The Human Services Commission approved these minutes on June 30, 2020

CITY OF BELLEVUE
HUMAN SERVICES COMMISSION
MINUTES

February 4, 2020 Bellevue City Hall
6:00 p.m. City Council Conference Room 1E-113

COMMISSIONERS PRESENT:	Chairperson Ma, Commissioners Amirfaiz, Kline, Mansfield, Piper
COMMISSIONERS ABSENT:	Commissioners Jain, Mercer
STAFF PRESENT:	Alex O'Reilly, Dee Dee Catalano, Christy Stangland, Toni Esparza, Devin Konick-Seese, Department of Parks and Community Services
GUEST SPEAKERS:	Randon Aea, International Community Health Services; Victor Loo, Asian Counseling and Referral Services; Jim Vollendroff, Behavioral Health Planning UW Medicine
RECORDING SECRETARY:	Gerry Lindsay

1. CALL TO ORDER

The meeting was called to order at 6:00 p.m. by Chair Ma who presided.

2. ROLL CALL

Upon the call of the roll, all Commissioners were present with the exception of Commissioners Jain and Mercer, both of whom were excused.

3. APPROVAL OF MINUTES

A. January 7, 2020

A motion to approve the minutes as submitted was made by Commissioner Piper. The motion was seconded by Commissioner Mansfield and the motion carried without dissent; Commissioner Amirfaiz abstained from voting.

B. January 22, 2020

Chair Ma noted on page one the call to order was by Chair Ma rather than Chair Mercer.

A motion to approve the minutes as amended was made by Chair Ma. The motion was seconded Commissioner Amirfaiz and the motion carried without dissent; Commissioners Piper and Kline abstained from voting.

4. ORAL AND WRITTEN COMMUNICATIONS

Mr. Darrel Tsukiji and Ms. Alin Leyva, both members of the Youth Link Board, invited the Commissioners to attend the Annual Youth Link Gumbo night event. Ms. Leyva said the event was slated for February 27 from 5:00 p.m. to 7:00 p.m. at Crossroads Community Center. She said the event has been held annually for the past 18 years and is always a welcoming and social event. Mr. Tsukiji said the environment allows for dialoging with young people in the community about youth topics and ideas. There always is a lot of good food and fun activities. He said anyone wanting to attend should contact Patrick Alina in Planning and Community Development by February 14.

5. COMMUNICATIONS FROM CITY COUNCIL, COMMUNITY COUNCIL, BOARDS AND COMMISSIONS

6. STAFF AND COMMISSIONER REPORTS

Chair Ma reported that along with staff he submitted the Needs Update to the City Council on February 3. He said their comments were very promising in terms of possibly increasing the budget for human services, especially in light of the increasing needs in the community. Councilmember Stokes raised the notion of having human services collaborate beyond just the funding cycle on topics such as affordable housing.

Human Services Manager Alex O'Reilly indicated that Chair Ma did a very good job of representing the Commission before the Council. Human Services Planner Christy Stangland and Assistant Director of the Department of Parks and Community Services Toni Esparza also did well in giving an overview of the human services mandate. The staff received a few additional questions after the presentation, the responses for which are being worked on.

Ms. O'Reilly announced that the Commission's new Council liaison is Deputy Mayor Nieuwenhuis.

Ms. Stangland agreed that Chair Ma did an excellent job representing the Commission. She said several Councilmembers talked about how important the work of the Commission is. A couple of Councilmembers suggested the Human Services Commission is one of the hardest commissions to serve on given the difficult decisions that must be made during the funding process. It was clear the Council values the work of the Commission.

Ms. Stangland reported that the Eastside Human Services Forum held its annual meeting recently and they included a panel of affordable housing providers. On the overall question of what is needed, the focus was on support for funding services and encouraging affordable housing production in the community.

