System Performance Committee (SPC) Meeting Agenda
Thursday, July 28th, 2022 ‖ 9:00 AM – 11:00 AM

SACRAMENTO STEPS FORWARD
Ending Homelessness. Starting Fresh.

Zoom Meeting || **Meeting ID:** 834 1484 2046 || **Passcode**: 087264

One tap mobile +16694449171,,83414842046#,,,,*087264# US (Sacramento)
Dial by your location: +1 669 900 9128 US (Sacramento)
Find your local number here.

Agenda Item	Presenter(s):	Time	Item Type
I. Welcome/Introductions	Lisa Bates & Stefan Heisler, SPC Co-Chairs	9:00 AM (5 minutes)	Informational
II. Approval of 5/26/22 Meeting Minutes	Stefan Heisler	9:05 AM (5 minutes)	Action
III. Announcements: (Upcoming Events & Recent Actions)	SPC Co-Chairs, SPC Members, SSF Staff, & Guests	9:10 AM (5 minutes)	Informational
IV. 2022 Unsheltered Special NOFO Discussion	Michele Watts, SSF Chief Planning Officer	9:15 AM (10 minutes)	Informational
V. GAPS Analysis Updates	Tom Albanese, Consultant	9:25 AM (35 minutes)	Informational
VI. Cal-AIM HHIP Community Investments	Lisa Bates & Managed Care Partners	10:00 AM (60 minutes)	Informational
VII. Meeting Adjourned **Next SPC Meeting: Thursday, Aug. 25, 2022 from 9:00 AM - 11:00 AM**			

For any questions or concerns, please contact Jesse Archer, CoC Analyst, Sacramento Steps Forward.

System Performance Committee (SPC) Meeting Minutes

Thursday, May 26th, 2022 ‖ 9:00 AM – 11:00 AM

SACRAMENTO STEPS FORWARD

Ending Homelessness. Starting Fresh.

Recording of Zoom Meeting. The chat is below the minutes.

Attendance:

Member	Area of Representation	Present
Amani Sawires Rapaski	Substance Abuse & Housing Programs	No
Avery Holland	Service Provider	No
Cheyenne Caraway	Housing Authority	Yes
Danielle Foster	Local Government	Yes
Dawn Basciano	State Government	Yes
Emily Halcon	Local Government	Yes
Erin Johansen	Mental Health	No
Gina Roberson	Domestic Violence	Yes
Lisa Bates, Co-Chair	Lead Agency	Yes
Lorraine Wilkins	Education & Service Provider	Yes
Mike Jaske	Faith Community Advocate	Yes
Monica Rocha-Wyatt	Mental Health	No
Rebecca Sterling	Service Provider	No
Sanford Robinson	Veterans	Yes

If you have any questions or would like more information about this meeting, contact Scott Clark with Sacramento Steps Forward at sclark@sacstepsforward.org.

Sher Singh	DEI Chair	No
Stefan Heisler, Co-Chair	City of Rancho Cordova	No
Tahirh Kraft	Service Provider	Yes

SSF Staff	SSF Title
Christina Heredia	Referral Specialist
Jillyan McKinney	Racial Equity Specialist
Jesse Archer	CoC Analyst
Josh Lowy	Programmer Analyst
Kaylin Jones	CoC Project Coordinator
Lisa Bates	Chief Executive Officer
Michelle Watts	Chief Planning Officer
Peter Bell	CE Manager
Scott Clark	Portfolio and Team Excellence Lead
Tanesha Travis	PLE Coordinator
Theresa Bible	Outreach Navigator – Meadowview
Ya-yin Isle	Chief Strategic Initiatives Officer

Racial Equity Committee Member Liaison
Bo Cassell, Dawn Basciano

Guests

Anglea Drake, Bo Cassell, Brandon Wirth, Cedric's Iphone, EllisCe, Joseph Smith, Josh Arnold, Lori Eastwood, Tom Albanese,

Agenda Item	Presenter(s):	Time	Item Type
I. Welcome & Introductions	Lisa Bates, SSF Chief Executive Officer (Co-Chair)	9:00 AM (5 minutes)	Information
Co-Chair Lisa Bates called the meeting to order at 9:02, after quorum was achieved and welcomed those attending the meeting.			
II. Approval of 4/14/22 Meeting Minutes	Lisa Bates	9:05 AM (5 minutes)	Action
Lisa Bates asked for a motion to approve the April 14, 2022 minutes. ***Action***: Motion/Second Tahrih Kraft/Mike Jaske to approve the April meeting minutes as written. Action approved.			
III. Announcements (Upcoming Events & Recent Actions)	SPC Co-Chairs, SPC Members, Guests	9:10 AM (5 minutes)	Information
- Lisa Bates mentioned they were still deliberating on whether the full CoC meeting will be June 1 (special date, 1 week early) or June 8 (regular date). - Danielle Foster mentioned The City of Sacramento is preparing a Request for Proposals to identify partner agencies that can assist the City with anti-displacement programming around the UC Davis Aggie Square development on Stockton Boulevard. Programming may include things like home repair assistance, homelessness prevention, first-time homebuyer loans, and other similar efforts.			
IV. 100 Day Encampment Challenge Outcomes	Rolf Davidson, SSF, Director of Programs, Theresa	9:15 AM (20 minutes)	Information

	Bible, SSF, Outreach Navigator		

Theresa Bible shared her experience on the 100 Day Challenge as a Team Lead. The goal was that during the 100 days they would safely and stably house 43 individuals and that they would connect 43 individuals to a pathway to housing.

While the team did not meet their housing goals, they did accomplish the following:

- The group created a by name list to share with all on the team, as a live document.
- They had dedicated team members.

The powerpoint presentation is available here. Questions were asked, please see chat and recording for more information.

V. 2022 Gaps Analysis & HHAP-3 Action Plan	Ya-yin Isle, Chief Strategic Initiatives Officer, Tom Albanese, Consultant	9:35 AM (60 minutes)	Information & Discussion

- Ya Yin shared the Local Homelessness Action Plan, including strategies and the data planned for the state HHAP-3 application due at the end of June.
- Consultant Tom Albanese recapped the process to date for creation of the gaps analysis and to find the top level estimate of people that experience literal homelessness. His team is working on a gaps analysis workbook that will allow SSF staff to replicate his process for future gaps analyses.
- Tom's presentation provided information on the elements of the analysis, a summary table and key takeaways.

The powerpoint presentation is available here. Questions were asked, please see the recording and chat for more information.

