2021

NEEDS AND GAP ANALYSIS OF

San Joaquin County's Health and Behavioral Health Care System for the Unhoused

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GLOSSARY OF ACRONYMS

ACS | American Community Survey

ADA | Americans with Disabilities Act

Caltrans | California Department of Transportation

CalWORKs | California Work Opportunity and Responsibility to Kids

CDBG | Community Development Block Grant

CSBG | Community Services Block Grant

CTSA | Consolidated Transportation Service Agency

DOF | Department of Finance

DOT | Department of Transportation

FY | Fiscal Year

JPA | Joint Powers Authority

LTA | Lake Transit Authority

LTF | Local Transportation Fund

MOU | Memorandum of Understanding

NEMT | Non-Emergency Medical Transportation

OAA | Older American Act

RTPA | Regional Transportation Planning Agency

Section 5310 | Enhanced Mobility of Seniors & People with Disabilities program

SGR | State of Good Repair

SSBG | Social Services Block Grant

SSTAC | Social Services Transportation Advisory Council

TDA | Transportation Development Act

TIRCP | Transit and Intercity Rail Capital Program

VA | Veterans Administration

Executive Summary

Concern, fear, frustration, and empathy are just some of the experiences that have come to characterize social and political attention on homeless individuals in San Joaquin County in recent years. Health and behavioral health issues are a significant challenge for unhoused individuals, and the COVID-19 pandemic has only amplified their importance. Against this background, the Kaiser Foundation Health Plan, Inc. commissioned the University of the Pacific's Center for Business and Policy Research (CBPR) to conduct a study on the health and behavioral health care system for homeless people in San Joaquin County, California.

The care system of homeless individuals, particularly the health and behavioral health care system, has had limited scrutiny in San Joaquin County. The present analysis is an initial investigation into an area that is fundamental to building an equitable and inclusive system to reduce and eventually eliminate homelessness. Some of the major themes that emerged from the project, as well as areas that warrant further policy and action, are highlighted in this overview.

Issues of Definition

There are many ways to define homelessness, which include frequency (high/low), duration (short/long), the physical nature (street/shelter/a friend or relative's couch), and social structure (individual/partners/families). These differences in the homeless populations' characteristics often form the basis and focus for an agency's assistance (children, families, unmarried individuals, seniors, veterans, men or women). However, the variety of definitions can make it harder for people to find and access appropriate services. Federal agencies use a range of definitions, so a child experiencing homelessness may be eligible for services through an organization that receives funding from the Department of Education, but not one that receives funding through the Department of Housing and Urban Development (HUD) because it uses a narrower definition of homelessness. Developing an integrated health and behavioral health care plan for a homeless individual is more challenging when agencies use different definitions of homelessness because of reporting and qualification requirements. We believe that understanding these issues of definition are an important starting point as they create a substantial burden on those trying to coordinate resources for a homeless individual.

Data Availability and Quality

Quantitative and qualitative data is necessary to understand the challenges and opportunities facing the health and behavioral health care system for unhoused individuals. However, our analysis found major barriers to obtaining and using data to inform decisions. Several factors contribute to this situation, among them are the various definitions used to characterize homeless individuals, a reticence by many people to be classified as homeless, and a lack of coordination across the information systems.

Different definitions create a variety of estimates when counting individuals experiencing homelessness, tracking the use of homelessness services, and documenting unmet needs of the homeless population; all of which must be accounted for in an effort that seeks to address and prioritize actions to improve the health and behavioral health system. Secondly, many homeless individuals' distrust, isolation, and desire to remain anonymous limits information that they share, which further reduces available data on their needs and where gaps in the health and behavioral health system exist. Lastly, there is a significant coordination challenge

associated with the data collected by agencies that assist homeless patients. The services and resources provided to individuals experiencing homelessness are frequently critical and so these agencies need to ensure reporting standards are maintained. Integration and coordination which risks endangering those standards is an unacceptable risk. As a result, information systems integration is limited and efforts to coordinate requires awareness of the nuances in definitions as well as a coordinating vocabulary.

Respondent Fatigue

Although it is clearly important to gather better and more consistent data on individuals experiencing homelessness, it must be remembered that the resource demands on organizations for assembling this information are far from trivial. There is a need to work across the primary information sources currently being gathered to determine how they can be used to increase the coverage of those experiencing and at risk of homelessness. Given the various definitions of homelessness and the multiple platforms and systems gathering this data, it is critical to engage the people responsible for compiling this information as efforts are made to improve its integration. While a platform that links databases may have strong appeal, the burden on those helping homeless individuals must be carefully considered if that platform requires duplication and repetition of data entry. In addition, further data is likely to incur capital and operating costs on the organizations serving the homeless population. These additional demands on organizations and their staff are a burden that must be carefully weighed with respect to benefits from greater scope, coordination, and integration of information technology systems.

Coordinated System of Care

Given the multitude of challenges facing homeless individuals, a coordinated system of care that brings together a range of services and resources is necessary, especially when they have health and behavioral health care needs. The county's coordination and integration of care for the unhoused has advanced considerably in recent years. In 2019, the San Joaquin Continuum of Care (CoC) was established as the County's backbone agency for homelessness response and in 2020 the CoC's Strategic Plan was adopted. Other important components include the 2019 establishment of the CoC's Emergency Shelter committee, which coordinates resources and activities across the county's emergency shelters for homeless individuals as well as the launch of the San Joaquin Whole Person Care program in 2017, which encourages information sharing, coordinated care, and ongoing evaluation of the care being provided to the unhoused.

However, a coordinating body or structure focused on the health and behavioral health care of homeless patients is currently lacking in the county's coordinated system of care. We found that many facilities providing health and behavioral health care to the unhoused remain dependent on personal networks and limited information is shared across the system. This situation creates an information gap that limits the ability to effectively plan and coordinate resources. Therefore, building collaboration across the county's health and behavioral health care system for homeless individuals is important to develop a truly coordinated system of care in the county.

Recommended Actions

To address these gaps and needs, we recommend a few initiatives aligned with the San Joaquin CoC Strategic Plan be considered:

1. **Support and Develop Integrated Information Technology System** – Facilitating common reporting and sharing of information on the unhoused across the health and behavioral health system is necessary for coordinating and integrating care. In addition, expanding information beyond what is currently available through the Homeless Management Information System (HMIS) to link healthcare entities with community-based organizations should be a priority. Our analysis suggests that if building a more holistic HMIS system is not possible, the Connected Community Network (CCN) for San Joaquin county which uses the Unite Us platform and network services is a promising alternative resource.

2. **Adopt an Integrated Healthcare System Framework** – Developing an integrated health and behavioral health care framework for the unhoused should leverage resources and support the broader coordinated system of care. This is a necessary process that must accompany the development of an integrated information technology system if that effort is to be successful. In building this function, the Integrated Healthcare framework and program from the Center of Excellence for Integrated Health Solutions (CIHS) may be useful in guiding and supporting these efforts.

3. **Advocate for Continued Application of Supportive Housing** – A supportive housing framework provides tenants affordable housing with wraparound support services, which stabilizes their lives and significantly reduces associated health and behavioral health challenges. Therefore, in addition to more directly engaging in efforts to facilitate housing opportunities, a targeted initiative by the health and behavioral health system to ensure adequate supportive housing is available to the community appears to be another useful focus area for action.

Concluding Remarks

This study has identified challenges and opportunities facing the health and behavioral health care system for homeless individuals in San Joaquin county. The research findings and recommendations of this project are focused on starting a process to strengthen and build that system while also working within and through the broader coordinated system of care in the county. These findings are intended to be disseminated and discussed to identify and prioritize actions to assist homeless individuals in the county. Through dissemination and discussion, this project can advance interest in and understanding of this important, but relatively neglected, dimension of homelessness.

SECTION ONE – Introduction

This report is an initial assessment of the post-hospital discharge system for homeless people in San Joaquin County, California. As this is a complex issue with multiple factors influencing patients and service providers alike, we believe it is useful to clarify the scope of analysis within the context of the broader health and behavioral healthcare system for unhoused individuals. The figure below represents four distinct types of care and six different kinds of health and behavioral health entities.[1] The top half of the figure represents a situation where health and behavioral health needs are stable. This might be through support programs [6] or health outreach workers [1]. Ideally, as health or behavioral health needs arise, an adjacent entity or type of care in the system can be accessed so that the individual returns to the top half of the figure without needing the more intensive levels of care located on the bottom half of the figure. However, medical needs, constraints on service providers as well as homeless individuals' own desires lead to a much more complicated reality where individuals jump in and out at various points in the care system. This also creates a situation where many unhoused individuals move back and forth across parts of the system rather than following a smooth progression through the health and behavioral health care system.

As a result, despite focusing on the needs and gaps associated with the discharge of homeless individuals from the county's hospitals (represented by the "*Acute Care and Inpatient Service [3]*" entities in Figure 1) to recovery and transitional care facilities (represented in the figure by *"Skilled Care Facilities and services [4]"* and *"Step-down or residential maintenance programs [5]"* entities), this analysis also considers factors pushing and pulling homeless people out of the system as well as upstream and downstream capacity. Understanding the context in which the system operates is also important. Therefore, before assessing the system itself we discuss policies and legislation that carry significant influence over the post-hospital discharge system in Section Two.

In Sections Three, Four, and Five we respectively assess the demand, supply, and gaps of the system for health and behavioral health services to homeless individuals. The population of

1 For a more in-depth discussion please see Section 2.2.

FIGURE 1 Representation of the Health and Behavioral Health Care System for the Unhoused

homeless people in the county and recent trends in their numbers are discussed in the first part of Section Three profiling demand. That is followed by an overview of health care demand by homeless individuals, which includes a discussion on the range of health and behavioral health needs before looking at specifics around demand within the health incident care portion of the system.

The structure and capacity of health and behavioral health services for unhoused individuals are then examined in Section Four. While recognizing that a range of entities supply these services, the assessment attempts to identify those focused on, or significantly involved with, health and behavioral health services to homeless individuals. These are cataloged across the different types of care they provide.

Building on the overviews of need (Section Three) and availability of services (Section Four), the discharge system's gaps are examined in Section Five. This is done through a combination of stakeholder and provider interviews as well as an extensive review of available literature. Central to this aspect of the report is its building an initial identification of critical challenges and opportunities for the discharge system. However, given the systemic nature of health and behavioral health care, broader connections are also discussed.

Recommendations are presented in Section Six, the final section of the analysis. While this analysis was started before the impacts of the COVID-19 pandemic became apparent, its impacts have highlighted several opportunities and challenges to the health and behavioral health system available to homeless people in San Joaquin County. These have been identified and incorporated in the recommendations despite further issues arising as the impacts of the pandemic and associated policies continue to evolve. The need for enhanced coordination and networks is recurrent throughout the report, as such strengthening system-wide structures are featured in many of the recommendations. Given that healthcare and behavioral healthcare outcomes frequently depend on broader social and community needs, some strategies, tactics, and policies in the recommendations also address those needs.

SECTION TWO – Policy and Legislative Landscape

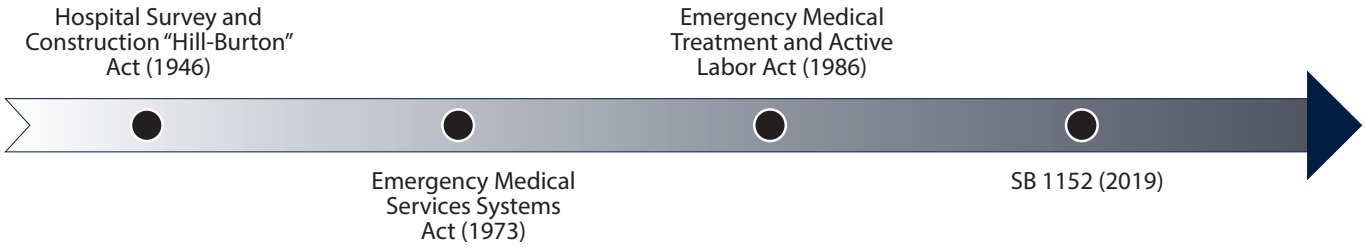
Treating health and mental health needs of people experiencing homelessness is often more effective when it is connected to efforts that also seek to address housing, income maintenance, and other social service needs. Therefore, several important policies and pieces of legislation are designed to facilitate coordination across the spectrum of agents who help unhoused individuals are discussed in this section. This section concludes with a brief discussion of funding resources and their current or potential scope to support delivering health and behavioral health care to people who are unhoused. Before turning to those descriptions, we begin with a brief overview of how hospitals emerged as primary providers of medical care for people experiencing homelessness and other individuals in need.

