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MULTNOMAH COUNTY

FY 2022 Budget Work Session Follow Up – Health Department

Health Department – May 12 & 13, 2021

Question 1

Commissioner Meieran (District 1): Please provide a list of all program offers that provide services to the houseless community and what specific services those program offers offer to houseless individuals.

Response:

Behavioral Health Division

The program offers noted here are a blend of contracted services and services provided directly by Multnomah County Behavioral Health. In FY 2020, 44,941 persons were enrolled in a County program (non-contract). In addition, the Multnomah County Call Center received 65,000 to 70,000 calls, which may or may not have been from persons enrolled in county services (either contracted or provided by County staff). The majority of services were offered through contracted providers, which capture output numbers through a variety of measures (eg, individuals served, contracted beds).

The Behavioral Health Division is engaged in a continuous Quality Improvement Process to create more efficient procedures to capture the volume and results of the services offered. We use Evolv as our Electronic Health Record (EHR) for services that are provided directly by the Multnomah County Behavioral Health Division. However, not all of our Behavioral Health programs use Evolv or use it in the same way, and data tracked has been specific to the funding source and/or reporting requirements. As such, not all programs have historically tracked housing status and we are only able to provide estimates for those programs. Further, the bulk of the services funded through Behavioral Health are contracted services and unless their contract requires an outcome on housing, we don't have that data. Estimates are noted in the program descriptions.

We have just completed an upgrade to EvolvNX, and will be embarking on our next round of improvement projects to include standardizing key data elements that will support better outcome alignment and program planning. All of this to say, we are continuing to improve our ability to count, measure and evaluate service data and outcomes.

Joint Office of Homeless Services (JOHS) Partnership

The Joint Office of Homeless Services is funding some Behavioral Health's services and housing initiatives as reflected below. Each of these are new projects and the first six to twelve months are pilot projects in which we will refine the outcome measures to assure we are capturing the most meaningful information. In all instances, the goal is to increase housing access and stabilization, the degree to which will be refined during the pilot period. The following are JOHS program offers that include behavioral health supports for houseless individuals:

Program Offer 30401B - Administration and Operations - Human Resources/Operations Support

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- Addictions Benefits Coordination Team: Funds 3.00 FTE Direct Outreach plus 0.50 Program Supervisor to support houseless persons (serving 300 persons annually), engaging individuals in harm reduction related to substance use while supporting individuals in accessing resources to support wellness, including housing, employment, physical healthcare, and other behavioral health services.
- Assertive Community Treatment (ACT): The assertive community treatment or ACT Teams serve adults with severe and persistent mental illness challenges and diagnoses. Their team-based model of care positions them to support clients to find housing units and retain housing. This investment is for long-term rental assistance for 100 clients.
- Choice Wraparound Services for SPMI: Provides two teams at two motel sites in Multnomah County. Each team will consist of a Peer Support Specialist and a Qualified Mental Health Associate supporting clients with severe and persistent mental illness. These teams will be onsite at the motels approximately 40 hours/week to provide Peer Support, Skills Training, and connection to community supports.
- African American Stabilization Treatment Preparation: This culturally specific model builds on the success of our existing STP model. The full program includes outreach, engagement, stabilization and transition to housing for African Americans engaged with criminal justice. JOHS will help fund the housing portion.

Prog. Name/# or Description	Service	Number Served	Total
30401B - Administration and Operations - Human Resources/Operations Support			
Addictions Benefits Coordination (ABC) team	Outreach	300 Clients/Year	$540,000
Assertive Community Treatment (ACT)	PSH	100 Clients/Year	$1,000,000
Choice wraparound services for SPMI	Wraparound	100 Clients/Year	$1,000,000
African American Stabilization Treatment Preparation (STP)	Culturally specific engagement/housing	80 Clients/Year	$500,000

Program Offer 30400D - Supportive Housing - Metro Measure Expansion - Countywide Coordination

Law Enforcement Assisted Diversion - The Law Enforcement Assisted Diversion program is going to be renamed and will be part of the new Addictions Benefits Coordination model, of which this portion focuses on individuals who are engaged with or at risk of engagement with law enforcement and have substance use concerns. These funds are for rent assistance and other program support. The full scope of services will be as described above in the Addictions Benefits Coordination.

