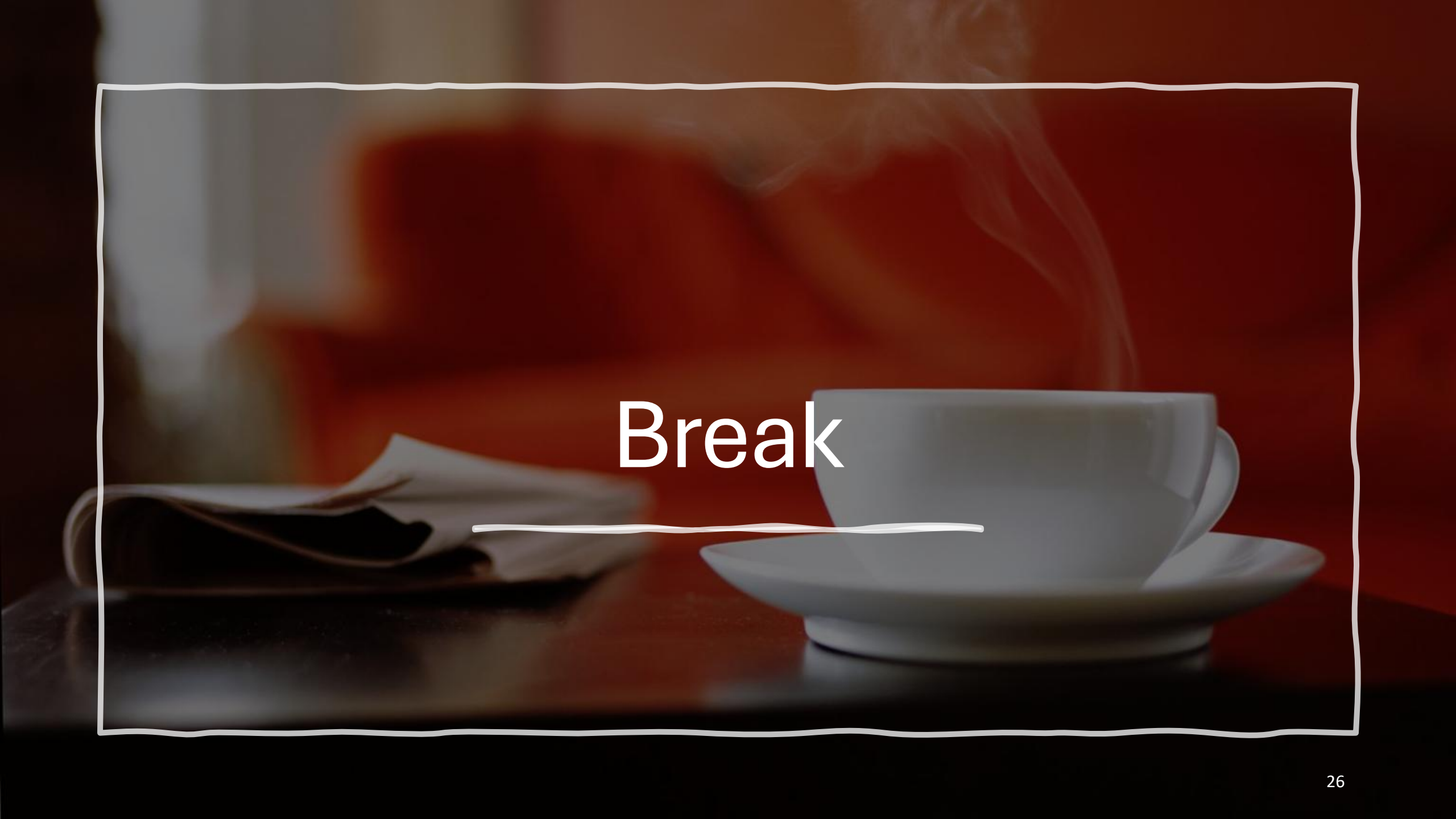
- Primary Care/FQHC
- Mental Health and/or SUD Providers
- ECM (if Member is enrolled)
- Mobile Health and Street Outreach
- Employment and Education partners
- Other providers or organizations supporting the Member

Info Gathering for a Housing Support Plan





Temperature check


Break

Questions?
Reflections?