2.1 Policies and Legislation Guiding Hospitals' Provision of Care to the Unhoused

In addition to trauma care, a variety of policies, legislation, and social conventions have established hospitals' emergency care system as the healthcare safety net. Hospitals have provided medical care for the poor and sick for centuries, but by the late nineteenth century hospitals were evolving from being places of care for the destitute to centers of medical innovation.[2] As infection prevention advanced and lessons from World War I and World War II led to better organization of critical care resources, hospitals emerged as the preferred destination for health care services. In the United States, the growing demand for hospitals in communities across America was supported by the federal government's passage of the 1946 Hospital Survey and Construction (Hill-Burton) Act which

2 For an overview of the evolving role of hospitals in society, see for example The Hospital in History, (1989) eds. L. Granshaw and R. Porter. Routledge.

FIGURE 2 Timeline of Federal and State Legislation on the Provision of Care to the Unhoused



funded the construction of thousands of hospitals and other health facilities. In return, they agreed to provide services to people unable to pay, make their services available to all persons residing in the facility's area, and if a non-profit, demonstrate 'community benefit' which is commonly met by providing care to the uninsured.[3] While combined with the Public Health Services Act of 1975, the Hill-Burton Act continued to provide direct, community-based federal health care construction financing until 1997.

The growth of health facilities that the Hill-Burton Act supported enabled a rapid rise in demand for the newly developed emergency care system during the 1950s and 1960s.[4] Despite its growing popularity, the emergency care system remained relatively disorganized. In response, national standards of emergency care were established through the Emergency Medical Services Systems Act of 1973. That legislation is considered one of the foundational policies of the modern emergency medical care system, focusing on the arrangement of personnel, facilities, and equipment for effective coordination and delivery of services. The system that the Act developed succeeded in reducing the social burdens of heart disease, stroke, and trauma. However, the limited alternatives led to the emergency care system being so utilized by the general population that emergency departments soon became heavily burdened, unable to care for the influx of patients, and began to turn people away. In response, the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA) required all hospitals participating in Medicare to admit any patient that comes to the emergency department regardless of their ability to pay. Emergency departments thereby became a healthcare safety net, providing care and diagnostics for millions of low-income and uninsured patients.[5]

Although EMTALA was intended to increase access for all patients, it may have unintentionally reduced access. Instead of providing medical care to patients who lacked the financial resources to pay for medical care as required by EMTALA, many medical specialists simply refused to take emergency department hours without additional pay or stipends from the hospital. This led to several unintended impacts including the closure of 27% of nonrural emergency departments in the United States between 1990 and 2009.[6] The decline of emergency departments due to lack of funding and compensation combined with increased demand for emergency services results in a heavy workload for current providers and decreased inpatient revenue, which many hospitals rely on to stay in operation.

Discharging homeless patients is a related challenge for hospitals. Distrust, isolation, and other health, behavioral health as well as substance abuse issues prevalent among the unhoused makes their discharge process particularly difficult. As a result of hospitals across California not appropriately managing and planning the discharge process, the State Legislature passed *Senate Bill 1152 "Hospital patient discharge process: homeless patients"* (SB 1152). SB 1152 came into effect during 2019 and

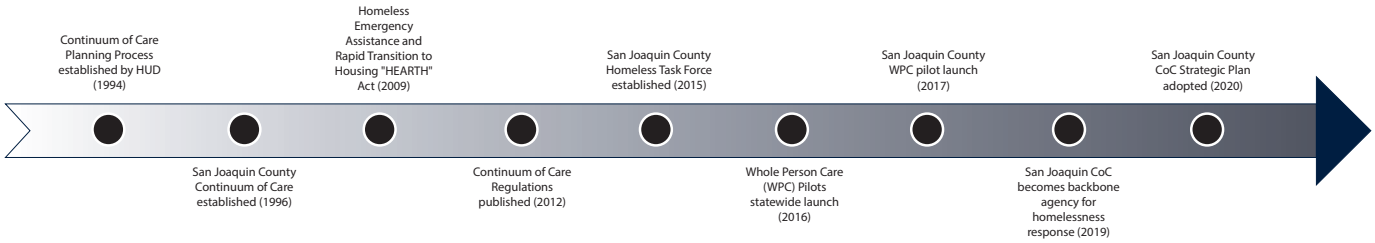
3 https://www.hrsa.gov/get-health-care/affordable/hill-burton/index.html

4 Several factors led to this growth in addition to the Hill-Burton Act, for a discussion see Beatrix Hoffman's "Emergency Rooms: The Reluctant Safety Net." In Rosemary Stevens, Charles Rosenberg, and Lawton R. Burns, eds., History and Health Policy: Bringing the Past Back In. New Brunswick, NJ: Rutgers University Press, 2006.

5 "Emergency Care: Then, Now and Next." https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.0683.

6 https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.0683

FIGURE 3 Timeline of Policies and Legislation Facilitating Coordination of Assistance for Homeless People



compliance with the statute is a condition of their licensure. When discharging a homeless patient SB 1152 now requires hospitals to:

- Supply necessary medical equipment and/or medication.
- Secure a sheltered discharge location, but patients may be discharged to a location of their choice.
- Provide transportation to the discharge location, within 30 miles or 30 minutes of the hospital.
- Provide a meal and weather-appropriate clothing.
- Provide referrals to health and mental health resources.
- Offer screening for infectious diseases and vaccination.
- Offer to enroll in eligible, affordable health insurance coverage.

In addition, every hospital is required to establish a written homeless patient discharge planning policy and process, a discharge log, and document compliance. SB 1152 creates important standards for the discharge care of homeless patients, but its impact depends significantly on availability of community resources and effectiveness of coordination.

2.2 Policies and Legislation Facilitating Coordination

While it may be possible to identify distinct events that led to an individual or household becoming homeless, the causes of homelessness are frequently from many sources. These varied factors can include health and behavioral health problems, limited housing options, insufficient income, domestic violence, and social inequities. In such an environment, it is often necessary to bring a variety of resources together to provide solutions. Effective coordination is therefore an important component of efforts to not just manage, but end homelessness. In San Joaquin County, an important embodiment of that coordinated effort is the San Joaquin Continuum of Care (CoC).

Recognizing the need for community partnership and collaboration in addressing homelessness, the U.S. Department of Housing and Urban Development (HUD) adopted a Continuum of Care (CoC) program in 1994. The CoC program requires a community-based planning process occur to be eligible for its funds, but it is also explicitly designed to support communities' development of multi-year strategic planning and networks across their service system to address homelessness. Following this HUD requirement, the San Joaquin County CoC was established in 1996. The CoC process was subsequently formalized in law under the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009. Regulations governing the CoC process were adopted in 2012, which requires a CoC to monitor and evaluate projects, appoint a representative governing board, and build community membership. The program's regulations also require the CoC to designate, monitor, and operate a homeless management information system (HMIS) as well as undertake the development of a CoC plan that facilitates the coordinated implementation of housing and services for homeless individuals.[7]

7 For further details of the HUD CoC, see the program website at: https://www.hudexchange.info/programs/coc/

While the HUD CoC program built a platform to coordinate the community's efforts to alleviate homelessness, in San Joaquin County broader adoption of the CoC process did not follow directly from the 1996 establishment of the San Joaquin CoC. Instead, the broader community network and planning process envisioned in the CoC Program began development follow the 2015 establishment of a San Joaquin County Homeless Task Force. Through that task force, the San Joaquin CoC became the established backbone agency for the County's homelessness response in 2019. In 2020, the County as well as all seven incorporated cities adopted the San Joaquin CoC's Strategic Plan in response to homelessness.

In addition to the top-down coordination of the CoC program, California's Department of Health Care Services (DHCS) launched a Whole Person Care pilot (WPC) program in 2016. The WPC program works to coordinate services from the bottom-up, identifying Medi-Cal enrollees who are mentally ill and are experiencing homelessness or are at risk of homelessness then encouraging information and data sharing, coordinating programs to provide necessary care, and evaluating progress. San Joaquin County joined the WPC pilot program in 2017, which aims to coordinate health, behavioral health, and social services in an effective and patient-centered manner while reducing inappropriate emergency department and inpatient use. The WPC pilot program is currently scheduled to conclude in December 31, 2021.[8] Nonetheless, it is an important initiative to demonstrate the benefits of addressing the fragmented and limited coordination in the provision of services to individuals at risk or experiencing homelessness. In the context of this analysis, it is also particularly important given its emphasis on increasing coordination between healthcare providers and community organizations providing wrap-around services to prevent unnecessary visits to emergency rooms.

An important review of practices addressing the needs of homeless individuals in San Joaquin county was the 2020 Grand Jury study on homelessness.[9] That report noted that limited coordination and communication across individual actors had characterized the previous Grand Jury study on homelessness in 2015-2016. While noting that communication and collaboration have improved, the report highlighted that the work being done currently is not being communicated to the broader community and is often difficult to access. Further, it noted that there needs to be more community-wide planning and strategic use of resources. There is also a need to establish a coordinated system of care for the homeless community.

California's State Assembly and Senate currently also have several pieces of legislation that would further encourage coordination to assist individuals experiencing homelessness.[10] A couple of proposals involve improving data on homelessness; these include developing an integrated data warehouse to track Medi-Cal expenditures on homeless individuals,[11] and reporting on funding and outcomes to address homelessness.[12] Other proposals involve improving collaborative planning. These include a statewide needs and gaps analysis for the provision of housing and wraparound services to homeless individuals,[13] and developing and implementing a statewide strategic plan to address homelessness in the state.[14]

Perhaps the most significant proposal currently being developed is the California Advancing and Innovating Medi-Cal (CalAIM) proposal for delivery-system, program, and payment reform.[15] CalAIM seeks to build on the WPC model and use non-clinical interventions to address social determinants of health. Its vision is to create an

8 The program will transition to CalAIM in 2022, for further details see: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx

9 https://www.sjcourts.org/divisions/civil-grand-jury/api/grabReport.php?id=298

10 "California Legislative Information." https://leginfo.legislature.ca.gov/faces/home.xhtml

11 AB 67 – Homeless Integrated Data Warehouse

12 AB 2746 – Funding Accountability: state funding for homelessness

13 AB 3269 – State and Local Agencies Homelessness Plan

14 SB 333 – Homeless Coordinating and Financing Council

15 https://www.dhcs.ca.gov/calaim

CONTINUUM OF CARE – MEANINGS AND USAGE

In 1987 Congress passed what would be known as the McKinney-Veto Homeless Assistance Act, which was the first federal law specifically addressing homelessness. Through that act its housing programs are administered by HUD. While HUD initially did not require any systemic planning by local recipients since 1994 HUD has required each community to come together and submit a single comprehensive Continuum of Care (CoC) application rather than allowing individual applications from providers in the community. The shift to community-based applications by HUD was intended to encourage community-wide planning and coordination among homeless service providers and others to help bring together a spectrum of supportive programs and social services to address homeless individuals' needs and eventually facilitate their leaving homelessness. Currently, within the HUD context today the concept of a CoC is used in a variety of ways, with reference at different times to a CoC planning process, the collection of stakeholders involved in the planning process, the geographic area covered by the CoC, or actual grants received from HUD under the program.

In addition to this spectrum of resources to assist individuals experiencing homelessness a CoC is a framework of integrated systemic care in health, behavioral health, and substance abuse. While interrelated concepts the frameworks themselves are distinct. To highlight these differences, we briefly describe other usages of CoC below:

- In healthcare the CoC describes how healthcare providers follow a patient from preventative care through medical incidents, rehabilitation, and maintenance. It also includes the facilities and providers of those services to a patient from a clinic to an acute care hospital and on to ambulatory care or long-term care facilities.
- The behavioral health CoC distinguishes multiple opportunities to address behavioral health problems and disorders ranging from promotion, where environments and conditions to support individual's behavioral health are developed, to prevention, treatment, and recovery. Corresponding to these different types of care are a range of behavioral health care facilities ranging from outpatient clinics to home-base services, crisis services, and residential treatment facilities.
- In addiction treatment and substance abuse recovery CoC refers to the spectrum of services an individual needs over time as they progress through their treatment. As in other medical contexts these range from extended care to partial hospitalization, residential treatment, and medically managed inpatient services as well as aftercare.

Regardless of the context a basic feature of all CoC framework is the provision of a bundle of care options that follow an individual through time, adapting to their changing needs.

integrated "wellness" system that supports and anticipates health needs to prevent illness and reduce the impact of poor health. Among the key components to realize this vision is moving Medi-Cal into an integrated system that links managed care, behavioral health, dental, and other county-based services. It also envisions directly addressing the needs of beneficiaries toward social determinants of health including housing navigation and support services, recuperative care, and other services such as sobering centers. While development of the system has been delayed by the COVID-19 pandemic, CalAIM is now targeting a start date of January 1, 2022, with complete integrated pilot programs potentially being launched as early as 2026.