VI. HUD FY2021 CoC NOFO core Debrief	Michele Watts, SSF, Chief Planning Officer	10:35 AM (15 minutes)	Information & Discussion

Michele Watts gave a broad update on the 2021 competition HUD CoC Application scoring debrief. The Sacramento CoC's scores were near the top of all CoC scores, showing tremendous improvement likely due to local efforts like the gaps analysis, coordinated entry evaluation, and racial equity action plan. It's clear what areas points were lost on and the team intends to work to strengthen those responses. SSF and Homebase will return to the SPC in June with a broader presentation on the 2021 competition CoC Application scores. The 2021 HUD CoC Application scoring debrief is available here.			
VII. Community Updates on Issues Impacting System Performance	SPC Members	10:50 AM (10 minutes)	Information & Discussion
No announcements were made			
VII. Meeting Adjourned at 10:35 AM. **Next SPC Meeting: Thursday, June 23 from 9:00am to 11:00am**			

SPC Meeting Chat

09:04:35 From Sacramento Steps Forward to Everyone: Approve April meeting minutes

09:04:40 From Danielle Foster to Everyone: Danielle abstains--was absent

09:04:40 From Emily Halcon to Everyone: Yes

09:04:40 From Lisa Bates (She/Her) - SSF to Everyone: Aye

09:04:42 From Cheyenne Caraway to Everyone: yes

09:04:44 From Tahirih Kraft, Sacramento Self-Help Housing to Everyone: yes

09:04:52 From GINA Roberson (she/hers) WEAVE to Everyone: yes

09:04:56 From Dawn Basciano to Everyone: Approve

09:07:41 From Jillyan Sylvia McKinney (she/her) SSF, Racial Equity Specialist to Everyone: Hi Bo, welcome to the space

09:08:39 From Dawn Basciano to Everyone: Wrlcome Bo

09:08:43 From Danielle Foster to Everyone: Here is the link for registering to receive information about contracting opportunities with the City of Sacramento- http://www.cityofsacramento.org/finance/procurement/bid-information

09:26:39 From Jillyan Sylvia McKinney (she/her) SSF, Racial Equity Specialist to Everyone: Theresa, this is such an amazing presentation. Thank you so much for your love and commitment to this project.

09:26:58 From Tahirih Kraft, Sacramento Self-Help Housing to Everyone: Theresa, Great Job Thank You

09:27:29 From Jesse SSF, CoC Analyst to Everyone: Thanks Theresa for sharing!

09:27:37 From Christina H SSF Referral Specialist (she, her) to Everyone: Amazing Theresa! Great Job!

09:27:44 From Lori Easterwood (she/her) Folsom to Everyone: Thanks, Theresa!

09:32:03 From Danielle Foster to Everyone: Troy is AWESOME!

09:34:26 From Danielle Foster to Everyone: Thanks Theresa!! Great insights and information

09:35:41 From Tanesha Travis to Everyone: awesome job and presentation theresa!

09:42:23 From GINA Roberson (she/hers) WEAVE to Everyone: is this information available to us?

09:45:41 From Angela Drake to Everyone: Very helpful to have the health info

09:58:37 From Cheyenne Caraway to Everyone: Im sorry all I have to jump off for another meeting

10:06:03 From Lisa Bates (She/Her) - SSF to Everyone: brb

10:14:58 From Emily Halcon to Everyone: Yes, HSP = Housing Support Program

10:16:50 From Danielle Foster to Everyone: thanks for these key takeaways, Tom

10:31:48 From Peter Bell (he/him) to Everyone: Wow, really well done!

10:33:27 From Tahirih Kraft, Sacramento Self-Help Housing to Everyone: That is great news

10:35:13 From Jesse SSF, CoC Analyst to Everyone: Thanks all!

Unsheltered Special NOFO Presentation

Sacramento CoC Board- July 13, 2022

SACRAMENTO STEPS FORWARD

Special NOFO Opportunity & Local Response Process & Timeline

- Special NOFO Opportunity **DUE OCT. 20, 2022**
- Intent of Funding and Funds Available to the Sacramento CoC
- Eligible Projects & Project Applicants
- Criteria
- Proposed Local Response Process & Timeline

SACRAMENTO STEPS FORWARD

Special NOFO Opportunity

SACRAMENTO
STEPS FORWARD

Special NOFO Opportunity

Intent of Funding

- Designed to support communities in their efforts to reduce unsheltered homelessness with efforts informed by recent evidence that people who are unsheltered experience significantly greater health challenges, trauma, and violence than their sheltered peers
- Serving individuals and families experiencing homelessness with severe service needs

SACRAMENTO STEPS FORWARD

Special NOFO Opportunity

Funds Available to the Sacramento CoC

- Unsheltered Homelessness Set-Aside: up to $10,636,073 over 3 years (renewable on annual basis thereafter)
- Rural Homelessness Set-Aside: $0 (Sacramento CoC is not eligible for the Rural Set-Aside)

SACRAMENTO
STEPS FORWARD

Special NOFO Opportunity

Eligible Project Types

- Permanent Housing Projects: Permanent Supportive Housing, Rapid Rehousing, and Joint Transitional Housing and Rapid Rehousing
- HMIS
- Supportive Services Only
- CoC Planning

SACRAMENTO STEPS FORWARD

Special NOFO Opportunity

Eligible Applicants

- CoC Collaborative Applicant submits the Special NOFO Consolidated Application & is eligible to submit a Planning Grant Project Application
- CoC HMIS Lead Agency is eligible to submit a HMIS Project Application
- Nonprofits, Housing Authorities, Local Government, Tribal Jurisdictions are eligible to submit Permanent Housing and SSO Project Applications

SACRAMENTO
STEPS FORWARD

Special NOFO Opportunity

Criteria- **100 points**

- Project Capacity, Review, and Ranking (4 points); System Performance (18 points); CoC Coordination and Engagement (8 points) - (**30 points**)
- CoC Plan for Serving Individuals and Families with Severe Service Needs (**70 points**)
- Bonus Points based on Sacramento's 2019 Unsheltered PIT (**10 points**)

SACRAMENTO
STEPS FORWARD

Special NOFO Opportunity

CoC Plan for Serving Individuals and Families Experiencing Homelessness with Severe Service Needs

- 15-page narrative
- Leverage housing and healthcare resources; strategy to identify, shelter, and house people who are unsheltered and use performance data to inform strategy updates; prioritize unsheltered households
- Involve individuals with lived expertise in decision-making

SACRAMENTO STEPS FORWARD

Local Response Process & Timeline

SACRAMENTO STEPS FORWARD

Local Response Process & Timeline

Consolidated Application Due October 20, 2022

- Expect to complete special NOFO concurrently with regular NOFO
- Develop Plan for Individuals and Families Experiencing Homelessness with Severe Service Needs
- Projects must demonstrate how they support plan implementation and priorities

SACRAMENTO STEPS FORWARD

Local Response Process & Timeline

Consolidated Application cont.