Program Offer 30400C - Supportive Housing - Metro Measure Expansion - Local Bond Units & Site-Based Commitments

Cedar Commons is a permanent supportive housing project in partnership with BHD, JOHS and Central

City Concern to provide housing and supportive services for 30 clients. This funding is specific to rental assistance for these clients to reduce risk of housing instability due to income change.

JOHS is also supporting activities across the County that will lead to better overall coordination, including 3.00 FTE Cross Department Housing Coordinators, one of which will be housed in the Behavioral Health Community Mental Health Program. This collaboration will also improve data sharing through the Service Coordination Portal Engine, known as SCoPE, of which 1.00 FTE SCoPE Analyst will be housed in the Health Department (see Program Offer 30003B).

Below are Health Department Program Offers that serve houseless individuals:

Community Mental Health Program (CMHP)

Program Offer 40069 - Crisis Services Services include crisis intervention (crisis assessment and level of care determination, peer services (follow up post crisis), resource connection (referrals to BH and other providers in the community), staff and supports for 24/7 Behavioral Health Call Center, walk-in clinic services (accessible, walk-in supports for those in crisis, including psychiatric prescriber services) and Emergency Department diversion services (outreach and support to individuals identified by local emergency departments to help support and assist in access to services and decrease the risk of further crises). Roughly 32% of clients served are identified as houseless.

Program Offer 40070B - Crisis Assessment Treatment Center Crisis Assessment Treatment Centers offer short term (up to 30 days) stabilization services for those requiring a secure alternative to incarceration or hospitalization. Houselessness information is not specifically tracked from the intake form and CATC does not provide data on housing status. Approximately, 50% of clients served are unhoused.

Program Offer 40072 - Commitment Services When an individual's behavioral health challenges require involuntary treatment, commitment services are provided. Services include precommitment investigation, commitment monitoring during trial visits to the community, facilitating financial & medical entitlement e.g. Social Security and other benefits and ensuring that individuals transition into the appropriate level of community care. Roughly 50% of clients served are unhoused.

Program Offer 40074 - Mental Health Residential Services This program supports over 650 individuals who participate in residential treatment services to around 90 residential programs that support stability, health and safety. Residential staff provide monitoring, oversight and technical/clinical consultation. Roughly 5% of clients served are either on an active 30-day notice to move or have received multiple notices of disturbance, placing them at risk for eviction.

Program Offer 40088A, 40088B, 40088C - Coordinated Diversion for Persons with Mental Illness

The programs within the Coordination Diversion unit serve clients who are justice-involved and who have behavioral health needs. This program connects defendants to community treatment, and financial and medical entitlements. The program also provides mental status evaluations and linkage to basic needs in the community, and time-limited coordination/linkage to treatment services.

Connection to housing supports is a service that is offered to all clients who would benefit or who request it. Approximately, 80% of clients served through these programs are houseless and about 50% of clients accept this form of support. Clients are referred to permanent supportive housing, shelters, residential treatment, adult foster homes and independent living.

Program Offer 40071 - Behavioral Health Division Adult Protective Services (APS) receives/screens abuse reports for individuals with severe and persistent mental illness and other vulnerable adults. Abuse reports can come from the alleged victims of abuse, community members, caregivers, and/or mandatory reporters across Multnomah County. Program receives approximately 1,200 abuse reports annually. About 20% of cases screened for abuse, represent individuals who are unhoused. Risk assessment and protective services, including safety planning, is conducted on all reports, to minimize the risk to vulnerable individuals. Risk case management is a service within the APS program that is offered to individuals, alleged victims, who are not yet connected to behavioral health services or supports. This service is provided to approximately 100 individuals per year, roughly 80% of whom are houseless.

Addictions Treatment

Program Offer 40085: 40085A, 40085B, 40085C, 40085D - Adult Addictions Treatment Continuum
Serves more than 3,000 individuals/yr and provides a continuum of adult Substance Use Disorder (SUD) treatment and recovery support services. These are contracted services which do not require reporting on housing status, but may include housing outcomes as a reflection of treatment success.