2.3 Policies and Legislation Integrating Health and Behavioral Health Care

Integral to the coordinated approach of addressing the needs of homeless individuals is the simultaneous treatment of mental health and substance abuse with their physical health ailments. In California, the Mental Health Services Act (MHSA) of 1999 is an important source of resources and framework to ensure mental health conditions are treated similarly to physical health conditions. Although several subsequent bills have added to or amended MHSA to increase effectiveness,[16] potential for reform remains. The MHSA applies only

[16] Several bills strengthening the MHSA came into effect 1 January 2021. These include SB 855 - Health Coverage: mental health or substance use disorders, which further strengthens the MHSA by defining mental health and substance use disorders as "medically necessary" treatments. Another is AB 1976 – Mental health services: assisted outpatient treatment, which requires a county or group of counties to implement an Assisted Outpatient Treatment (AOT) Program.

to private insurers and not Medicare or self-insured plans. Some potential solutions to improve MHSA implementation include developing a framework for funding decisions, refining intended and measurable outcomes, and targeting specific resources for infrastructure input.[17] The federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans and health insurance issuers to ensure that member costs and treatment limitations for mental health or substance use disorder benefits are no more restrictive than those of all medical/surgical benefits. This parity of resources from the MHSA and MHPAEA are particularly significant for homeless individuals who are much more likely than the non-homeless population to have mental health and substance use disorders.[18]

Among recent proposals to further enhance mental health and substance abuse services is legislation that would require licensed substance abuse programs to have a written patient discharge plan policy that included post-treatment housing for patients,[19] and piloted early intervention and treatment through intensive outreach and wrap-around services.[20] Future legislation that may still be enacted includes a pilot project for community-based care and treatment that addresses the multiple needs of individuals suffering from mental illness and substance use disorder, other medical comorbidities, and homelessness.[21]

2.4 San Joaquin County Homelessness Program and Project Funding

The San Joaquin Continuum of Care (CoC) monitors funding used throughout San Joaquin county for services to the homeless. They estimate that in Fiscal Year (FY) 2020 $29.6 million was awarded through grants and applications to provide services for homeless individuals in San Joaquin county. This information, summarized in Figure 4, shows that six of the seventeen programs identified by the SJCoC provided nearly 80% of funding. Further, the largest source, the HEAP program, is a one-time block grant and composed nearly a quarter of FY2020 funds. We briefly review these programs' purposes with an emphasis on projects involving the health and behavioral health care system.[22] Lastly, we conclude this subsection with a brief discussion of some additional financial resources available to the community.

Homeless Emergency Aid Program (HEAP)[23]

The HEAP program was enacted by statute in 2018 and allocated $500 million for California's CoCs to address homelessness. The San Joaquin CoC received an allocation of $7.2 million. Among other projects supported for funding was a $1.1 million award to Community Medical Centers for a new respite care facility in Stockton providing low-barrier emergency shelter to individuals with substance use disorders for up to two weeks at a time. In addition to short-term shelter, the center will provide supportive services, counseling, and case management.[24]

HUD CoC Program[25]

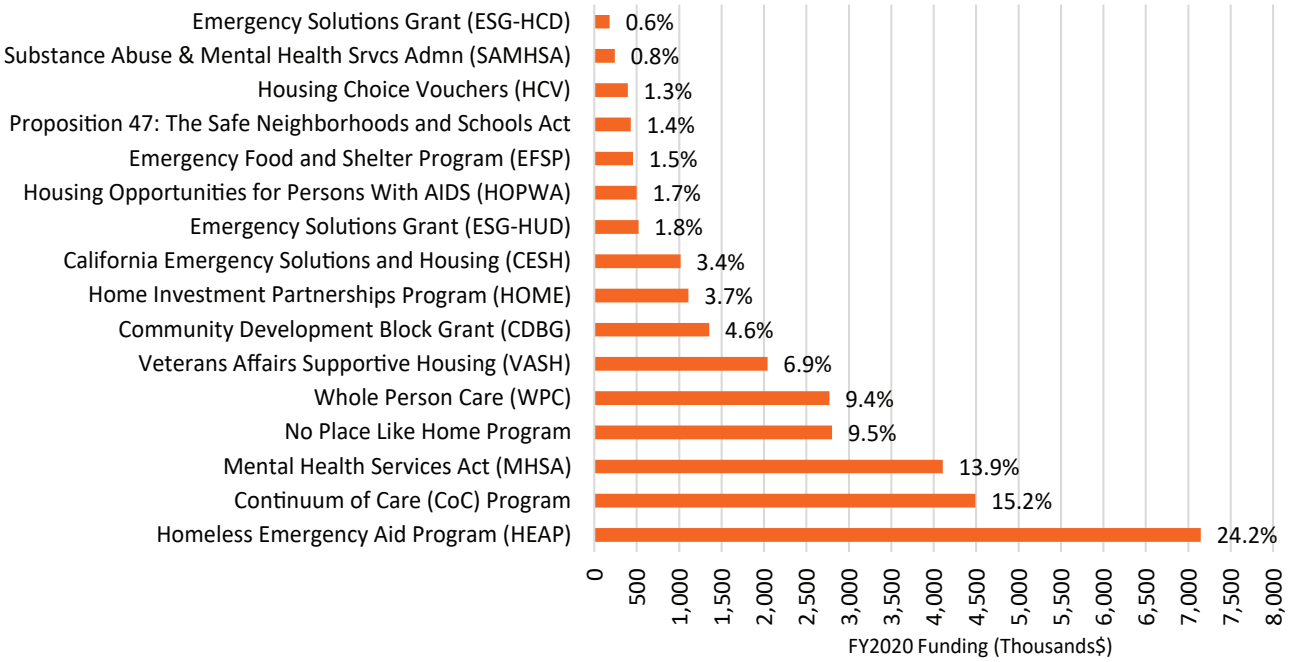
These funds are restricted for permanent supportive housing and rapid re-housing projects and cannot be used for emergency shelters or similar projects. San Joaquin County, in its role as the designated Collaborative Applicant of the SJCoC selected the projects for which funding was requested. FY 2019 funding totaled $4.4 million & FY 2020 totaled $4.5 million.

Mental Health Services Act Grants[26]

MHSA addresses a broad continuum of prevention, early intervention, and service needs and the necessary infrastructure, technology, and training elements that effectively support the public

17 https://lao.ca.gov/handouts/Health/2019/The-Mental-Health-Services-Act-Issues-for-Legislative-Consideration-120919.pdf
18 See for instance: "Trends, Causes, and Outcomes of Hospitalizations for Homeless Individuals", R. Wadhera et al. 2019, Medical Care 51(1), 21-27. https://www.ingentaconnect.com/content/wk/mcar/2019/00000057/00000001/art00005
19 AB 224 – Alcohol and drug programs: discharge plans
20 AB 1275 – Mental health services: county pilot program
21 AB 2025 – Mental illness and substance use disorder: restorative care program: pilot projects
22 For further details see on the programs see the program website links included in footnotes with each and for further specifics on the local projects supported by these programs see the SJCoC website at: http://www.sanjoaquincoc.org/funding/
23 https://www.bcsh.ca.gov/hcfc/aid_program.html
24 For further details on the SJCoC HEAP awards see: http://www.sanjoaquincoc.org/h-e-a-p/
25 https://www.hudexchange.info/programs/coc/
26 https://www.dhcs.ca.gov/services/mh/Pages/MH_Prop63.aspx

FIGURE 4 2019-2020 Homelessness Program/Project Funding in San Joaquin County



behavioral health system. In FY2020 $4.1 million was allocated under this program. Its funding includes $2 million for Community Medical Centers Assessment and Respite Center (CMC-ARC) to support respite care clinic location to provide assessment and respite services for individuals that are unserved, underserved, and inappropriately served by existing behavioral health systems of care. It also included $826,000 for Law Enforcement Assisted Diversion (LEAD) program that redirects individuals from criminal justice system involvement into community-based social, health, and behavioral services.

No Place Like Home Program[27]

This program's purpose is to acquire, design, construct, rehabilitate, or preserve permanent supportive housing for persons who are experiencing homelessness, chronic homelessness, or who are at risk of chronic homelessness, and who need mental health services. $6.5 million was awarded in Third Round allocations to San Joaquin County, applications closing 19 January 2021. In FY 2020 $2.8 million was awarded to the Housing Authority of San Joaquin (HASJ) for permanent supportive housing for the seriously mentally ill.

Whole Person Care[28]

As discussed in Section 2.1, the Whole Person Care pilot program supports coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. FY 2020 funding of $2.8 million.

HUD-Veterans Affairs Supportive Housing (HUD-VASH) program[29]

This program combines rental assistance for homeless Veterans with case management and clinical services through the Department of Veterans Affairs' medical centers and community-based outreach clinics. These funds are awarded through vouchers to assist homeless veterans and their families afford decent, safe, and sanitary housing. In FY 2020 San Joaquin county received $2 million in funds through the VASH program which equated to 259 vouchers at a value of $657 per month each.

27 https://www.hcd.ca.gov/grants-funding/active-funding/nplh.shtml

28 https://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx

29 https://www.hud.gov/program_offices/public_indian_housing/programs/hcv/vash

Community Development Block Grant (CDBG) Program[30]

This program provides annual grants on a formula basis to states, cities, and counties to develop viable urban communities by providing decent housing and a suitable living environment, and by expanding economic opportunities, principally for low- and moderate-income persons. In FY 2020 funds for the program totaled $1.4 million.

Home Investment Partnerships Program (HOME)[31]

HOME provides formula grants to States and localities that communities use - often in partnership with local nonprofit groups - to fund a wide range of activities including building, buying, and/or rehabilitating affordable housing for rent or homeownership or providing direct rental assistance to low-income people. In FY 2020 funds for this program totaled $1.1 million.

California Emergency Solutions and Housing (CESH) Program[32]

CESH funds may be used for five primary activities: housing relocation and stabilization services (including rental assistance), operating subsidies for permanent housing, flexible housing subsidy funds, operating support for emergency housing interventions, and systems support for homelessness services and housing delivery systems. In addition, some administrative entities may use CESH funds to develop or update a Coordinated Entry System (CES), Homeless Management Information System (HMIS), or Homelessness Plan. A first-round award of $1 million was made on 11 January 2019 to San Joaquin County Community Development Department.

Emergency Solutions Grant Program – Housing and Urban Development (ESG-HUD)[33]

This program provides grant funding assisting people to quickly regain stability in permanent housing after experiencing a housing crisis and/or homelessness. In FY 2020 funding for this program totaled $0.5 million.

Housing Opportunities for Persons With AIDS Program (HOPWA)[34]

This program provides grants for projects that benefit low-income persons living with HIV/AIDS and their families. In FY2020 funding for this program totaled $0.5 million.

Emergency Food and Shelter Program (EFSP)[35]

A program to facilitate the transition from temporary shelter to permanent homes with attention to the specialized needs of homeless individuals with mental and physical disabilities and illness and which facilitates access for homeless individuals to other sources of services and benefits. FY2020 Total $0.5 million.

Proposition 47: The Safe Neighborhoods and Schools Act[36]

Felony convictions were resentenced or reclassified as misdemeanors under the proposition. A portion of the associated cost savings from not incarcerating low-level drug and theft offenders is available to counties through a competitive grant process for mental health and substance use treatment to reduce recidivism. In FY 2020 funding from these provisions totaled $0.4 million.

Housing Choice Vouchers Program (HCV)[37]

Housing assistance for very low-income families, the elderly, and the disabled to afford decent, safe, and sanitary housing in the private market. In FY2020 funding totaled $0.4 million consisting of 50 vouchers at a value of $657 each per month.

Substance Abuse and Mental Health Services Administration Grants (SAMHSA)[38]

These grants support substance abuse and mental

30 https://www.hud.gov/program_offices/comm_planning/cdbg
31 https://www.hud.gov/program_offices/comm_planning/affordablehousing/programs/home/
32 https://www.hcd.ca.gov/grants-funding/active-funding/cesh.shtml
33 https://www.hudexchange.info/programs/esg/
34 https://www.hudexchange.info/programs/hopwa/
35 https://www.efsp.unitedway.org/efsp/website/websiteContents/index.cfm
36 https://www.bscc.ca.gov/s_bsccprop47/
37 https://www.hud.gov/program_offices/public_indian_housing/programs/hcv/about
38 https://www.samhsa.gov/grants

health services. They also support substance abuse prevention and treatment services through the identification and dissemination of best practices. Monitoring the prevalence and incidence of substance abuse is an additional part of the program. In FY 2020 funding totaled $0.2 million.