- Project Review and Ranking requirement similar to regular NOFO
- Engagement of Persons with Lived Expertise in Decision-Making

SACRAMENTO
STEPS FORWARD

Local Response Process & Timeline

- JULY- Prepare Plan for Individuals and Families Experiencing Homelessness with Severe Service Needs
- AUGUST- CoC Board approval of priorities and plan & preparation of application materials by providers
- SEPTEMBER- Panel review and ranking of applications
- OCTOBER- Approve final ranked list and submit to HUD by 10/20/22

SACRAMENTO STEPS FORWARD

Local Response Process & Timeline

JULY Plan Preparation- Detail

- Brief CoC Board & All Committees on Funding Opportunity
- Recruit and convene Persons with Lived Expertise (PLE) Workgroup (via HUD REQ & Coordinated Entry TA CORE Team & REQ Committee)
- SSF Staff & Consultants Prepare Plan Content for Input
- Consult PLE Workgroup, REQC, PRC, Exec Committee on proposed plan

SACRAMENTO STEPS FORWARD

Local Response Process & Timeline

- Provide Additional Opportunities for Input
- Prepare Potential Applicants for Competition Following CoC Board Approval of Plan
- Present Plan for Approval at August 10, 2022 CoC Board Meeting

SACRAMENTO STEPS FORWARD

Gaps Analysis: Final Estimates

PIT Population Estimates

2019

- 5,561 total
  - 1,661 sheltered
  - 3,900 unsheltered
- 40% unsheltered adults indicated one or more disabilities impairing ability to secure employment or housing
- 30% chronic (1,647 people)

2022

- 9,278 total
  - 2,614 sheltered
  - 6,664 unsheltered
- 58% unsheltered adults indicated one or more disabilities impairing ability to secure employment or housing
- 48% chronic homeless (4,314 people)
- Fewer newly homeless likely due to eviction protections and additional rental assistance – expect newly homeless numbers to increase

SACRAMENTO STEPS FORWARD

Gaps Analysis: Final Estimates

Annual *Population* Estimates

Preliminary (based on 2019 PIT)

- ***16,500-20,000 people annually experience literal homelessness***
  - Applied extrapolation method selected by SPC (4/14/2022): Multiply 2019 PIT by 3, then deduct for CY2021 estimate of sheltered individuals
    - 17,355 total people
    - 9,557 sheltered
    - 7,798 unsheltered (not otherwise included in annual shelter estimate to determined unduplicated annual total)
  - Range of -5% and +15% applied to annual estimate of 17,355 to reflect likely higher estimate pending PIT
  - 24% chronically homeless adults

Updated (based on 2022 PIT)

- ***Overall, no change to estimated range: 16,500-20,000 people annually experience literal homelessness***
  - Applied modified extrapolation factor (1.5) for unsheltered consistent with PIT methodology and findings
    - **19,553 total people (+2,198, +12.7%) – within original estimated range**
    - 9,557 sheltered
    - **9,996 unsheltered (+2,198)**
  - **36% chronically homeless adults**

SACRAMENTO STEPS FORWARD

Gaps Analysis: Final Estimates

Annual *Prevention/Crisis/Rehousing Service Needs* Estimates

- ***Prevention, diversion, outreach, shelter, rehousing assistance: no change***
  - Current estimates assume high need for/use of all service types and higher rates of newly homeless similar to pre-pandemic, as pandemic relief wanes and market conditions continue to worsen for low wealth/income households.
  - Newly homeless rates should be re-examined prior to next PIT count

- ***Permanent supportive housing and other dedicated permanent housing assistance with ongoing services: updated***
  - Disability rates and chronicity substantially increased
  - PSH: for chronically homeless
  - Other dedicated PH with services: for non-chronic, disabled
  - **Prior PSH Units Estimate: 5,900 to 7,100 units (for all current/new chronically homeless over 5 yrs; -5%/+10%)**
  - **Updated PSH Units Estimate: 7,100 to 8,600 units (for all current/new chronically homeless over next 5 yrs; -10%/+10%)**
    - Estimate additional 1,500 chronically homeless individuals and small number of chronically homeless families need PSH currently
    - Assumes approximately 170 people will "age in to" chronic homelessness each year (lower relative to PIT trends, but assumes significant new investments over 5 years in crisis and rehousing services)
  - ***No change*: Other PH w/Services Estimate: 1,600 to 2,000 annual placements**
    - Assumes continued high need for affordable/service-supported housing placements other than PSH

SACRAMENTO STEPS FORWARD

Gaps Analysis: Final Estimates

Annual *Prevention/Crisis/Rehousing Service Needs* Estimates

- ***Prevention, diversion, outreach, shelter, rehousing assistance: no change***
  - Current estimates assume high need for/use of all service types and higher rates of newly homeless similar to pre-pandemic, as pandemic relief wanes and market conditions continue to worsen for low wealth/income households.
  - Newly homeless rates should be re-examined prior to next PIT count

- ***Permanent supportive housing and other dedicated permanent housing assistance with ongoing services: updated***
  - Disability rates and chronicity substantially increased
  - PSH: for chronically homeless
  - Other dedicated PH with services: for non-chronic, disabled
  - **Prior PSH Units Estimate: 5,900 to 7,100 units (for all current/new chronically homeless over 5 yrs; -5%/+10%)**
  - **Updated PSH Units Estimate: 7,100 to 8,600 units (for all current/new chronically homeless over next 5 yrs; -10%/+10%)**
    - Estimate additional 1,500 chronically homeless individuals and small number of chronically homeless families need PSH currently
    - Assumes approximately 170 people will "age in to" chronic homelessness each year (lower relative to PIT trends, but assumes significant new investments over 5 years in crisis and rehousing services)
  - ***No change*: Other PH w/Services Estimate: 1,600 to 2,000 annual placements**
    - Assumes continued high need for affordable/service-supported housing placements other than PSH

SACRAMENTO STEPS FORWARD

Gaps Analysis: Final Estimates

Estimated Annual Prevention and Homeless Assistance Needs (updated based on 2022 PIT Count)

FUTURE STATE ESTIMATES: Based on need (not current capacity); assumes services are available, accessible, welcoming, and generally utilized ***except*** for small estimated number expected to not engage in any assistance (~9%)