7. INFORMATION FOR THE COMMISSION

A. Integrated Managed Care Panel

Ms. O'Reilly noted the Commission was quickly moving toward kicking off an intense funding cycle. She said staff would be bringing information regarding systems issues to the Commission ahead of the funding process. She introduced Jim Vollendroff with Behavioral Health Planning at the University of Washington; Victor Loo with Asian Counseling and Referral Services; and Randon Aea with International Community Health Services to discuss integrated managed care. She noted that agencies that previously provided primarily healthcare for Medicaid patients must now also provide behavioral healthcare services.

Mr. Vollendroff said he formerly directed the King County Behavioral Health and Recovery Division before joining the University of Washington to develop a behavioral health institute aimed at advancing behavioral health practices and to accelerate the timeline it takes evidence-based treatment approaches to get into practice in communities. He said he is personally in long-term recovery and the treatment services provided by agencies benefit people like him, adding that absent the services he received as an adolescent he would not be in the position he is currently.

Mr. Vollendroff said it used to be that mental health and substance abuse disorders were completely separate. There were separate state agencies addressing each, and the funding flowed from the state to the counties for those services via separate contracts. In 2014 the state decided the services should be integrated both to provide better services and to achieve better outcomes. The state subsequently went a step further by incorporating physical health into the equation. Behavioral health services now address mental health and substance abuse disorders. On average, persons with mental health and addiction problems die an average of 25 to 30 years earlier than the general population, and the reason for that early mortality is primarily driven by a lack of integrated care. From a systems viewpoint, very few disagree that integrating care is a good thing. There are, of course, multiple paths to integration, which is where there are ongoing conversations locally as well as nationally.

Mr. Vollendroff noted that Western State Hospital in Pierce County has faced some challenges which resulted in the loss of their federal funding. That, coupled with the notion of integration, pushed the Governor to see the need to do something significant. During the last legislative session, one of the largest investments ever in behavioral health was authorized. The infusion of new resources, however, only put things back to where they were in 2008 during the economic downturn.

The state's priorities are largely focused on how to provide more community based services aimed at keeping people well in their communities. By and large it has been recognized that people do not get well in hospitals. People do get stabilized in hospitals, and hospitals remain a part of the treatment continuum, but they get well through outpatient services in their communities surrounded by their support systems. Residential services are needed for acute care, but the shorter those inpatient episodes of care are, the better off patients are. There are currently only two state hospitals, one in Eastern Washington and one in Pierce County. The legislature funded a new teaching hospital to be built in King County on the grounds of Northwest Hospital; it will be the state's first new inpatient facility in over a hundred years. In addition, there are smaller short-term hospitals called evaluation and treatment facilities that will be built around the state. Treatment options are being expanded to make sure there will be more medication-assisted treatment programs, including methadone programs, both inpatient and outpatient. Housing is seen as an important continuum of care option for people who go into treatment to avoid having people discharged from treatment having no place to live, triggering a restart of the cycle. There is a huge workforce shortage related to behavioral health. The Affordable Care Act was a great thing in that it made more people eligible for Medicaid, giving more people access to treatment services, but with a shortfall in staff as the workforce caseloads increased and the number of individual services per client went down, impacting the overall quality of services and the ability of agencies to serve people.

The Governor has focused on integrating behavioral and mental health together. In 2014 the legislature passed SB-6312 which ended the bifurcated system in which it was the role of the counties to manage the Medicaid money for behavioral health. Washington is a carve-out state, which means when the federal government allocated funding for those eligible for Medicaid, behavioral health is carved out and allocated to counties, with the medical part going to health plans, or insurance companies. There is accordingly one entity to manage the system addressing behavioral health and physical healthcare issues. The bill represented a major system change and was therefore phased in. King County became a fully integrated managed care system in 2020. Medicaid funds now flow to five managed healthcare plans instead of to the counties. Four of the companies are for-profit entities headquartered outside of Washington state, and one is a non-profit headquartered in the state. The entities receive the Medicaid funds and contract back with the county which contracts with its network of providers. That results in layers of the funding being siphoned off to pay for people operating their parts of the system, and fewer dollars going to people who are served.