Emergency Solutions Grant Program – California Housing and Community Development (ESG-HCD)[39]

Provides grant funding to engage homeless individuals and families living on the street, fund rapidly re-house homeless individuals and families, help operate and provide essential services in emergency shelters for homeless individuals and families and prevent individuals and families from becoming homeless. In FY 2020 funding totaled $0.2 million.

Other financial resources to support the healthcare system for homeless individuals

Housing for a Healthy California Program[40]

The program allocates funds competitively to developers for operating reserve grants and capital loans to acquire existing and construct new supportive housing for Medi-Cal recipients who are experiencing homelessness, or chronic homelessness, and a high-cost health user. This program is intended to allow individuals experiencing significant barriers to housing stability to benefit from supportive housing opportunities while decreasing their utilization of emergency departments, inpatient care, and nursing home stays. In 2020, $43.5 million was allocated statewide with $84.6 million requested, but no applications were received from San Joaquin county.

Homeless Housing, Assistance and Prevention Grant Program (HHAP) [41]

The first round of the HHAP program was enacted by statute in 2019 and allocated $650 million to support regional coordination and expand or develop local capacity to address their immediate homelessness challenges. The City of Stockton, San Joaquin County, and the San Joaquin Continuum of Care (SJCoC) have received HHAP grant allocations totaling $12.4 million and collaboratively developed a single joint Notice of Funding Availability (NOFA) and application through which they will administer funds under the San Joaquin CoC's Strategic Plan. Each jurisdiction is making funding award decisions individually; there is no crossover between funding sources or distribution. A variety of projects were funded with the first round of funds ranging from outreach and coordination to emergency shelters and rental assistance. A second round of HHAP grants was announced in November 2020 and allocated $300 million statewide to build on regional collaboration developed through previous rounds of HHAP and HEAP funding and to develop a unified regional response to homelessness. In total $5.8 million has been allocated to the community, with the City of Stockton receiving $3.0 million, the San Joaquin CoC $1.5 million, and San Joaquin County $1.3 million.

COVID-19 Emergency Homeless Funding Grant Allocations[42]

In March 2020, $100 million in emergency funding was allocated to local governments statewide to help protect this vulnerable population and reduce the spread of COVID-19 by safely getting individuals into a shelter and providing immediate housing options. In total $2.1 million has been allocated to the community, with the City of Stockton receiving $1.1 million, the San Joaquin CoC $0.5 million, and San Joaquin County $0.5 million.

Project Roomkey[43]

Project Roomkey provides non-group housing for people experiencing homelessness. It was established in March 2020 as part of the State of California's response to the COVID-19 pandemic. The goal of Project Roomkey is to use hotel and motel rooms as well as trailers around the state

39 https://www.hcd.ca.gov/grants-funding/active-funding/esg.shtml
40 https://www.hcd.ca.gov/grants-funding/active-funding/hhc.shtml
41 https://www.bcsh.ca.gov/hcfc/hhap_program.html
42 https://www.bcsh.ca.gov/hcfc/documents/covid19_funding_faqs.pdf
43 https://www.cdss.ca.gov/inforesources/cdss-programs/housing-programs/project-roomkey

to provide increased shelter options for medically vulnerable people experiencing homelessness and thereby minimize strain on health care system capacity. The majority of Project Roomkey expenditures are federally reimbursable under FEMA, for both room occupancy agreements and operating services, at 75 percent federal share of cost.

Project Homekey[44]

Project Homekey is the next phase in the state response to protecting people experiencing homelessness from serious illness including COVID-19. Approximately $550 million of the State's federal Coronavirus Aid Relief Funds (CRF) and $50 million General Fund monies have been allocated for a total of $600 million in Homekey grant funds. The state must spend CRF by December 30, 2020 and spend General Funds by June 30, 2022. Under Project Homekey, local entities will partner with state entities to acquire hotels, motels, vacant apartment buildings, and residential care facilities to serve the homeless population. As of September 28, 2020, the City of Stockton has been awarded nearly $4.3 million in funding. The City plans to acquire and renovate an existing 39-unit motel into permanent housing in partnership with the Central Valley Low Income Housing Corporation and Stocktonians Taking Action to Neutralize Drugs (STAND).

Dignity Health's Homeless Health Initiative

As a result of Dignity Health and Catholic Healthcare Initiatives merger in 2019 a 5-year $20 million Homeless Health Initiative was established to co-locate, coordinate, and integrate health, behavioral health, safety, and wellness services with housing and other social services in the communities where Dignity Health has hospitals across California. Since Stockton's St. Joseph's Medical Center is a member of Dignity Health, several local projects have received grants from the Homeless Health Initiative. Beneficiaries include a $1.8 million grant in 2020 to Stocktonians Taking Action to Neutralize Drugs (STAND) to provide permanent housing for individuals experiencing homelessness and $250,000 to support Project Homekey.

SECTION THREE – A Profile of the Population of People Without Homes

3.1 Target Population Characteristics

While homeless people tend to rely on emergency rooms, clinics, and other facilities that serve the poor, it is important to recognize the diversity of the homeless population and their health care and healthcare-related needs. Given that many homeless individuals distrust and are isolated from the health and behavioral health care system, it is difficult to get information on them and their needs. In assessing the demand for health services, this section relies on several different sources of information including interviews with hospital managers and staff. While isolation and distrust are common problems in assessing the homeless population's health and behavioral health needs, improving understanding of the homeless subpopulations and their needs is also critical to ensuring the health system is working as effectively as possible. Therefore, we return to this in Section Five of the analysis.

3.2 Demographics of the Unhoused Population in San Joaquin County

In 2019, 2,629 homeless individuals were living in San Joaquin County; 1,071 were sheltered and 1,558 were unsheltered[45]. The San Joaquin Continuum of Care (SJCoC), as required by the Department of Housing and Urban Development (HUD), gathered this data for the 2019 Point in Time Count (PIT). It consisted of a massive volunteer effort to count and survey individuals experiencing homelessness on a single day. The true count of people experiencing homelessness throughout a year is likely much higher than represented in the PIT. However, the PIT provides the most comprehensive and reflective count available and is

44 https://www.hcd.ca.gov/grants-funding/active-funding/homekey.shtml

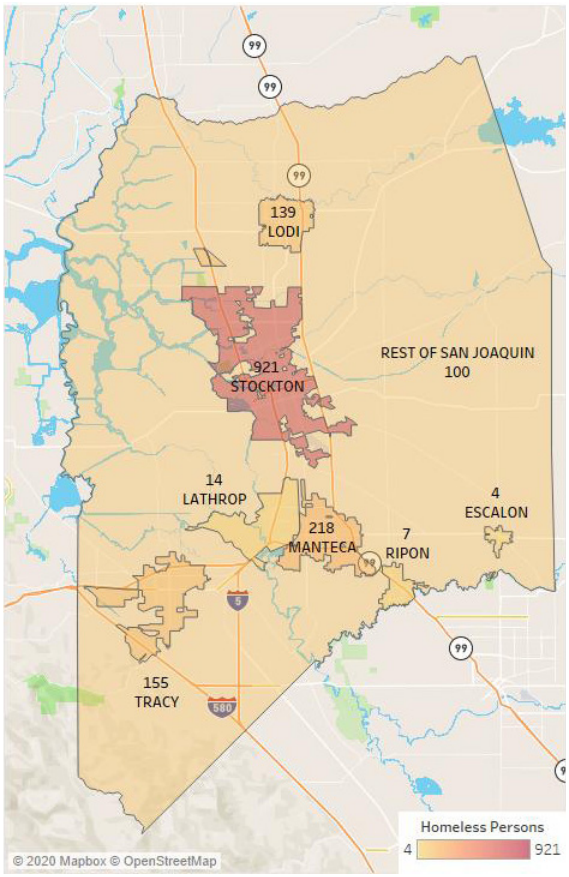
45 "Sheltered homeless" was defined as those having emergency or temporary shelter.

TABLE 1 2019 Demographics of the Homeless Population in San Joaquin County

TOTAL	2629	
Sheltered	1071	41%
Unsheltered	1558	59%
GENDER		
Female	37%	
Male	63%	
Transgender, Female	0.1%	
RACE/ETHNICITY		
White	65%	
Black or African-American	25%	
Asian	2%	
American Indian or Alaska Native	1%	
Native Hawaiian or Other Pacific Islander	2%	
Latino	28%	
AGE		
Under 18	13%	
18-24	6%	
25-54	58%	
55-59	14%	
60+	10%	

Source: San Joaquin Continuum of Care, Report on the Point in Time Count of the Sheltered and Unsheltered Homeless, 2019

FIGURE 5 Unsheltered Homeless Individuals, 2019



particularly important for counting the unsheltered homeless population, whose information is not always captured in the Homeless Management Information System (HMIS). Limited resources and difficulties in contacting or tracking individuals contribute to variations between PIT and HMIS data, but together, they can provide a profile of the homeless population in the county.

Based on these datasets and as an introduction to its larger strategic plan for the county, Homebase described demographic and subpopulation trends of the homeless population summarized below.[46]

Un/sheltered Status

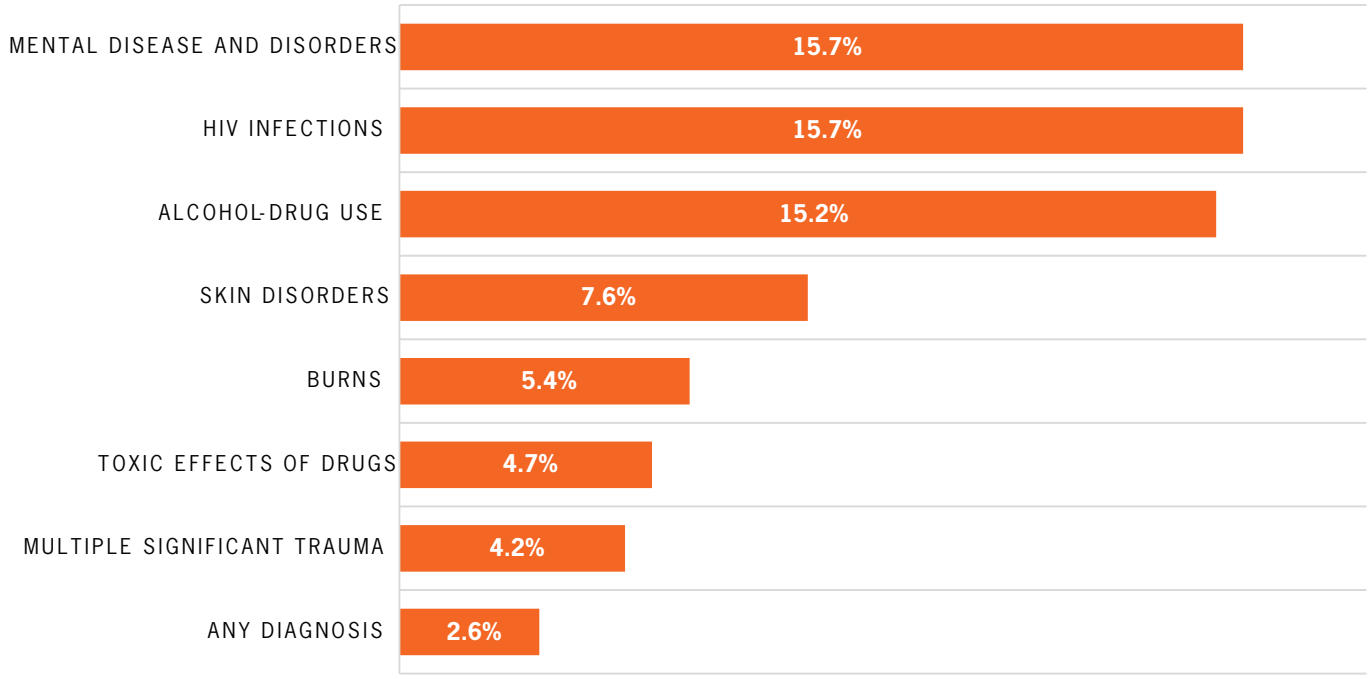
The majority of the homeless in San Joaquin County are unsheltered, meaning they do not have emergency or temporary shelter[47]. A person may be unsheltered due to a variety of reasons, including the inability to locate or travel to shelters, low capacity of shelters, sobriety requirements, personal choice, and having possessions, pets, or partners. Figure 5 displays the total number of unsheltered homeless in each of San Joaquin County's cities. The majority reside in Stockton, the county's most populous city and hub for supportive services. Collecting accurate data on the number and needs of unsheltered individuals, who are often the most visible face of homelessness, is critical for resource evaluation and allocation.

