



State of California  
**BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY**



# **California Interagency Council on Homelessness**

## **Council Meeting**

March 4, 2026

# Agenda

- I. Call to Order, Tribal Land Acknowledgement, and Roll Call
- II. Consent Calendar
- III. Council Co-Chair Opening Remarks
- IV. Executive Officer Updates
- V. Advisory Committee Updates
- VI. Lived Experience Advisory Board Updates
- VII. Councilmember Department Updates
- VIII. General Public Comments
- IX. Final Remarks and Adjournment

# I. Call to Order, Tribal Land Acknowledgement, and Roll Call

# Tribal Land Acknowledgement

We wish to acknowledge that Sacramento is the unceded homeland of the Southern Maidu, Valley and Plains Miwok, the Nisenan people, the Patwin Wintun people, and members of the Wilton Rancheria Tribe, who have inhabited this landscape since time immemorial.

We extend our gratitude to the ancestors of all California Native American Tribes and their descendants, as we recognize that wherever we are joining from in our virtual community, we are all on California Native American land.

# Council Member Roll Call

- Please say "here" or "present"

## II. Consent Calendar

Adoption of the Meeting Summary from:

- December 3rd, 2025, Council Meeting
- September 3rd, 2025 Council Meeting

# Public Comment on Agenda Item II - Consent Calendar

- Public comment related to Consent Calendar items only
- If joining by Zoom, click the “raise hand icon”
- If connected by phone, press “\*9” to indicate that you would like to comment

# Council Member Vote

- Shall items on the Consent Calendar be approved?

# III. Council Co-Chair Opening Remarks

# IV. Executive Officer Updates

# V. Advisory Committee Updates

# VI. Lived Experience Advisory Board (LEAB) Updates

# VII. Councilmember Department Updates



# The Behavioral Health Services Act (BHSA)

*California Interagency Council on Homelessness  
(Cal ICH)*



**Secretary Kim Johnson**

The California Health and Human Services Agency (CalHHS)

# What does Success Look Like?

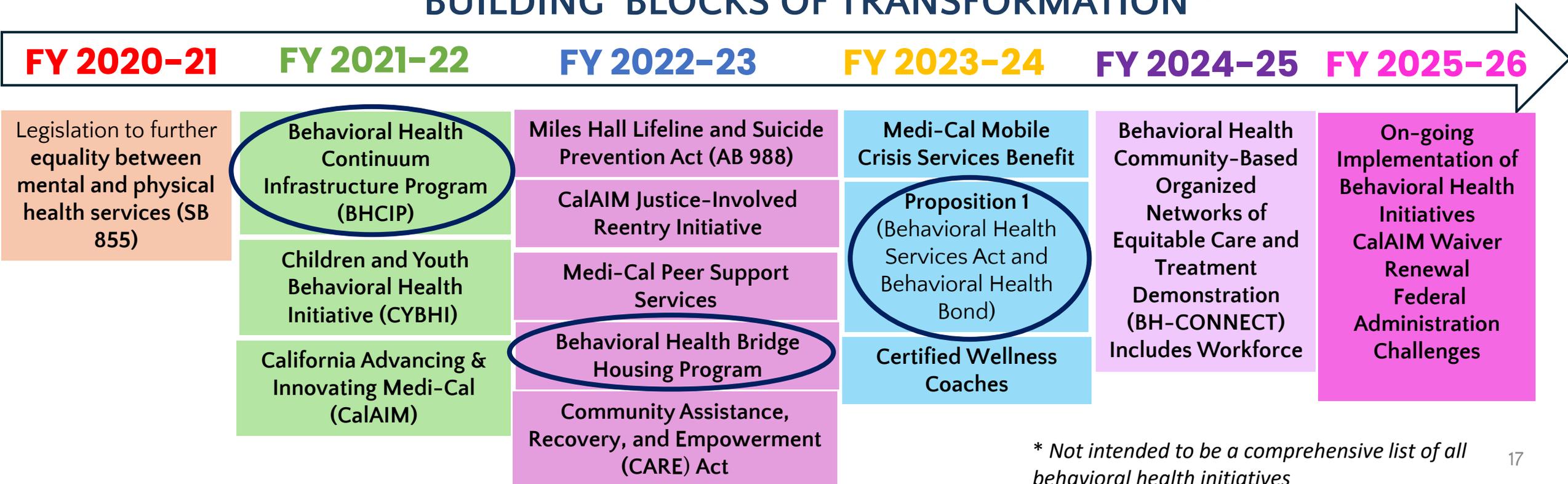
**“Mental Health for All”** – building a **stronger and more equitable behavioral health system.**

- Every Californian—especially people who have had the hardest time getting help—can get high-quality mental health and substance use treatment when and where they need it.
- More treatment services and housing, growing and diversifying the workforce, and making care more culturally and linguistically responsive.
- Focusing on prevention, early help, comprehensive services determined by need, and long-term recovery to make it easier for people to get the right care at the right time—leading to better health and stronger communities across the state.

# Building Out California's Behavioral Health Continuum of Care



## BUILDING BLOCKS OF TRANSFORMATION \*



\* Not intended to be a comprehensive list of all behavioral health initiatives

# Key Opportunities

## Sustainable Investment in Workforce

3% of funds are allocated to the California Department of Healthcare Access & Information (HCAI) to support the behavioral health workforce statewide.



## Inclusion of Substance Use Disorder

BHSA expands eligible services beyond those with serious mental illness to include SUD treatment for children, youth, adults & older adults.



## Housing is Health

Housing is an essential component of behavioral health treatment, recovery & stability.



## Supporting Children & Youth

Supports children & youth who have serious mental illness & behavioral health needs. Intervening early in the life course reduces the possibility of having mental health or SUD needs in the first place.



## Measuring Progress & Impact

Counties are required to submit *Integrated Plans and Behavioral Health Outcomes, Accountability, and Transparency Reports*, which must cover ALL behavioral health services—including those funded by BHSA, Medi-Cal, county realignment & other funds.



# Target the Most In Need & Reduce Disparities

## BHSA priority populations:



**Homeless** or at risk of homelessness



Involved in the **criminal justice system** or at risk of criminal justice system involvement



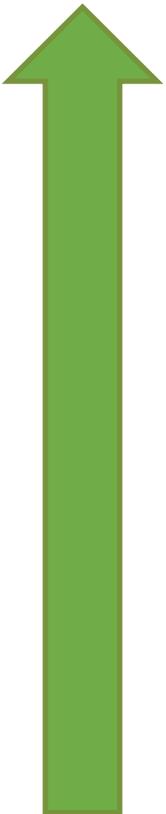
Leaving an **institutional setting** or at risk of institutionalization (e.g. conservatorship)



**Children and youth**, including those involved in the **child welfare system**

# Achieving Transformation: Measure Impact

## Goals for Improvement

- 
- Care Experience
  - Access to Care
  - Quality of Life
  - Engagement in School
  - Engagement in Work
  - Social connection
  - Prevention & Treatment of Co-Occurring  
Physical Health Conditions

## Goals for Reduction

- 
- Suicides
  - Overdoses
  - Untreated BH Conditions
  - Homelessness
  - Institutionalization
  - Justice Involvement
  - Removal of Children from home

# California's Vision: Mental Health for ALL

## Building Out California's Behavioral Health Continuum of Care



Prevention &  
Early Intervention



Parity in Care



Outpatient  
Care



Crisis Care



Inpatient  
Care



Supportive  
Care

**Workforce and Facilities/Housing**

**Equity**

**Oversight and Accountability**

# California Interagency Council on Homelessness (Cal ICH)

*Michelle Baass, Director*

*Glenn Tsang, Policy Advisor for Homelessness and Housing*  
Department of Health Care Services

# Agenda

- » Behavioral Health Transformation Overview
- » Behavioral Health Services Act – Housing Interventions
- » Questions

# Behavioral Health Transformation (BHT)

# Key Components of BHT



## Behavioral Health Services Act

- ✓ Expands services to include treatment for those with SUDs
- ✓ Identifies priority populations
- ✓ Updates local categorical funding buckets, including:
  - ✓ 30% for housing interventions
  - ✓ 35% for Full Service Partnership (FSP) Programs
  - ✓ 35% for Behavioral Health Services and Supports
- ✓ New investments in housing and workforce



## Increasing Accountability

- ✓ Creates County Integrated Plan
- ✓ Establishes Outcomes, Accountability, and Transparency Report
- ✓ Creates a BHSA Revenue Stability Workgroup
- ✓ Directs DHCS to develop a plan for parity between commercial and Medi-Cal MH/SUD benefits
- ✓ Requires alignment of county behavioral health plan contracts with Medi-Cal Managed Care Plan (MCP) contracts



## Infrastructure Bond Act

A \$6.38 billion bond to build 11,150 new treatment beds and housing units, specifically:

- ✓ Grants for behavioral health treatment and residential settings
- ✓ Housing investments for veterans who are experiencing or at risk of homelessness
- ✓ Other investments for Californians who are experiencing or at risk of homelessness

# Behavioral Health Services Act

## Behavioral Health Services Act:

- » **Updates allocations** for local services and state-directed funding categories
- » Broadens the target population to **include individuals with Substance Used Disorders (SUDs)**
- » Focuses on the **most vulnerable and at-risk**, including children and youth
- » Advances community-defined practices as a key strategy for **reducing health disparities** and **increasing community representation**
- » Revises county processes and improves **transparency and accountability**

## Behavioral Health Services Act Funding Overview

90% County Allocation

10% State Directed

# Behavioral Health Services Act Funding Breakdown

90%

**County Allocations**

30%

## **Housing Interventions**

Interventions include rental subsidies, operating subsidies, shared housing, and family housing for eligible children and youth.

35%

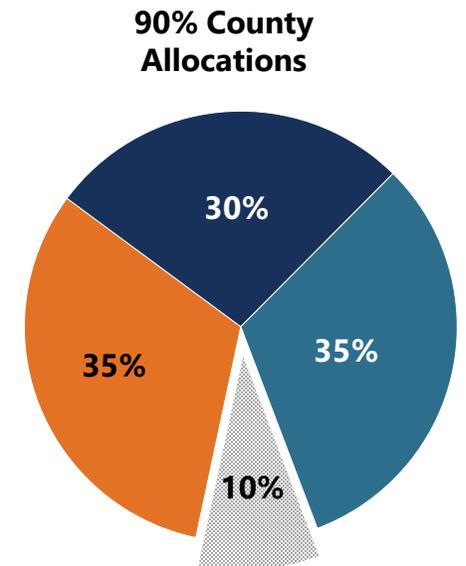
## **Full Service Partnership (FSP) Services**

Comprehensive and intensive care for people at any age with the most complex needs (also known as the “whatever it takes” model).

35%

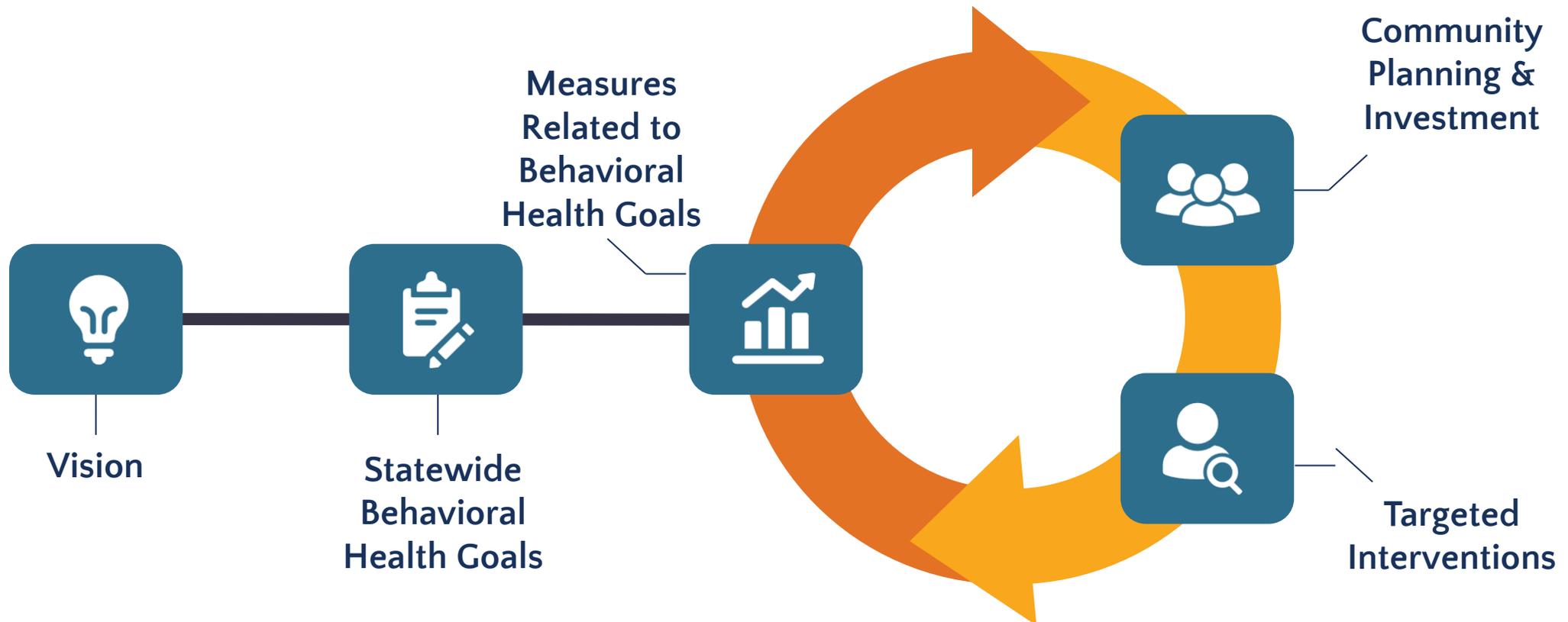
## **Behavioral Health Services and Supports (BHSS)**

Includes early intervention, outreach and engagement, workforce, education and training, capital facilities and technological needs, and innovative pilots and projects.



# Population Behavioral Health Framework

DHCS is developing a **population behavioral health approach** to meet the needs of all individuals eligible for behavioral health services, improve community well-being, and promote health equity. The approach is designed to enable the behavioral health delivery system to make data-informed decisions to better meet the needs of individuals within the communities they serve.



# Statewide Population Behavioral Health Goals

**DHCS' behavioral health approach is grounded in the following 14 goals to improve health and wellbeing of Californians living with behavioral health needs.**



## **Goals for Improvement**

1. Care Experience
2. Access to Care
3. Engagement in School
4. Engagement in Work
5. Prevention and Treatment of Co-Occurring Physical Health Conditions
6. Quality of Life
7. Social Connection



## **Goals for Reduction**

1. Suicides
2. Overdoses
3. Untreated Behavioral Health Conditions
4. Institutionalization
5. Homelessness
6. Justice-Involvement
7. Removal of Children from Home

# Behavioral Health Continuum Infrastructure Program

- » In 2021, DHCS was authorized to establish the Behavioral Health Continuum Infrastructure Program (BHCIP) for eligible grantees to expand substance use disorder and mental health facilities across California.
  - Between November 2021 and June 2023, DHCS awarded **\$1.65 billion** to support mobile crisis services (round 1), county and tribal planning (round 2), and expansion of SUD and mental health facilities (rounds 3-5).
- » The Infrastructure Bond Act of 2024 provides additional funding for BHCIP grants.
  - An **additional \$3.3 billion** was conditionally awarded in May 2025 through the first round of Bond BHCIP funding. DHCS is reviewing applications for the second round of BHCIP Bond funding, and award announcements are anticipated in late Spring 2026.

## BHCIP rounds 3-5 have supported:\*

**2,601**

New residential and inpatient beds

**281,146**

Individuals served in outpatient settings

## Through new BHCIP Bond funding, DHCS anticipates:\*

**6,800**

New residential and inpatient beds

**26,700**

New outpatient slots

» *\*Data sourced from the [BHCIP dashboard](#) and is subject to change.*

# Housing Interventions (30% County Allocation)

# California's Investments in Behavioral Health Housing

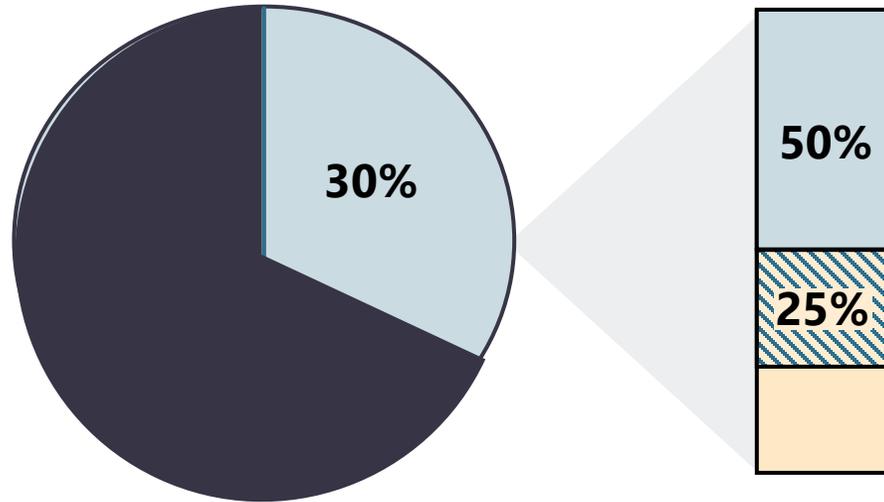
California is currently making unprecedented investments, both one-time and ongoing, to dramatically expand community-based behavioral health housing and social supports for individuals living with mental illness and/or a substance use disorder.