A quick note on Enhanced Care Management (ECM)…

What is Enhanced Care Management (ECM)?

Provides systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered for Members with the most complex medical and social needs

In **Alameda County**, Housing Community Supports is accessed through the Coordinated Entry system, thus ECM should be a service that participants are referred to for coordination.

Eligibility for ECM

Member must be **enrolled in a MCP**

Member must **meet <u>at least one</u> of the ECM Populations of Focus**

What are the ECM Populations of Focus?

Individuals.

- Experiencing Homelessness
- At Risk for Avoidable Hospital or ED Utilization
- With Serious Mental Health and/or SUD Needs
- Transitioning from Incarceration

Adults/Residents

- Living in the Community and At Risk for LTC Utilization
- In Nursing Facility Transitioning to the Community

Children and Youth:

- Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition
- Involved in Child Welfare

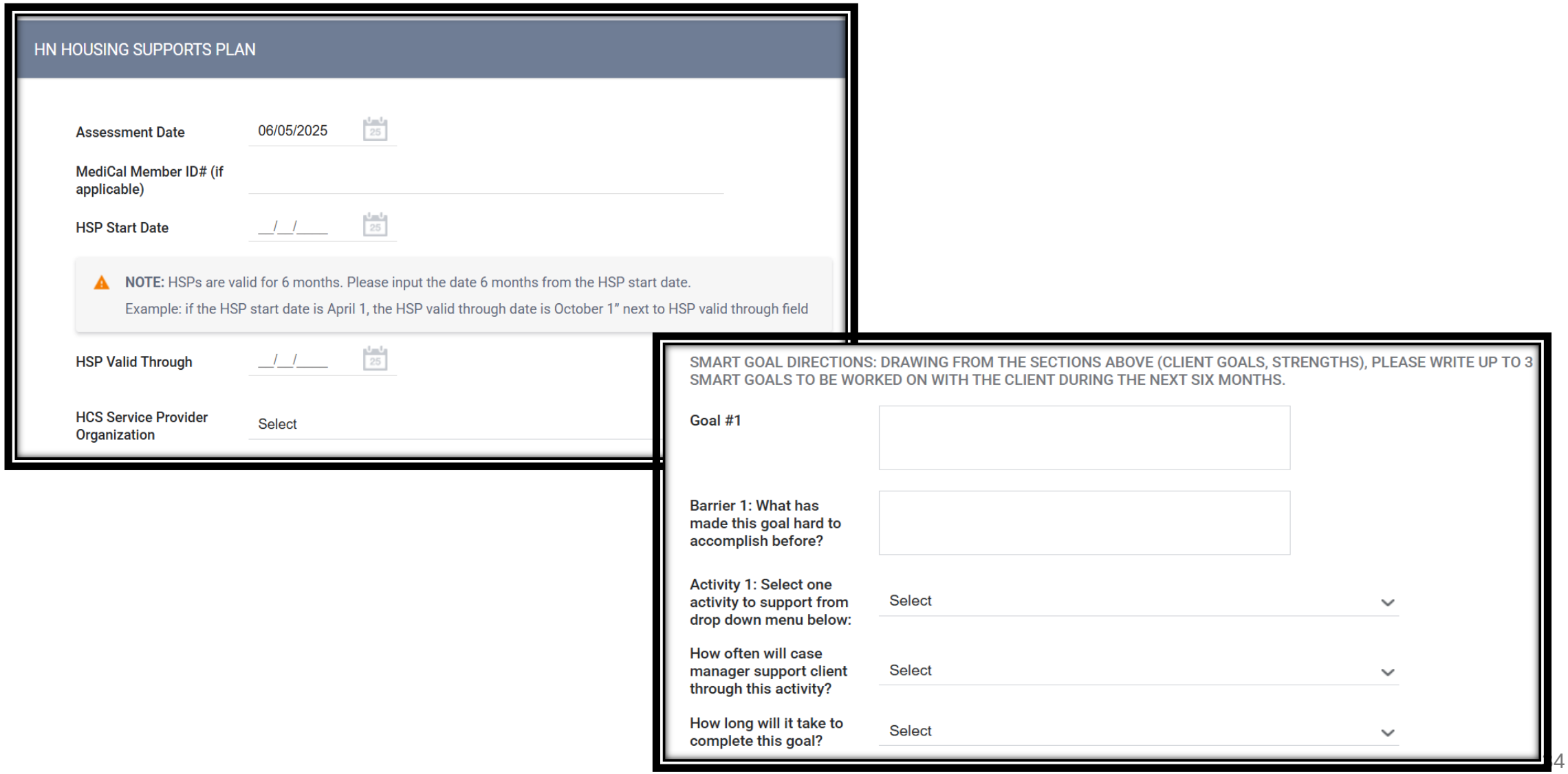
Birth Equity Population of Focus

What are the **COMPONENTS** of Housing Support Plans (HSPs)?

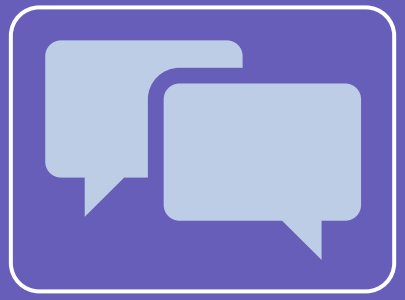
HSP: **a personalized housing road map for an individual**

- Collaborative, developed in partnership with case manager and client and inclusive of client’s desires, preferences, and strengths
- Must include SMART goals, based on the housing assessment- with a goal of meeting the goal within the six-month HSP period
- Updated every 180 days, and revised as a client's situation changes

Screen shots of HSP in HMIS (Alameda Co)



Components of a Housing Support Plan



Client voice included

Individualized Assessment of Need for Ongoing Services

Goals, Activities and Timeline (SMART Goals)

CSH

Including the client voice in HSP

1. What are the client's desires, aspirations, hopes and goals related to their housing?
2. What current resources and client strengths can help in achieving these goals?