The following services are prioritized for houseless individuals or those with housing instability/housing not conducive to SUD recovery:

- Supported Housing beds (around 270 annually) linked to intensive outpatient treatment services
- Housing Case Management and referral/linkage to housing supports and coordination
- Emergency Rent Assistance (rent, deposits, barrier removal including arrearage of utility payments, moving costs, etc.) for individuals enrolled in a SUD Outpatient Treatment program.
    - We have a specific state fund (CFAA, AD-64, Housing Assistance Support Program) that funds approximately $192,345 in rent assistance per year for a minimum of 29 unduplicated individuals per year. OHA sets the minimum number served.

- In our outpatient treatment contracts, currently 10% of their annual funding can be spent on emergency housing support (rent assistance, downpayment, moving costs, utility arrearage). Maximum in FY22 is $46,800. Number of individuals served and dollars spent fluctuates every year.
- Throughout our cost reimbursement contracts, providers sometimes request client basic needs assistance line items when they complete their annual budgets. Providers are required to keep documentation around these expenses.
- In the last 3 years, an average of $1,222 was spent per client.

○ LEAD: Let Everyone Advance with Dignity (LEAD). Reduce criminal justice encounters among those at risk due to Substance Use Disorder (SUD). Target populations include African Americans, the houseless, and those with a history or risk of criminal justice involvement. This program is being redeveloped and will be re-named in FY22 as part of the restructuring of the Addictions Benefits Coordination team. Services include engaging individuals in harm reduction related to substance use while supporting individuals in accessing resources to support wellness, including housing, employment, physical healthcare, and other behavioral health services.

Program Offer 40089 - Addictions Detoxification & Post Detoxification Housing This program provides approximately 2,400 admissions annually for withdrawal management to medically stabilize a highly vulnerable and diverse client population for residential, outpatient, and recovery support services. This program's Supportive Housing and Care Coordination services target houseless individuals and provides additional engagement and stability by assisting clients in accessing supportive services promoting recovery, stability, and self-sufficiency. Outcome measures for this program include:

Withdrawal Management Care Coordinator (serves persons exiting withdrawal management) Services Outcome:

- 43% of individuals exiting Hooper withdrawal management, transition to the next level of care, leading to additional engagement, stability and housing.

Supported Housing/Withdrawal Management (serving people actively enrolled in withdrawal management) Outcomes:

- Average length of stay in supported housing is 14-15 weeks
- This year 168 individuals received supportive housing

Program Offer 40090 - Family & Youth Addictions Treatment Continuum This program provides alcohol and drug-free supportive housing resources for families of adult parent(s) who are in Substance Use Disorder (SUD) treatment. Annually, approximately 100 families receive housing support in family-focused recovery housing communities. The Family Action Network (FAN) provides payment of rent and associated expenses inclusive of deposits, move-in costs, and utilities and supportive services. In FY20, 81% of clients were identified as being in stable, safe housing upon end of service.

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Care Coordination

Program Offer 40075- Choice Model This program serves adults with severe and persistent mental illness; facilitates communication between the individuals, their families, and community resources, provides access to mental health treatment for individuals who do not have adequate health insurance, and provides temporary, transitional, and permanent housing. In FY 2022, Choice Model Budget for Crisis and Transitional Motel support is being significantly enhanced through Partnership with JOHS/Metro. Investment with specific funding for Motel Wraparound Program, including funding for motel placements and support services are provided onsite by New Narrative. This is designed to address basic needs and enhance opportunities for clients to work on housing and other goals to promote stability and recovery. At any given time Choice provides services to approximately 650 clients and of those, typically 10%-20% are houseless.

Program Offer 40081 - Care Coordination

- Adult Intensive Care Coordination (A-ICC). This program serves CCO Members and uninsured clients with significant or complex behavioral health or substance use disorder (SUD) needs; needs assessment and care planning, connection to Behavioral Health Treatment Services, other medical services, flex funding (e.g. transportation, clothing), and community resources. At any given time approximately 50% of AICC clients are houseless.
- Multnomah Intensive Transition Team (M-ITT): This program provides flexible, low-barrier, collaborative, intensive, short-term transitional support intervention to ensure clients access services; provide continuity of care following hospital discharge, connect individuals to ongoing specialty services, and reduce inpatient readmissions. At any given time approximately 50% of M-ITT clients are houseless.
- Wraparound: This program works with children and youth experiencing serious mental health or behavioral challenges who have multi system involvement, and brings together youth, family, school teachers and service providers to create an individualized plan for addressing children's needs. Wraparound serves a small number of youth/families who are houseless and larger numbers who are not stably housed.
- Youth Intensive Care Coordination (Y-ICC): Serves CCO Members and non-member exceptions with significant or complex behavioral health needs. Care coordination includes needs assessment and care planning with youth and family/guardian for youth up to age 21 as appropriate. Y-ICC serves a small number of youth/families who are houseless and larger numbers who are not stably housed.