## **DHCS Key Housing Related Investments:**

- » Behavioral Health Bridge Housing Program
- » New behavioral health initiatives under CalAIM, including Community Supports and Transitional Rent
- » ***Behavioral Health Services Act, Housing Interventions***

# Housing Interventions Funding Requirements

**30% of the funds distributed to counties must be used for Housing Interventions**



**50% of the Housing Intervention funds must be used for persons who are chronically homeless, with a focus on individuals living in encampments**

**Up to 25% of the Housing Intervention funds may be used for Capital Development projects**

- » Counties have the flexibility to move 7% of funds to/from Housing Interventions into another category (FSP or BHSS)
- » Counties with a population of less than 200,000 may request an exemption from the required 30% allocation of Behavioral Health Services Act funds for Housing Interventions\* (*Note: exemption process under development*)
- » If a capital development project recognizes chronically homeless individuals as a priority population, the project funding will contribute toward the 50% requirement.

# Housing Interventions Component

The development of the Housing Interventions component of the Behavioral Health Services Act funding breakdown reflects the following policy priorities:

- » Reduce homelessness among those with a behavioral health condition
- » Provide individuals with Permanent Supportive Housing (PSH)
- » Connect individuals to supportive behavioral health services
- » Support the provision of low-barrier, harm reduction, and Housing First principles
- » Complement ongoing state, county, city, Continuum of Care (CoC), and tribal efforts to address homelessness
- » Provide flexibility for counties to respond to local conditions and needs and innovate

# Eligible Populations for Housing Interventions

## To qualify for Housing Interventions, individuals must:

- » Meet Behavioral Health Services Act eligibility requirements; and
- » Meet the Behavioral Health Services Act definition of:
  - **Experiencing homelessness;**
  - **At risk of homelessness; or**
  - **Chronically homeless**
- » Persons eligible for Housing Interventions under the Mental Health Services Act (MHSA)

## Priority Populations

- » Children and youth in or at risk of being in the juvenile justice system, reentering the community from a youth correctional facility, in the child welfare system, or at risk of institutionalization
- » Adults or older adults in or at risk of being in the juvenile justice system, reentering the community from prison or jail, at risk of conservatorship, or at risk of institutionalization

*Note: The provision of Housing Interventions to individuals with a Substance Use Disorder is optional for counties.*

# Experiencing Homelessness and At Risk of Homelessness

## Definition

- » For purposes of the BHSA, DHCS is adopting the definitions of experiencing homelessness and at risk of homelessness consistent with CalAIM Community Supports, aligning with the federal definition provided in 24 CFR Section 91.5.

## Modifications

- » Exiting institutions or incarceration qualifies as homeless if previously or newly homeless during stay.
- » Imminent housing loss timeframe extended to 30 days.
- » No income threshold required for homeless status.

## Eligibility Nuances

- » Anyone previously homeless or at risk before receiving Transitional Rent or certain MHSA housing is considered homeless for Behavioral Health Services Act purposes.

# Allowable Expenditures for Housing

County programs for housing interventions may include:

- » Rental Subsidies (including project-based housing and master leasing)
- » Operating Subsidies
- » Other Housing Supports
  - » Landlord Outreach and Mitigation Funds
  - » Participant Assistance Funds
  - » Housing Transition Navigation Services and Tenancy and Sustaining Services
  - » Outreach and Engagement
- » Allowable Settings – including Permanent Supportive Housing,
- » Capital Development Projects

# Allowable Settings: Permanent, No Time Limit

**Housing Interventions funding will be allowable, without time-limits, in the following settings:**

- » Supportive housing
- » Apartments, including master-lease apartments
- » Single and multi-family homes
- » Housing in mobile home communities
- » Single room occupancy units
- » Accessory dwelling units, including Junior Accessory Dwelling Units
- » Tiny Homes
- » Shared housing (i.e., living with roommates)
- » Recovery/Sober Living housing, including recovery-oriented housing
- » Assisted Living (Adult Residential Facilities, Residential Facilities for the Elderly, and licensed board and care)
- » License-exempt room and board
- » Other settings identified under the Transitional Rent benefit

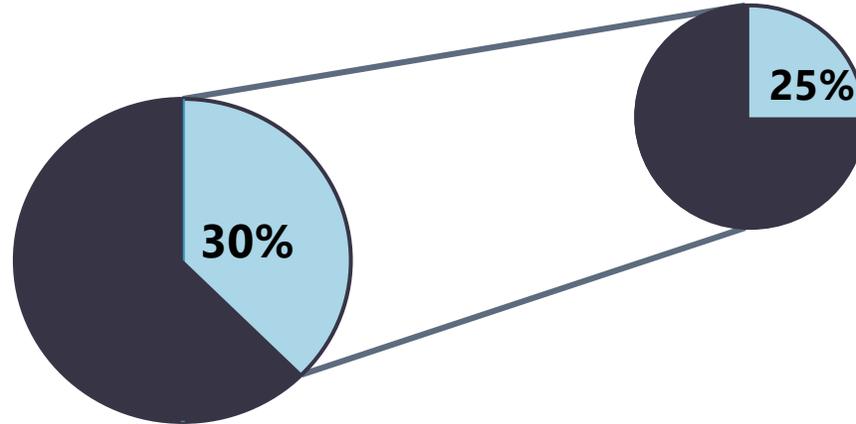
# Allowable Settings: Interim, Time Limit

**Housing Interventions funding will be allowable, with time-limits, in the following settings, once Transition Rent benefit is exhausted:**

- » Hotel and motel stays
- » Non-congregate interim housing models
- » Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls), does not include behavioral health residential treatment settings
- » Recuperative Care
- » Short-Term Post-Hospitalization housing
- » Tiny homes, emergency sleeping cabins, emergency stabilization units
- » Peer respite
- » Other settings identified under the Transitional Rent benefit

# Capital Development Project Funding

**30% of the funds distributed to counties must be used for Housing Interventions**



**Up to 25% of the Housing Intervention funds may be used for Capital Development projects**

- » Counties can use capital development funds to fully fund projects or fill funding gaps in developments with permanent supportive housing (PSH) units for Behavioral Health Services Act eligible individuals and families.
- » Funds may be accrued over multiple years if counties follow state reversion rules.
- » PSH developments often require combining multiple funding sources; counties should align requirements with other programs to simplify administration.
- » The funding cap is \$450,000 per housing unit for construction or rehabilitation.

# Questions

# Resources

## DHCS Websites



- » See the [DHCS Housing for Health](#) website for more information on all of DHCS' housing initiatives
- » Explore the [Behavioral Health Transformation](#) website to discover additional information and access resources.

## Technical Assistance



DHCS provides technical assistance, including the development of informational materials, that counties can use to create their Integrated Plan.

## Questions and Feedback



Please send any other questions or feedback about Behavioral Health Transformation to [BHTInfo@dhcs.ca.gov](mailto:BHTInfo@dhcs.ca.gov).

## BHT Policy Manual



For more information on the [BHT Policy Manual](#) or specifically on Housing Interventions, FSP and BHSS, please visit [7. BHT Components and Requirements](#).

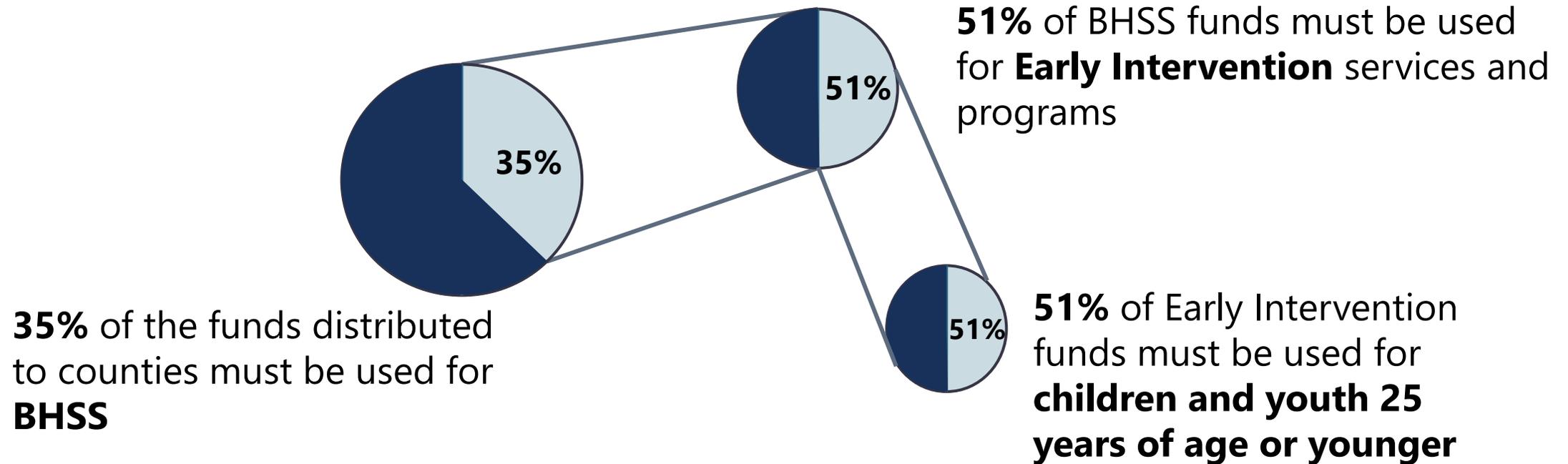
# Thank You

For More Information

[BHTinfo@dhcs.ca.gov](mailto:BHTinfo@dhcs.ca.gov)

# Behavioral Health Services and Supports (35% County Allocation)

# Behavioral Health Services and Supports (BHSS) Funding Requirements



Counties have the flexibility to transfer 7% of funds from BHSS into another funding category (FSP or Housing Interventions) for a maximum total shift of 14% into a single funding category.

# Behavioral Health Services and Supports

BHSS funds are used to provide supportive services to individuals that may not qualify for FSP services, early intervention programming, and certain infrastructure needs. Per WIC Section 5892, BHSS includes:

- » Early Intervention
- » Children's, Adult, and Older Adult Systems of Care
- » Outreach and Engagement
- » Workforce, Education, and Training
- » Capital Facilities and Technological Needs
- » Innovative behavioral health pilots and projects

Other than Early Intervention, counties are not required to fund any of the listed program categories. Counties have the flexibility to fund any other category according to local needs.

# Behavioral Health Services and Supports

<b>Early Intervention</b>	<ul style="list-style-type: none"><li>» Must include 1) outreach, 2) access and linkage to care, and 3) mental health and substance use disorder early treatment services and supports</li><li>» Include culturally and linguistically appropriate interventions</li><li>» Emphasize the reduction of the likelihood of adverse outcomes, including homelessness</li></ul>
<b>Children's, Adult, and Older Adult Systems of Care</b>	<ul style="list-style-type: none"><li>» May cover services for individuals who are not enrolled in an FSP and that do not include Housing Interventions</li></ul>
<b>Outreach and Engagement</b>	<ul style="list-style-type: none"><li>» May cover activities and strategies that reach, identify, and engage individuals and communities in the behavioral health system, including peers and families, and to reduce disparities</li><li>» Distinct from those that may be funded as part of BHSS Early Intervention Programs, Housing Interventions, or FSP programs</li></ul>

# Behavioral Health Services and Supports

<b>Workforce, Education, and Training</b>	<ul style="list-style-type: none"><li>» May fund, in accordance with county needs, activities to support employment in the Public Behavioral Health System (including county-contracted providers), including but not limited to:<ul style="list-style-type: none"><li>• Workforce Recruitment, Development, Training, and Retention</li><li>• Professional Licensing and/or Certification Testing and Fees, Continuing Education</li><li>• Loan Repayment, Retention Incentives and Stipends</li><li>• Internship and Apprenticeship Programs</li></ul></li></ul>
<b>Capital Facilities and Technological Needs</b>	<ul style="list-style-type: none"><li>» Projects may include the acquisition and development of land, the construction or renovation of buildings, or the development, maintenance, or improvement of information technology to support behavioral health administration and services.</li></ul>
<b>Innovative Behavioral Health Pilots and Projects</b>	<ul style="list-style-type: none"><li>» Counties may pilot and test innovative behavioral health models of care programs or innovative promising practices for programs in all funding components (BHSS, FSP, Housing Interventions).</li><li>» These innovative promising practices will be funded through each component.</li></ul>

# Full Service Partnership (35% County Allocation)

# Full Service Partnership (FSP)

- » **FSP programs** provide individualized, team-based care to individuals living with significant behavioral health needs through a “whatever it takes” approach.
- » **Participants benefit** from a community-based, whole-person approach that is trauma-informed, recovery-focused, age-appropriate, and delivered in partnership with families or an individual’s natural supports.
- » **Required Services:** Assertive field-based initiation for SUD, Assertive Community Treatment (ACT) /Forensic Assertive Community Treatment (FACT)\*\* or FSP Intensive Care Management (ICM). High-Fidelity Wraparound (HFW)\*\* Individual Placement and Support (IPS) model of Supported Employment\*\*

# Required Services

- » **Assertive Community Treatment (ACT)** is a highly established, evidence-based practice (EBP) for people with complex, significant behavioral health needs and a treatment history (e.g., hospital/ER, residential care). ACT is designed for individuals often experiencing homelessness, justice involvement, and/or low engagement with traditional outpatient services.
- » **Forensic Assertive Community Treatment (FACT)** builds on ACT for people with significant needs who are also involved with the criminal justice system, supporting community reintegration and reducing recidivism risk.
- » **The Individual Placement and Support (IPS)** model of supported employment is an evidence-based intervention that engages people with severe mental illness in finding and maintaining competitive employment or education of their own choice.
- » **High Fidelity Wraparound** is a team-based and family-centered evidence-based practice that includes an “anything necessary” approach to care for children/youth living with the most intensive mental health or behavioral challenges.

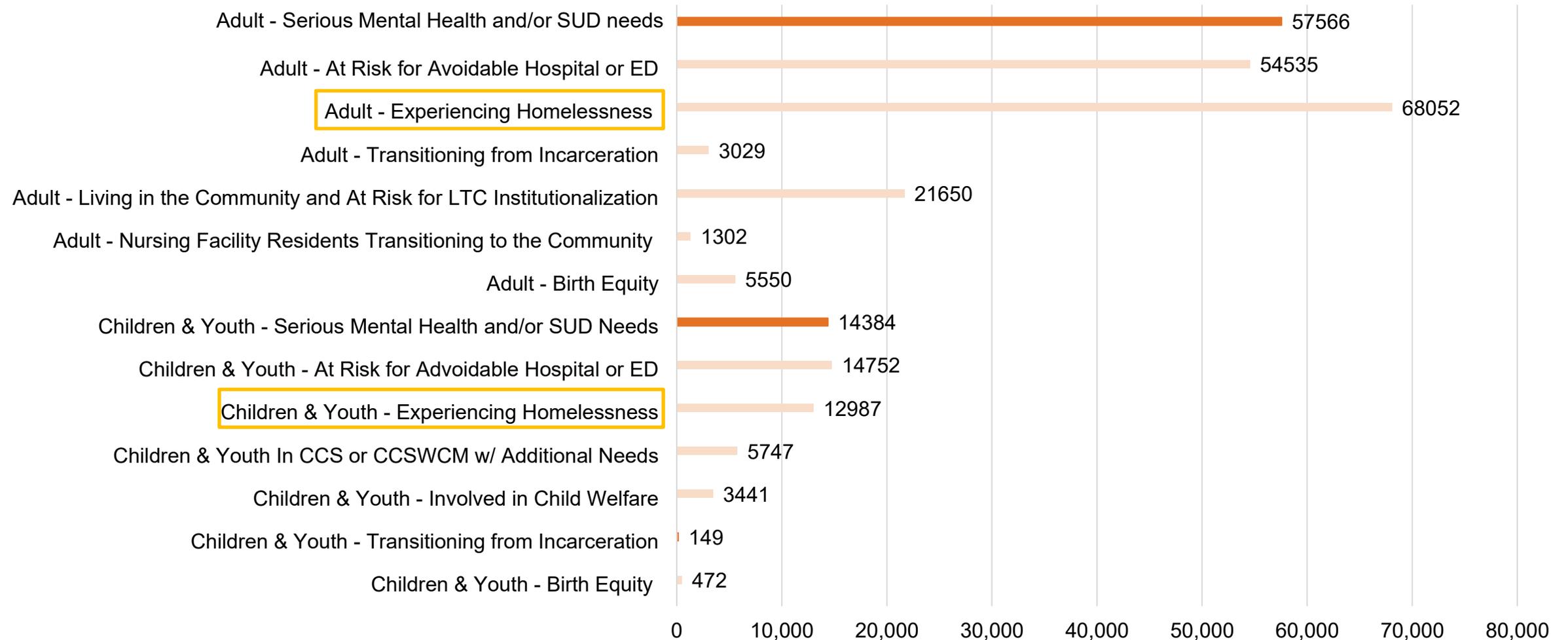
# Adult FSP Levels of Care

## Intensive Case Management (ICM)

- » FSP ICM supports people **stepping down from ACT or those with moderate-to-significant** needs who don't meet ACT eligibility
- » FSP ICM is **team-based, community-focused, and long-term, with small caseloads and a multidisciplinary team delivering individualized supports** (e.g., peers, crisis intervention, psychosocial rehab, psychotherapy, medication management).
- » **Step-down beyond FSP:** when someone no longer meets FSP-level need, services may transition to outpatient mental health and substance use disorder (SUD) care funded through Behavioral Health Services and Supports (BHSS).