Assistance Type (among those using the system)	**Individuals (12,010)**	**Family Households (1,184)**	**Estimated Total System Capacity NEED**	**Estimated Total System Capacity GAP** (additional capacity needed)
Targeted Homelessness Prevention (including one-time and short-term prevention assistance for highest risk)	~ 36% (3,200 individuals)	~ 38% (350 families)	~ 16 Full-Time Equivalent (FTE) staff @ 20 cases/FTE ≥ $11.3M Annual Financial Assistance (above current levels)	~ 16 Full-Time Equivalent (FTE) staff @ 20 cases/FTE ≥ $11.3M Annual Financial Assistance (above current levels)
Among those not prevented...				
Diversion (including housing problem-solving and diversion provided through Coordinated Access System)	100% (6,500 individuals)	100% (700 families)	Estimated FTEs and financial assistance costs pending implementation of new Coordinated Access System and further analysis of baseline need.	Pending further analysis of needed capacity. *There is little diversion assistance currently available.*
Among those not diverted...				
Street Outreach (providing individualized engagement and connection to shelter, rehousing assistance, other services)	~ 55% (4,700 individuals)	~ 36% (300 families)	~ 21 FTEs @ 40 cases/FTE	Pending further analysis of current and planned capacity.
Temporary Housing (emergency shelter, transitional housing, interim housing)	~ 90% (7,800 individuals)	~ 98% (700 families)	IND: 2,200 to 2,700 beds FAM: 300 to 350 units	Near-term: pending further analysis of current capacity Future: -0- gap for families assuming fully developed prevention, rehousing assistance. TBD singles pending further analysis.
Short/Medium-Term Rehousing Assistance (including rapid rehousing, other individualized rehousing assistance)	~ 64% (5,600 individuals)	~ 66% (500 families)	IND: 2,800 to 3,400 case slots (avg daily active cases) FAM: 250 to 320 case slots ~ 150 FTEs @ 22 cases/FTE ≥ $18M Annual Financial Assistance	COMBINED: 600-750 case slots ~ 29 FTEs @ 22 cases/FTE ≥ $3.6M Annual Financial Assistance
Permanent Supportive Housing and other Dedicated Permanent Housing Assistance with Ongoing Services	~ 34% (3,000 individuals annually, plus 1,500 current CH)	~ 18% (130 families)	PSH Units COMBINED: 7,100 to 8,600 units/vouchers (for all current/new chronic) Other PH w/Services COMBINED: 1,600 to 2,000 annual placements (for non-chronic, disabled)	PSH Units/Vouchers COMBINED: 4,100 to 5,000 units Other PH w/Services COMBINED: 1,600 to 2,000 annual placements

Gaps Analysis: Final Estimates

Estimated Annual Prevention and Homeless Assistance Needs (updated based on 2022 PIT Count)

FUTURE STATE ESTIMATES: Based on need (not current capacity); assumes services are available, accessible, welcoming, and generally utilized ***except*** for small estimated number expected to not engage in any assistance (~9%)

Assistance Type (among those using the system)	Individuals (12,010)	Family Households (1,184)	Adults with Self-Reported BH Conditions	
			Adults in Individual HHs	Adults in Family HHs
Targeted Homelessness Prevention (including one-time and short-term prevention assistance for highest risk)	~ 36% (3,200 individuals)	~ 38% (350 families)	*64% (2,048 adults)*	*40% (182 adults)*
Among those not prevented...				
Diversion (including housing problem-solving and diversion provided through Coordinated Access System)	100% (6,500 individuals)	100% (700 families)	*64% (4,160 adults)*	*40% (364 adults)*
Among those not diverted...				
Street Outreach (providing individualized engagement and connection to shelter, rehousing assistance, other services)	~ 55% (4,700 individuals)	~ 36% (300 families)	*75% (3,525 adults)*	*63% (246 adults)*
Temporary Housing (emergency shelter, transitional housing, interim housing)	~ 90% (7,800 individuals)	~ 98% (700 families)	*65% (5,070 adults)*	*43% (391 adults)*
Short/Medium-Term Rehousing Assistance (including rapid rehousing, other individualized rehousing assistance)	~ 64% (5,600 individuals)	~ 66% (500 families)	*64% (3,584 adults)*	*40% (260 adults)*
Permanent Supportive Housing and other Dedicated Permanent Housing Assistance with Ongoing Services	~ 34% (3,000 individuals annually, plus 1,500 current CH)	~ 18% (130 families)	*88% (3,960 adults)*	*68% (115 adults)*

Gaps Analysis: Example Multi-Year System Development Plan

DHCS Housing and Homelessness Incentive Program (HHIP)

Program Updates for Sacramento CoC System Performance Committee

July 28, 2022

aetna℠ Anthem BlueCross health net KAISER PERMANENTE® MOLINA HEALTHCARE®

HHIP High-Level Overview

HHIP Background & Overview

Housing and Homelessness Incentive Program (HHIP)* is a voluntary Medi-Cal Managed Care Plan (MCP) Incentive Program that aims to improve health outcomes and access to whole person care services by addressing housing insecurity and instability as social determinants of health for the Medi-Cal population.

DHCS' HHIP program goals include:

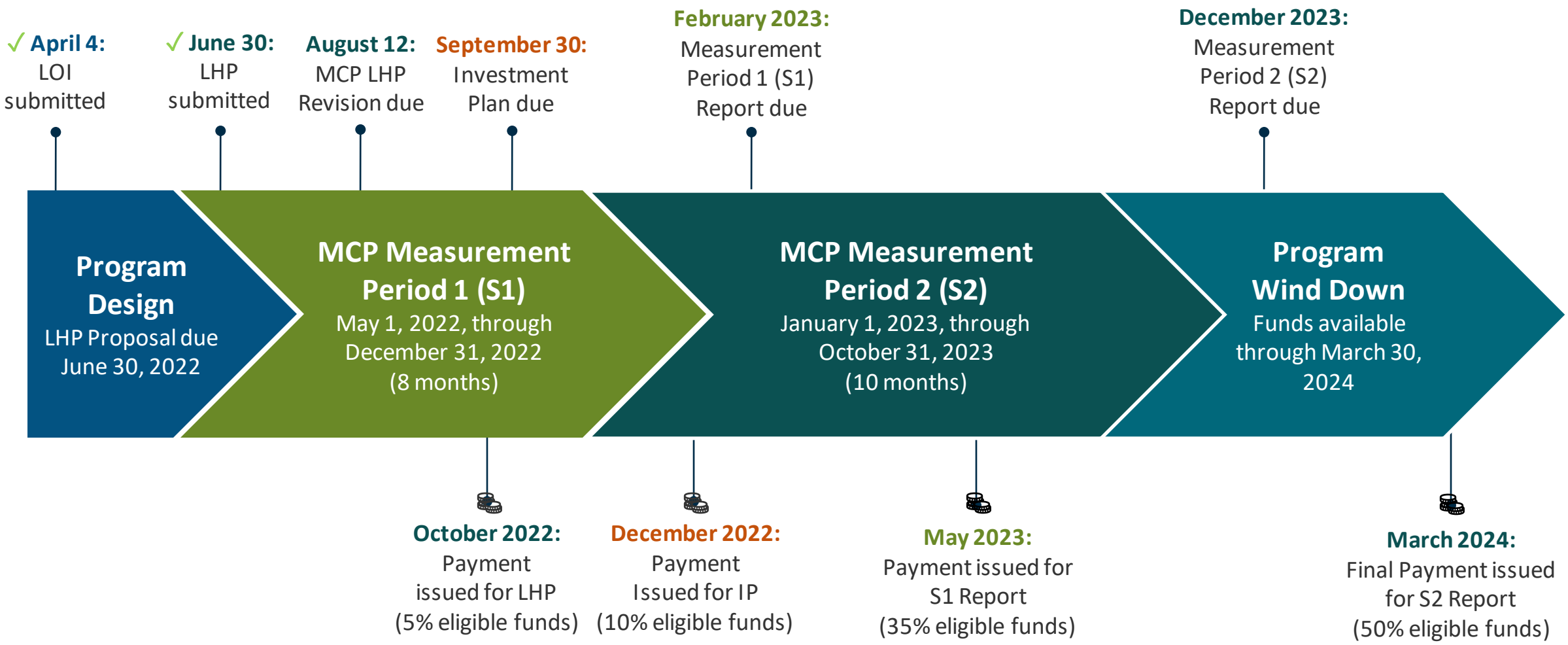
- Help MCPs develop the capacity and partnerships to connect members to needed housing services, and
- Reduce and prevent homelessness.

