HC² STRATEGIES
HEALTHY CONNECTED COMMUNITIES

SYSTEM OF CARE
ASSET MAP GUIDE


HC2
STRATEGIES
HEALTHY CONNECTED COMMUNITIES

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HC² Strategies, Inc. (2025). *Asset Map Guide: Building Systems of Care.*

INTRODUCTION

A guide for how to create and maintain a system of care asset map

System of care asset mapping began as a practice to teach providers how to understand the range of services available in a community to meet the needs of complex populations. Having a visual representation of the continuum of services can help providers see the options for clients and think about who they might partner with to collaborate in care.

Over time, with integration of evidence-based best practices and testing from sites across the country, map templates have been created for several populations with complex needs. The framework can be used to build system of care asset maps for multiple additional populations.

What is a System of Care Asset Map?

A well-developed system of care represents service offerings along a continuum toward long-term sustainable support and well-being for a population.

The purposes of a System of Care Asset Map are to:

Describe the system serving certain populations, such as those experiencing homelessness, including the assets available in the community to meet their needs.

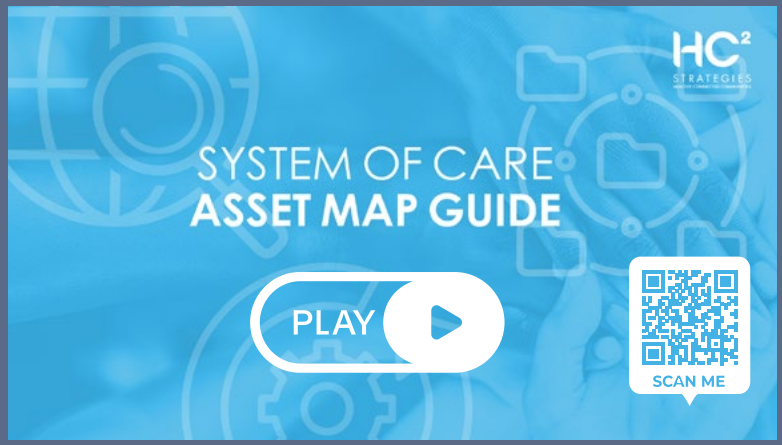
Consider partners in delivery to meet a client's needs. Having a quick reference and hyperlink to an organization's website helps to see possibilities in coordination of care and services for client referrals.

Close the gaps in a collective process. By visualizing the assets in a community, it's also possible to see where services to meet client needs are missing. Communities have used the tool as a strategic planning resource to prioritize where they might want to invest in expanding the system of care.

WATCH THE VIDEO BELOW

What Is a System of Care Asset Map?

Explained by Lauran Hardin, Chief Integration Officer



No one knows a community better than those who serve and live in it.

By working together to map our assets, we lay the groundwork for stronger partnerships, smarter solutions, and a more connected path to well-being for all.

When we visualize existing community resources along a continuum, we can better evaluate the system as a whole, including parts that may be well-developed or under-developed. Community leaders and providers can use the asset map for strategic action planning in the community to focus on building missing services in the continuum and become more proactive rather than reactive in meeting client needs. When analyzed in conjunction with specific county subpopulation data, gaps and next action steps can be identified. The final tool can also be used for staff training and as a resource for providers to quickly identify partners for certain services with hyperlinks to the agencies.

The maps are based in community wisdom, pulling together Internet research, interviews with key community members, and reviews and edits by the community. The components of the system of care were developed from evidence and from iteration and application in multiple sites across the country, and they are presented with the invitation to add categories. Because the maps are static by nature, they should be dated with the time of completion and updated at least annually as services change frequently in communities.

A few notes on what system of care asset mapping is not....

What System of Care Asset Mapping is Not

01 **It is not a replacement for 211, Unite Us, Find Help, or other community resource directories.** It's a targeted analysis of the continuum of services for a specific population to help providers deliver care.

02 **It isn't designed to be a tool for all community members.** Although it may be helpful for the general public to see the resources, it's designed to be used by those developing services in the community and delivering and coordinating care.

03 **It's not intended to capture everyone who intersects with the population of focus.** It's primarily designed to capture the "built" environment that exists to meet one population's specific needs. There are many layers of care coordinators who are not included in the System of Care Asset Map (i.e., primary care, hospital case managers, specialty service case managers, etc.)


5 CORE
COMPONENTS

01 Population

For which population are you mapping assets in the system of care? This Asset Guide provides templates for the following populations: homelessness, mental health, substance use, justice involved, birth equity, older adults experiencing homelessness, and end of life.

02 Region

Where is the system of care you are investigating? Be specific – this could be a region, a county, a city, or any other geographic area.