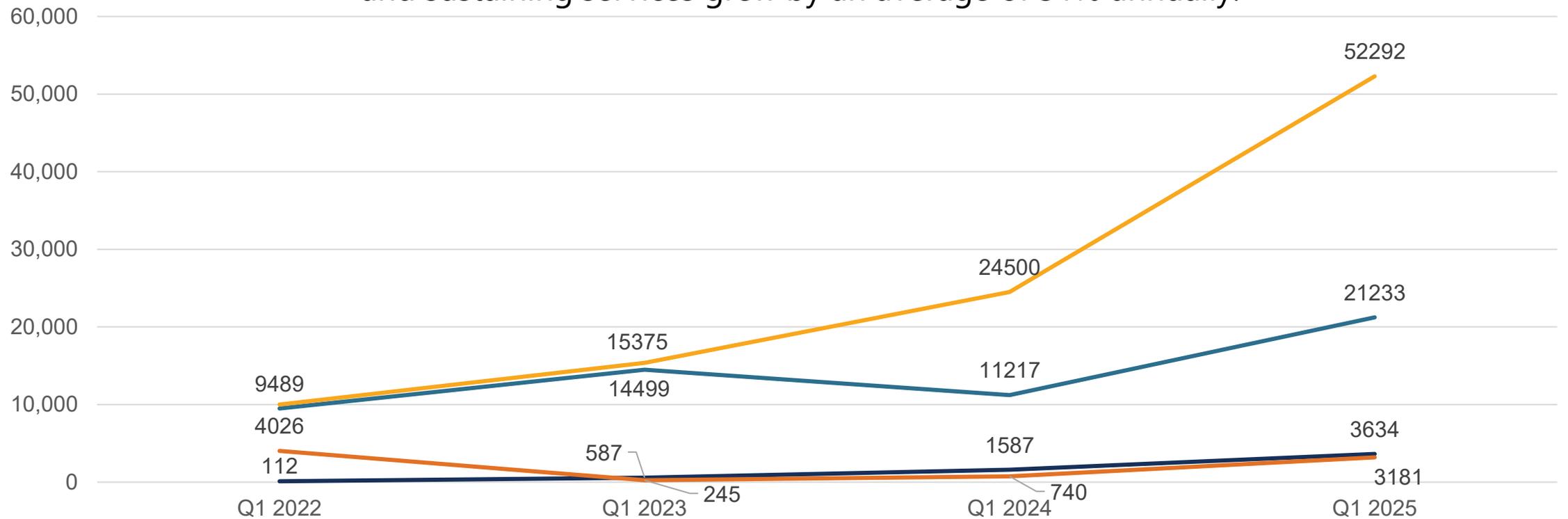
# Improving Access to Care: CalAIM Enhanced Care Management (ECM)

Over 177,000 Medi-Cal members received ECM in Q1 2025, including more than 71,000 members with serious mental health and/or SUD needs.



# Reducing Homelessness: CalAIM Housing-Related Community Supports

Utilization of housing-related community supports is growing rapidly: the rate of members using housing transition navigation services grew by approximately 35% annually between 2022 and 2025, and tenancy and sustaining services grew by an average of 31% annually.



— Housing Deposits — Housing Tenancy & Sustaining Services — Housing Transition Navigation Services — Short-Term Post-Hospitalization Housing

# Reducing Homelessness: Behavioral Health Bridge Housing (BHBH)

- » BHBH, signed into law in September 2022, is providing over \$1 billion to county behavioral health agencies and tribal entities to address the immediate housing and treatment needs of people experiencing homelessness with serious behavioral health conditions.
- » BHBH funding is driving approximately:
  - **3,448 new housing beds** created through infrastructure projects.
  - **4,700 beds funded annually** through rental assistance programs, shelter/interim housing, and/or auxiliary funding to assisted living.
- » As of June 2025, **over 10,600 people** have received housing through BHBH.

	Total Awards	Eligibility
<b>Round 1</b>	\$907M	Behavioral health agencies
<b>Round 2 &amp; 2B</b>	\$50M	Tribal entities Request For Applications
<b>Round 3</b>	\$132.5M	Behavioral health agencies with Round 1 contracts

# VETERANS SUPPORT TO SELF-RELIANCE PILOT: HEALTH AND HOUSING STABILITY IN PSH FOR AGING AND HIGH ACUITY VETERANS

Presented by Amy Fairweather, Director of Policy at Swords to Plowshares  
and Maya Buenaventura, Policy Researcher, RAND



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# BARRIERS TO AGING IN PLACE IN PSH

- 1 EVICTIONS**  
RELATED TO HABITABILITY  
AND/OR BEHAVIORAL HEALTH.
- 2 PREVENTABLE HEALTH DECLINE**  
AND INABILITY TO SELF-MANAGE  
HEALTH CONDITIONS.
- 3 ACCESS TO QUALITY SUPPORT  
SERVICES**  
IMPACTS HOW LONG ELDERLY OR  
HIGH ACUITY RESIDENTS CAN  
REMAIN IN THEIR CURRENT  
HOUSING.



# WHAT'S MISSING?

ENABLING VETERANS TO AGE IN PLACE IS KEY TO WELL-BEING.



**Inability to manage health conditions may lead to premature move to skilled nursing.**

**Current VA benefit system does not provide funding for a continuum of care.**

**System of services, benefits and agencies is complex to navigate.**

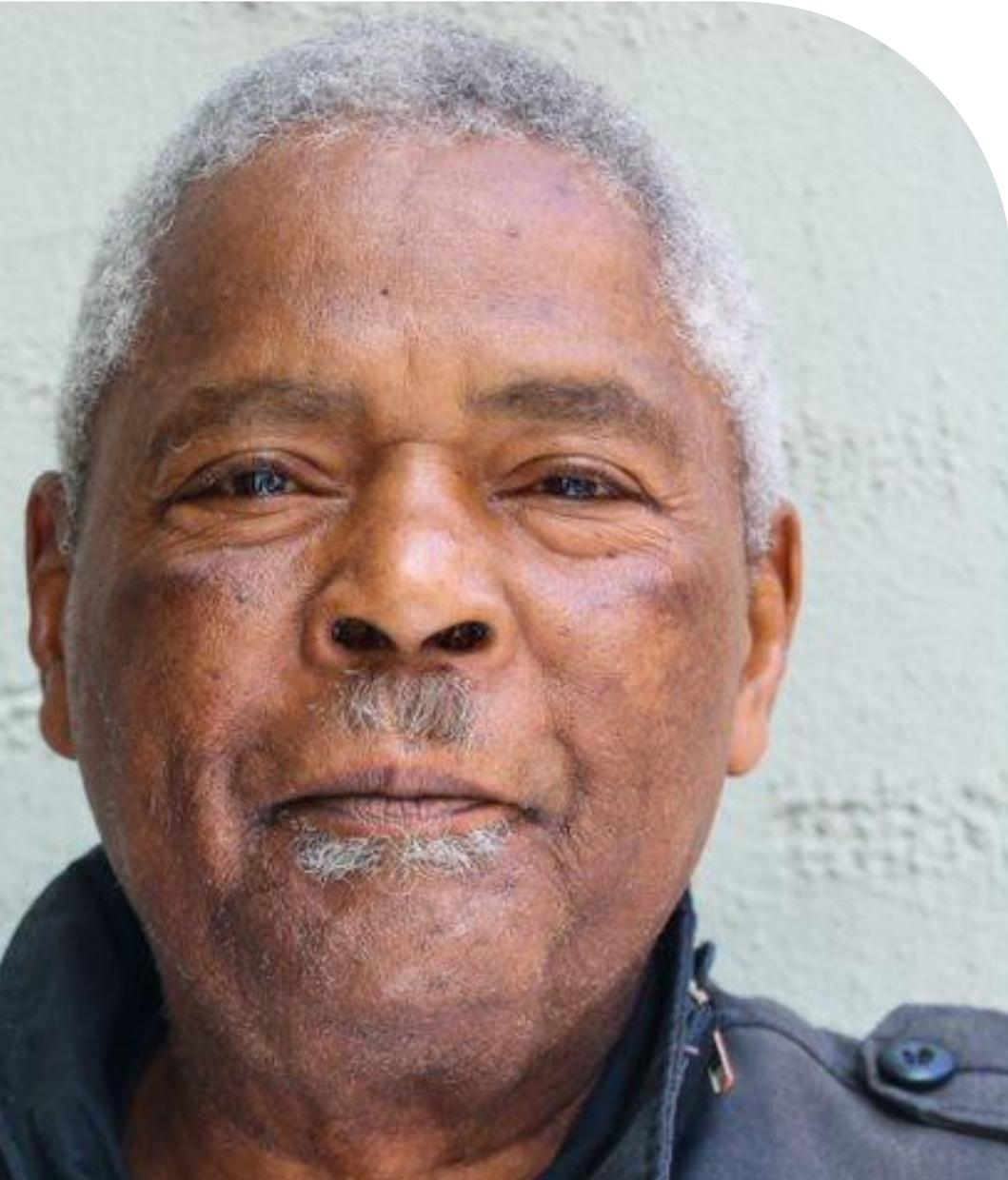
**Not all veterans access VA benefits or are eligible.**

**Veterans with higher levels of VA disability income are not eligible for Medicaid services including In-Home Supportive Services.**

# VSSR PILOT: ADMINISTERED BY CALIFORNIA DEPARTMENT OF VETERANS AFFAIRS (CALVET)

- **US Vets:** Long Beach (3 sites) and Inland Empire
- **PATH:** San Diego
- **Nation's Finest:** Mather Airforce Base and Sonoma County
- **Swords to Plowshares:** San Francisco (6 sites)
- **Swords to Plowshares Policy Department:** Design, technical assistance and process evaluation consultant.
- **RAND:** Impact Evaluation consultant.





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# PILOT GOALS

Demonstrate enhanced supportive services model that enables aging and high acuity veterans who have experienced chronic homelessness to **retain housing, age in place, and maintain and/or improve quality of life.**

Overcome and prevent challenges related to **maintaining personal and living space hygiene, adjusting to housing rules and responsibilities, isolation, increased mental health needs, disruptive behavior, premature need for skilled nursing care, and premature death, overdose, and suicide.**

# STAFF INTERVENTIONS

Mental and Behavioral Health Management

Habitability Interventions

Nutrition Assistance

Healthcare Utilization/ Management

Mobility/ Accessibility



Mental Health Specialists/ Social Workers



Peer Support Specialists



Service Assistants

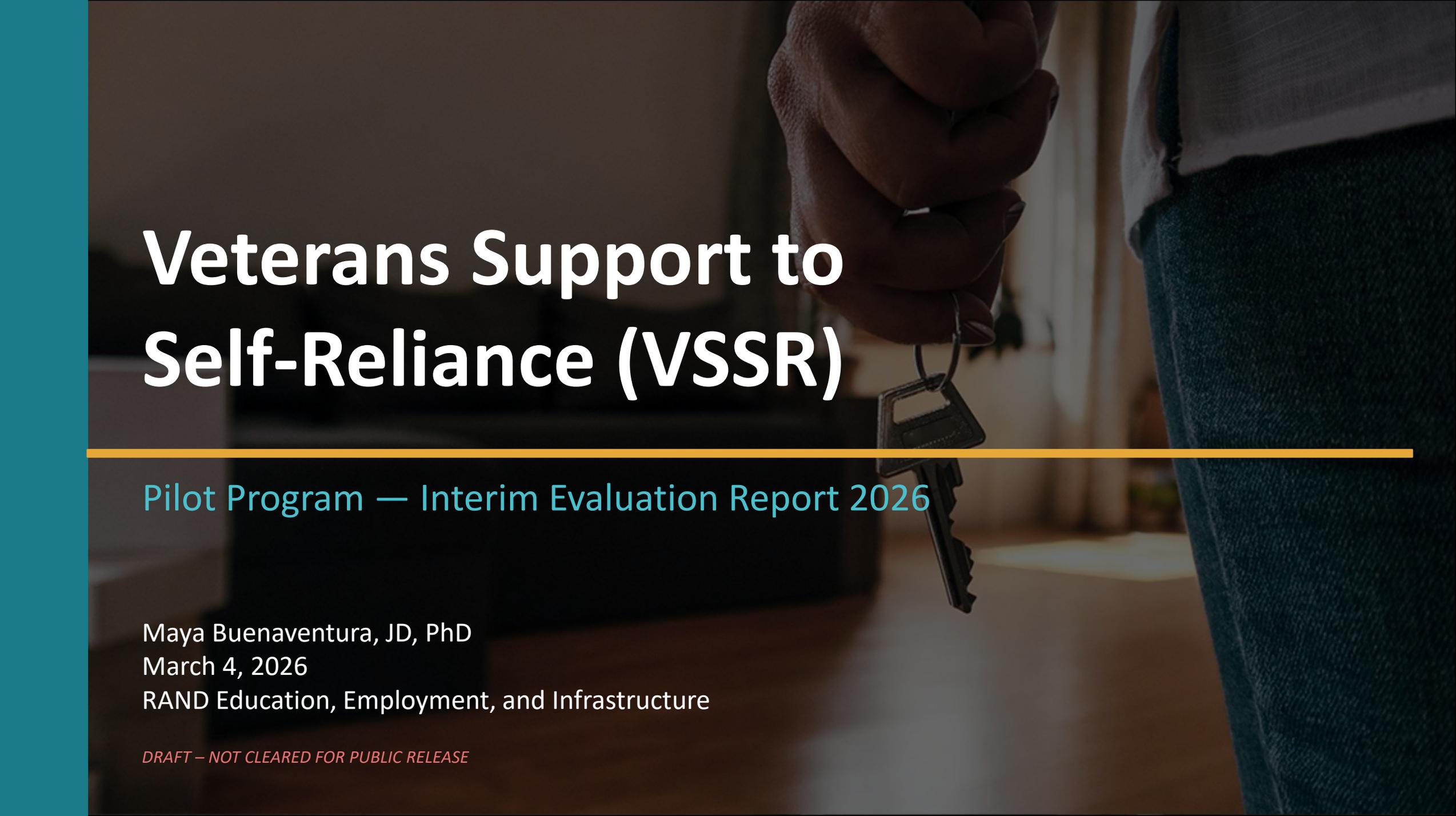


Occupational Therapists + Nurses



Transportation Specialists





# Veterans Support to Self-Reliance (VSSR)

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Pilot Program — Interim Evaluation Report 2026

Maya Buenaventura, JD, PhD

March 4, 2026

RAND Education, Employment, and Infrastructure

*DRAFT – NOT CLEARED FOR PUBLIC RELEASE*

# What is RAND Evaluating?

*The big question: What changes in health, wellbeing, and housing stability are observed among veterans receiving enhanced supportive services in permanent supportive housing?*

1

**Who did we reach (age, health, history)?**

2

**Did they stay housed?**

3

**Did things get better (health, daily living)?**

4

**What helped most? Specific services (group activities, hands-on help) linked to better outcomes?**

5

**What makes life feel good?**

# Where the Data Comes From

Q

## Staff Check-Ins (Every 3 Months)

- Staff completed quarterly assessments for each veteran
- Health, daily activities, services, household issues
- 515 veterans at entry; 361 followed for one year or more

V

## Veterans' Own Annual Survey

- Veterans completed annual self-assessments
- Housing, health, daily activities, social ties, and overall wellbeing
- 109 participants completed both Year 1 and Year 2 surveys

H

## Move-Out Records

- Log of every veteran who left the program, when, and why
- We sorted exits into: (1) moved to independent living, (2) moved to higher care, (3) eviction / homelessness
- Covers full program period: June 2023 – November 2025

## How We Analyzed It

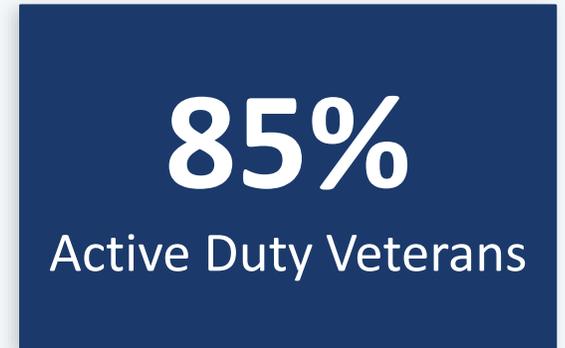
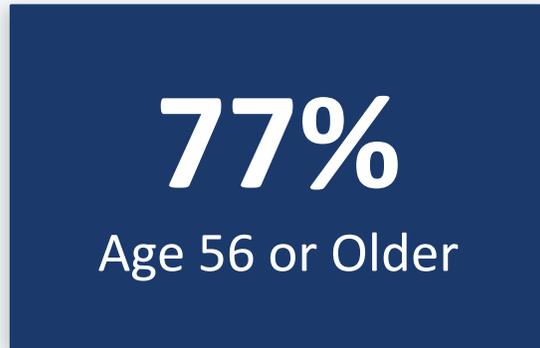
Snapshot  
at Entry

Before  
& After

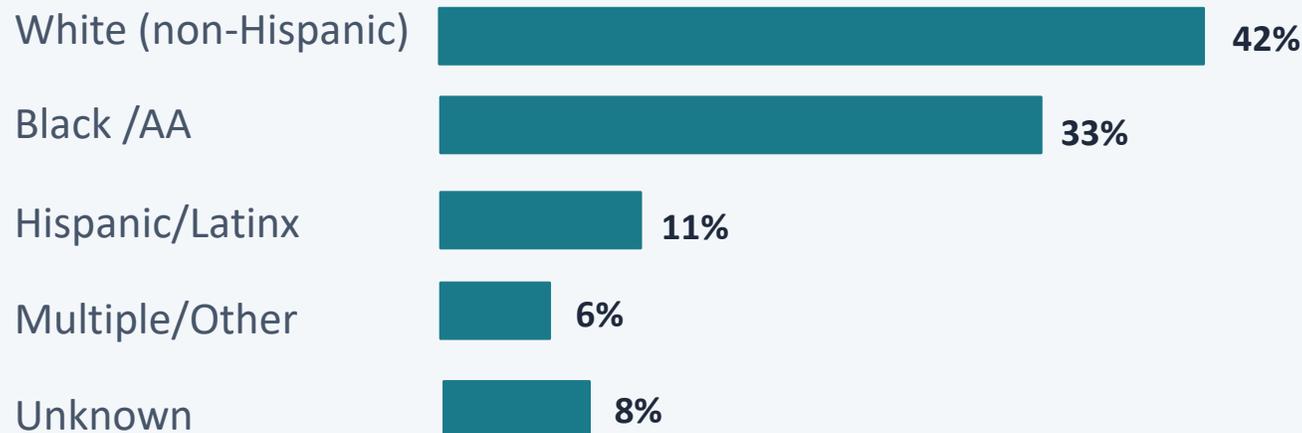
What's  
Linked?