DHCS determined the total eligible funds that participating MCPs can earn per county based on Medi-Cal membership, MCP revenue, and the 2019 PIT Count.**

To draw down funds, MCPs must demonstrate progress toward HHIP program metrics. This will require collaboration with the CoC and local housing stakeholders.

** HHIP is funded by the American Rescue Plan Act: $644 million in state funds + $644 million in matching federal funding*
*** Subject to the requirement of 42 Code of Federal Regulations (CFR) section 438.6(b)(2) that incentive payments not exceed five percent of the value of payments attributable to the enrollees or services covered by the incentive arrangement. DHCS may, at its discretion, use an updated PIT count as appropriate to redetermine the amounts for Program Year 2.*

HHIP Deliverable and Payment Timeline



HHIP Program Measures

MCPs must demonstrate progress on HHIP measures to draw down funds.

Priority Area 1: Partnership and Capacity to Support Referrals for Services	Priority Area 2: Infrastructure to Coordinate and Meet Member Housing Needs	Priority Area 3: Delivery of Services and Member Engagement
1.1 Engagement with CoC, such as, but not limited to: attending CoC meetings, joining the CoC board, subgroup or workgroup, and attending CoC webinars.	**2.1 Connection with street medicine team** that is providing healthcare for individuals who are homeless **Priority Measure***	**3.1 Percent of MCP Members screened for homelessness/risk of homelessness**
1.2 Connection and integration with the local homeless Coordinated Entry System **Priority Measure***	**2.2 MCP connection with the local Homeless Management Information System (HMIS)** **Priority Measure***	**3.2 MCP Members screened for homelessness or risk of homelessness who were discharged from an inpatient setting** or have been to the emergency department for services two or more times in a 4-month period
1.3 Identifying and addressing barriers to providing medically appropriate and cost-effective housing-related Community Supports services or other housing-related services to MCP members experiencing homelessness	**2.3 MCP process for tracking and managing referrals for housing-related Community Supports** offered during the measurement period, including: 1. Housing Transition Navigation 2. Housing Deposits 3. Housing Tenancy and Sustaining Services 4. Recuperative Care 5. Short-Term Post-Hospitalization Housing 6. Day Habilitation Programs	**3.3 MCP members experiencing homelessness who were successfully engaged in ECM**
1.4 Partnerships with counties, CoC, and/or organizations that deliver housing services (i.e., interim housing, rental assistance, supportive housing, outreach, prevention/ diversion) with whom the MCP has a data sharing agreement that allows for timely information exchange and member matching **Priority Measure***		**3.4 MCP members experiencing homelessness receiving at least one housing related Community Supports**, including: 1. Housing Transition Navigation 2. Housing Deposits 3. Housing Tenancy and Sustaining Services 4. Recuperative Care 5. Short-Term Post-Hospitalization Housing 6. Day Habilitation Programs **Priority Measure***
1.5 Data sharing agreement with county MHPs and DMC-ODS (if applicable)		**3.5 MCP Members who were successfully housed** **Priority Measure***
1.6 Partnerships and strategies the MCP will develop to address disparities and equity in service delivery, housing placements, and housing retention (aligns w/ HHAP-3)		**3.6 MCP Members who remained successfully housed** **Priority Measure***
1.7 Lessons learned from development and implementation of Investment Plan (IP)		

Note: **Priority Measures*** will be weighed heavily by DHCS when reviewing MCP reports to determine funds earned. Measures are either P4P (pay-for-performance) or P4R (pay-for-reporting)

DHCS Two-Year HHIP Outcomes

Priority Area 1: Partnerships and Capacity to Support Referrals for Services (1/2)

Measurement Area	HHIP Program Outcomes (May 2022 through December 2023)
1.1 Engagement with CoC, including, but not limited to: attending CoC meetings; joining CoC board, subgroup, workgroup; attending webinars.	MCPs attend 100% of meetings held that they committed to attending in the LHP
1.2 Connection and integration with the local homeless Coordinated Entry System **Priority Measure***	MCP becomes a CES access point (if feasible) and makes updates to the CES assessment and prioritize process to enhance the evaluation of health factors and associated risks
1.3 Identifying and addressing barriers to providing medically appropriate and cost-effective housing-related Community Supports services or other housing-related services to MCP members who are experiencing homelessness	MCP must describe the steps taken to address the barriers to providing CS services and whether the approach is sustainable beyond HHIP
1.4 Partnerships with counties, CoC, and/or organizations that deliver housing services (i.e., interim housing, rental assistance, supportive housing, outreach, prevention/diversion) with whom the MCP has a data sharing agreement that allows for timely exchange of information and member matching **Priority Measure***	75% of providers that MCP has contracted with to deliver housing-related services (interim housing, rental assistance, supportive housing, outreach, prevention/diversion) must actively share MCP Member housing status information in accordance with their local data sharing agreement and/or California's Data Sharing Framework Data Sharing Agreement

DHCS Two-Year HHIP Outcomes

Priority Area 1: Partnerships and Capacity to Support Referrals for Services (2/2)

Measurement Area	HHIP Program Outcomes (May 2022 through December 2023)
1.5 Data sharing agreement with county MHPs and DMC-ODS (if applicable)	Data sharing agreement in place with county MHPs and DMC-ODS (if applicable) that aligns with California's Data Sharing Framework Data Sharing Agreement and includes ability to perform member matching and sharing information on housing status
1.6 Partnerships and strategies the MCP will develop to address disparities and equity in service delivery, housing placements, and housing retention (Aligns with HHAP-3 Application)	MCP implements partnerships with local organizations, including but not limited to providing funding, referrals, and other supports, to address the stated disparities and inequities in the CoC's HHAP-3 related to service delivery, housing placements, and housing retention
1.7 Lessons learned from development and implementation of the Investment Plan (IP)	MCPs will reflect on whether investments were successful in progressing HHIP program goals, lessons learned, and what investments will sustain HHIP program goals moving forward in alignment with CalAIM.