Gender

Of all the individuals experiencing homelessness in the county, 63% identify as male and 37% identify as female. Men were more likely to be unsheltered, while women were more likely to have families with children. Both of these groups have high needs and limited resources.

46 The San Joaquin Community Response to Homelessness, Homebase, SJCoC
47 Using PIT and HUD definition

FIGURE 6 Major Diagnostic Category of Homeless Patients Discharged from California Hospitals, 2017



Source: Phillip Reese, California Healthline

Race and Ethnicity

In San Joaquin County, 25% of the homeless population identifies as Black or African American, despite this group being only 7% of the population.[48] This large discrepancy is seen across the nation, where people of color, particularly Black or African Americans, are disproportionately homeless.

Age

Most people experiencing homelessness in the county are between the ages of 25 and 54. However, both children and older adults make up a significant portion of those requiring additional services. According to the PIT definition of homelessness, there were 342 homeless children under the age of 18, comprising 13% of the homeless population. Using the McKinney-Vento Act's broader definition of homeless, the numbers are significantly higher. In the 2017-18 school year, schools in the county documented 4,330 children experiencing homelessness. At the same time, the county is grappling with meeting the needs of an aging homeless population. This is a combination of chronically homeless people aging along with the rest of the population, and older adults experiencing homelessness for the first time. In 2019, 24% of the homeless population were over the age of 55, representing a large group of people with unique and potentially more complex medical needs.

3.3 Health and Behavioral Health Needs

The nexus of health and housing is complex. Health issues, including physical, mental, and behavioral, can contribute to loss of stable housing and entry into homelessness. The opposite is also true, in that a lack of stable, safe housing can create health problems or exacerbate existing ones. A myriad of reasons contributes to the multidimensional health needs of homeless people, including exposure to harsh or unsanitary conditions, low access to health care, and competing priorities such as food and employment insecurity. Homelessness then impedes rehabilitation and recovery after medical attention is provided. Individuals may be less able to attend follow-up appointments and manage continuing treatment, which leads to worsening of the original

48 United States Census Bureau, American Community Survey 5-Year Estimates, 2018

injury or illness. In addition, health needs, access to health services, and health outcomes vary among the subpopulations discussed in the above profile, including un/sheltered status, gender, race, and age.

Despite the efforts of healthcare and social workers, hospitals are not always equipped to address the complex needs of their homeless patients. Additionally, the flow and readmission of homeless patients through emergency departments can create capacity issues for health services that are already limited. However, because they often lack access to consistent primary and preventative care and because of their heightened health risks, many homeless patients' main interactions with the healthcare system occur in hospitals and emergency departments. Much of the available information regarding their health and behavioral health needs is thus captured in hospital data.

The California Office of Statewide Health Planning and Development (OSHPD) collects and produces data from all hospitals in the state, including demographic and diagnoses data of inpatient and emergency departments. In 2017, homeless patients across California made approximately 100,000 hospital visits. Of those visits, 35% involved a mental health diagnosis, compared to 6% of all hospital discharges. The San Joaquin PIT survey found that 26% self-reported a serious mental health problem and 45% a substance use disorder. OSHPD collects information regarding the major health diagnostic category of homeless patient discharges, displayed in Figure 6. Homeless patients had high hospitalization rates for treatment of mental illnesses, HIV infections, and alcohol or drug use. The occurrence of these health conditions among the homeless is disproportionate to their population, and many of these diagnoses require recurring treatment and safe environments for full recovery or management.[49]

SJCoC volunteers surveyed unsheltered homeless and analyzed HMIS information as part of the PIT outreach process. Due to stigmas and lack of awareness, these self-reported numbers may underrepresent the true prevalence of health conditions among homeless people. Survey questions involving health needs consisted of the following:

- *Have you ever abused drugs or alcohol, or been told you do?*
- *Have you ever had treatment for a mental health problem?*
- *Do you have regular access to medical care?*

SJCoC reported the following results[50]:

45%	alcohol or drug abuse	15.50%	1 disabling condition
26%	psychiatric/emotional conditions	21.00%	2 disabling conditions
9%	physical disability	14.80%	3 disabling conditions
14%	chronic health problems		
1%	HIV or AIDS		

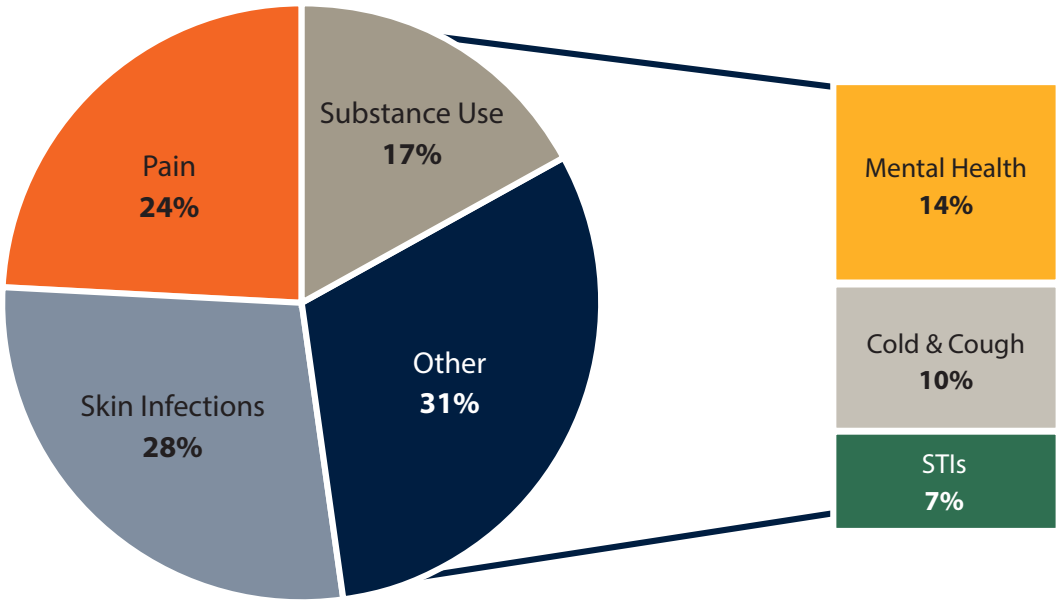
Social workers and staff in San Joaquin county hospitals reported the most common comorbidities associated with emergency department usage by the homeless to be diabetes, chronic wounds and skin infections, and substance abuse.

For this analysis, we conducted surveys of emergency department staff and supervisors across health facilities in San Joaquin county. The results of these surveys are illustrated in Figure 7. Our surveys suggest that the most common diagnoses regarding unhoused patients in various emergency departments were related to skin and wound infections, musculoskeletal complaints, substance use, and mental health crises. Notably, six out of seven survey respondents reported skin issues to be a common complaint. The average recent return rate amongst surveyed hospital systems was 29% of unhoused patients. While reasons for recent

49 Phillip Reese, California Hospitals See Massive Surge In Homeless Patients, California Healthline

50 San Joaquin Continuum of Care, 2019 Homeless Census and Survey, dashboard summary

FIGURE 7 Most Common Diagnosis of Homeless Population in ED



returns varied, the most reported was a lack of follow-up and/or worsening of the original condition. Every survey respondent found that the most common comorbidities associated with emergency department usage in the unhoused population were diabetes, chronic wounds and skin infections, and substance use. Other common diagnoses noted included hypertension and mental health crises. There was also a frequent acknowledgment that lack of access to basic human needs likely exacerbated these patients' conditions, such as lack of access to food, shelter, and primary healthcare. Very few unhoused patients end up being admitted to the hospital from the emergency department, reported as less than 12% of these patients on average.

Interviews were also conducted for this analysis with several of the hospitals in the county. In those interviews, the social/case work managers described typical consultations with homeless patients, their transition care (discharge) management, and key challenges associated with the homeless patients' system of care. While the needs and gaps they identified in homeless patient care are discussed in Section Five, similar processes were described for the transition care

TABLE 2 Sample of Homeless Patient Transition Care Destinations

1	Admitted to hospital (Inpatient)
1	Transferred by 5150 to in patient behavioral health treatment
1	Discharged before social worker arrived to work the next morning
1	Placed in recuperative care at a shelter, but then had to go to a room and board
1	Placed in skilled nursing facility
5	Discharged without being seen or against medical advice
10	Discharged back to their outside area of residence (car, tent, etc.)
20 of which 19 ED and 1 inpatient	

TABLE 3 San Joaquin County Enrolled Medi-Cal Fee-for-Service Providers by Type

Type of Provider	Licensed Facilities	Type of Provider	Licensed Facilities
Certified Hospice Centers	10	Health Access Programs	20
Chronic Dialysis Clinics	16	Long Term Care Facility	64
Community Clinics	10	Medi-Cal Drug Treatment Centers	12
Community Inpatient Hospitals	6	Outpatient Heroin Detox Centers	8
Community Outpatient Hospitals	11	Rehabilitation Clinics	4
County Inpatient Hospitals	1	Residential Care Facilities for the Elderly	7
County Outpatient Hospitals	1	Rural Health Clinics/Federally Qualified	31
Developmental Screening and Trauma Centers	31	Surgical Clinics	8

Source: Medi-Cal Active Enrolled Providers, San Joaquin County, December 2020.

of patients. Table 2 shows an audit of homeless patients' transition care destinations during a week early in 2020 before COVID-19 restrictions at an area hospital. The hospital had 20 homeless patients 19 of whom were in the emergency department while one was an admitted patient (inpatient). Among other features, the high percentage (50%) that requested to be discharged back to their outside residence is notable, as is the proportion (25%) who were discharged without being seen or against medical advice.

SECTION FOUR – Health & Behavioral Health Services for the Unhoused

Although only part of the broad continuum of care needed to support and alleviate homelessness, we discussed a conceptualization of the health and behavioral health care system for the unhoused in Section One. In assessing the needs and gaps of the hospitals transition care of homeless patients, it is helpful to revisit the previously mentioned conceptualization of the health and behavioral health care system. Therefore, a more detailed representation of that system is presented in Figure 8 on the next page.

Table 3 shows that there are numerous facilities and services available under the Medi-Cal system, but in practice, the system serving the homeless population is much narrower. Med-Cal currently facilitates a range of health and behavioral health services through different programs. As a result, a Medi-Cal recipient can have six or more different programs to address their medical needs. Managing so many providers would be a challenge in any circumstance, but it is particularly difficult for those experiencing homelessness. While addressing that complexity is one of the goals of the CalAIM initiative discussed in Section 2.1, currently, the complexity of the system and limited support services leads to many homeless patients uninsured and constrains their access to many of these facilities.

To identify the actual health and behavioral health system in San Joaquin county a list of key providers was compiled based on conversations with the hospitals and members of the San Joaquin CoC.[51] That list, included as Appendix A, shows that among the facilities and services available to homeless patients, only a portion are focused on the needs of individuals experiencing homelessness.

Preventative Care

In terms of the community [0] and primary care and wellness [1] facilities and services in the community, the Community Medical Centers (CMC)

51 While not involved in compiling the list itself, it would not have been possible without the assistance of the County's Emergency Shelter Committee members and especially without the patient guidance from Kayce Rane in the San Joaquin County District Attorney's Office.