Quality of  
Life Drivers

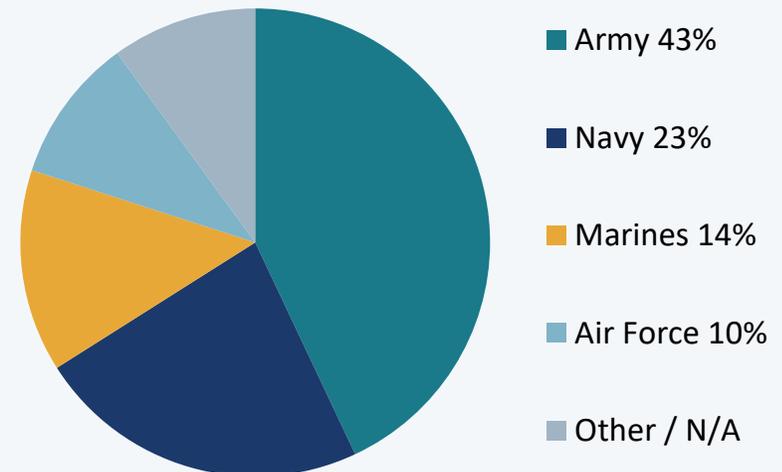
# Participant Demographics (n = 515)



## Race / Ethnicity

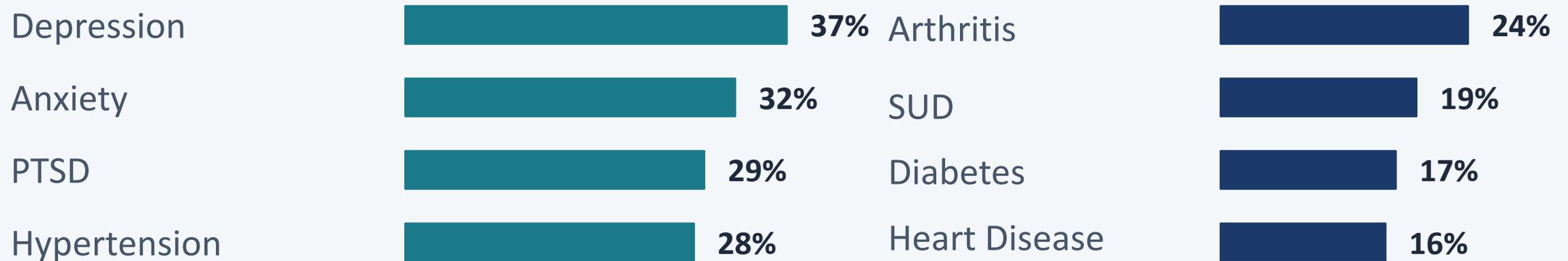


## Military Branch



# A High-Acuity, High-Need Population

## Most Prevalent Health Conditions



**60%**

Reported fair, poor, or very poor health

**31%**

Had 4 or more chronic conditions

**24%**

Experienced a fall in prior 3 months

**16%**

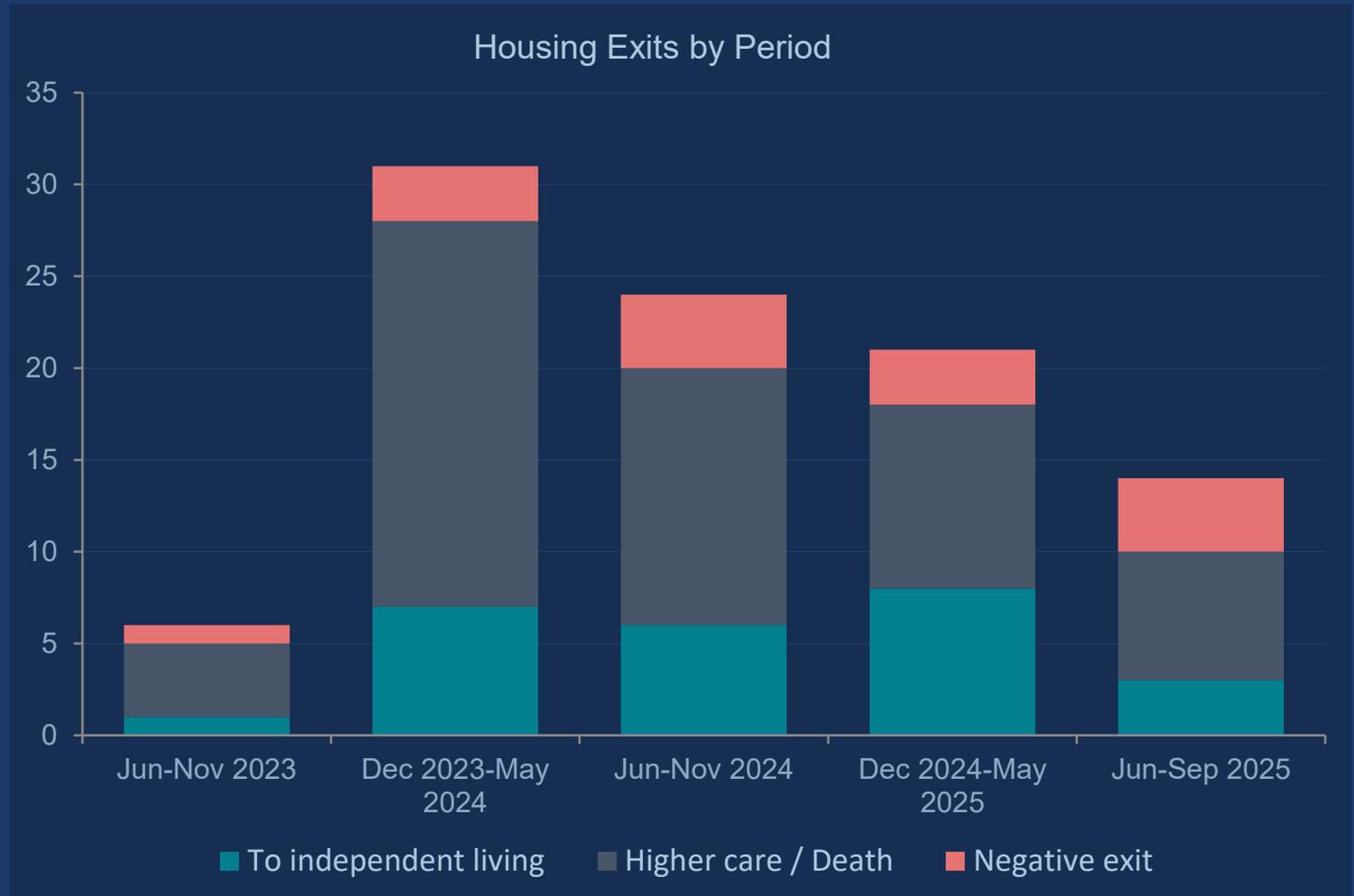
Visited an ER in prior 3 months

# Keeping Veterans Housed

# 3%

Negative Housing  
Exit Rate

*(eviction, incarceration,  
return to homelessness)*



## Health Outcomes After One Year (n = 361)

**-58%**

Fall incidents

21% → 9%

**-71%**

Emergency medical visits

14% → 4%

**-34%**

Ambulance / 911 calls

9% → 6%

**+53%**

Eating 3 meals per day

35% → 53%

**-49%**

Missed medical appointments

35% → 18%

**-21%**

Alcohol use

36% → 29%

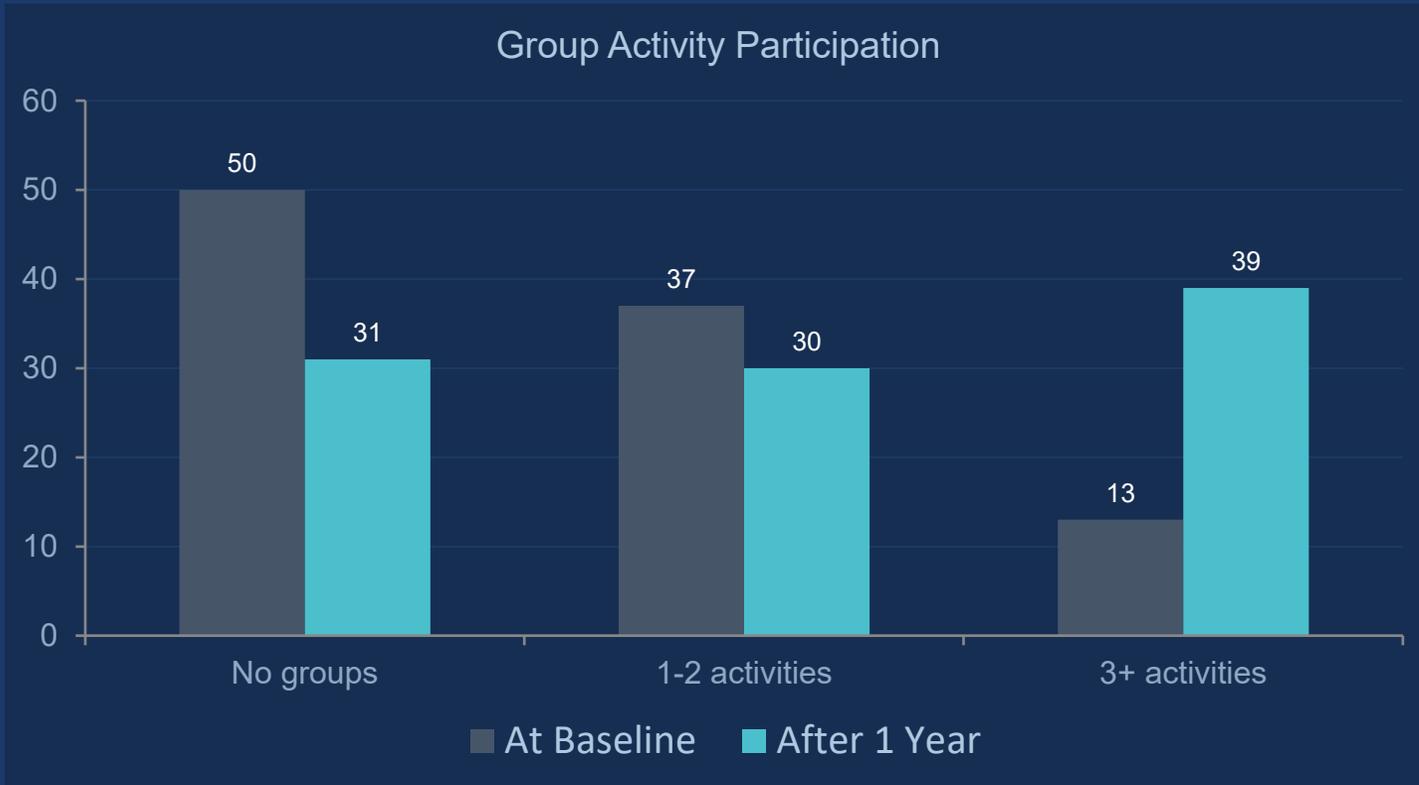
# Unmet Needs for Daily Living Assistance

*Share of veterans who needed help but weren't receiving it — at enrollment vs. after one year*

Type of Assistance	At Enrollment	After 1 Year	Change
Grocery shopping / Errands	24%	6%	<b>-74%</b>
Companionship / Emotional support	26%	~4%	<b>-84%</b>
Medical appointment assistance	22%	~4%	<b>-82%</b>
Housekeeping / Managing household	29%	14%	<b>-51%</b>
Meal preparation	15%	9%	<b>-44%</b>
Laundry	14%	7%	<b>-47%</b>
Mobility assistance	8%	~4%	<b>-50%</b>
Phone or computer help	10%	~4%	<b>-60%</b>

*Significant declines across nearly all categories.*

# Group Participation & Social Behavior



**3x**

Increase in residents participating in 3+ group programs

**-38%**

Fewer residents with no group participation

**+208%**

Growth in those attending 3 or more activities

*Note: Those leaving their apartment daily declined slightly (71%→59%), while those leaving 3+ times/week increased — suggesting a shift from informal wandering to structured activity participation.*

# Which Services Are Linked to Better Outcomes?

Service Type	Good/Very Good Health	Lower Acute Care Use	Fewer Falls	Better Social Engagement
ADL / IADL Assistance	—	Higher acute care*	—	—
Group Program Participation	✓ 2.6× odds**	✓ Lower**	✓ Lower**	✓ Higher**
Habitability Discussions	—	—	—	—

## ★ Group Programs Are a Standout Service

Participating in group programs was associated with 2.6× higher odds of good/very good health, lower acute care use, fewer falls, and higher odds of leaving one's unit at least 3 times per week. These associations held even after controlling for age, gender, comorbidities, and site. Note: associations may reflect participant motivation as much as program impact.

# What Drives Veterans' Self-Rated Quality of Life?

*From annual self-administered resident survey (n = 109 per year, 2 years of data)*



All five factors remained significantly associated with quality of life after controlling for age, gender, race/ethnicity, chronic conditions, and site. This highlights that housing security and social connectedness are as important as physical health to veterans' wellbeing.

# Areas of Complexity & Caution

## Substance Use: A More Complex Picture

- Alcohol use declined (-21%)
- Cannabis & opioid use appeared to rise
- **Likely a reporting artifact as staff became more familiar with residents**
- Staff observations and resident disclosure improve over time
- Overall no-substance-use rate unchanged (52% → 54%)

## Outpatient Care: Shifting, Not Declining

- Primary care fell 15%; specialty care rose 26%
- Mental health outpatient visits down 50%
- Some care likely shifted on-site to VSSR
- A rebalancing — not a loss of care

# What the Evidence Suggests

1

## Program Is Reaching the Right People

The demographic and health profile confirms that VSSR is serving high-need, high-acuity veterans — those most likely to benefit from enhanced supports.

2

## Housing Stability Is Being Maintained

A 3% negative exit rate is very strong by PSH standards. Enhanced services appear to be keeping high-acuity veterans housed.

3

## Group Engagement Is a Key Driver

Group programs are the service most consistently linked with better health, fewer falls, and reduced acute care. Investing in and scaling group programming matters.

4

## Housing Security = Quality of Life

Veterans who feel safe and aren't worried about losing their housing report better quality of life. This suggests that the program's focus on housing stability has a direct wellbeing payoff.

5

## Unmet Needs Persist

Despite progress, over 10% still lack housekeeping help. This is a potential area for improvement.

## Important Caveats to Keep in Mind

- No control group
- Descriptive analyses only
- Staff-reported data at baseline may vary in quality
- Self-report bias
- Sample may not generalize to later enrollees, outcomes beyond one year
- No access to VA medical records/claims data to verify health service use

*Despite these limitations, the consistency of positive trends across multiple outcomes and data sources lends credibility to the findings.*

# Next Steps & Closing

- 1 Incorporate additional quarterly data as it becomes available through June 2026
- 2 Examine associations between service delivery and housing exits, habitability trends, and healthcare utilization
- 3 Disaggregate findings by demographics, voucher type, and region — where sample sizes allow
- 4 Assess whether positive changes are sustained beyond the first year of enrollment
- 5 Explore links between annual survey quality-of-life data and quarterly service use — including whether greater program participation is associated with improvements in self-reported loneliness and wellbeing
- 6 Assess long-term sustainability of the VSSR service delivery model
- 7 Produce final evaluation report — August 2026



---

# THANK YOU



VETS HELPING VETS SINCE 1974

Amy Fairweather

[afairweather@stp-sf.org](mailto:afairweather@stp-sf.org)



Maya Buenaventura

[mbuenave@rand.org](mailto:mbuenave@rand.org)

## VIII. General Public Comment

- Public comment on items discussed this meeting
- If joining by Zoom, click the “raise hand icon”
- If connected by phone, press “\*9” to indicate that you would like to comment

# XI. Final Remarks and Adjournment

- Next Council meeting: June 3, 2026, at 1:00 pm

# Contact Information

- Cal ICH Website: <https://www.bcsh.ca.gov/calich>
- Questions: [calich@bcsh.ca.gov](mailto:calich@bcsh.ca.gov)
- Social Media
  -  [https://twitter.com/Cal\\_ICH](https://twitter.com/Cal_ICH)
  -  <https://facebook.com/CaliforniaICH>
  -  <https://linkedin.com/company/california-interagency-council-on-homelessness>



State of California  
**BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY**



# **California Interagency Council on Homelessness**

## **Council Meeting**

March 4, 2026

# Agenda

- I. Call to Order, Tribal Land Acknowledgement, and Roll Call
- II. Consent Calendar
- III. Council Co-Chair Opening Remarks
- IV. Executive Officer Updates
- V. Advisory Committee Updates
- VI. Lived Experience Advisory Board Updates
- VII. Councilmember Department Updates
- VIII. General Public Comments
- IX. Final Remarks and Adjournment

# I. Call to Order, Tribal Land Acknowledgement, and Roll Call

# Tribal Land Acknowledgement

We wish to acknowledge that Sacramento is the unceded homeland of the Southern Maidu, Valley and Plains Miwok, the Nisenan people, the Patwin Wintun people, and members of the Wilton Rancheria Tribe, who have inhabited this landscape since time immemorial.