Public Health

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Program Offer 40010A - Communicable Disease Prevention & Control This program services our houseless community by providing Hep A, Hep B, Twinrix, and Flu vaccines. Prior to the onset of the COVID-19 pandemic, we also provided TB screening, evaluation and latent TB infection treatment to our homeless population. Services are still on hold due to the pandemic, but we do not turn any clients away if they come in looking for Hep A, Hep B, Twinrix, and Flu vaccines.

For clients with communicable diseases we provide housing in the form of motel vouchers for people who need housing to help prevent transmission of their diagnosed disease. This service is most frequently used for tuberculosis and shigella, but we have the ability to house anyone diagnosed with a communicable disease. We have up to $30,000 per fiscal year budgeted for vouchers through Home Forward. We provide food delivery with accommodation for dietary needs while clients are housed through our program.

For unhoused clients with active TB, an assigned nurse case manager and community health worker will assist clients to ensure they have access to needed services to provide support and housing once TB treatment is complete. After the isolation and quarantine period has ended for TB patients, the case manager is responsible for linking clients to any needed services such as housing, medical care, food assistance, and other services needed by the client.

Program #40061 - Harm Reduction Harm Reduction Program provides direct services as well as administration of funding to Outside In. MCPH and Outside In sites collectively provide services a total of 71 hours a week, providing:

- Syringe Services (SSP): syringe access, safer injection supplies, syringe disposal, safer sex supplies (condoms), fentanyl test kits
- Naloxone Distribution and Overdose prevention education,
- Low-barrier services at MCHD Harm Reduction Clinic:
    - STI Testing and treatment, Wound / Abscess Care, other acute medical needs
    - MCHD Medication-Supported Recover Program (LCSW on-site, MSR medical appointments available on Mondays)
    - Central City Concern Hepatitis C treatment navigator on-site Thursdays
    - OHP Enrollment
    - Referrals to Hooper Detoxification Center
- Low barrier HIV and HCV testing at Outside In
- Referrals and warm hand-offs to SUD Treatment, Housing support, Food or clothing resources, or other resources identified as a need by program participants.

MCHD's indoor and mobile sites are located throughout Multnomah County (Downtown Portland, Southeast Portland, and East Multnomah County). Outside In's main site is in

Downtown Portland , and its other two are located in neighboring Clackamas County. Some clients travel from other counties to access services, as well.

- These programs serve approximately 7,000 individuals per year, in the Portland metro area. (6,820 served through March in FY21)
    - Clients predominantly reside in Multnomah County (79%), 10% live in Clackamas County, and the remaining 11% live in other counties that neighbor Multnomah—Washington County (6%); Clark County, Washington (4%); and Columbia County (1%).
- The most common housing status is houseless (43%, n=2,933), and 23% are temporarily/unstably housed. Only one-third (33%) are stably housed.

Program staff also participate in several workgroups and provide technical assistance and training to address syndemic health issues impacting houseless populations and people who use drugs. Activities Include:

- HIV Syndemic Workgroup
- Overdose Monitoring Workgroup
- OHA "Save Lives Oregon" Technical Assistance Committee
- OHA Harm Reduction and Recovery Support Program (Panelist)
- Health Dept. Housing Coordination Group
- Providing Naloxone Train-the-Trainer Courses
- Administering MCHD Pharmacy Narcan Purchasing program
- As needed technical support and training to CBOs serving unhoused and people who use drugs throughout the state to support increased knowledge and implementation of harm reduction principles or services.