Mr. Vollendroff said the state is trying to incentivize providers in a number of ways to transform the system in terms of pay and the types of treatment programs implemented. The state applied to the Center for Medicaid Services, a federal agency, for a transformation grant to help providers and the system transform. In doing so they set up yet another organization called the Accountable Community of

Health, which in King County is called Healthier Here. Healthier Here is helping to manage the major Medicaid transformation on both the behavioral health and physical health sides by providing training, technical assistance and other resources to provider organizations.

Chair Ma said he was unclear about the money flow. Mr. Vollendroff allowed that it is complicated, and stressed that he was only talking about Medicaid populations, those who are eligible for resources from the federal government. In King County Mental Health and Drug Dependency tax dollars are used to help cover non-Medicaid services. He said the fact is that not everyone who needs help is eligible for Medicaid which is where funding from counties and cities is helpful. Additionally, not all services are Medicaid reimbursable. King County takes money from different pots to braid together a delivery system supportive of a provider network that reaches all populations. The vast majority of the funds comes from Medicaid, but also in the mix are dollars from MIDD, Best Start for Kids, and other sources.

Ms. O'Reilly clarified that most of the city's human services dollars go to people who are not Medicaid eligible. Where an agency cannot provide a specific service because a client is not eligible for Medicaid, or because the service is not Medicaid reimbursable, the local dollar grants can be tapped to fund services to some extent.

Mr. Loo said ACRS began in 1973. In 2019 the agency had more than 300 employees who served over 27,000 unduplicated individuals. The employees collectively speak some 45 languages and dialects. Funding from Bellevue was used in 2019 to serve about 300 individuals who did not have access to Medicaid, those who can be classified as the working poor.

Mr. Loo said ACRS had integrated managed care before it became popular. The agency is not a primary care provider but as an organization it addresses social determinants of health, including housing, employment and citizenship. ACRS has for many years partnered with International Community Health Service to provide primary care services. Using private funding, the agency about 12 years ago developed a program called Wellness for Asian Pacific Americans. That allowed the agency to think about how integrated managed care can work for the immigrant and refugee community. It is unusual for a community based organization to provide primary care on site; it is usually a large entity like a hospital that incorporates into its healthcare system a behavioral health program. ACRS recognized the need to provide care to the Asian and Pacific Islander communities in a safe and welcome environment. Through a contract with ICHS, that organization comes to ACRS to provide primary care services. Many immigrants and refugees are low income or no income and have no access to primary care.

The integrated approach focuses on three components: mind, body and spirit. Mr. Loo said when he goes to see his primary care physician he is afforded a consultation time of 15 to 20 minutes. Under the ACRS model, however, patients see doctors for a minimum of 45 minutes. The result has been the detection of issues that

had not been discovered by other doctors. The shortage of behavioral health providers is not just a local phenomenon but rather is an national issue. Bi-lingual and bi-cultural behavioral health providers are almost nonexistent. Without addressing the social determinants of health, without addressing physical health conditions, and without addressing behavioral healthcare, it is not possible to treat a person as a whole.

Commissioner Amirfaiz asked about the tier system. Mr. Loo said there are currently some 45 behavioral health providers in the King County network, with a mix of behavioral health and substance abuse providers. The mental health system for many years was under a system based on a per member per month reimbursement rate. In 2016 when the two systems integrated, the substance abuse disorder system moved away from a fee for service system and into a flat rate casework system. The casework system has pros and cons. Substance abuse disorder payments are on the order of $3800 per year per client. Providers receive those dollars to manage their budgets for the entire year for each client. Because it is not a fee for services system, flexibility is built in, though certain guidelines must be followed. Because it is a flat rate, however, the amount may not be enough to cover the costs for clients found to be in need of more intensive care. The MIDD funding for non-Medicaid clients does not support certain services. Re-engagement and outreach is a critical service for the Asian/Pacific Islander community and it is not funded through the system. Interpretation services are funded on a very limited basis, though funding for the services are increased for certain populations. Behavioral health providers know the reimbursements under the current system are not sufficient.