We extend our gratitude to the ancestors of all California Native American Tribes and their descendants, as we recognize that wherever we are joining from in our virtual community, we are all on California Native American land.

# Council Member Roll Call

- Please say "here" or "present"

## II. Consent Calendar

Adoption of the Meeting Summary from:

- December 3rd, 2025, Council Meeting
- September 3rd, 2025 Council Meeting

# Public Comment on Agenda Item II - Consent Calendar

- Public comment related to Consent Calendar items only
- If joining by Zoom, click the “raise hand icon”
- If connected by phone, press “\*9” to indicate that you would like to comment

# Council Member Vote

- Shall items on the Consent Calendar be approved?

# III. Council Co-Chair Opening Remarks

# IV. Executive Officer Updates

# V. Advisory Committee Updates

# VI. Lived Experience Advisory Board (LEAB) Updates

# VII. Councilmember Department Updates



# The Behavioral Health Services Act (BHSA)

*California Interagency Council on Homelessness  
(Cal ICH)*



**Secretary Kim Johnson**

The California Health and Human Services Agency (CalHHS)

# What does Success Look Like?

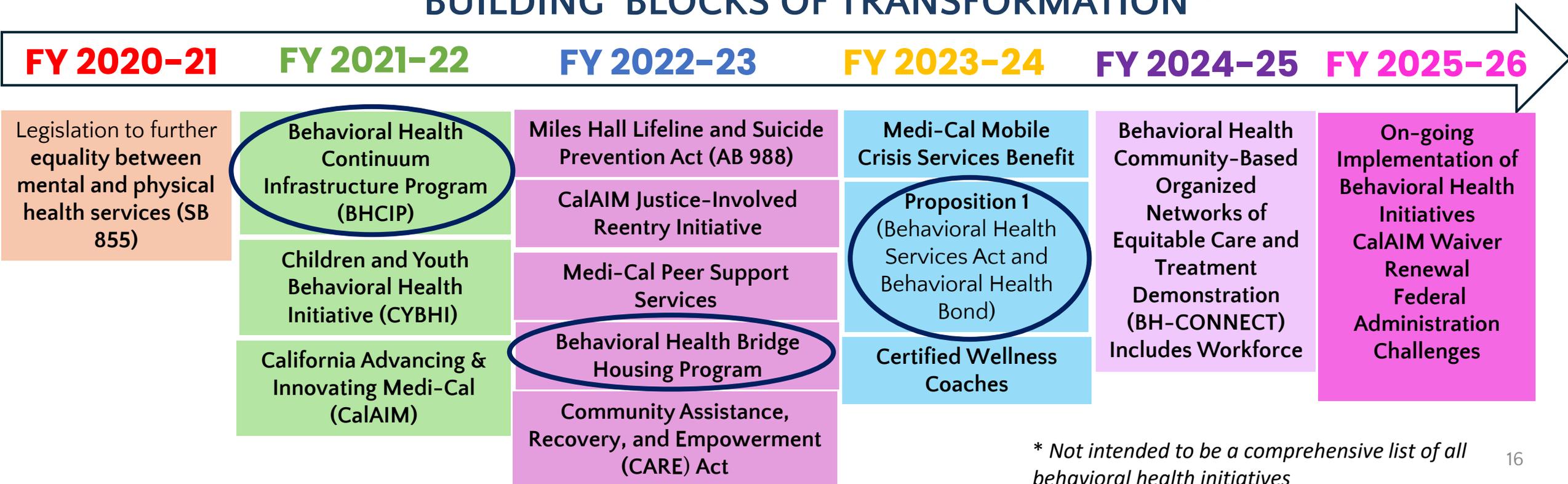
**“Mental Health for All”** – building a **stronger and more equitable behavioral health system.**

- Every Californian—especially people who have had the hardest time getting help—can get high-quality mental health and substance use treatment when and where they need it.
- More treatment services and housing, growing and diversifying the workforce, and making care more culturally and linguistically responsive.
- Focusing on prevention, early help, comprehensive services determined by need, and long-term recovery to make it easier for people to get the right care at the right time—leading to better health and stronger communities across the state.

# Building Out California's Behavioral Health Continuum of Care



## BUILDING BLOCKS OF TRANSFORMATION \*



\* Not intended to be a comprehensive list of all behavioral health initiatives

# Key Opportunities

## Sustainable Investment in Workforce

3% of funds are allocated to the California Department of Healthcare Access & Information (HCAI) to support the behavioral health workforce statewide.



## Inclusion of Substance Use Disorder

BHSA expands eligible services beyond those with serious mental illness to include SUD treatment for children, youth, adults & older adults.



## Housing is Health

Housing is an essential component of behavioral health treatment, recovery & stability.



## Supporting Children & Youth

Supports children & youth who have serious mental illness & behavioral health needs. Intervening early in the life course reduces the possibility of having mental health or SUD needs in the first place.



## Measuring Progress & Impact

Counties are required to submit *Integrated Plans and Behavioral Health Outcomes, Accountability, and Transparency Reports*, which must cover ALL behavioral health services—including those funded by BHSA, Medi-Cal, county realignment & other funds.



# Target the Most In Need & Reduce Disparities

## BHSA priority populations:



**Homeless** or at risk of homelessness



Involved in the **criminal justice system** or at risk of criminal justice system involvement



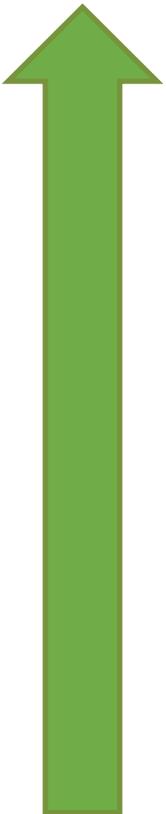
Leaving an **institutional setting** or at risk of institutionalization (e.g. conservatorship)



**Children and youth**, including those involved in the **child welfare system**

# Achieving Transformation: Measure Impact

## Goals for Improvement

- 
- Care Experience
  - Access to Care
  - Quality of Life
  - Engagement in School
  - Engagement in Work
  - Social connection
  - Prevention & Treatment of Co-Occurring  
Physical Health Conditions

## Goals for Reduction

- 
- Suicides
  - Overdoses
  - Untreated BH Conditions
  - Homelessness
  - Institutionalization
  - Justice Involvement
  - Removal of Children from home

# California's Vision: Mental Health for ALL

## Building Out California's Behavioral Health Continuum of Care



Prevention &  
Early Intervention



Parity in Care



Outpatient  
Care



Crisis Care



Inpatient  
Care



Supportive  
Care

**Workforce and Facilities/Housing**

**Equity**

**Oversight and Accountability**

# California Interagency Council on Homelessness (Cal ICH)

*Michelle Baass, Director*

*Glenn Tsang, Policy Advisor for Homelessness and Housing*  
Department of Health Care Services

# Agenda

- » Behavioral Health Transformation Overview
- » Behavioral Health Services Act – Housing Interventions
- » Questions

# Behavioral Health Transformation (BHT)

# Key Components of BHT



## Behavioral Health Services Act

- ✓ Expands services to include treatment for those with SUDs
- ✓ Identifies priority populations
- ✓ Updates local categorical funding buckets, including:
  - ✓ 30% for housing interventions
  - ✓ 35% for Full Service Partnership (FSP) Programs
  - ✓ 35% for Behavioral Health Services and Supports
- ✓ New investments in housing and workforce



## Increasing Accountability

- ✓ Creates County Integrated Plan
- ✓ Establishes Outcomes, Accountability, and Transparency Report
- ✓ Creates a BHSA Revenue Stability Workgroup
- ✓ Directs DHCS to develop a plan for parity between commercial and Medi-Cal MH/SUD benefits
- ✓ Requires alignment of county behavioral health plan contracts with Medi-Cal Managed Care Plan (MCP) contracts



## Infrastructure Bond Act

A \$6.38 billion bond to build 11,150 new treatment beds and housing units, specifically:

- ✓ Grants for behavioral health treatment and residential settings
- ✓ Housing investments for veterans who are experiencing or at risk of homelessness
- ✓ Other investments for Californians who are experiencing or at risk of homelessness

# Behavioral Health Services Act

## Behavioral Health Services Act:

- » **Updates allocations** for local services and state-directed funding categories
- » Broadens the target population to **include individuals with Substance Used Disorders (SUDs)**
- » Focuses on the **most vulnerable and at-risk**, including children and youth
- » Advances community-defined practices as a key strategy for **reducing health disparities** and **increasing community representation**
- » Revises county processes and improves **transparency and accountability**

## Behavioral Health Services Act Funding Overview

90% County Allocation

10% State Directed

# Behavioral Health Services Act Funding Breakdown

**90%** **County Allocations**

**30%**

## **Housing Interventions**

Interventions include rental subsidies, operating subsidies, shared housing, and family housing for eligible children and youth.

**35%**

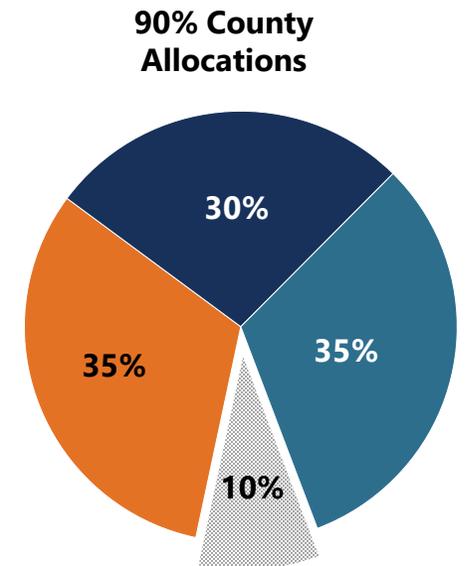
## **Full Service Partnership (FSP) Services**

Comprehensive and intensive care for people at any age with the most complex needs (also known as the “whatever it takes” model).

**35%**

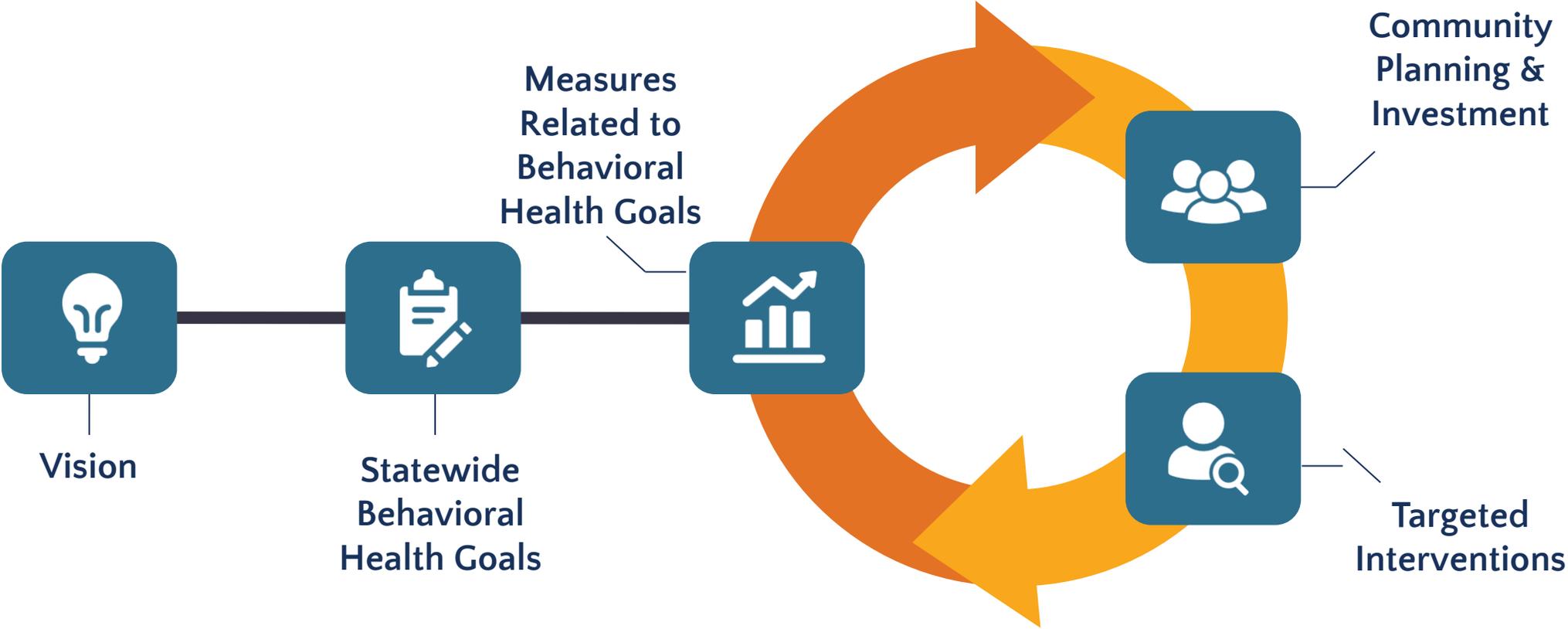
## **Behavioral Health Services and Supports (BHSS)**

Includes early intervention, outreach and engagement, workforce, education and training, capital facilities and technological needs, and innovative pilots and projects.



# Population Behavioral Health Framework

DHCS is developing a **population behavioral health approach** to meet the needs of all individuals eligible for behavioral health services, improve community well-being, and promote health equity. The approach is designed to enable the behavioral health delivery system to make data-informed decisions to better meet the needs of individuals within the communities they serve.



# Statewide Population Behavioral Health Goals

**DHCS' behavioral health approach is grounded in the following 14 goals to improve health and wellbeing of Californians living with behavioral health needs.**



## **Goals for Improvement**

1. Care Experience
2. Access to Care
3. Engagement in School
4. Engagement in Work
5. Prevention and Treatment of Co-Occurring Physical Health Conditions
6. Quality of Life
7. Social Connection



## **Goals for Reduction**

1. Suicides
2. Overdoses
3. Untreated Behavioral Health Conditions
4. Institutionalization
5. Homelessness
6. Justice-Involvement
7. Removal of Children from Home

# Behavioral Health Continuum Infrastructure Program

- » In 2021, DHCS was authorized to establish the Behavioral Health Continuum Infrastructure Program (BHCIP) for eligible grantees to expand substance use disorder and mental health facilities across California.
  - Between November 2021 and June 2023, DHCS awarded **\$1.65 billion** to support mobile crisis services (round 1), county and tribal planning (round 2), and expansion of SUD and mental health facilities (rounds 3-5).
- » The Infrastructure Bond Act of 2024 provides additional funding for BHCIP grants.
  - An **additional \$3.3 billion** was conditionally awarded in May 2025 through the first round of Bond BHCIP funding. DHCS is reviewing applications for the second round of BHCIP Bond funding, and award announcements are anticipated in late Spring 2026.

## BHCIP rounds 3-5 have supported:\*

**2,601**

New residential and inpatient beds

**281,146**

Individuals served in outpatient settings

## Through new BHCIP Bond funding, DHCS anticipates:\*

**6,800**

New residential and inpatient beds

**26,700**

New outpatient slots

» \*Data sourced from the [BHCIP dashboard](#) and is subject to change.

# Housing Interventions (30% County Allocation)

# California's Investments in Behavioral Health Housing

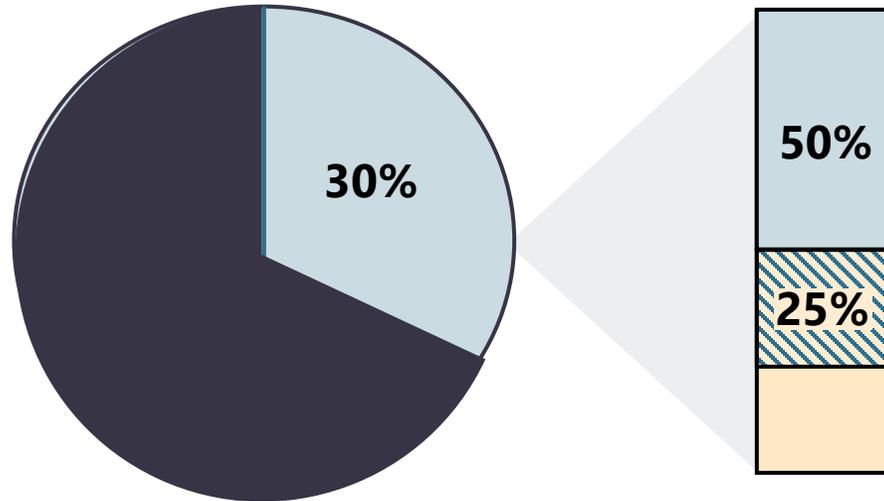
California is currently making unprecedented investments, both one-time and ongoing, to dramatically expand community-based behavioral health housing and social supports for individuals living with mental illness and/or a substance use disorder.