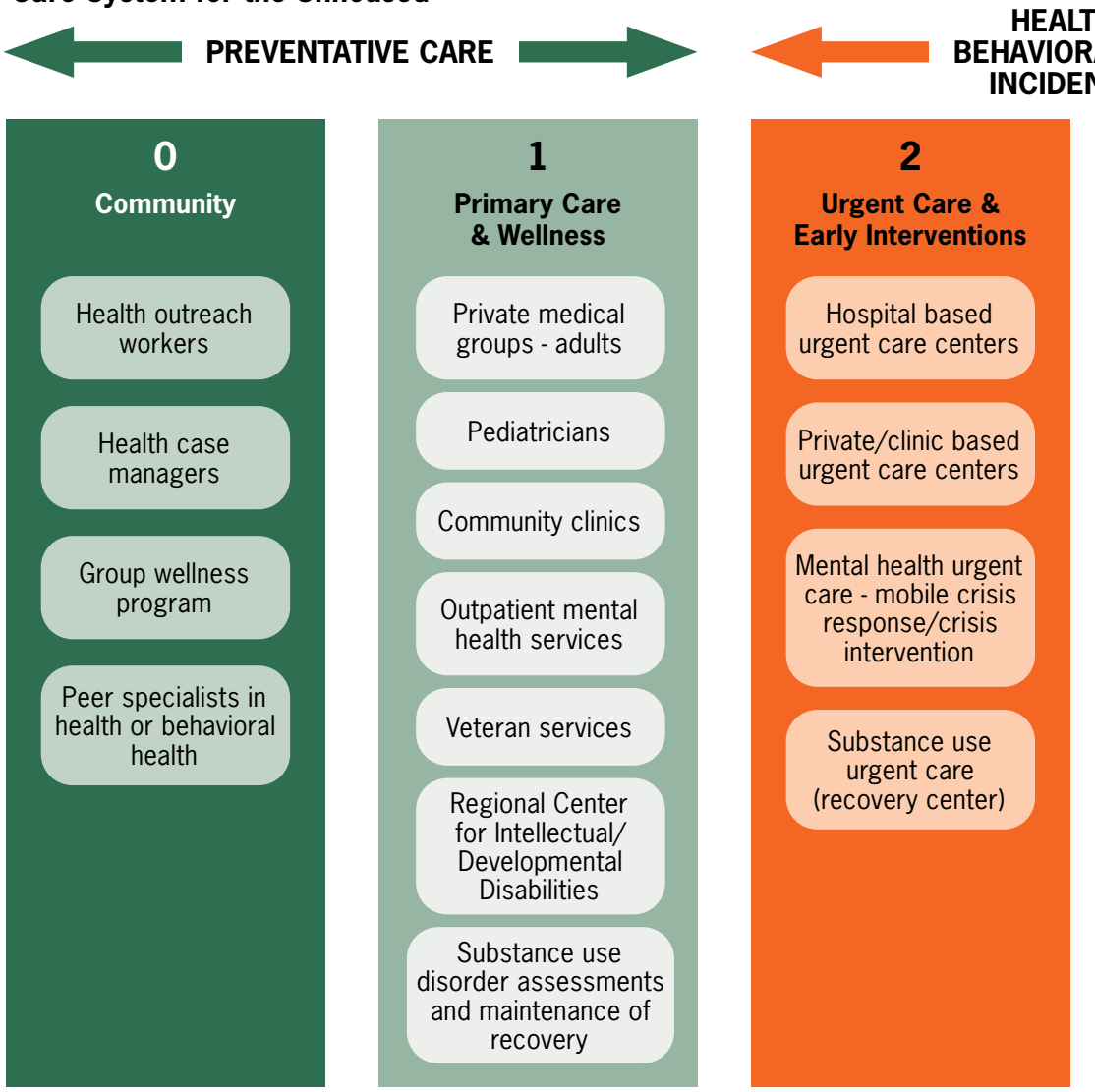
outreach and clinics are the primary resource for people experiencing homelessness in the county. In addition, and sometimes in partnership, several of the county's emergency shelters for homeless individuals offer health and hygiene clinics and services. Other community facilities, such as St. May's Dining Room and Tracy Community Connections Center also offer hygiene and medical services. San Joaquin County Behavioral Health Services (SJCBHS) Homeless Outreach Services is another important resource for preventative care of homeless individuals. Additional preventative care in the community is also provided by San Joaquin County Public Health Services (SJCPHS) through their health center, family health programs, and communicable disease control program. Community preventative dental care is also available through the San Joaquin Treatment + Education for Everyone on Teeth + Health (SJ TEETH) which is administered by First 5 San Joaquin.

Health and Behavioral Health Incident Care

While the seven hospitals with emergency care departments form the health and behavioral health safety net across the county, a range of other facilities provide outpatient [2] and inpatient [3] incident care. SJCBHS operates numerous clinics across the county that offer outpatient behavioral health and substance abuse services. In addition, the Women's Center Youth and Family Services offer several programs to assist in the care of victims of domestic violence, sexual assault, and human trafficking. In addition, several of the county's emergency shelters offer counseling and mental health referrals.[52] Outpatient substance abuse care is available through several of the SJCBHS facilities as well as drug treatment centers across the county. In addition to the County's acute care emergency response services for medical emergencies, SJCBHS operates a Homeless Engagement and Response Team (H.E.A.R.T), Crisis Community Response Team (CCRT), and the Mental Health Crisis Clinic. In addition to the inpatient health care provided by the county's seven hospitals with emergency care departments, inpatient behavioral

52 For a list of the County's emergency shelters, their client focus and capacities during the summer of 2020 see Appendix B.

FIGURE 8 Details of the Health and Behavioral Health Care System for the Unhoused

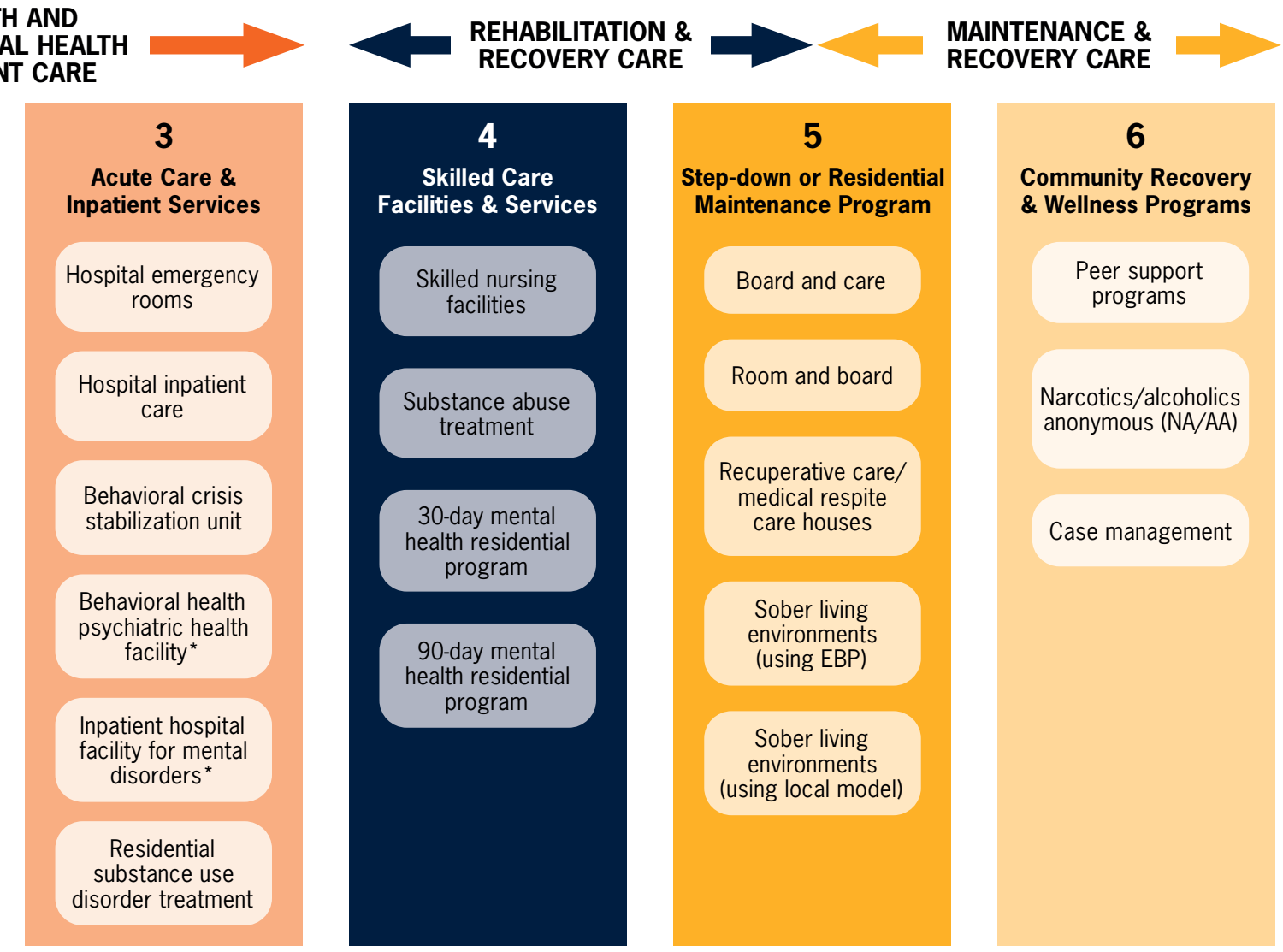


health services are provided at St. Joseph's Behavioral Health Center and SJCBHS Psychiatric Health Facility.

Rehabilitation & Recovery Care

These facilities are the primary resources for managed care of homeless patients that are discharged from the county's hospitals. There are many skilled nursing and assisted living facilities [4] located across the county, but in many cases, these facilities do not accept homeless patients. There are also nearly 200 licensed adult residential facilities [5] in the county,[53] these facilities are sometimes referred to as board and care facilities and provide care for the elderly as well as some patients with behavioral health care needs. In addition, there are room and board facilities [5] which are unlicensed but provide accommodation for some patients after discharge from hospitals. In addition to these facilities, the county has a medical recuperative care facility [5] at the Gospel Rescue Mission in Stockton where sixteen 24-hour shelter beds are available for people who are too well to be in the hospital, but too sick to recuperate on the streets. There are also several sober living and substance abuse rehabilitation centers. Several of these are operated through or in parallel with emergency shelters for homeless individuals.

53 California Department of Social Services Caregiver Background Check Bureau, Care Facility Search (December 2020): https://www.ccld.dss.ca.gov/carefacilitysearch/



Maintenance & Recovery Care

These facilities and services are designed to keep individuals in a sustainable health and behavioral health environment. They consist of a variety of programs such as Narcotics Anonymous and Alcoholics Anonymous. They also include county case management services which facilitate job training, housing assistance, and other support services to help end individuals' homelessness and maintain them once housed.

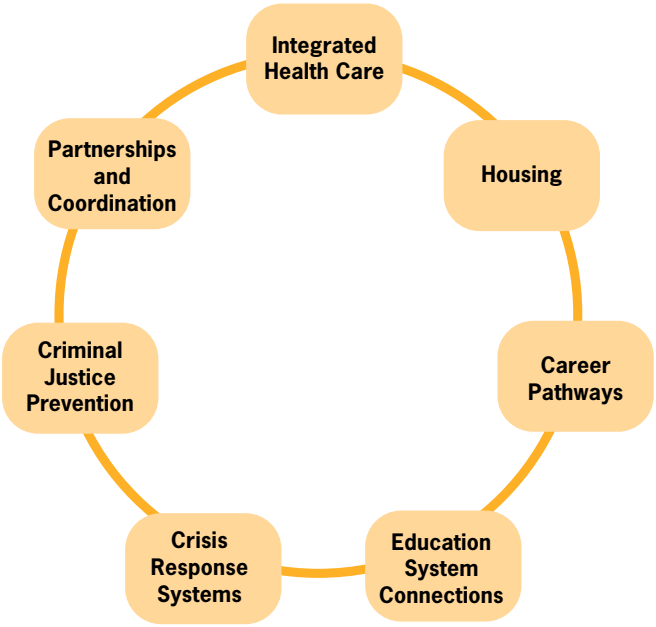
SECTION FIVE – Assessment of the Post-Hospital Discharge System

In 2018, there were 1,244 inpatient discharges of homeless patients in San Joaquin County hospitals according to OSHPD data. This consisted of 1.68% of all inpatient discharges, which is 4.9 times higher than their proportion of the county population. The majority, 74%, of these inpatients were admitted from the emergency department. Although it is an approximation, given that our survey estimates around 12% of homeless emergency department patients are admitted that would imply there were about 7,700 homeless patient visits to the county's emergency departments in 2018.[54] Statewide, there were also more emergency department visits than inpatient admissions of homeless individuals in 2018. However, detailed numbers, diagnoses, and discharges of homeless patients visiting emergency departments are not as well documented. Unless they are transferred to another facility such as hospice care or a skilled nursing facility, homeless patients discharged from the emergency department are often categorized as routine discharges, "discharged to home or self-care".[55]

In general, every time a homeless patient is discharged the hospitals' social/case worker coordinates with the County's CareLink homeless outreach workers as part of the patients transition care planning. Even before SB 1152, the discharge or transition planning process was a challenge. The hospitals' ability to discharge and ensure that patients were not readmitted is dependent on the strength of other parts of the health and behavioral health care system and the coordinated system of care for the unhoused. It also depends on the broader continuum of care for the county's homeless population.