Mr. Vollendroff stressed that the tiered system no longer exists. The system was established during the time when there were separate contracts. The way in which individuals accessed mental healthcare and determining who would pay for it required the creation of a system. The county was only responsible for providing services to individuals who had serious and persistent mental illness, not for those who for example had mild depression. Providers had to go through an assessment process to determine if a client met the eligibility requirements to be tiered. That has all gone away under the new integrated managed care system.

Mr. Loo said the county system is also evolving with regard to payment reform. While the approach has been rolled out, implementation will not occur until the third quarter of 2020. As a result, behavioral health providers are experiencing some major system changes that they are not fully prepared for. With challenges come opportunities and the behavioral health providers are looking to tap into other resources.

Mr. Aea said he serves as the Behavioral Health Manager for ICHS. He said the agency operates two school-based clinics, one of which is in Bellevue at Highland Middle School. The agency also operates a medical/dental clinic in Bellevue and the same in other jurisdictions. Most people will enter the behavioral health world through a medical provider. Only a few will seek out behavioral health services on their own,

and indeed many are held back by the attached stigmas, which include cultural and language stigmas.

Mr. Aea said the integration of outpatient care with clinic-level care will result in a higher level of care through a provider such as ACRS. Currently ICHS has a provider at its Shoreline clinic that provides substance abuse services, and that person is a member of both the ACRS team and the ICHS team. The approach allows for one-stop shopping at that location with dental, medical, behavioral and pharmacy services. With all of the services offered in one place, all of the service providers can talk to each other and make sure clients are getting all the care they need and deserve.

Historically, things have been run by the medical model with doctors in charge when it comes to patient care. Where a patient needed counseling or substance abuse support, the doctor would make a referral. The result was that the doctor never knew if the client received the services they needed. Having services all in one place means removing a number of barriers to clients. Where a person needs a higher level of care, the partnership allows for that and facilitates it. Instead of waiting for a doctor to refer a patient, the patient's clinical screening data is reviewed. The schedule of all the patients who need to see a certain doctor on a certain date will be reviewed by all providers and instead of waiting there is a proactive engagement with the patients. Mr. Aea said a person with a high level of medical need and are positive for depression will definitely be seen by one of his staff. A patient with a lower level of medical need but who is actively smoking but wants to quit will also be seen. A patient with high medical needs who just was released from the hospital will be seen as well. Homeless persons, even if they do not have a high medical need, will be engaged.

Commissioner Kline noted that in some instances ICHS has staff working at ACRS facilities, and that in other instances staff from ACRS work at ICHS offices. She asked what the most common scenario is for Bellevue residents for where they would receive services. Mr. Loo said the desire is for ICHS and ACRS to co-locate an office in Bellevue. That cannot, however, be guaranteed to happen soon. The Bellevue ACRS office is fairly close to the Bellevue ICHS office and referrals are made to them. Co-location would create a much more efficient work flow for patients to access.

Mr. Vollendroff pointed out that other organizations that are funded by the city are likely doing similar things. Sometimes it makes more sense to bring medical staff into a program such as ACRS, but at other times it makes more sense to bring behavioral health care staff into primary care facilities. Ultimately the focus is on trying to reach people earlier. In behavioral health, the historic approach has been to wait until people at the equivalent of being at Stage IV cancer before getting them treatment. Once presented at a place like ACRS, the staff there were expected to do miraculous things. It makes much more sense to begin services at the equivalent of Stage I.

Mr. Loo suggested that an alternative path to providing access is through tele-health services. He said that along with mobile van services providing multi-disciplinary care is something the city might want to consider funding.

Mr. Aea added that ICHS plans to renovate the Bellevue clinic to include behavioral services. The ultimate intent is to have the pendulum swing from ICHS to ACRS. When patients get better they can come back to ICHS, or if they relapse or need more services, they can go back to ACRS.