DHCS MCP Two-Year HHIP Outcomes

Priority Area 2: Infrastructure to Coordinate/Meet Member Housing Needs

Measurement Area	HHIP Program Outcomes (May 2022 through December 2023)
2.1 Connection with street medicine team providing healthcare for individuals who are homeless **Priority Measure***	MCPs should contract with a street medicine team for each of their counties (or, for rural counties, provide equivalent services). There should be a 10% increase in MCP members receiving street medicine services across the two reporting periods.
2.2 MCP connection with the local Homeless Management Information System (HMIS) **Priority Measure***	MCP should be able to share data with and receive data from the local Homeless Management Information Systems (HMIS), match member information and HMIS client information, and receive timely alerts when MCP member experiences a change in housing status
2.3 MCP process for tracking and managing referrals for housing-related Community Supports offered during the measurement period, including: 1. Housing Transition Navigation 2. Housing Deposits 3. Housing Tenancy and Sustaining Services 4. Recuperative Care 5. Short-Term Post-Hospitalization Housing 6. Day Habilitation Programs	50% of housing-related CS providers that the MCP contracts with should be able to electronically receive, follow-up, and close a referral. Between the two reporting periods, there should be a 5% increase.

DHCS MCP Two-Year HHIP Outcomes

Priority Area 3: Delivery of Services and Member Engagement

Measurement Area	HHIP Program Outcomes (May 2022 through December 2023)
3.1 Percent of MCP Members screened for homelessness/risk of homelessness	5% increase during each reporting period for # of MCP members screened for homelessness compared to the total MCP membership
3.2 MCP Members screened for homelessness or risk of homelessness who were discharged from an inpatient setting or have been to the emergency department for services two or more times in a 4-month period	5% increase during each reporting period of # members discharged from inpatient setting who were screened for homelessness compared to all members discharged
3.3 MCP members experiencing homelessness who were successfully engaged in ECM	5% increase during each reporting period of # members engaging with ECM (as reported in the most recent Quarterly Implementation Monitoring Report)
3.4 MCP Members experiencing homelessness receiving at least one housing-related Community Supports, including: 1. Housing Transition Navigation 2. Housing Deposits 3. Housing Tenancy and Sustaining Services 4. Recuperative Care 5. Short-Term Post-Hospitalization Housing 6. Day Habilitation Programs **Priority Measure***	5% increase during each reporting period of # members experiencing homelessness who received at least one the MCP's offered housing-related Community Supports
3.5 MCP Members who were successfully housed **Priority Measure***	10% increase from the LHP, and 25% increase from S1 to receive all points. Partial points are available if the S2 improvement is less than 25%.
3.6 MCP Members who remained successfully housed **Priority Measure***	85% of members successfully housed (see Measure 3.5) remain housed in the next reporting period. Partial points are available if achievement is less than 85%.

Next Steps

MCP and Sacramento CoC Coordination through 2022

May 2022: HHIP Measurement Period 1 Begins. MCPs must report on HHIP activities starting May 1.

June 30: MCPs submitted Local Homelessness Plans (LHPs) to DHCS.

July 2022+: MCPs/CoC to implement HHIP processes to ensure progress on measures.

September 30: MCPs will submit Investment Plans (IP) to DHCS.

October 2022: MCPs to receive funds for LHP submission.

December 2022: MCPs to receive funds for IP submission. Measurement Period 1 ends December 31.

We are here!

Next Steps: Discussion of Proposed MCP Approach

In the Sacramento County LHP submitted to DHCS on June 30, MCPs highlighted three priority areas:

1. Improving data sharing/HMIS integration;
2. Bolstering the Coordinated Entry System; and
3. Strengthening provider capacity to improve standards and quality of housing-related interventions (i.e., street medicine, recuperative care, landlord engagement, etc.)

MCPs propose framing our HHIP investments in two ways: **1) CoC-specific investments, and 2) community-wide investments.**

1) CoC-Specific Investments:

- In the near-term, MCPs propose aligning on the following strategies reflected in the CoC Action Plan:
  - 1) CES,
  - 2) HMIS, and
  - 3) Provider capacity-building/training.

Next Steps: Discussion of Proposed MCP Approach (continued)

2) Community-Wide Investments:

- MCPs have committed to continued discussions with stakeholders on system-level responses that could include, but are not limited to:
  - Street Medicine
  - Social Health Information Exchange
  - Landlord engagement
  - Non-congregate site (recuperative care, short-term post-hospitalization)
  - Housing Community Support Hub Model
- MCPs have committed that these discussions would occur through the **CoC System Performance Committee**.

Potential **CoC-Specific** HHIP Investments and Alignment with Local Homeless Action Plan

Homeless Action Plan Strategy	Potential Investment Area	Requested Investment Amount
	**1. Improving data sharing/HMIS integration**	
	2. Bolstering the Coordinated Entry System	
	**3. Strengthening provider capacity to improve standards and quality of housing-related interventions (i.e., street medicine, recuperative care, landlord engagement, etc.)**	
	4. Housing Community Support HUB Model	

Potential **Community-Wide** HHIP Investments and Alignment with Local Homeless Action Plan

Homeless Action Plan Strategy	Potential Investment Area	Requested Investment Amount
	**1. Cross-system data sharing through the Social Health Information Exchange**	$5M
	2. Street Medicine Coordination and Linkages to CalAIM and Providers	$500K
	**3. Purchase a non-congregate shelter site/hotel to expand short-term post-hospitalization and post-incarceration housing**	$10M
	**4. Expand Landlord Engagement and Rehousing Supports**	$10M

Discussion on Proposed Community-Wide Investments

Discussion on Proposed Community-Wide Investments

Discussion Questions:

1. Which of the proposed community-wide investments resonate best with you and why?
   - Street Medicine
   - Social Health Information Exchange
   - Landlord engagement
   - Non-congregate site (recuperative care, short-term post-hospitalization)
   - Housing Community Support Hub Model
2. Which of the proposed community-wide investments do you think will have the greatest impact and why?
3. How would you rank the proposed community-wide investments in order of import (1- greatest, 5- lowest)?

Any questions or input about HHIP?

Aetna: James Trout, troutj@aetna.com
Anthem: Kris Kuntz, Kristopher.Kuntz@anthem.com
Health Net: Amber Kemp, Amber.Kemp@cahealthwellness.com
Kaiser Permanente: Kristin Kane, Kristin.A.Kane@kp.org
Molina Healthcare: Hannah Kim, Hannah.kim1@molinahealthcare.com

Appendix: DHCS Two-Year Requirements for Key HHIP Measures

DHCS Two-Year Requirements for HHIP Measures

Measurement Area	S1 Measure Numerator	S1 Measure Denominator	S1 P4R vs. P4P	S2 Measure Numerator	S2 Measure Denominator	S2 P4R vs. P4P
1.1 Engagement with CoC, including, but not limited to: - Attending CoC meetings - Joining the CoC board - Joining a CoC subgroup or workgroup - Attending a CoC webinar During program evaluation, DHCS will administer surveys to the CoC so that the Department can better understand the level of engagement from the MCP.	Based on the engagement described in the LHP, **cite the number and type of CoC meetings attended during the measurement period**, such as: - # of CoC board meetings attended - # of CoC workgroups attended - # of a CoC webinars attended - # of other CoC meetings attended	Number and type of CoC meetings held during the measurement period: - # of CoC board meetings attended - # of CoC workgroups attended - # of a CoC webinars attended - # of other CoC meetings attended	P MCP should attend 100% of CoC meetings held that they committed to in the LHP	Based on the engagement described in the LHP, **cite the number and type of CoC meetings attended during the measurement period**: - # of CoC board meetings attended - # of CoC workgroups attended - # of a CoC webinars attended - # of other CoC meetings attended	Number and type of CoC meetings held during the measurement period: - # of CoC board meetings attended - # of CoC workgroups attended - # of a CoC webinars attended - # of other CoC meetings attended	P MCP should attend 100% of CoC meetings held that they committed to attend in the LHP
	Describe the CoCs needs for conducting the 2023 PIT count and how the MCP anticipates supporting the CoC for the 2023 PIT count.	N/A	-	-	-	-