## **DHCS Key Housing Related Investments:**

- » Behavioral Health Bridge Housing Program
- » New behavioral health initiatives under CalAIM, including Community Supports and Transitional Rent
- » ***Behavioral Health Services Act, Housing Interventions***

# Housing Interventions Funding Requirements

**30% of the funds distributed to counties must be used for Housing Interventions**



**50% of the Housing Intervention funds must be used for persons who are chronically homeless, with a focus on individuals living in encampments**

**Up to 25% of the Housing Intervention funds may be used for Capital Development projects**

- » Counties have the flexibility to move 7% of funds to/from Housing Interventions into another category (FSP or BHSS)
- » Counties with a population of less than 200,000 may request an exemption from the required 30% allocation of Behavioral Health Services Act funds for Housing Interventions\* (*Note: exemption process under development*)
- » If a capital development project recognizes chronically homeless individuals as a priority population, the project funding will contribute toward the 50% requirement.

# Housing Interventions Component

The development of the Housing Interventions component of the Behavioral Health Services Act funding breakdown reflects the following policy priorities:

- » Reduce homelessness among those with a behavioral health condition
- » Provide individuals with Permanent Supportive Housing (PSH)
- » Connect individuals to supportive behavioral health services
- » Support the provision of low-barrier, harm reduction, and Housing First principles
- » Complement ongoing state, county, city, Continuum of Care (CoC), and tribal efforts to address homelessness
- » Provide flexibility for counties to respond to local conditions and needs and innovate

# Eligible Populations for Housing Interventions

## To qualify for Housing Interventions, individuals must:

- » Meet Behavioral Health Services Act eligibility requirements; and
- » Meet the Behavioral Health Services Act definition of:
  - **Experiencing homelessness;**
  - **At risk of homelessness; or**
  - **Chronically homeless**
- » Persons eligible for Housing Interventions under the Mental Health Services Act (MHSA)

## Priority Populations

- » Children and youth in or at risk of being in the juvenile justice system, reentering the community from a youth correctional facility, in the child welfare system, or at risk of institutionalization
- » Adults or older adults in or at risk of being in the juvenile justice system, reentering the community from prison or jail, at risk of conservatorship, or at risk of institutionalization

*Note: The provision of Housing Interventions to individuals with a Substance Use Disorder is optional for counties.*

# Experiencing Homelessness and At Risk of Homelessness

## Definition

- » For purposes of the BHSA, DHCS is adopting the definitions of experiencing homelessness and at risk of homelessness consistent with CalAIM Community Supports, aligning with the federal definition provided in 24 CFR Section 91.5.

## Modifications

- » Exiting institutions or incarceration qualifies as homeless if previously or newly homeless during stay.
- » Imminent housing loss timeframe extended to 30 days.
- » No income threshold required for homeless status.

## Eligibility Nuances

- » Anyone previously homeless or at risk before receiving Transitional Rent or certain MHSA housing is considered homeless for Behavioral Health Services Act purposes.

# Allowable Expenditures for Housing

County programs for housing interventions may include:

- » Rental Subsidies (including project-based housing and master leasing)
- » Operating Subsidies
- » Other Housing Supports
  - » Landlord Outreach and Mitigation Funds
  - » Participant Assistance Funds
  - » Housing Transition Navigation Services and Tenancy and Sustaining Services
  - » Outreach and Engagement
- » Allowable Settings – including Permanent Supportive Housing,
- » Capital Development Projects

# Allowable Settings: Permanent, No Time Limit

**Housing Interventions funding will be allowable, without time-limits, in the following settings:**

- » Supportive housing
- » Apartments, including master-lease apartments
- » Single and multi-family homes
- » Housing in mobile home communities
- » Single room occupancy units
- » Accessory dwelling units, including Junior Accessory Dwelling Units
- » Tiny Homes
- » Shared housing (i.e., living with roommates)
- » Recovery/Sober Living housing, including recovery-oriented housing
- » Assisted Living (Adult Residential Facilities, Residential Facilities for the Elderly, and licensed board and care)
- » License-exempt room and board
- » Other settings identified under the Transitional Rent benefit

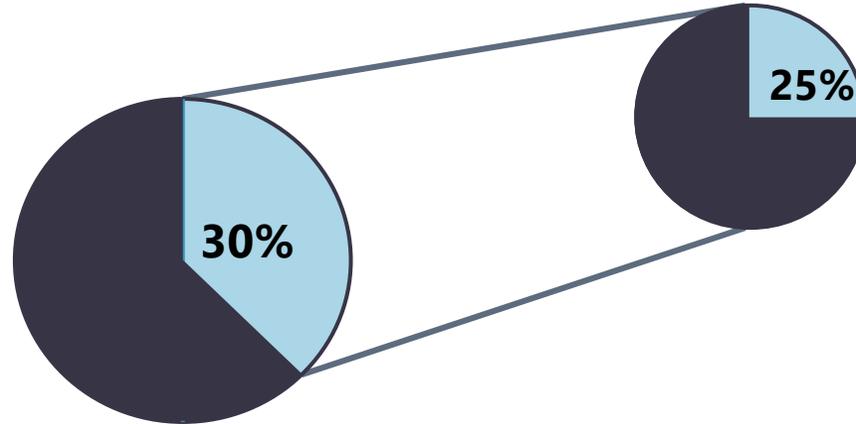
# Allowable Settings: Interim, Time Limit

**Housing Interventions funding will be allowable, with time-limits, in the following settings, once Transition Rent benefit is exhausted:**

- » Hotel and motel stays
- » Non-congregate interim housing models
- » Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls), does not include behavioral health residential treatment settings
- » Recuperative Care
- » Short-Term Post-Hospitalization housing
- » Tiny homes, emergency sleeping cabins, emergency stabilization units
- » Peer respite
- » Other settings identified under the Transitional Rent benefit

# Capital Development Project Funding

**30% of the funds distributed to counties must be used for Housing Interventions**



**Up to 25% of the Housing Intervention funds may be used for Capital Development projects**

- » Counties can use capital development funds to fully fund projects or fill funding gaps in developments with permanent supportive housing (PSH) units for Behavioral Health Services Act eligible individuals and families.
- » Funds may be accrued over multiple years if counties follow state reversion rules.
- » PSH developments often require combining multiple funding sources; counties should align requirements with other programs to simplify administration.
- » The funding cap is \$450,000 per housing unit for construction or rehabilitation.

# Questions

# Resources

## DHCS Websites



- » See the [DHCS Housing for Health](#) website for more information on all of DHCS' housing initiatives
- » Explore the [Behavioral Health Transformation](#) website to discover additional information and access resources.

## Technical Assistance



DHCS provides technical assistance, including the development of informational materials, that counties can use to create their Integrated Plan.

## Questions and Feedback



Please send any other questions or feedback about Behavioral Health Transformation to [BHTInfo@dhcs.ca.gov](mailto:BHTInfo@dhcs.ca.gov).

## BHT Policy Manual



For more information on the [BHT Policy Manual](#) or specifically on Housing Interventions, FSP and BHSS, please visit [7. BHT Components and Requirements](#).

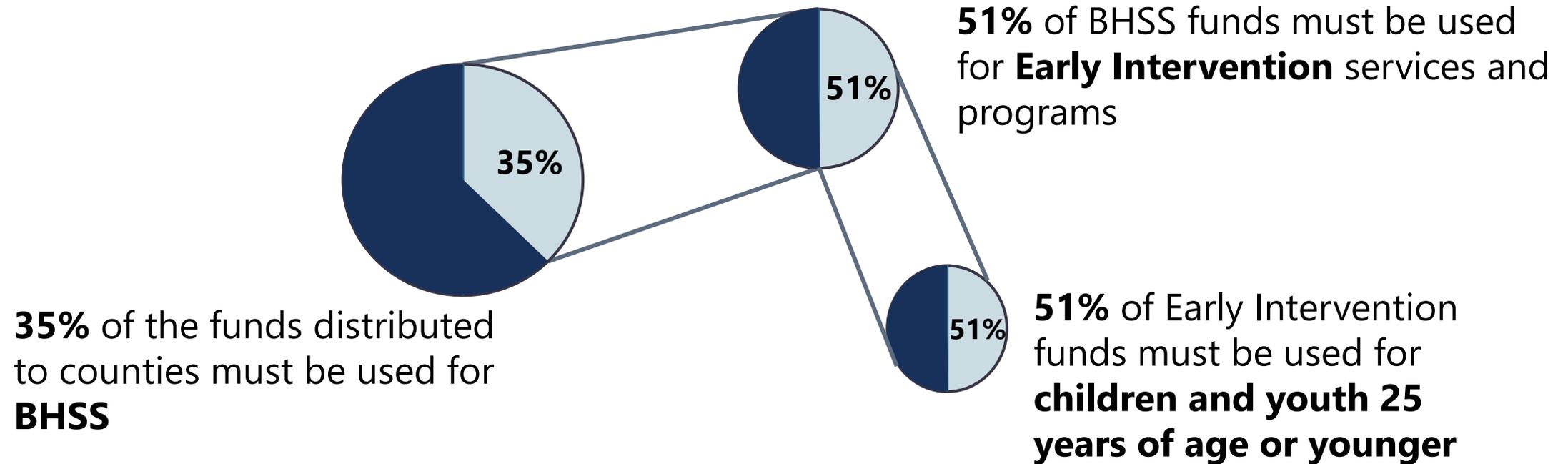
# Thank You

For More Information

[BHTinfo@dhcs.ca.gov](mailto:BHTinfo@dhcs.ca.gov)

# Behavioral Health Services and Supports (35% County Allocation)

# Behavioral Health Services and Supports (BHSS) Funding Requirements



Counties have the flexibility to transfer 7% of funds from BHSS into another funding category (FSP or Housing Interventions) for a maximum total shift of 14% into a single funding category.

# Behavioral Health Services and Supports

BHSS funds are used to provide supportive services to individuals that may not qualify for FSP services, early intervention programming, and certain infrastructure needs. Per WIC Section 5892, BHSS includes:

- » Early Intervention
- » Children's, Adult, and Older Adult Systems of Care
- » Outreach and Engagement
- » Workforce, Education, and Training
- » Capital Facilities and Technological Needs
- » Innovative behavioral health pilots and projects

Other than Early Intervention, counties are not required to fund any of the listed program categories. Counties have the flexibility to fund any other category according to local needs.

# Behavioral Health Services and Supports

<b>Early Intervention</b>	<ul style="list-style-type: none"><li>» Must include 1) outreach, 2) access and linkage to care, and 3) mental health and substance use disorder early treatment services and supports</li><li>» Include culturally and linguistically appropriate interventions</li><li>» Emphasize the reduction of the likelihood of adverse outcomes, including homelessness</li></ul>
<b>Children's, Adult, and Older Adult Systems of Care</b>	<ul style="list-style-type: none"><li>» May cover services for individuals who are not enrolled in an FSP and that do not include Housing Interventions</li></ul>
<b>Outreach and Engagement</b>	<ul style="list-style-type: none"><li>» May cover activities and strategies that reach, identify, and engage individuals and communities in the behavioral health system, including peers and families, and to reduce disparities</li><li>» Distinct from those that may be funded as part of BHSS Early Intervention Programs, Housing Interventions, or FSP programs</li></ul>

# Behavioral Health Services and Supports

<b>Workforce, Education, and Training</b>	<ul style="list-style-type: none"><li>» May fund, in accordance with county needs, activities to support employment in the Public Behavioral Health System (including county-contracted providers), including but not limited to:<ul style="list-style-type: none"><li>• Workforce Recruitment, Development, Training, and Retention</li><li>• Professional Licensing and/or Certification Testing and Fees, Continuing Education</li><li>• Loan Repayment, Retention Incentives and Stipends</li><li>• Internship and Apprenticeship Programs</li></ul></li></ul>
<b>Capital Facilities and Technological Needs</b>	<ul style="list-style-type: none"><li>» Projects may include the acquisition and development of land, the construction or renovation of buildings, or the development, maintenance, or improvement of information technology to support behavioral health administration and services.</li></ul>
<b>Innovative Behavioral Health Pilots and Projects</b>	<ul style="list-style-type: none"><li>» Counties may pilot and test innovative behavioral health models of care programs or innovative promising practices for programs in all funding components (BHSS, FSP, Housing Interventions).</li><li>» These innovative promising practices will be funded through each component.</li></ul>

# Full Service Partnership (35% County Allocation)

# Full Service Partnership (FSP)

- » **FSP programs** provide individualized, team-based care to individuals living with significant behavioral health needs through a “whatever it takes” approach.
- » **Participants benefit** from a community-based, whole-person approach that is trauma-informed, recovery-focused, age-appropriate, and delivered in partnership with families or an individual’s natural supports.
- » **Required Services:** Assertive field-based initiation for SUD, Assertive Community Treatment (ACT) /Forensic Assertive Community Treatment (FACT)\*\* or FSP Intensive Care Management (ICM). High-Fidelity Wraparound (HFW)\*\* Individual Placement and Support (IPS) model of Supported Employment\*\*

# Required Services

- » **Assertive Community Treatment (ACT)** is a highly established, evidence-based practice (EBP) for people with complex, significant behavioral health needs and a treatment history (e.g., hospital/ER, residential care). ACT is designed for individuals often experiencing homelessness, justice involvement, and/or low engagement with traditional outpatient services.
- » **Forensic Assertive Community Treatment (FACT)** builds on ACT for people with significant needs who are also involved with the criminal justice system, supporting community reintegration and reducing recidivism risk.
- » **The Individual Placement and Support (IPS)** model of supported employment is an evidence-based intervention that engages people with severe mental illness in finding and maintaining competitive employment or education of their own choice.
- » **High Fidelity Wraparound** is a team-based and family-centered evidence-based practice that includes an “anything necessary” approach to care for children/youth living with the most intensive mental health or behavioral challenges.

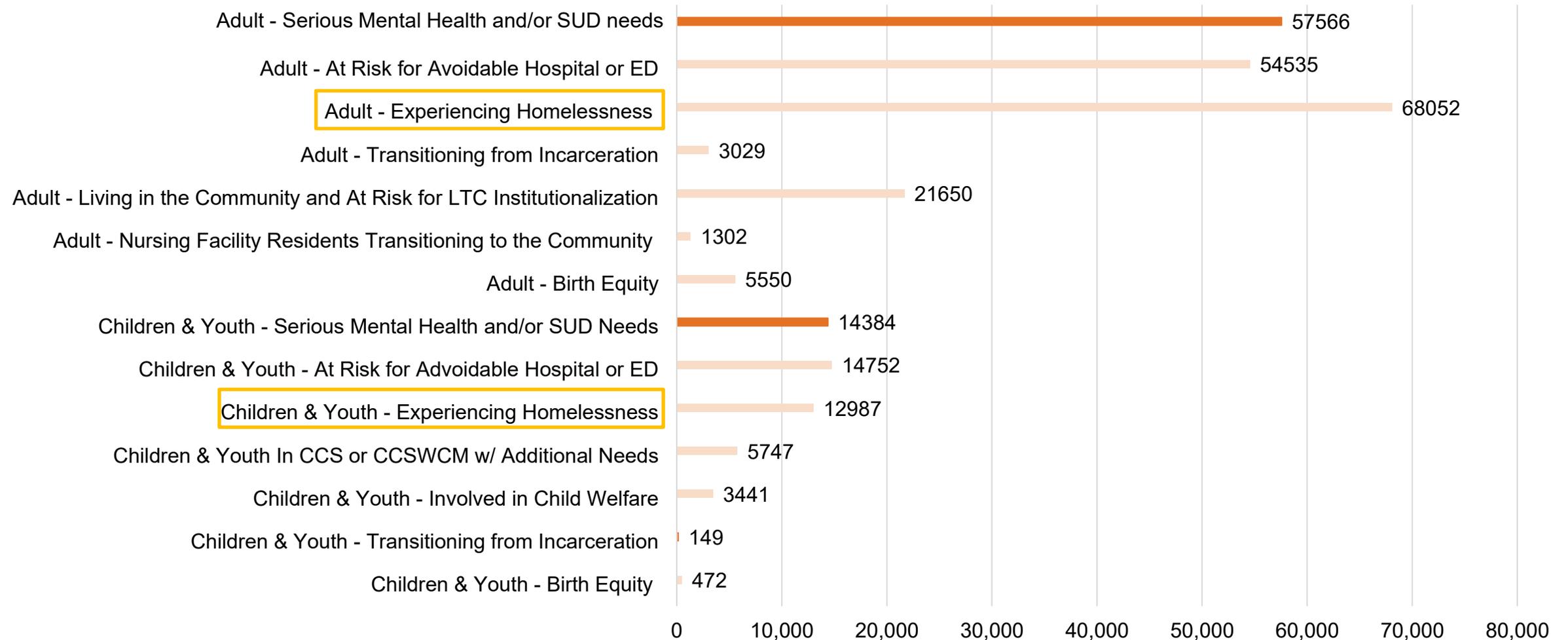
# Adult FSP Levels of Care

## Intensive Case Management (ICM)

- » FSP ICM supports people **stepping down from ACT or those with moderate-to-significant** needs who don't meet ACT eligibility
- » FSP ICM is **team-based, community-focused, and long-term, with small caseloads and a multidisciplinary team delivering individualized supports** (e.g., peers, crisis intervention, psychosocial rehab, psychotherapy, medication management).
- » **Step-down beyond FSP:** when someone no longer meets FSP-level need, services may transition to outpatient mental health and substance use disorder (SUD) care funded through Behavioral Health Services and Supports (BHSS).