Ms. O'Reilly noted that applications for the next two-year funding cycle are due in April. She asked if the Commission should expect to see more references in the applications to the integrated managed care model. Mr. Vollendroff suggested the Commission should include questions in the application that specifically ask about the integration of physical and behavioral health services. If it is too late to do so, the review process should certainly include looking for indications of the integrated approach. Mr. Loo suggested the Commission should also consider funding a community based organization to provide health navigation services. As a federally qualified health center, ICHS is eligible to receive funding to provide health navigation services. Most behavioral health providers and community based organizations are not eligible to access funds to provide health navigation services.

Ms. Stangland said the release of information between ICHS and ACRS makes sense under a partnership agreement. In the event a client went to one entity but did not find a good fit with the partner entity and thus goes somewhere else, she asked how the communication makes sure the integrated health is still happening if it is not with the partnered agency. Mr. Loo said work is under way to implement electronic health records for both agencies. While not every provider will have access to it, the technology can reduce some barriers. There is always the option of going the old fashioned way of seeking and honoring a release of information. Mr. Aea added that there are conversations happening on several levels aimed at finding efficiencies in sharing information through a community information exchange.

Ms. Stangland said during her work as a service provider she regularly saw people getting mad at their behavioral health provider, firing them and going to another. It was like starting over again. She said she was excited to hear about steps to improve the sharing of information.

Mr. Aea stressed that the rights of patients must be respected. He said there are barriers that have historically kept providers from talking to each other and that has not really helped anyone. Ways to get through those barriers need to be found.

B. Human Services Overarching Themes for 2021-2022 Funding Cycle

Grant Coordinator Dee Dee Catalano noted the Commission had previously discussed combining the focus areas with overarching themes from the Needs Update. A list of potential themes was reviewed and the staff were directed to

wordsmith them and list them in priority order. She stated the overarching themes, once approved, will be included in the supplemental that applicants receive, and will be referred to by the Commission in reviewing applications.

Commissioner Kline commented that at first glance the list seemed a bit long. Ms. Catalano agreed, suggesting that some items could be combined. Commissioner Kline said she understood the concerns of applicants regarding whether or not the Commission will seek to fund only those issues outlined in the focus areas, but she added that a list that is comprehensive to the point of including everything that rises up in the Needs Update will not ultimately be a very useful tool. It would be better to have a fairly concise list of four or five items.

Chair Ma pointed out that the audience for the overarching themes is not just the Commission. Commissioner Kline said while that is true, the overarching themes are part of the Commission's process of reviewing applications and determining how to allocate the available funds. Chair Ma suggested the Commission could have its own focus areas outside of the overarching themes. Part of the objective of the supplemental is to summarize the issues raised by the Needs Update. It goes beyond merely highlighting areas for the Commission to consider during the funding process.

Ms. Catalano said the overarching themes serve as a summary for applicants to understand what is in the Needs Update. The Commission funds the continuum of services, but with having a few focus areas, it could appear to applicants that those are the areas the Commission will work to fund.

Chair Ma commented that the Commission had discussed eliminating the focus areas to avoid pigeonholing anyone. To pare down the list would be to step back in that direction again.

Commissioner Amirfaiz said as the needs increase they are included in the overarching themes. She suggested the mental health and substance abuse disorder treatment theme could be combined with youth homelessness by wordsmithing that indicates the mental health and substance abuse treatments are for youth and adults.

Commissioner Piper asked if the concern was that the overarching themes list could appear to be exhaustive to applicants. Ms. Catalano said the concern was that the shorter focus areas list was included in the supplemental. The overarching themes are the issues that rose to the top in the Needs Update. The fear was that having only a few focus areas in the supplemental would make it appear the Commission was focusing only on those issues instead of the full continuum of services.

Commissioner Kline said the Commission takes funding the continuum as a given. The focus areas have traditionally been used by the Commission to herald areas of inequities or deficiencies in the scope of the services being provided and to incentivize the provision of services in those areas. The focus areas did serve to drive applications to the areas where the Commission felt there were deficiencies, and they

gave the Commission a tool to refer back to during the final funding process. If the Commission feels it meets its charge by funding the continuum of services and believes it is not the obligation of the Commission to try to increase services in any particular area, highlighting all of the issues in overarching themes will make it easier for those applying for funding to believe they have a better shot at getting funded.