What does ongoing engagement look like?

What are SMART Goals?

SMART Goals

S	**Specific**	Define clear objectives, very specific, clear, focused and actionable.
M	**Measurable**	Tracking progress is clear and simple. Name the number of times during a time period an action will happen.
A	**Achievable**	Set realistic expectations that are attainable in the next 6 months.
R	**Relevant**	Aligned with client's values and aspirations, is "person-directed" not just person-centered. Also relevant to their housing stability and life stability.
T	**Timely/Timebound**	Clear timelines for working towards goals and a set timeframe for achieving. The HSP is for 6-months, but not all goals may take 6 months, try to break into smaller (achievable) goals.

What works for SMART goals?

What helps you craft high-quality smart goals?

What types of feedback can help you improve SMART goals in the future?

Do you follow a formula?

SMART Goals - Examples

NOT IN SMART GOAL FORMAT ☹	SMART! ✓ *Frequency* ✓ *Timeframe* ✓ *Detailed activities*
Meet with case manager to get document ready for housing.	Meet with housing navigator for a minimum of 30 mins, 2x a week for 3 months: to work on getting identification, filling out housing applications and subsidy documents.
Will do applications.	Fill out and complete three housing applications with case manager every month for six months, including submission of application.
Will work on skill building in unit.	Will meet with case manager weekly for a month to do laundry together so I can make sure I know all the steps, including getting funds to pay, have supplies on hand (e.g. detergent) and monitoring the time in the washer and dryer so I know when to switch over and collect dry clothes when done.

SMART Goals – *Live Examples / Menti*

NOT IN SMART GOAL FORMAT ☹	SMART! ✓ *Frequency* ✓ *Timeframe* ✓ *Detailed activities*
Will outreach client in housing.	