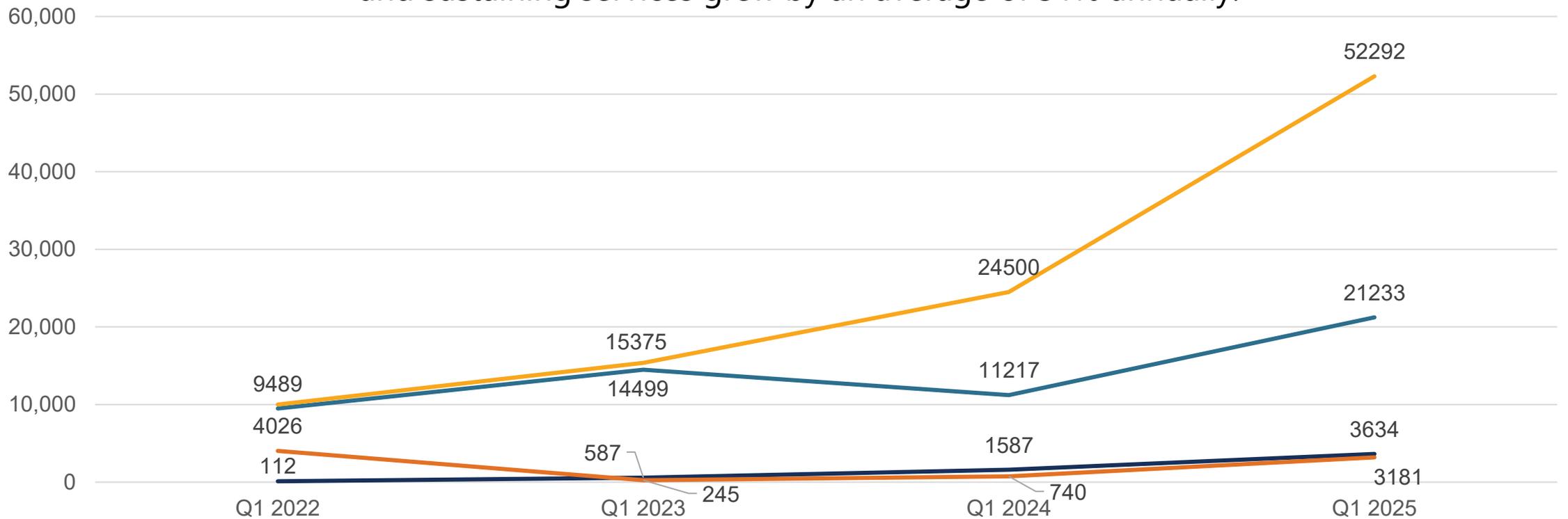
# Improving Access to Care: CalAIM Enhanced Care Management (ECM)

Over 177,000 Medi-Cal members received ECM in Q1 2025, including more than 71,000 members with serious mental health and/or SUD needs.



# Reducing Homelessness: CalAIM Housing-Related Community Supports

Utilization of housing-related community supports is growing rapidly: the rate of members using housing transition navigation services grew by approximately 35% annually between 2022 and 2025, and tenancy and sustaining services grew by an average of 31% annually.



— Housing Deposits — Housing Tenancy & Sustaining Services — Housing Transition Navigation Services — Short-Term Post-Hospitalization Housing

# Reducing Homelessness: Behavioral Health Bridge Housing (BHBH)

- » BHBH, signed into law in September 2022, is providing over \$1 billion to county behavioral health agencies and tribal entities to address the immediate housing and treatment needs of people experiencing homelessness with serious behavioral health conditions.
- » BHBH funding is driving approximately:
  - **3,448 new housing beds** created through infrastructure projects.
  - **4,700 beds funded annually** through rental assistance programs, shelter/interim housing, and/or auxiliary funding to assisted living.
- » As of June 2025, **over 10,600 people** have received housing through BHBH.

	Total Awards	Eligibility
<b>Round 1</b>	\$907M	Behavioral health agencies
<b>Round 2 &amp; 2B</b>	\$50M	Tribal entities Request For Applications
<b>Round 3</b>	\$132.5M	Behavioral health agencies with Round 1 contracts

# VETERANS SUPPORT TO SELF-RELIANCE PILOT: HEALTH AND HOUSING STABILITY IN PSH FOR AGING AND HIGH ACUITY VETERANS

Presented by Amy Fairweather, Director of Policy at Swords to Plowshares  
and Maya Buenaventura, Policy Researcher, RAND



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# BARRIERS TO AGING IN PLACE IN PSH

- 1 EVICTIONS**  
RELATED TO HABITABILITY  
AND/OR BEHAVIORAL HEALTH.
- 2 PREVENTABLE HEALTH DECLINE**  
AND INABILITY TO SELF-MANAGE  
HEALTH CONDITIONS.
- 3 ACCESS TO QUALITY SUPPORT  
SERVICES**  
IMPACTS HOW LONG ELDERLY OR  
HIGH ACUITY RESIDENTS CAN  
REMAIN IN THEIR CURRENT  
HOUSING.



# WHAT'S MISSING?

ENABLING VETERANS TO AGE IN PLACE IS KEY TO WELL-BEING.



**Inability to manage health conditions may lead to premature move to skilled nursing.**

**Current VA benefit system does not provide funding for a continuum of care.**

**System of services, benefits and agencies is complex to navigate.**

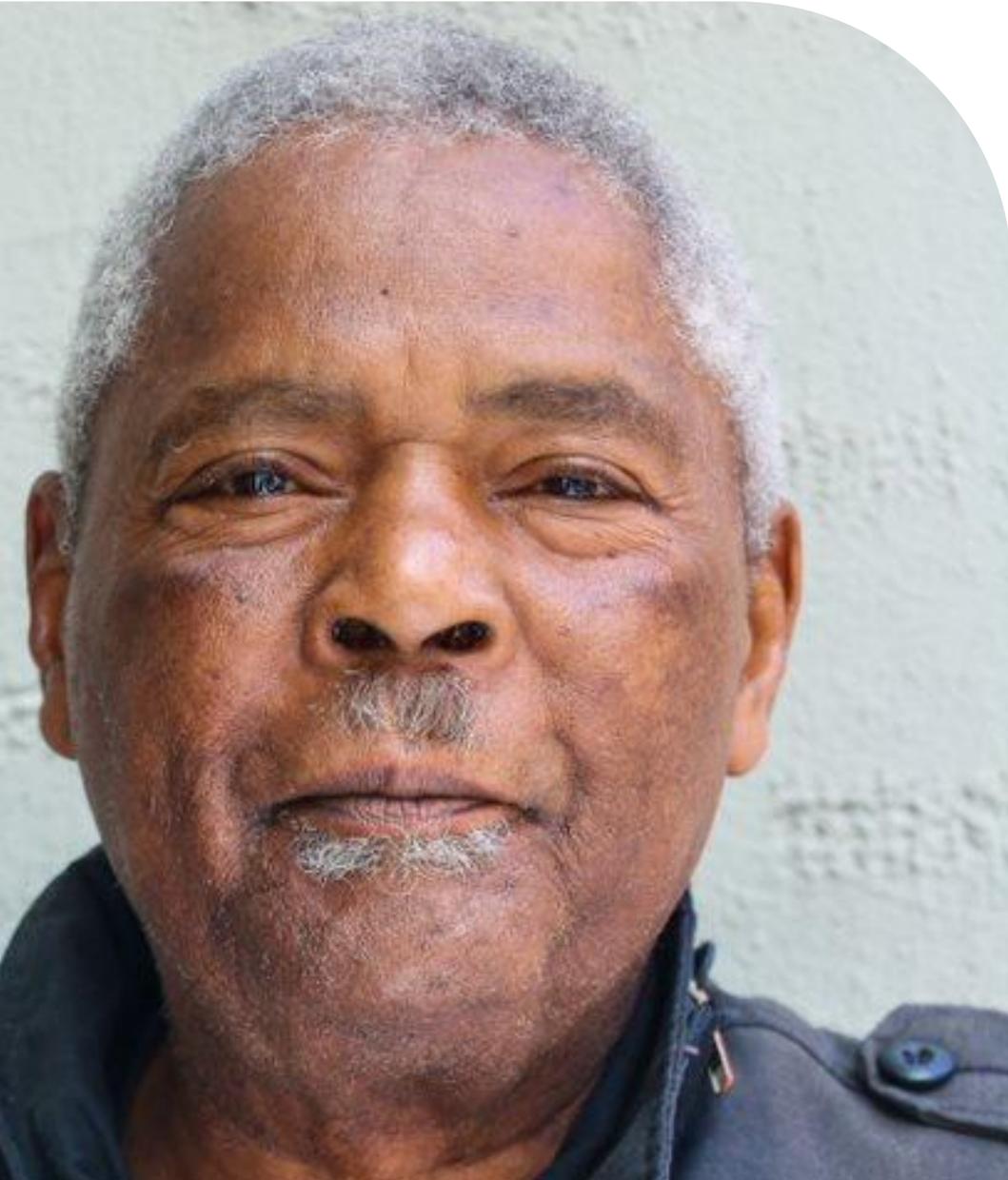
**Not all veterans access VA benefits or are eligible.**

**Veterans with higher levels of VA disability income are not eligible for Medicaid services including In-Home Supportive Services.**

# VSSR PILOT: ADMINISTERED BY CALIFORNIA DEPARTMENT OF VETERANS AFFAIRS (CALVET)

- **US Vets:** Long Beach (3 sites) and Inland Empire
- **PATH:** San Diego
- **Nation's Finest:** Mather Airforce Base and Sonoma County
- **Swords to Plowshares:** San Francisco (6 sites)
- **Swords to Plowshares Policy Department:** Design, technical assistance and process evaluation consultant.
- **RAND:** Impact Evaluation consultant.





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# PILOT GOALS

Demonstrate enhanced supportive services model that enables aging and high acuity veterans who have experienced chronic homelessness to **retain housing, age in place, and maintain and/or improve quality of life.**

Overcome and prevent challenges related to **maintaining personal and living space hygiene, adjusting to housing rules and responsibilities, isolation, increased mental health needs, disruptive behavior, premature need for skilled nursing care, and premature death, overdose, and suicide.**

# STAFF INTERVENTIONS

Mental and Behavioral Health Management

Habitability Interventions

Nutrition Assistance

Healthcare Utilization/ Management

Mobility/ Accessibility



Mental Health Specialists/ Social Workers



Peer Support Specialists



Service Assistants

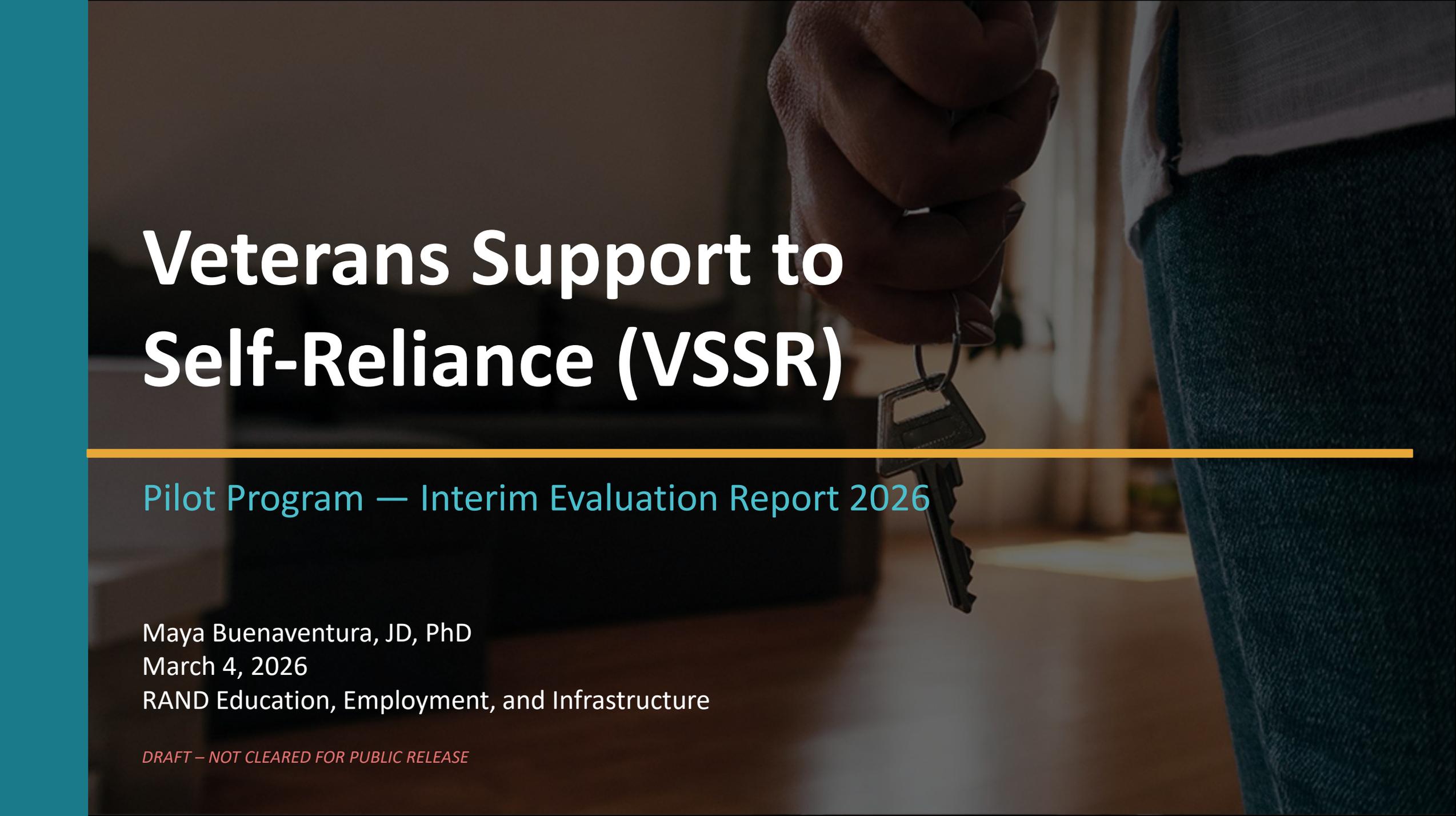


Occupational Therapists + Nurses



Transportation Specialists





# Veterans Support to Self-Reliance (VSSR)

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Pilot Program — Interim Evaluation Report 2026

Maya Buenaventura, JD, PhD  
March 4, 2026  
RAND Education, Employment, and Infrastructure

*DRAFT – NOT CLEARED FOR PUBLIC RELEASE*

# What is RAND Evaluating?

*The big question: What changes in health, wellbeing, and housing stability are observed among veterans receiving enhanced supportive services in permanent supportive housing?*

1

**Who did we reach (age, health, history)?**

2

**Did they stay housed?**

3

**Did things get better (health, daily living)?**

4

**What helped most? Specific services (group activities, hands-on help) linked to better outcomes?**

5

**What makes life feel good?**

# Where the Data Comes From

Q

## Staff Check-Ins (Every 3 Months)

- Staff completed quarterly assessments for each veteran
- Health, daily activities, services, household issues
- 515 veterans at entry; 361 followed for one year or more

V

## Veterans' Own Annual Survey

- Veterans completed annual self-assessments
- Housing, health, daily activities, social ties, and overall wellbeing
- 109 participants completed both Year 1 and Year 2 surveys

H

## Move-Out Records

- Log of every veteran who left the program, when, and why
- We sorted exits into: (1) moved to independent living, (2) moved to higher care, (3) eviction / homelessness
- Covers full program period: June 2023 – November 2025

## How We Analyzed It

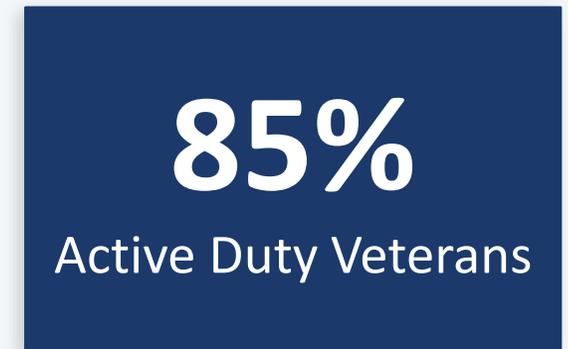
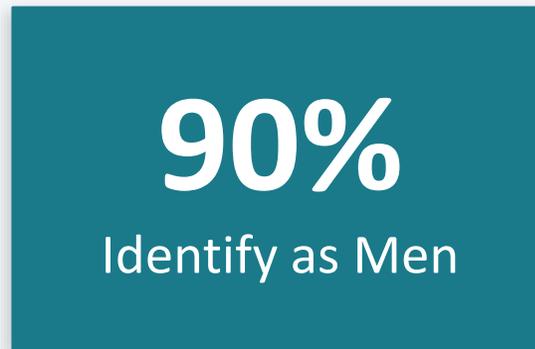
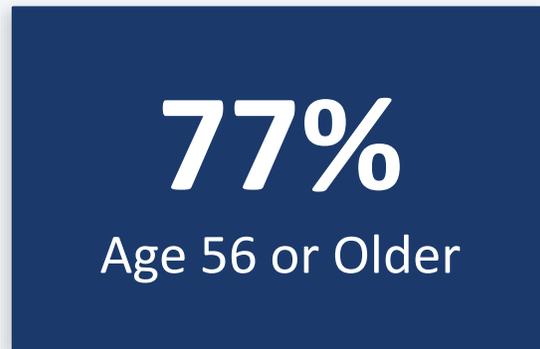
Snapshot  
at Entry

Before  
& After

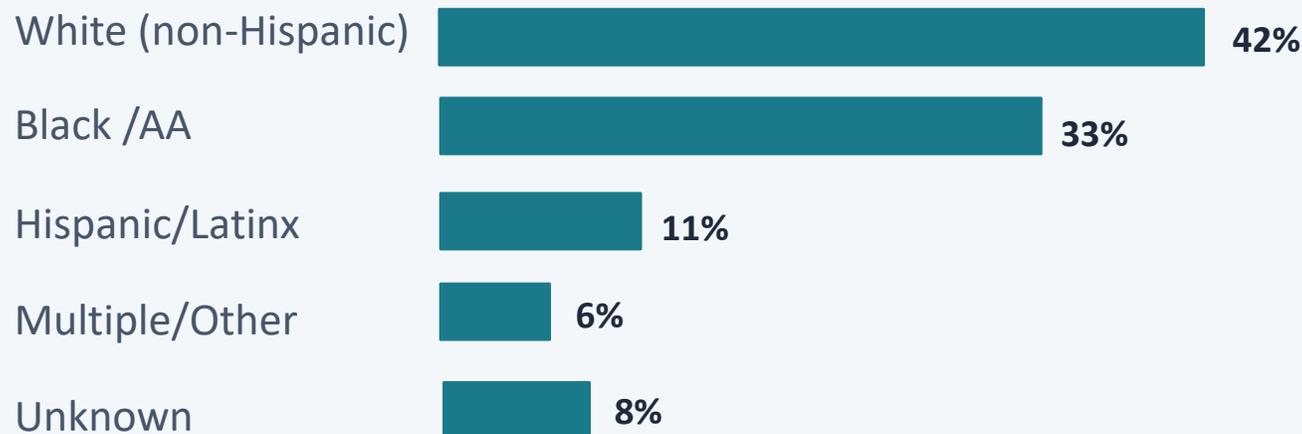
What's  
Linked?