Fundamentally, reducing the number of homeless individuals reduces the burden on their health and behavioral health system and thereby the post-hospital discharge system. We therefore briefly review some key components needed to alleviate homelessness, represented in Figure 9.[56] Housing is a foundation that facilitates access to services and supports needed to recover and achieve stability. Chronic health and behavioral health conditions often affect homeless individuals' ability to stay housed, so ensuring they have access to comprehensive health care is critical. Increasing access to meaningful and sustainable career pathways through job training and employment

FIGURE 9 Important Components to End Homelessness



54 This is estimated by taking 74% of the inpatient discharges, 921, and then dividing that by the 12% estimated to be admitted from the emergency department.

55 OSHPD California Emergency Department and Ambulatory Surgery Patient Data Reporting Manual, Disposition of Patient, July 2020

56 These components are a summary of the e United States Interagency Council on Homelessness (USICH) solutions to homelessness: https://www.usich.gov/solutions/

is also seen as a highly effective way to support individuals as they move out of homelessness. Schools are an important connection for children and youth experiencing homelessness providing safety, stability, and access to community services that can often mitigate the impact of homelessness. There is also a need to ensure access to jail diversion and alternatives to incarceration so that these individuals are not caught in a downward spiral in the criminal justice system where they move from the streets to jail. Lastly, there needs to be a responsive and coordinated crisis response system which prioritizes housing and links these individuals to additional support services to help them resolve crises and secure permanent housing opportunities. While all these components exist in San Joaquin County, some need to be strengthened and their coordination should be further developed as a comprehensive coordinated system of care is still developing.

In our conversations with management and staff at the hospitals, they reported the most difficult patients to manage after discharge were those with medication-intensive conditions. For example, patients with insulin-dependent diabetes need a place for their insulin to be refrigerated and to receive safe, consistent injections. After discharge, some patients need continuing antibiotic treatment, but transportation to outpatient treatment centers is not always available. Providers may also hesitate to leave in PICC lines/IV lines because of liability and safety concerns. Wound care, particularly for feet, requires patients to clean wounds, change dressings, and rest the injury. Many of the emergency shelters are not able to have people stay for the full day to rest as they clean their facilities daily. Accessing transportation for follow-up care or to access other support services was also seen as a key challenge.

In terms of resources that are provided to unhoused patients who are discharged, our survey respondents said that some form of transportation assistance (taxi voucher, bus pass), an informational packet on community resources, and a consult with the department's social worker was common. Difficulties in discharging unhoused patients from the emergency department were centered around patients wanting more resources from the emergency department, such as food or a warm temporary shelter, and providers feeling uncomfortable about the likelihood of losing the patient to follow-up. Of note, when asked about protocols for discharging unhoused patients from the emergency department, almost all our survey respondents were generally unaware of any official hospital protocols.

When a patient is no longer in need of inpatient care, but still required additional rehabilitative care or just was not well enough to return to an unsheltered environment, the hospitals reported several further challenges. While the recuperative care facility at Gospel Rescue Mission was reported to be very valuable, it was not suitable for some patients. While skilled nursing facilities (SNFs) and rehabilitation facilities were used for homeless patient recovery, hospitals reported that nearly all would only accept Medi-Cal enrolled patients and even then, they wanted assurances about housing or other placement arrangements before accepting them as they are similarly obliged to ensure a reasonable discharge plan exists when the patient is eventually ready to leave. As mentioned in Section Four, board and care and room and board facilities were also identified as important destinations for discharging homeless patients. However, there is no organized structure connecting the state licensed board and care facilities with the hospitals and even more informal networks existed between the hospitals' social workers and the county's network of room and board facilities.

With growing coverage and important reforms like CalAIM potentially raising the scope of integrated available services, it is important for the hospitals to ensure that all eligible Medi-Cal recipients are registered or get registered while in their care. While currently not mandated, facilitating homeless individuals' access to other programs such as Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) benefits would also be helpful. Similarly, using the opportunity while in contact to put the unhoused patients in contact with supportive housing resources is

important. The discharge requirements of SB 1152 reinforce the existing relationship that hospital leaders, social workers, and discharge planners have with post-hospital care centers. However, based on the interviews conducted for this analysis those connections are frequently individualized rather than being systematic and connected to the broader system of coordinated entry. In addition, the requirements to offer homeless patients medical screening and testing creates a significant opportunity to build a confidential database on patient needs in the community which can assist in aligning service needs to outreach offerings in the community.

One of the more significant needs that has been further heightened by the SB 1152 requirements is ensuring the existence of a comprehensive coordinated system of care for the homeless population. If there is not a well-functioning system providing preventative and non-acute care, the hospitals' emergency care systems will be the destination for this care. Similarly, if there are no facilities available to discharge patients to, hospitals face continuing to care for patients who do not need their higher level of care. Also, if the community is unable to provide suitable housing options these individuals are likely to have less successful recoveries and additional health care needs. Therefore, beyond just leveraging the mandates of SB 1152 there is a necessity for the County's broader continuum of care to be functioning if additional burdens are not to be put on the hospitals. This is a mutually reinforcing situation that can benefit the homeless patients themselves, the health and behavioral health systems, and the broader continuum of care. In this context, we can identify a set of policy and coordination needs and gaps.

Policy and Coordination Gaps and Needs

- **Coordination within hospitals, between hospitals, and with other caregivers is limited.** While San Joaquin County has recently adopted a comprehensive plan to address homelessness, there are still limited structures in place to facilitate coordination across the entire system. While post-hospital placement of homeless patients is now a requirement, there are no formal structures to coordinate this activity. Coordination across hospitals in the planning and placement of homeless patients is limited and even more stark in terms of the rehabilitation and recovery care system. In addition, there appears to be a need to improve awareness of discharge policies and procedures within the hospitals themselves.
- **Support and Develop San Joaquin County's Coordinated System of Care**
  - » **San Joaquin County Program Administrator for Homeless Initiatives lacks permanent funding and sufficient support.** Despite San Joaquin County's appointment of a Program Administrator for Homeless Initiatives in 2018, that position remains funded through a grant rather than line-item contributions from the county and cities. Significantly, the Grand Jury review has noted that despite the administrator taking on many key functions to facilitate coordination across the system there is no department structure, administrative support, or staff to assist.
  - » **San Joaquin Continuum of Care lacks a committee focused on the health and behavioral health care system.** While the San Joaquin Continuum of Care consists of representatives from across the County's system of homelessness care, it currently does not have a committee focused on the health and behavioral health care system for the homeless. Even if such a coordinating body is decided to be outside the scope of the CoC, it should exist in some form within the county's coordinated system of care.
- **Facilities and Services**
  - » **More Respite Care spots for hospital discharge may be needed.** While one facility already exists, there is a need to examine the potential expansion of medical respite care in the county. The medical respite care program is an important tool in homeless patients transition care. It provides short-term residential care that allows individuals experiencing homelessness the opportunity to rest in a safe environment while accessing medical care and other supportive services.
  - » **Behavioral Health Services May Need Expansion.** Despite policies promoting parity, it is important to evaluate the availability of behavioral health, including substance use disorder treatment services to ensure the necessary spectrum of medical care is available.

SECTION SIX – Recommendations

It is important to recognize that COVID-19 has exacerbated policy issues and strained resources across the state, namely the homelessness crisis, healthcare system capacity, and local budgets. The public health crisis of COVID-19 compounded with major economic fallout has multiple domino effects, such as additional financial strain on resident housing costs, increasing the amount of people at risk, or experiencing homelessness. Additional precautions must be made to protect the public health, especially when sheltering or providing medical treatment to individuals from different households in the same facilities. COVID-19 has also disproportionately affected communities of color and low-income communities, which are already at a higher risk for job loss and experiencing homelessness.[57] There are several social challenges intertwined with improving the health and behavioral health outcomes of homeless individuals ranging from housing and workforce development to socio-economic inequities and substance abuse. Addressing these challenges requires a holistic approach that is inherently collaborative and multi-disciplinary. While creating additional challenges, the pandemic has also illustrated the benefits of effectively coordinating resources and redirecting clients in need of medical care to the appropriate community health services instead of accessing general hospital care. The pandemic has also created a sense of urgency among public health, homelessness, and economic issues to mitigate further damage to communities. The following recommendations draw on this context and insights from the entire analysis to suggest ways to improve people experiencing homelessness' health and behavioral health.

6.1 Support and Develop Integrated Information System

It is necessary to recognize that there are a range of unknowns about both demand for and supply of health and behavioral health care to individuals experiencing homelessness in San Joaquin county. As a result, working collectively to develop actionable data should be a priority. A first step in addressing the information needs is to ensure compliance and reporting of homeless patient care is occurring in the hospitals. In addition, following national best practices such as encouraging staff at all area hospitals to consistently use the ICD-10 (International Classification of Diseases, Tenth Revision) diagnosis code for homelessness (Z59.0) in medical records will make it easier to use hospital data to identify patients who experience homelessness, plan for appropriate discharge and care coordination, and better understand the needs, costs, and patterns of service use for these patients.

Connected Community Network

The Connected Community Network is designed to provide the general public with access to resources and programs offered through community-based organizations. It has a special focus on vulnerable at-need populations and intends to help address a majority of non-clinical factors such as education, social support, and health behaviors that impact an individual's health. United Way of San Joaquin, 211, and Dignity Health are working to develop this network in San Joaquin county.

It also appears that the mandated homeless management information system (HMIS) while valuable and critical to several HUD programs, needs to be examined regarding its adequacy for managing, tracking, and planning across the broader continuum of care. Given this multitude of needs, we suggest that development of a complementary and integrated information system platform might need to be developed. Without reliable information on the scale and nature of homeless patient discharges, scale and/ or scope to build additional capacity or to modify existing

57 https://www.ppic.org/blog/how-covid-19-could-deepen-californias-housing-crisis/?utm_source=rss&utm_medium=rss&utm_campaign=how-covid-19-could-deepen-californias-housing-crisis?utm_source=ppic&utm_medium=email&utm_campaign=blog_subscriber

Unite Us Platform and Network Services

The Unite Us platform provides a unifying infrastructure between health care entities and community-based organizations. Unite Us is designed to build and scale a community's coordinated care network, track outcomes, and identify service gaps and at-risk populations. Once a network partner identifies a person's social needs, they can instantly send a secure electronic referral to the most appropriate network partner(s) for that specific service. Partners involved in that person's care will have visibility into whether or not the referral is accepted and once accepted, whether or not that person received the services and what happened as a result. Network partners can choose to participate in whatever way works best for them and can change how they participate in the network over time. Network partners are connected to each other through Unite Us' shared technology platform. Using an intuitive platform Unite US is designed to support meaningful collaboration, community-wide care coordination, and secure, bidirectional data sharing.

capacity in the system remains unclear. Therefore, in addition to the availability of facilities, better data is needed on the health and behavioral health needs of homeless patients discharged from acute care facilities. While there are many ways to develop this type of information system, we believe that the existing Connected Community Network which is built on the Unite Us Platform holds particular promise.[58] The next step would be to begin a discussion around which system has the best potential to facilitate a coordinated information technology system and what should be the appropriate scope, resources, and time necessary to develop such a platform.

6.2 Adopt an Integrated Healthcare System Framework

The development of a coordinated system of homeless care is a goal of the 2020 San Joaquin County Strategic Plan to address homelessness. Integrated, interdisciplinary care is essential to address the multiple and complex needs of displaced people. Supporting those broad efforts is therefore important but, complementing that is focused coordination of health and behavioral health care. Such an entity would build a system of coordination among health and behavioral health service providers for homeless patients in San Joaquin county. In pursuit of this, we suggest that the Integrated Healthcare framework and program from the Center of Excellence for Integrated Health Solutions (CIHS) be used to guide and support these efforts.[59]

Table 4 presents an overview of the CIHS Integrated Health Care framework, which creates an evaluation of returns from integration to determine what level is most appropriate given local considerations. This framework targets integration across preventative care as well as maintenance and recovery. Evidence from their efforts in other areas suggests that this sort of integrated health care provides cost-effective care to people experiencing homelessness and allows systematically addressing clinical barriers such as conflicting paradigms in physical and behavioral health care systems. It also has been shown to assist in alleviating programmatic barriers such as time constraints, lack of training for interdisciplinary care, information sharing challenges, and concerns about client confidentiality. The coordination facilitated through the Integrated Healthcare framework standardizes how health and social care providers communicate and track outcomes together. It also unites stakeholders from healthcare, government, and the community around a shared goal to improve health.