DHCS Two-Year Requirements for HHIP Measures

Measurement Area	S1 Measure Numerator	S1 Measure Denominator	S1 P4R vs. P4P	S2 Measure Numerator	S2 Measure Denominator	S2 P4R vs. P4P
1.2 Connection and integration with the local Coordinated Entry System **Priority Measure***	Provide documentation of MCP contact with the CES to coordinate on members' housing needs and provide evidence of referrals when indicated as well as a **narrative description of the MCP's action plan for becoming a CES access point, if feasible,** based on the assessment submitted with the LHP.	N/A	R	Provide a narrative description of **any updates made to the CES process as part of the MCP's involvement**, including how health factors and risks were incorporated into the CES assessment and prioritization process, as well as the MCP's progress toward becoming a CES access point based on the action plan submitted in S1.	N/A	R

DHCS Two-Year Requirements for HHIP Measures

Measurement Area	S1 Measure Numerator	S1 Measure Denominator	S1 P4R vs. P4P	S2 Measure Numerator	S2 Measure Denominator	S2 P4R vs. P4P
1.3 Identifying and addressing barriers to providing medically appropriate and cost-effective housing-related Community Supports services or other housing-related services to MCP members who are experiencing homelessness Potential barriers include: -Adequate network of providers to meet demand -Outreach and engagement efforts -Availability of affordable long-term housing -Accessible services and supports for individuals with SMI/SED -MCP's housing-related programmatic infrastructure is in early stages of development	N/A	N/A	N/A	Based on the barriers described in the LHP, provide a narrative description of the approach the MCP took to address the barriers. Include information on the sustainability of the approach and how the MCP will continue to address these barriers beyond HHIP.	N/A	R

DHCS Two-Year Requirements for HHIP Measures

Measurement Area	S1 Measure Numerator	S1 Measure Denominator	S1 P4R vs. P4P	S2 Measure Numerator	S2 Measure Denominator	S2 P4R vs. P4P
1.4 Partnerships with counties, COC, and/or organizations that deliver housing services (i.e., interim housing, rental assistance, supportive housing, outreach, prevention/diversion) with which the MCP has a data sharing agreement that allows for timely exchange of information and member matching **Priority Measure***	**For each provider type the MCP has contracted with to deliver housing-related services**, either directly or through an intermediary, number of providers or partners who have **signed a local data sharing agreement that allows for sharing of information for members experiencing homelessness and/or have signed California's Data Sharing Framework Data Sharing Agreement:** - Interim housing - Rental assistance - Supportive housing - Outreach - Prevention/diversion If the data sharing agreement is through an intermediary, the MCP must be able to access the members' information related to their housing status.	Number of providers by provider type that the MCP has contracted with to deliver housing-related services: - Interim housing - Rental assistance - Supportive housing - Outreach - Prevention/diversion	R	**For each provider type the MCP has contracted with to deliver housing-related services**, either directly or through an intermediary, number of providers or partners who are **actively sharing MCP Member housing status information in accordance with their local data sharing agreement and/or California's Data Sharing Framework Data Sharing Agreement**: - Interim housing - Rental assistance - Supportive housing - Outreach - Prevention/diversion If the data sharing agreement is through an intermediary, the MCP must be able to access the members' information related to their housing status.	Number of providers by provider type that the MCP has contracted with to deliver housing-related services: - Interim housing - Rental assistance - Supportive housing - Outreach - Prevention/diversion	P 75% required

DHCS Two-Year Requirements for HHIP Measures

Measurement Area	S1 Measure Numerator	S1 Measure Denominator	S1 P4R vs. P4P	S2 Measure Numerator	S2 Measure Denominator	S2 P4R vs. P4P
1.5 Data sharing agreement with county MHPs and DMC-ODS (if applicable)	MCP, county MHPs or DMC-ODS (if applicable) in the county who signed a local data sharing agreement and/or California's Data Sharing Framework Data Sharing Agreement Yes/No	N/A	P Yes/No	Data sharing agreement in place with county MHPs or DMC-ODS (if applicable) that includes ability to perform member matching and sharing information on housing status. Yes/No	N/A	P Yes/No

DHCS Two-Year Requirements for HHIP Measures

Measurement Area	S1 Measure Numerator	S1 Measure Denominator	S1 P4R vs. P4P	S2 Measure Numerator	S2 Measure Denominator	S2 P4R vs. P4P
1.6 Partnerships and strategies the MCP will develop to address disparities and equity in service delivery, housing placements, and housing retention (Aligns with HHAP Round 3 Application)	Provide a narrative description of how the MCP is working with housing partners to identify: 1. Disparities and inequities that currently exist in your county related to housing, and 2. MCP's approach to partner with local organizations, including but not limited to providing funding, referrals, and other supports, to address the stated disparities and inequities as they related to service delivery, housing placements, and housing retention	N/A	R	Provide a narrative evaluation of the MCP's implementation of partnerships with local organizations, including but not limited to providing funding, referrals, and other supports, to address the stated disparities and inequities as they related to service delivery, housing placements, and housing retention	N/A	P MCPs should have fully implemented their approach described in LHP
1.7 Lessons learned from development and implementation of the Investment Plan (IP)	Provide a narrative description of: 1. Which investments were successful in progressing HHIP goals 2. Which investments were not successful in progressing HHIP goals 3. Lessons learned from what worked and what did not work to meet the goals.	N/A	R	Provide a narrative description of: 1. Which investments were successful in progressing HHIP 2. Which investments were not successful in progressing HHIP 3. Lessons learned from what did and did not work to meet goals 4. Which investments have the capacity to sustain HHIP goals going forward and how they align with CalAIM efforts.	N/A	R