Program Offer 40010B - Communicable Disease Clinical and Community Services This program provides the following:

- Low barrier STI testing, treatment, and PrEP management at the Public Health Clinic
- Limited TB evaluation and treatment
- Field work to locate and coordinate treatment for unhoused residents who test positive for STIs through any health system
- HIV/STI partner notification services for unhoused residents, including field visits to camps and homeless service sites to locate individuals without phones or addresses
- Syphilis treatment in the field at homeless camps, and temporary motel housing while completing syphilis treatment in priority situations

- Community screening for HIV/syphilis/HCV four times weekly at homeless service sites
- Linkage to care and supportive referrals for unhoused residents newly diagnosed with HIV
- Distribution of home HIV test kits in partnership with unhoused newly diagnosed community members who provide them to others in their social network.
- Field outreach to unhoused HIV positive residents who have not engaged in medical for more than a year to offer re-linkage support (Data to Care)
- Distribution of naloxone and safer injection supplies at the Public Health Clinic and through DIS field outreach to camps
- Ongoing participation in Joint Office of Homeless Services weekly calls to ensure area providers are aware of HIV/STI prevention services and provide updates on trends
- Leadership of the HIV/syphilis/HCV Syndemic Response Workgroup coordinating TriCounty management of the ongoing outbreaks among people who inject/use meth and are unhoused
- Engagement of community partners to ensure the integration of HIV/STI prevention messaging in regional homeless outreach services
- Collaboration with COVID-19 program to ensure HIV/STI prevention messaging is integrated into culturally specific outreach to sex workers
- Funding and providing technical assistance to CBO subcontractors to deliver HIV testing to unhoused residents

Below is our housing data for newly diagnosed HIV cases over the past 3 years. These are the individuals that linkage to care and partner notification services are provided by Disease Intervention Specialists (DIS). Percentages of unhoused clients for syphilis and gonorrhea case investigators are similar.

2018- 12% unstably housed/homeless

2019- 28% unstably housed/homeless

2020- 20% unstably housed/homeless

We implemented an Enhanced Interview as part of our HIV/Syphilis Syndemic Response. We interviewed HIV cases that met our outbreak definition (people who use or inject any drug) and 41% reported they were unstably housed.

In terms of other information we know about our unhoused clients - they are frequent utilizers of emergency departments, and there is some overlap of MSM and heterosexual meth users. Housing instability has been a driving force in the increase of congenital syphilis, and most of these cases have delayed or have received no prenatal care.

All of our field-based testing is delivered at homeless service sites, so close to 100% of those clients are unhoused. Approximately 65% of our home HIV test distribution has been to unhoused individuals. All of our field-based treatment for syphilis is for unhoused clients.

Program Offer 40012B - Services for Persons Living with HIV- Regional Education and Outreach: This program provides housing services primarily for people living with HIV that are houseless or at-risk of becoming so. Housing services pay for rent assistance, medical motel vouchers, housing case management, housing placement services, and beds within home based recovery programs.

Approximately $325,000 goes towards psychosocial support which funds a day shelter providing meals, laundry facilities, phone and computer access, and mailing address. Anyone living with HIV is eligible to attend the day shelter, but it is primarily frequented by people that are experiencing houselessness. HGAP staff meet with JOH staff quarterly to ensure funding streams for people living with HIV (Ryan White and HOPWA) are aligned.

Integrated Clinical Services (ICS)

ICS provides services to people experiencing homelessness throughout its service provision including Primary Care, Dental, Pharmacy, SHC's and Integrated Behavioral Health Services. The Community Health Center receives funding from HRSA to provide health services to persons experiencing homelessness.

Question 2

Commissioner Meieran (District 1): Please provide a break out of the ARP funds based on funding source (i.e. HRSA, Multnomah County direct allocation, etc.), as well as to what areas the funds are allocated.

Response:

In the Chair's Executive Budget the COVID Rescue Plan funding totals: $57,833,450

This total includes the following:

1. Integrated Clinic Systems (ICS) direct ARPA funding from U.S. Department of Health and Human Services to expand access to COVID-19 vaccines, to better serve communities of color, low-income populations, and other underserved communities in the COVID-19 response. ***($10,9.9m from HHS makes up a portion of the total $13m request from ICS, it is not in addition too)*** $10,930,750

2. Public Health Epidemiology and Laboratory Capacity (ELC) funding through OHA for cultural and linguistic competence and responsiveness, testing coordination, case investigation and contact tracing, isolation and quarantine, social services and wraparound supports, and vaccine planning and distribution. ***($5.1m for Public Health COVID ELC funding is part of the total funding for Public Health response not in addition too)***	$5,185,503
3. Oregon Immunization Funding ***($1.3m from the State of Oregon for immunizations is part of the total funding for Public Health response, not in addition too)***	$1,379,330
4. Multnomah COVID American Rescue Plan (ARP) funding	$40,337,867

Question 3

Commissioner Meieran (District 1): Will the additional medical examiner FTE provide an opportunity to deepen the County's work around the annual Domicile Unknown report, such as by providing real-time understanding of and reporting on deaths of people experiencing houselessness (rather than the lookback approach of the report)?