Quality of  
Life Drivers

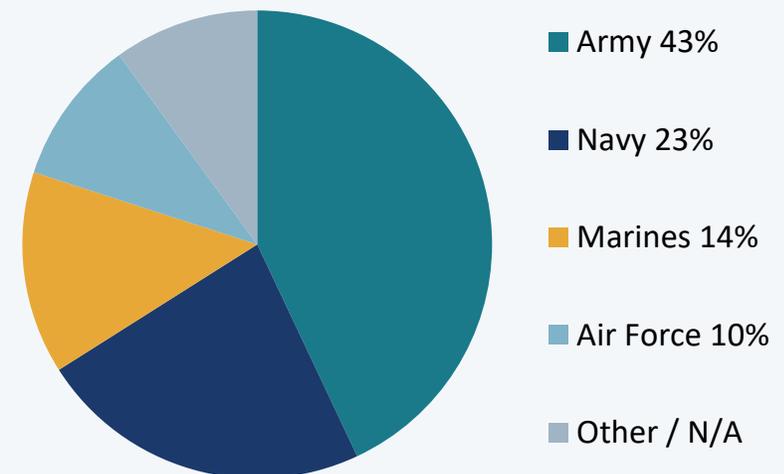
# Participant Demographics (n = 515)



## Race / Ethnicity

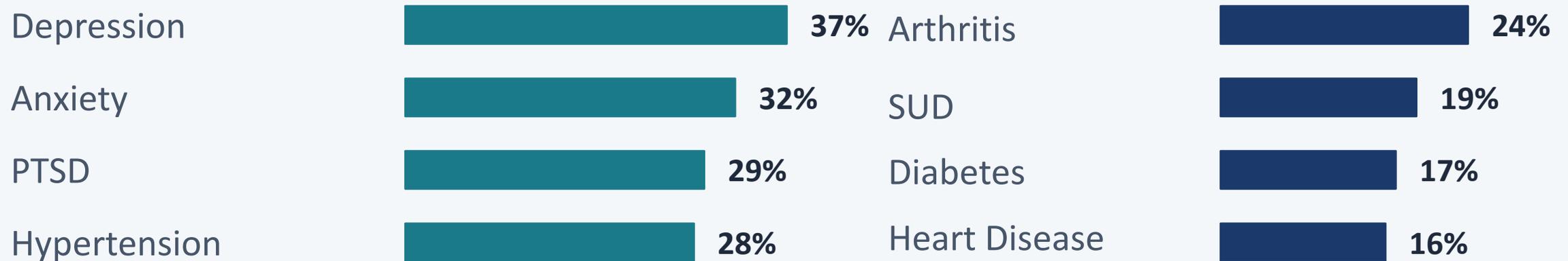


## Military Branch



# A High-Acuity, High-Need Population

## Most Prevalent Health Conditions



**60%**

Reported fair, poor, or very poor health

**31%**

Had 4 or more chronic conditions

**24%**

Experienced a fall in prior 3 months

**16%**

Visited an ER in prior 3 months

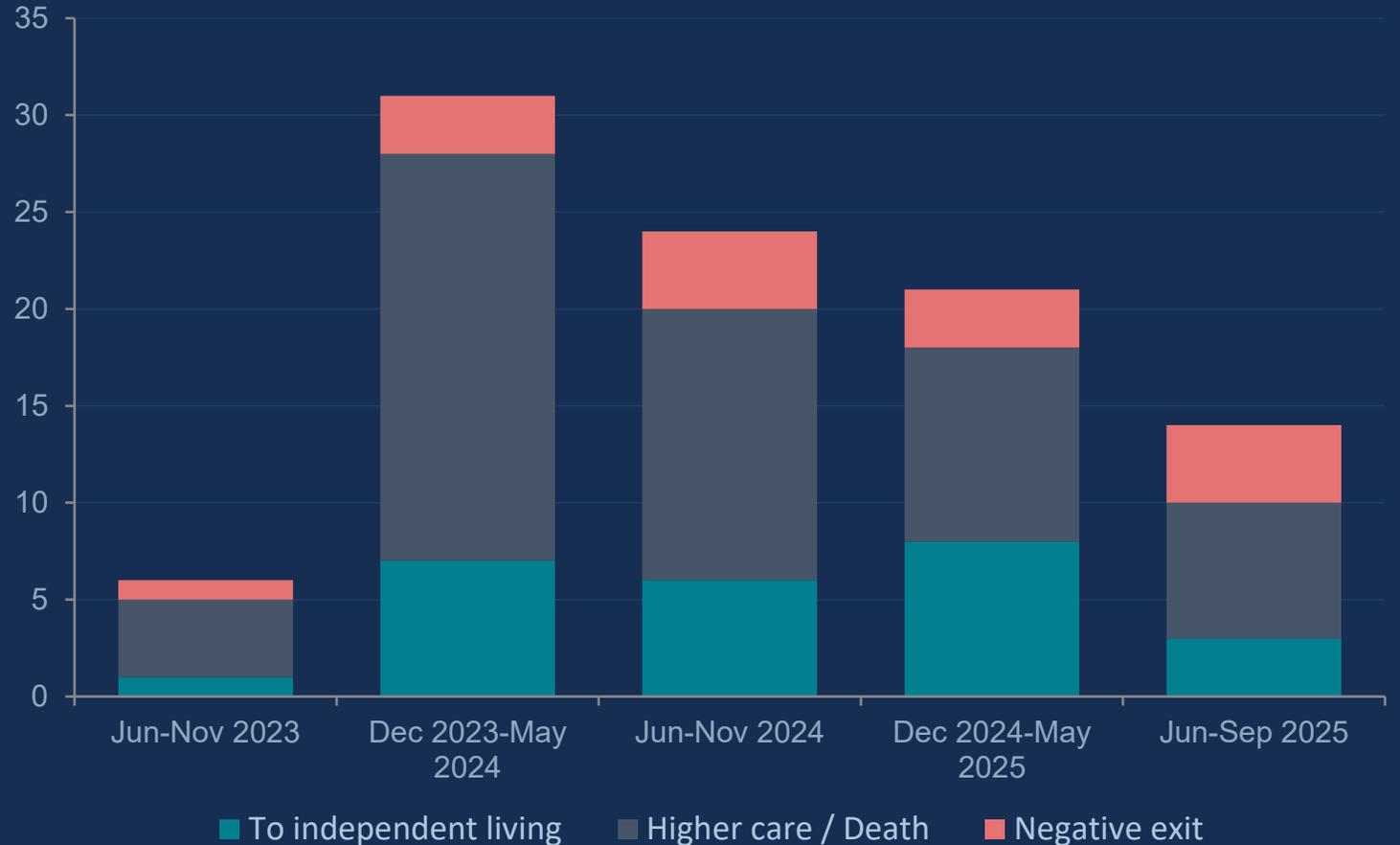
# Keeping Veterans Housed

3%

Negative Housing  
Exit Rate

*(eviction, incarceration,  
return to homelessness)*

Housing Exits by Period



## Health Outcomes After One Year (n = 361)

**-58%**

Fall incidents

21% → 9%

**-71%**

Emergency medical visits

14% → 4%

**-34%**

Ambulance / 911 calls

9% → 6%

**+53%**

Eating 3 meals per day

35% → 53%

**-49%**

Missed medical appointments

35% → 18%

**-21%**

Alcohol use

36% → 29%

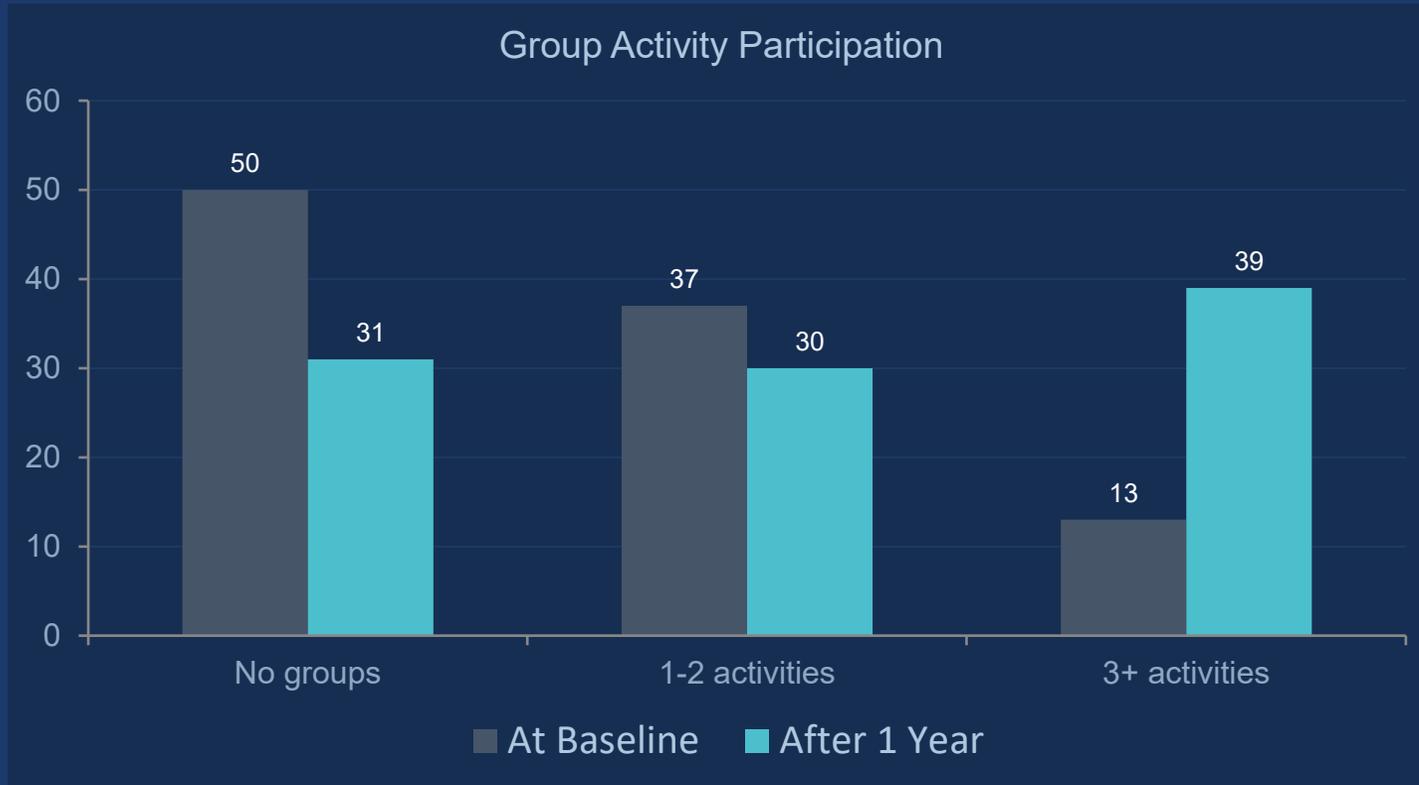
# Unmet Needs for Daily Living Assistance

*Share of veterans who needed help but weren't receiving it — at enrollment vs. after one year*

Type of Assistance	At Enrollment	After 1 Year	Change
Grocery shopping / Errands	24%	6%	<b>-74%</b>
Companionship / Emotional support	26%	~4%	<b>-84%</b>
Medical appointment assistance	22%	~4%	<b>-82%</b>
Housekeeping / Managing household	29%	14%	<b>-51%</b>
Meal preparation	15%	9%	<b>-44%</b>
Laundry	14%	7%	<b>-47%</b>
Mobility assistance	8%	~4%	<b>-50%</b>
Phone or computer help	10%	~4%	<b>-60%</b>

*Significant declines across nearly all categories.*

# Group Participation & Social Behavior

**3x**

Increase in residents participating in 3+ group programs

**-38%**

Fewer residents with no group participation

**+208%**

Growth in those attending 3 or more activities

*Note: Those leaving their apartment daily declined slightly (71%→59%), while those leaving 3+ times/week increased — suggesting a shift from informal wandering to structured activity participation.*

## Which Services Are Linked to Better Outcomes?

Service Type	Good/Very Good Health	Lower Acute Care Use	Fewer Falls	Better Social Engagement
ADL / IADL Assistance	—	Higher acute care*	—	—
Group Program Participation	✓ 2.6× odds**	✓ Lower**	✓ Lower**	✓ Higher**
Habitability Discussions	—	—	—	—

### ★ Group Programs Are a Standout Service

Participating in group programs was associated with 2.6× higher odds of good/very good health, lower acute care use, fewer falls, and higher odds of leaving one's unit at least 3 times per week. These associations held even after controlling for age, gender, comorbidities, and site. Note: associations may reflect participant motivation as much as program impact.

# What Drives Veterans' Self-Rated Quality of Life?

*From annual self-administered resident survey (n = 109 per year, 2 years of data)*



All five factors remained significantly associated with quality of life after controlling for age, gender, race/ethnicity, chronic conditions, and site. This highlights that housing security and social connectedness are as important as physical health to veterans' wellbeing.

# Areas of Complexity & Caution

## Substance Use: A More Complex Picture

- Alcohol use declined (-21%)
- Cannabis & opioid use appeared to rise
- **Likely a reporting artifact as staff became more familiar with residents**
- Staff observations and resident disclosure improve over time
- Overall no-substance-use rate unchanged (52% → 54%)

## Outpatient Care: Shifting, Not Declining

- Primary care fell 15%; specialty care rose 26%
- Mental health outpatient visits down 50%
- Some care likely shifted on-site to VSSR
- A rebalancing — not a loss of care

# What the Evidence Suggests

1

## Program Is Reaching the Right People

The demographic and health profile confirms that VSSR is serving high-need, high-acuity veterans — those most likely to benefit from enhanced supports.

2

## Housing Stability Is Being Maintained

A 3% negative exit rate is very strong by PSH standards. Enhanced services appear to be keeping high-acuity veterans housed.

3

## Group Engagement Is a Key Driver

Group programs are the service most consistently linked with better health, fewer falls, and reduced acute care. Investing in and scaling group programming matters.

4

## Housing Security = Quality of Life

Veterans who feel safe and aren't worried about losing their housing report better quality of life. This suggests that the program's focus on housing stability has a direct wellbeing payoff.

5

## Unmet Needs Persist

Despite progress, over 10% still lack housekeeping help. This is a potential area for improvement.

## Important Caveats to Keep in Mind

- No control group
- Descriptive analyses only
- Staff-reported data at baseline may vary in quality
- Self-report bias
- Sample may not generalize to later enrollees, outcomes beyond one year
- No access to VA medical records/claims data to verify health service use

*Despite these limitations, the consistency of positive trends across multiple outcomes and data sources lends credibility to the findings.*

# Next Steps & Closing

- 1 Incorporate additional quarterly data as it becomes available through June 2026
- 2 Examine associations between service delivery and housing exits, habitability trends, and healthcare utilization
- 3 Disaggregate findings by demographics, voucher type, and region — where sample sizes allow
- 4 Assess whether positive changes are sustained beyond the first year of enrollment
- 5 Explore links between annual survey quality-of-life data and quarterly service use — including whether greater program participation is associated with improvements in self-reported loneliness and wellbeing
- 6 Assess long-term sustainability of the VSSR service delivery model
- 7 Produce final evaluation report — August 2026



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# THANK YOU



Amy Fairweather  
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Maya Buenaventura  
[mbuenave@rand.org](mailto:mbuenave@rand.org)

## VIII. General Public Comment

- Public comment on items discussed this meeting
- If joining by Zoom, click the “raise hand icon”
- If connected by phone, press “\*9” to indicate that you would like to comment

# XI. Final Remarks and Adjournment

- Next Council meeting: June 3, 2026, at 1:00 pm

# Contact Information

- Cal ICH Website: <https://www.bcsh.ca.gov/calich>
- Questions: [calich@bcsh.ca.gov](mailto:calich@bcsh.ca.gov)
- Social Media
  -  [https://twitter.com/Cal\\_ICH](https://twitter.com/Cal_ICH)
  -  <https://facebook.com/CaliforniaICH>
  -  <https://linkedin.com/company/california-interagency-council-on-homelessness>