58 For information on the Connected Community Network see the United Way of San Joaquin at: https://www.unitedwaysjc.org/news/connected-community-network-ccn

Additional information on the Connected Community Network is also available at the Dignity Health site at: https://www.dignityhealth.org/ccn/how-it-works

Information on the Unite Us platform itself is available at: https://uniteus.com/

59 https://www.thenationalcouncil.org/integrated-health-coe/

This coordination supports WPC person-centered approaches to homeless care management and 2the community's broader coordination goals. Targeted ecological health care models visualize patients at the center of a network of relationships and challenges. Thereby, it also makes a significant contribution to strengthening other parts of the health and behavioral health system that hospitals and other incident care facilities depend on when caring for people experiencing homelessness.

TABLE 4 CIHS Standard Framework for Levels of Integrated Health Care

Coordinated	
Level 1	Minimal Collaboration
Level 2	Basic Collaboration at a Distance
Co-Located	
Level 3	Basic Collaboration Onsite
Level 4	Close Collaboration Onsite with Some System Integration
Integrated	
Level 5	Close Collaboration Approaching an Integrated Practice
Level 6	Full Collaboration in a Transformed/ Merged Integrated Practice

6.3 Advocate for Continued Application of Supportive Housing

A supportive housing framework provides tenants affordable housing with wraparound support services, which stabilizes their lives and significantly reduces returns to jail and homelessness, reliance on emergency health services, and improves overall quality of life. There are a few supportive housing programs currently operating in San Joaquin County. They provide housing to individuals who face a multitude of complex medical, mental health, and/or substance use issues that are co-occurring. While this is only one part of a solution that provides access to affordable and sustainable permanent housing, it targets populations with a reliance on emergency health services. Therefore, if the community's hospitals focus on the function of supportive housing programs, they can link their efforts directly to their supporting the broader continuum of care of homeless patients and support the goal of developing housing solutions which is also a goal of the 2020 San Joaquin County Strategic Plan to address homelessness. Housing solutions of all sorts are a foundation for addressing homelessness and thereby alleviating its specifically associated health and behavioral health challenges. It also creates discharge destinations that improve post-hospital health outcomes, facilitate the prevention of issues that increase demand for health and behavior health service in general, and especially increase demand for the hospitals' emergency care system.

APPENDIX A – Health and Behavioral Health Services and Facilities

Provider	Facility/Program/Service	City	Health & Mental Health Services
Community Medical Centers	Community Medical Centers - Admin Center	Stockton	Network of 21 neighborhood health centers
	Channel	Stockton	Family Practice, Internal Medicine, Women's Health, Pediatrics, Optometry, Chiropractic, Podiatry, OB/GYN, Perinatal, Health Education, Nutritional Counseling, Behavior Health, EIS/HIV testing, Physical Therapy, Preventive Dental, Diabetic Clinic, CPSP/SS, Pharmacy, Radiology/X-Ray, Dietitian, Psychiatric
	Gleason House	Stockton	Healthcare for the Homeless, Family Practice, Internal Medicine, Health Education, Nutritional Counseling, Behavioral Health, Case Management, and HIV Testing and Treatment.
	California St. (Pediatrics)	Stockton	Pediatrics
	King	Stockton	Family Practice, Women's Health, Pediatrics, Behavior Health
	Mariposa Road	Stockton	Family Practice, Pediatrics, OB/GYN, Health Education, Women's Health, CPSP, Behavioral Health
	Waterloo	Stockton	Dental - Limited Services Available, Family Practice, Family Planning Service, Teen Health Services, Pediatrics, OB/GYN, Perinatal, Health Education, Behavioral Health, Outreach and Enrollment Counselors, WIC, Sobering Center
	East March Lane - Caretoday & Primary Care	Stockton	Adult Medicine, Pediatrics, Extended Hours, Same Day Acute Care, Behavioral Health, Women's Health, Health Education, Case Management, Enrollment
	Weberstown Dental Clinic	Stockton	Limited Dental
	West Lane	Stockton	Family Practice, Internal Medicine, Diabetic Clinic, Pediatrics, Peds Cardiology, Peds Endocrinology, Peds Gastroenterology, Hepatology & Nutrition, OB/GYN, Perinatal, Podiatry, Women's Health, Health Education, Nutritional Counseling, Behavior Health, Dietitian, Enrollment, CPSP/SS, and HIV Testing and Treatment
	Sutter Street	Stockton	Immunizations, school enrollment physicals
	Lawrence	Lodi	Family Practice, Women's Health, Pediatrics
	Lodi	Lodi	Family Practice, Women's Health, Pediatrics, Podiatry, Dietitian, Geriatrics, Psychiatric, CPSP/SS, Health Education, EIS/HIV, Behavior Health, Enrollment
	Lodi Vine - Pediatrics & Family Care Clinic	Lodi	Pediatrics & Family Care
	Manteca	Manteca	Family Practice, Internal Medicine, Pediatrics, OB/GYN, Perinatal, Health Education, Nutritional Counseling, Podiatry, Laboratory and HIV Testing and Treatment
	Tracy Central	Tracy	Family Practice, Internal Medicine, Pediatrics, OB/GYN, Perinatal, Health Education, Nutritional Counseling, Behavioral Health, HIV Testing and Treatment
	Tracy Grant Line	Tracy	Family Practice, Internal Medicine, OB/GYN, Pediatrics, Behavior Health, Health Education, CPSP/SS, Dietitian, Enrollment, Psychiatry. WIC
	Tracy Dental Clinic	Tracy	Limited Dental
Community Partnership for Families of San Joaquin	Dorothy L Jones Community Resource Center [CMC]	Stockton	family resource center in southeast stockton. Focus on educational success, health and wellbeing, neighborhood safety. Partners with CMC and Table Community Foundation

APPENDIX A – Health and Behavioral Health Services and Facilities

Provider	Facility/Program/Service	City	Health & Mental Health Services
	Tracy Family Resource Center	Tracy	help AB109 realignment population (previous convicts) reintegrate into society. Partners with community based orgs, Sutter Hospital Community Foundation. Homeless outreach first Wednesday of every month
Dignity Health/St. Joseph's	St. Joseph's Behavioral Health Center	Stockton	35-bed inpatient hospital, day treatment, and outpatient services for those psychiatric and dependency disorders
Fathers & Families of San Joaquin	Stockton Trauma Recovery Center	Stockton	mental health treatment and case management for victims of violent crimes
Gospel Center Rescue Mission	GCRM Recuperative Care	Stockton	Recuperative care/medical respite care facility
	The New Life Program (NLP)	Stockton	Residential addiction treatment program for men, women, and families
H.O.P.E. Ministries	Raymus House	Manteca	counseling and mental health referrals
	HOPE Family Shelter	Manteca	counseling and mental health referrals
McHenry House	Tracy Family Shelter	Tracy	stress and anger counseling, substance abuse counseling,
Ready to Work		Stockton	case management, counseling, substance abuse support
St. Mary's Dining Room	St. Mary's St. Raphael's Dental Clinic	Stockton	volunteer dentists and dental students provide cleanings, extractions, fillings
	St. Mary's Virgil Gianelli Medical Clinic	Stockton	volunteer doctors, nurses, chiropractors, pharmacists, eye exams and prescriptions, health classes, diabetes education
Salvation Army	Adult Rehabilitation Center	Stockton	counseling, substance abuse rehabilitation
	Hope Harbor Shelter	Lodi	substance abuse rehabilitation
	Corps Community Center	Stockton	Domestic violence services
San Joaquin County Behavioral Health Services	Grant House	Stockton	Acute stabilization in a structured and therapeutic environment.
	Bright House	Structured behavioral program for the mentally ill.	
	Lodi Clinic	Lodi	Children and Adult outpatient program that provides psychiatric evaluation, medication support services, psycho-education, case management and group therapy.
	Psychiatric Health Facility (PHF)	Stockton	Provides 24-hour inpatient hospitalization with supportive psychiatric, medical, social work, and nursing treatment.
	Tracy Adult Outpatient Clinic	Tracy	Adult outpatient psychiatric services
	Homeless Youth Services	Stockton	Mental Health Outpatient Services for youth and their children, who are at risk of homelessness or running away
	Stockton Clinic	Stockton	Mental Health Outpatient Children and Youth Services, substance abuse services
	Manteca Clinic, with Valley Community Counseling (VCC)	Manteca	Mental Health Outpatient Children and Youth Services
	Tracy Clinic, with Valley Community Counseling (VCC)	Tracy	Mental Health Outpatient Children and Youth Services
	Family Ties	substance abuse services	
	Recovery House	substance abuse services	

APPENDIX A – Health and Behavioral Health Services and Facilities

Provider	Facility/Program/Service	City	Health & Mental Health Services
	Central Intake Unit	Stockton	substance abuse services
	Aegis Treatment Center	Stockton	substance abuse services
	5th Street Medical Clinic Stockton	Stockton	substance abuse services
	Aegis Treatment Center / Healthy Connections (California St.)	substance abuse services	
	Healthy Connections Lodi Clinic	Lodi	substance abuse services
	Manteca Healthy Connections	Manteca	substance abuse services
	MedMark Treatment Center	Stockton	substance abuse services
San Joaquin County Mental Health Services	The Crisis Clinic & Crisis Intervention Center	Stockton	mental health evaluations and referrals, non-urgent and non-crisis also welcome
Stockton Shelter for the Homeless	Stockton Shelter for the Homeless	Stockton	comprehensive assistance for pregnant mothers and newborns, drug screening and drug program access support
Tracy Community Connections Center	Tracy Community Connections Center	Tracy	health care referrals, hygiene and showers, housing and job search assistance
Women's' Center Youth & Family Services	Main Office	Stockton	domestic violence services, sexual assault services, human trafficking, parent academy, therapy services,
	DAWN House Shelter	Stockton	emergency shelter for women and women with children fleeing domestic violence
	California Office	Stockton	domestic violence services, sexual assault services, human trafficking, parent academy, therapy services,
	Safe House emergency shelter	Stockton	shelter and supportive services for runaway, throwaway and homeless youth
	Opportunity House Transitional Living Program		shelter and supportive services to prepare runaway, throwaway, and homeless youth for independent living
	North County	Lodi	domestic violence services, sexual assault services, human trafficking, parent academy, therapy services,
	South County	Manteca & Tracy	domestic violence services, sexual assault services, human trafficking, parent academy, therapy services,
	Serenity House	Tracy	emergency shelter for women and women with children fleeing domestic violence
Care Link	Community Medical Centers [Gleason House]		Medical outreach services & 24 hour emergency on-call medical services
San Joaquin County Behavioral Health Services	Allies Program II	Stockton	Provides treatment to clients with issues of substance abuse, mental illness and trauma
	Community Adult Treatment Services (CATS)	Stockton	Adult outpatient program that provides psychiatric evaluation, medication support services, psychoeducation, short-term group therapy, provides case management monitoring and follow-up for clients who are discharged from the inpatient program and who are at risk of re-hospitalization.
	Crisis Community Response Team (CCRT)	Stockton	Mobile multi-disciplinary crisis team for community adult mental health outreach, early intervention, and joint field response with law enforcement for crisis 5150 detention evaluations
	Crisis Intervention Services (CIS)	Stockton	Provides emergency crisis services in Mental Health Center or remotely as necessary
	Homeless Outreach Program		Provides outreach services including assessment, evaluation, and linkage to appropriate programs
	Shelters for the Homeless		Provides services at shelters

APPENDIX A – Health and Behavioral Health Services and Facilities

Provider	Facility/Program/Service	City	Health & Mental Health Services
San Joaquin County Public Health Services	Local Oral Health Program (LOHP) [SJ TEETH]	Stockton	improve dental health in community with focus on most vulnerable and underserved communities
	Communicable Disease Control Program	Stockton	provides surveillance & case investigation of all reportable communicable diseases, outbreak management, contact identification, patient & community education
	Stockton Health Center	Stockton	confidential STD testing and treatment, HIV testing, and family planning services
	Family Health Programs	Stockton	programs address preventable illnesses and death among women and children
San Joaquin Treatment + Education for Everyone on Teeth + Health (SJ TEETH) Coalition	Administered by First 5 San Joaquin	Stockton	improve dental health in community with focus on most vulnerable and underserved communities

APPENDIX B – July 2020 Emergency Shelter Inventory for San Joaquin County

Emergency Shelter Beds in San Joaquin County						
City	**Adult Men**	**Adult Women**	**Families with Children***	**Special Populations****	**Total Beds**	**% of Total Beds**
Lodi	59		36		95	12%
Manteca			87		87	11%
French Camp	16	35			51	6%
Stockton	230	58	123	116	527	67%
Tracy			32		32	4%
Other					0	0%
Total Service Capacity	**305**	**93**	**278**	**116**	**792**	**100%**

* Families with Children: Total Count excludes 198 motel vouchers which may be used throughout the County.

** Special Populations: Youth, Veterans, Mentally Ill, and Women fleeing situations of Domestic Violence.

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