Response:
Program #40052B - Medical Examiner Program The additional FTE keeps the medical examiner program staffed at the minimum level for a population the size of Multnomah County. The rationale for raising the total staffing from 8.00 FTE to 9.00 FTE is empirically based. Our population in Multnomah County is growing and aging. Even pre-COVID, medical examiner program staffing levels did not allow the program to meet basic benchmarks like timely arrival times to scenes, number of in-person investigation of deaths that meet criteria, and timely responses to inquiries from decedents' loved ones. This increase in the number of death investigators will allow the program to continue to collect detailed data for the annual Domicile Unknown report, including following up with family to obtain information regarding decedents' housing status and social context. The Domicile Unknown report is published annually. The boost in staffing may allow for providing provisional numbers ahead of finalized toxicology and data analysis, which would be closer to real-time information.

Question 4

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Commissioners Vega Pederson (District 3) and Jayapal (District 2): With respect to the isolation and quarantine budget, please provide a breakdown of costs, including identifying costs associated with staffing as compared to direct supports such as housing, food, utilities, etc.

Response: The COVID-19 Isolation & quarantine for Public Health Emergency Response in the amount of $20,399,000 is made up of the following estimated costs:

Personnel - ● 1.50 FTE Inspections to assist operators with re-opening, etc.; ● 1.00 Community Health Specialist to work with CBOs around Vaccine Hesitancy; this is a permanent position formerly in Early Childhood Services that will be transitioned to other funding after the pandemic response is concluded ● Program Tech to assist with housing needs. ● 7.00 Limited Duration positions for WIC client backlog	$968,331
Materials & Supplies	$87,000
Culturally specific contracts/Interpretation ● Supports County contact tracing and community testing and vaccination efforts ● Provide culturally centered education on Covid symptoms monitoring and prevention ● Provides informal counseling and emotional support to cope with social isolation ● Supports navigation and advocacy for various essential social services and resources (e.g., access to food, housing support) ● Provide additional support and education for individuals/families with chronic conditions ● Support/coordinate care with health systems	$4,200,000
Pandemic Response Call Center ● Estimated staffing and operational costs for Call Center ● This cost was not included in the Health Department FY 2021 budget ● The Call Center functions include screening and referral, providing guidance for businesses, supporting emergency management services, including communications; responding to calls related to donations and volunteers; assisting with scheduling COVID-19 testing and negative test result calls;	$4,682,062

conducting daily active monitoring for individuals connected to positive COVID-19 infections.	
Bienestar ● Process referrals for supportive services to meet Covid-19 response needs. ● Supportive services will include but are not limited to: rental assistance, energy assistance, and food assistance. ● Determines eligibility and payment approval determination and acquires supporting documentation prior to payment. ● Collaboration on a dashboard that includes number of COVID-19 cases; number of COVID-19 contacts; and number of referrals to community based organizations to assist individuals/households in accessing DCHS supportive services; and number/type of supportive services provided to individuals/households by DCHS staff. Demographic information will be included based on what is being collected.	$3,000,000
Transition EOC to Public Health ● Estimated staffing and operational costs ● This cost was not included in theHealth Department FY 2021 budget	$3,500,000
Isolation Food & Medical Costs ● We project approximately 50 people per week at $150 per week with groceries, over the counter medications, and delivery	$877,500
Isolation Housing (50 people for 3 weeks) ● We project 75% of the 50 clients per week needing assistance will be housed clients with average rent at $1,200 per month ● We project 25% of the 50 clients per week needing assistance will be unhoused clients with an average motel stay at $560 per week.	$2,712,450
Utility Assistance ● We project $250 per month in utilities for the 75% of the 50 clients per week who are housed	$339,300
Phone/communication Assistance ● We project 25% of the 50 clients per week will need phone service. Initial cost is $50 which includes 1 month of air time.	$32,500
Total	**$20,399,143**

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Question 5

Commissioner Jayapal (District 2): How does the $580,000 to build on culturally-specific coalition development and CBO technical assistance (Public Health slide 18) relate to the $1,166,000 for Community Partnerships & Capacity Building (Public Health slide 17)? What sorts of services or activities are included? Are they things the County is doing or that CBOs are delivering?