DHCS Two-Year Requirements for HHIP Measures

Measurement Area	S1 Measure Numerator	S1 Measure Denominator	S1 P4R vs. P4P	S2 Measure Numerator	S2 Measure Denominator	S2 P4R vs. P4P
2.1 Connection with street medicine team providing healthcare for individuals who are homeless Street Medicine defined as health and social services developed specifically to address the unique needs and circumstances of unsheltered homeless individuals delivered directly to these individuals in their own environment. **Priority Measure***	**Number of MCP members receiving care from the MCP's street medicine partner** (or for MCPs operating in a designated rural county the equivalent services provided directly by the MCP if a street medicine team is not present in the county).	DHCS to use PIT count	R	**Number of MCP members receiving care from the MCP's street medicine partner** (or for MCPs operating in a designated rural county the equivalent services provided directly by the MCP if a street medicine team is not present in the county).	DHCS to use PIT count	P 10% increase from Submission 1 required
2.2 Connection with the Homeless Management Information System (HMIS) **Priority Measure***	**Does the MCP have the ability to match their member information with HMIS client information?** Yes/No	N/A	P Yes/No	**Does the MCP have the ability to receive timely alerts from their local HMIS when an MCP's member experiences a change in housing status?** Yes/No	N/A	P Yes/No

DHCS Two-Year Requirements for HHIP Measures

Measurement Area	S1 Measure Numerator	S1 Measure Denominator	S1 P4R vs. P4P	S2 Measure Numerator	S2 Measure Denominator	S2 P4R vs. P4P
2.3 MCP process for tracking and managing referrals for the housing-related Community Supports it is offering during the measurement period, which may include: 1. Housing Transition Navigation 2. Housing Deposits 3. Housing Tenancy and Sustaining Services 4. Recuperative Care 5. Short-Term Post-Hospitalization Housing 6. Day Habilitation Programs MCPs will be evaluated based only on the Community Supports they are offering during the measurement period.	Number of contracted housing-related Community Supports providers who are able to electronically receive, follow-up and close a referral	Number of contracted housing-related Community Supports providers	P 50% required MCPs will be evaluated based only on the Community Supports the MCP is offering during the measurement period.	Number of contracted housing-related Community Supports providers who electronically received, followed-up, and closed a referral	Number of contracted housing-related Community Supports providers	P 5% increase from Submission 1 MCPs will be evaluated based only on the Community Supports the MCP is offering during the measurement period.

DHCS Two-Year Requirements for HHIP Measures

Measurement Area	S1 Measure Numerator	S1 Measure Denominator	S1 P4R vs. P4P	S2 Measure Numerator	S2 Measure Denominator	S2 P4R vs. P4P
3.1 Percent of MCP Members screened for homelessness/risk of homelessness	Number of MCP members screened for homelessness or risk of homelessness from May 1, 2022 to December 31, 2022	Total number of MCP members during the measurement period	P 5% increase from LHP required	Number of MCP members screened for homelessness or risk of homelessness from January 1, 2023 to October 31, 2023	Total number of MCP members during the measurement period	P 5% increase from Submission 1 required
3.2 MCP Members who were discharged from an inpatient setting or have been to the emergency department for services two or more times in a 4-month period who were screened for homelessness or risk of homelessness	Number of MCP members who were discharged from an inpatient setting or in the emergency department for services two or more times over four consecutive months screened for homelessness or risk of homelessness from May 1, 2022 to December 31, 2022	Number of MCP members who were discharged from an inpatient setting or in the emergency department for services two or more times over four consecutive months from May 1, 2022 to December 31, 2022	P 5% increase from LHP required	Number of MCP members who were discharged from an inpatient setting or in the emergency department for services two or more times over four consecutive months screened for homelessness or risk of homelessness from January 1, 2023 to October 31, 2023	Number of MCP members who were discharged from an inpatient setting or in the emergency department for services two or more times over four consecutive months from January 1, 2023 to October 31, 2023	P 5% increase from Submission 1 required

DHCS Two-Year Requirements for HHIP Measures

Measurement Area	S1 Measure Numerator	S1 Measure Denominator	S1 P4R vs. P4P	S2 Measure Numerator	S2 Measure Denominator	S2 P4R vs. P4P
3.3 MCP members experiencing homelessness who were successfully engaged in ECM	Number of MCP members in the ECM Population of Focus #1: Individuals and Families Experiencing Homelessness engaged in ECM (as reported in Quarterly Implementation Monitoring Report) during the measurement period	Number of MCP members experiencing homelessness during the measurement period.	R	Number of MCP members in the ECM Population of Focus #1: Individuals and Families Experiencing Homelessness engaged in ECM (as reported in Quarterly Implementation Monitoring Report) during the measurement period	Number of MCP members experiencing homelessness during the measurement period.	P 5% increase from S1 required
3.4 MCP members experiencing homelessness receiving at least one housing-related Community Supports, including: 1. Housing Transition Navigation 2. Housing Deposits 3. Housing Tenancy and Sustaining Services 4. Recuperative Care 5. Short-Term Post-Hospitalization Housing 6. Day Habilitation Programs **Priority Measure***	Number of MCP members experiencing homelessness **who received at least one the MCP's offered housing-related Community Supports** during the measurement period	Number of MCP members experiencing homelessness during the measurement period.	P 5% increase from LHP required (reported per CS, performance evaluated across aggregate)	Number of MCP members experiencing homelessness who received at least one the MCP's offered housing-related Community Supports during the measurement period	Number of MCP members experiencing homelessness during the measurement period.	P 5% increase from LHP or S1 required (whichever is higher, reported per CS, performanc e evaluated across aggregate)

DHCS Two-Year Requirements for HHIP Measures

Measurement Area	S1 Measure Numerator	S1 Measure Denominator	S1 P4R vs. P4P	S2 Measure Numerator	S2 Measure Denominator	S2 P4R vs. P4P
3.5 MCP Members who were successfully housed **Priority Measure***	Number of MCP Members experiencing homelessness who were housed for at least one month between May 1, 2022 and December 31, 2022	Number of MCP members experiencing homelessness during the measurement period	P 10% improvement from LHP	Number of MCP Members experiencing homelessness who were housed for at least one month between January 1, 2023 and October 31, 2023	Number of MCP members experiencing homelessness during the measurement period	P 25% improvement on S1 required to achieve the points in full. Partial points will be awarded for significant improvement that is less than 25%.

DHCS Two-Year Requirements for HHIP Measures

Measurement Area	S1 Measure Numerator	S1 Measure Denominator	S1 P4R vs. P4P	S2 Measure Numerator	S2 Measure Denominator	S2 P4R vs. P4P
3.6 MCP Members who remained successfully housed **Priority Measure***	Number of MCP Members who were housed from January 1, 2022 to April 30, 2022 who remained housed through December 31, 2022	Number of MCP members experiencing homelessness who were housed for at least one month between January 1, 2022 and April 30, 2022	P 85% required Partial points will be awarded for significant achievement that is less than 85%.	Number of MCP Members who were housed from January 1, 2022 to December 31, 2022 who remained housed through October 31, 2023	Number of MCP members experiencing homelessness who were housed for at least one month between January 1, 2022 and April 30, 2022	P 85% required Partial points will be awarded for significant achievement that is less than 85%.
				Number of MCP Members experiencing homelessness who were housed from May 1, 2022 to December 31, 2022 who remained housed through October 31, 2023	Number of MCP Members experiencing homelessness who were housed for at least one month between May 1, 2022 and December 31, 2022	