Chair Ma said it was his recollection that the purpose of the overarching themes was to eliminate barriers to providers seeking services they are trying to launch. The Commission can incentivize specific issues through the funding process simply by choosing to fund services that address specific areas rather than trying to pre-arrange things at the application end of things. Applicants use the Needs Update, but they are not going to create a new service in just a couple of months just to get funding for it. Commissioner Kline said her concern was not about creating new services so much as incentivizing those already providing a service to apply, particularly those who might not have applied otherwise. There is a risk in waiting to pick priorities after the applications are submitted. The Commission funds applications based on the needs in the community. The Commission can be greatly influenced by the merits of a great application, but the question is whether it should be prioritized over something the Commission has predetermined as a focus area. She added that there have been many funding cycles where the Commission has used the priority areas determined in advance based on the Needs Update as a means for demonstrating to the Council why more money was needed.

Chair Ma suggested the Commission could have its own list of focus areas and identified gaps developed before the applications are submitted for review. That list could be made official and something the Commission could fall back on in making requests to the Council for additional funding. Commissioner Kline said if she were an agency representative and found out there was another list, she would be disappointed it was not made known up front. If there is to be a separate list, there is no real purpose to even doing the supplemental.

Ms. Catalano pointed out that there is information in the supplemental beyond just the focus areas and overarching themes.

Commissioner Mansfield said coming from the side of having written grant requests, he liked the idea of having multiple points to write to rather than knowing specific attention will be given to a short list of items. He said an agency may not have a program that addresses any of the focus area issues, but may offer something that addresses one or more of the issues outlined in a much larger list, which the proposed overarching issues list is. He agreed he as an agency representative would be upset to learn of a second list.

Chair Ma said another option would be to make things very explicit by specifically ordering the overarching themes list in terms of the Commission’s priorities.

Commissioner Piper argued that the themes as drafted are not in fact overarching, with the exception of a few. Affordable housing is not necessarily an overarching theme. Ms. Catalano pointed out that the list highlights the overarching themes of the Needs Update that touch on different goal areas.

Chair Ma said the issue could be clarified by explaining what the overarching themes are and how they were derived, rather than simply presenting the list titled overarching themes. The other options would be to specifically prioritize the list, cutting it down to read as a focus area list, and leaving the list as drafted.

Ms. Stangland pointed out that there are several needs areas discussed in the Needs Update that are not included in the draft overarching themes list, including domestic violence, which is only covered under civil legal services. She agreed there should be a statement indicating the list is not an exhaustive list of all service needs. The older adult and disability services item is very important but is also a very broad phrase. Along with affordable dental care, the needs did not necessarily rise to the top in the presentation to the Council. The themes presented to the Council were affordable housing, living wage, cultural issues, transportation, behavioral health and mental health.

Commissioner Mansfield said he was leaning toward the option of combining some of the items.

Commissioner Amirfaiz commented that the items need to be weighed based on their percentages in the needs assessment from the phone survey, online survey and community conversations. Ms. Stangland pointed out that the phone survey involved random Bellevue residents sharing their perceptions of issues in the community and their households. The community conversations involved both consumers and providers. The different lenses yielded different results. Commissioner Amirfaiz agreed but suggested the issues that came up in the focus groups, the phone survey and the community conversations should be given more weight.

Chair Ma said he was hearing a call to pare down the list a bit more and to better align it with the Needs Update by explaining how each aligns with the collected data.

Commissioner Piper agreed the list should be pared down. He stressed that any explanatory statements should be clear about the intention of the Commission to fund all areas of the continuum, and should be clear that the overarching themes are specific areas of interest that emerged from the Needs Update.

Ms. Catalano commented that homelessness was not included on the draft list given the direction of the Commission previously to roll it into the category of affordable housing and keeping people in their homes.

In terms of paring down the list, Ms. O'Reilly agreed behavioral health issues could be revised as proposed as applying to all populations, not just children and youth.

Commissioner Piper proposed “On demand behavioral health services for all populations.”