Response: **Program Offer 40096A - Public Health Office of the Director** The $580,000 for culturally-specific coalition development and CBO technical assistance is a component of the $1,166,000. All of the $580,000 will be contracted work with CBOs.

- $200,000 Latinx coalition;
- $150,000 Pacific Islander coalition,
- $150,000 Black/Immigrant coalition,
- $80,000 technical assistance for small CBOs.

The REACH Program will take the lead on Black/Immigrant coalition development. For the Pacific Islander and Latinx coalitions, we will support the great efforts/collaboration happening in the communities already.

- CBOs will deliver (with county supporting funding/admin, and help bring cross-sector allies and partners to the table). The program will convene meetings and bring together parties from different community-based organizations and sectors (cities, health systems, other counties) to address community needs and priorities.
- Services by the CBOs include: convening, cross-sector partnerships development, community priorities identification, development of implementation strategies.

Question 6

Commissioner Meieran (District 1): Please explain the $802,524 increase in general fund for Program #40050D In/Out of Scope Services Lab and Medical Records.

Response: Historically ICS provided services to Corrections Health, such as lab, medical records management, dental oversight, language services and infection control services. To remain in compliance with HRSA grant requirements ICS can no longer provide these services.
To address this issue, Corrections Health added new staff to support infection control efforts. These efforts include managing fit testing for respirator use and training personnel. Corrections Health also provides laboratory support at both adult facilities to support CLIA activities and administrative support for staff credentialing and organization of language services. These were services previously provided by ICS.

In addition, it was determined that some support activities provided by ICS could not be easily moved or replicated in Corrections Health. This includes staff providing EPIC electronic health record support and Health Information Services (HIS); those responding to and processing information requests; referrals

and HIPAA investigations. These staff will remain in ICS and will have a portion of their time charged to Corrections Health.

Since Corrections Health was unable to cover these costs within their current general fund allocation, the general fund previously budgeted in ICS was reallocated to Corrections Health to cover these costs. This is the same issue resulting in a reallocation in Program 40096B Public Health In/Out of Scope Services Lab and Medical Records $461,588.

Question 7

Commissioner Meieran (District 1): Public Health has proposed ARP allocations for COVID Response (total $35.7M): Each of these three line items are designated as (existing) in the title. How are we forecasting the need for each of these three public health emergency response buckets? Is it based on current service level or are we anticipating continued ramp down of some elements through FY 2022?

Response: They are designated as existing in that they are built off of the work we did in FY 2021 and for FY 2022 we incorporated lessons learned. That being said, we forecast decreased utilization of wrap-around supports for FY 2022 with a projected reduction from 75 people per week to 50 people per week based on increased vaccination rates. The budget is large for the wrap-around support because we included actual costs for Bienestar, EOC transition to Public Health, and Call Center costs that we did not have in our budget last year. We know that we still have work to do in addressing vaccine uptake in BIPOC and other vulnerable communities. Vaccine costs were not included in last year's budget. We will need continued low barrier testing and vaccine capacity to address community needs and barriers particularly as other community vaccination and testing sites shut down. The FY 2022 budget for Contact Tracing is $4.9m (compared to $12.6m for FY2021) reflecting the reduced efficacy of contact tracing work. This function will be less useful with the high level of community spread of COVID-19. Some contract tracing capacity for high risk outbreak response is necessary, but not to the level we had early in the pandemic. This is the most significant decrease in our COVID response.

Question 8

Commissioner Jayapal (District 2): How much did we spend on Isolation and Quarantine

Response: The Health Department expects to spend $10,727,070, the total amount budgeted for Isolation and Quarantine. If there are any unspent funds at the close of the fiscal year, those funds will be returned to the County.