SMART Goals - DISCUSSION

What helps?

Tips & Tricks

What’s challenging?

Other Tools?

Brainstorming with colleagues and supervisors

Housing Support Plans: *Challenges & Solutions*

Have the HSP be a form built into HMIS and not a separate form to upload a pdf

Solution: THIS IS UNDERWAY; Will go-live in July!

AND no longer two separate forms for HSP and TSS

Client signature requirement

Solution: When the HSP build-out in HMIS goes live, no longer required, just an attestation by staff

30-day Requirement to complete 1st Housing Support Plan*

Solutions: Getting ROI's & use collateral information, CHR, probing questions using Motivational Interviewing, assertive engagement

**This is a requirement and is not flexible*

Housing Support Plans: *Challenges & Solutions* (con't)

Ensuring the HSP is a living, breathing document that is updated regularly

Solution: Build in checkpoints (e.g. post-crisis, post move, a new service enrollment or exit, etc.)

Complex health populations

Solution: care coordination, use partnerships

Connecting SMART goals to progress notes to demonstrate progress AND ongoing eligibility

Solution: next slide…

Documenting Need for Services (Medical Necessity)

Client needs the service based on HSP needs assessment

Clear connection of HSP goals to the needs assessment

Writer must explain the rationale and “tell the story” of why writer’s assistance will be of help

Reader must understand the service rationale

Progress notes are tied to HSP goals

Type and frequency of services is appropriate to interventions and goals

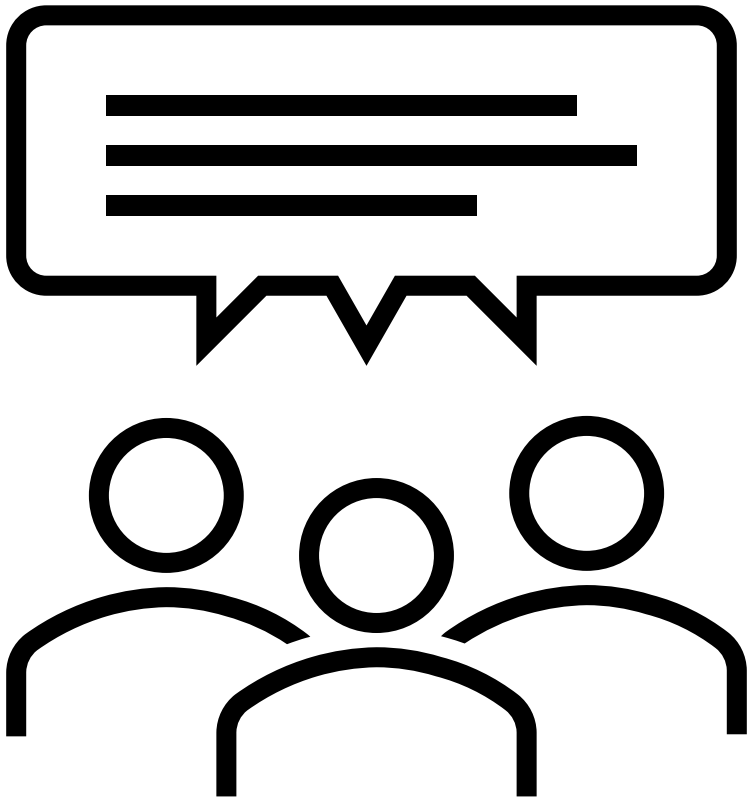
What to avoid?

Top reasons a HSP could be denied by funders:

- Copy and paste from one client to another, not individualized
- Having the same HSP at 30 days and 180 days without changes
- Not enough detail overall
- Stating a problem without the strategy to address it
- Lacking SMART goals
- Unable to demonstrate progress towards goals while also demonstrating ongoing eligibility

Next Steps

- Ongoing support needs
- Updated resource page from Alameda County on the website
- Office Hours hosted by Alameda County Housing & Homelessness Services



Thank you!

csh.org