Chair Ma agreed with the need to avoid listing specific populations. He agreed with combining “Services for the increasing number of children and youth experiencing mental health issues” and “Additional heroine and prescription opioid treatment services and mental health services.”

Commissioner Kline voiced concern about trying to combine two concepts into one. Overarching themes and priority funding areas are not necessarily the same. She said if the intent is to highlight areas the Commission would give more money to if more money was available, the items should truly be written as overarching themes. She added that any work to prioritize the list should be put off until the list itself is revised. She allowed that the list would be a more useful tool if prioritized.

Commissioner Piper supported the notion of combining the culturally responsive services with populations of interest. He agreed that affordable child care is not an overarching theme, though it certainly is a priority.

Chair Ma suggested affordable child care could be held up as an overarching theme if it were explained to include the associated issues of affordability, time and employment status.

Ms. Esparza proposed using the term “prominent issues” rather than “overarching themes.” Ms. Catalano said another option would be to use “overarching needs.”

Commissioner Kline suggested the word “overarching” was the problem given that it can be interpreted in many different and confusing ways.

Ms. O'Reilly said “gaps” might be the more appropriate word to use. Instead of “overarching themes,” it could be spelled out that the list represents the gaps identified in the Needs Update. There should not be two documents, one for the agencies and one for the Commission, to rely on in making funding decisions. The hope is that the supplement will include specifics that will add clarity for the agencies that may have been lacking in some areas about what the Commission funds otherwise, such as the technical things, so they can know what to expect.

Ms. Stangland suggested if the prominent issues are to reflect the Needs Update, leaving out homelessness would overlook a big need highlighted in the Needs Update. If the Commission is just selecting goal areas, there should be no statement indicating the list is connected to the Needs Update.

Chair Ma said he would include homelessness on the list given the data that was collected. Homelessness stands out as a rising need and a gap. He said he was concerned about tailoring the list too much toward what the Commission wants

versus what the data in the Needs Update highlights. He reiterated his desire to see the list pared down and cleaned up.

Commissioner Amirfaiz referred to the first item and pointed out that keeping people in their homes in fact prevents homelessness. Specifically adding addressing homelessness brings to light a separate issue to fund. It takes a lot of staff time to write proposals and the more concise the Commission is about what will be funded, the better it will be for everyone. Priorities are priorities, and if an agency does not offer a specific service, it can avoid wasting its staff time.

Ms. Stangland commented that homelessness is a clear priority of the Council.

Commissioner Kline reiterated the need to stress in the supplemental that Bellevue funds the continuum of services. The list of prominent gap issues should clearly be tied to the findings in the Needs Update.

Chair Ma agreed homelessness should be a bullet point separate from affordable housing.

Commissioner Kline said the memo sent to Councilmember Robinson at her request specifically mentioned basic needs such as housing and food. Ms. Stangland allowed that when housing is left to stand on its own, the term becomes much broader.

Ms. O'Reilly agreed to revise the document as directed and to bring a new draft to the Commission's next meeting for review along with the rest of the supplemental.

8. OLD BUSINESS – None

9. NEW BUSINESS

Commissioner Piper said he would be out of town on February 19 but could possibly participate remotely.

A motion to allow Commissioner Piper to participate in the February 19 meeting remotely was made by Commissioner Kline. The motion was seconded by Commissioner Mansfield and the motion carried unanimously.

Commissioner Amirfaiz noted she would not be able attend the February 19 meeting either. Ms. O'Reilly stated that Commissioner Jain would miss that meeting as well.

Ms. Stangland informed the Commissioners that she was reaching out to set up tours of Sophia Way, Friends of Youth and Congregations for the Homeless.

10. CONTINUED ORAL COMMUNICATIONS – None

11. ADJOURNMENT

A motion to adjourn was made by Commissioner Piper. The motion was seconded by Commissioner Mansfield and the motion carried unanimously.

Chair Ma adjourned the meeting at 7:59 p.m.

_____ _____
Secretary to the Human Services Commission Date

_____ _____
Chairperson of the Human Services Commission Date