03 Date

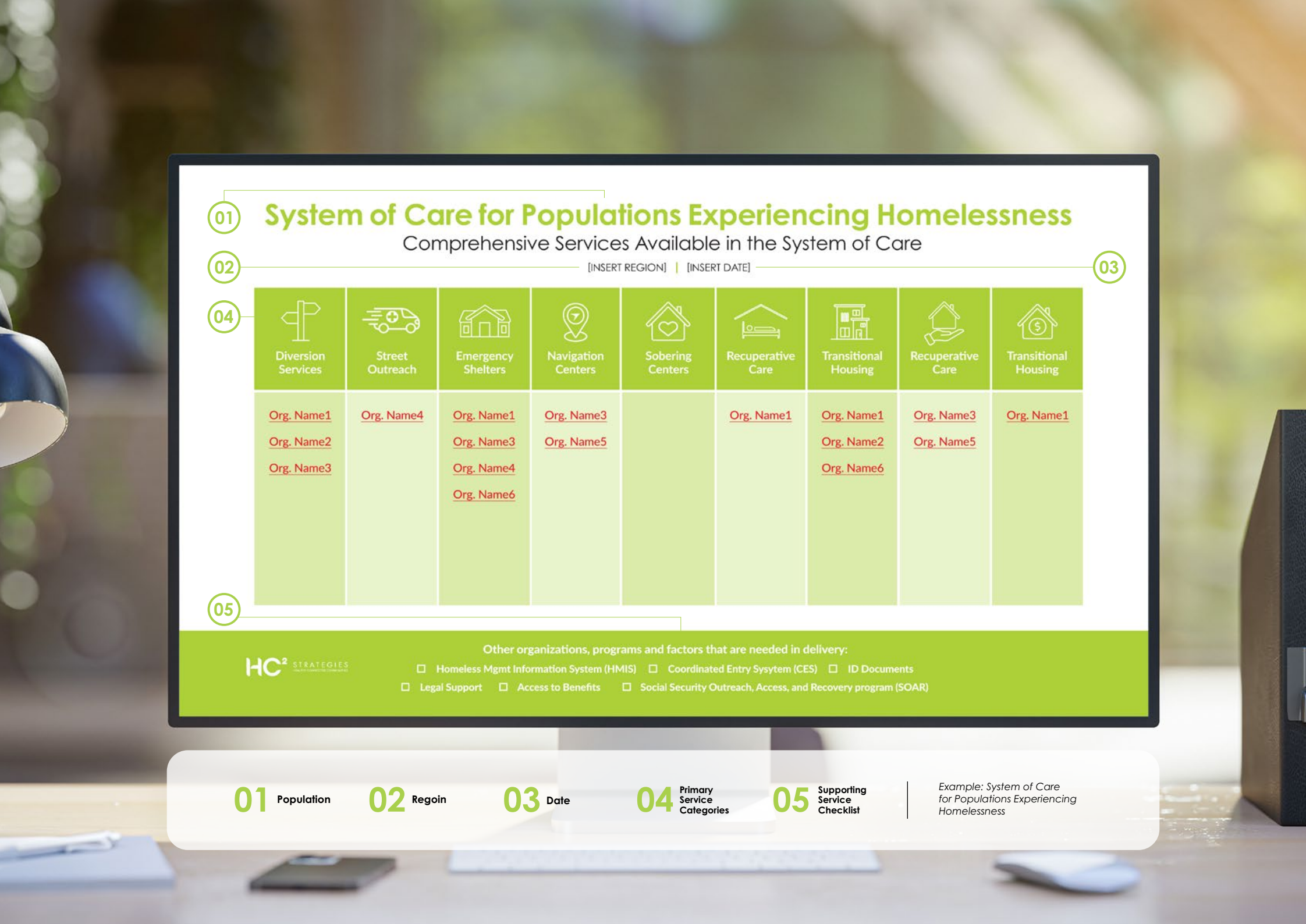
Including a date on your map is important for version tracking because the asset map will evolve over time as services in the region change.

04 Primary Service Categories

In the body of the asset map you will find categories of services, primarily reflecting the built environment, that comprise the continuum of resources to meet needs for the population.

05 Supporting Service Checklist

On the bottom of each map, there is a checklist of supporting services to consider that remove barriers for clients in that population. Understanding the status of these resources and learning about how they can be utilized to remove barriers for clients can help with service delivery.



01 Population

02 Regoin

03 Date

04 Primary Service Categories

05 Supporting Service Checklist

Example: System of Care for Populations Experiencing Homelessness

Internet Research

Individual Input

Community Input

Community Distribution

Updating Process

HOW TO COMPLETE AND MAINTAIN AN **ASSET MAP**

Internet Research

Start with Internet research to get a first draft of the assets and/or resources that exist in the community for each of the service types in the map. Document the organization/service names, and include hyperlinks to their websites. Tips for Internet search terms are included below for each population. You may choose to use AI to assist your research, asking for the organizations who provide services for the population in the region of choice and requesting categorization by the service categories.

Please note that you should still confirm each AI-generated suggestion to ensure the organization does serve the region and meets the definition of the service. If websites are unclear, phone calls can be an effective way to confirm and learn more about services. If an organization offers services in multiple categories, repeat its listing in every applicable category. With the finished product, you should be able to see at a glance where the community has many resources around a specific service, and where services or resources may be lacking.

Supporting Services for All Populations

The following Supporting Services are listed on relevant population asset maps. It will be important to find out if these are available in the region you're studying as they impact the system of care.

Information Systems

Homeless management information systems or health management information systems – can include helpful client and care coordination information.

Coordinated Entry System

Creates an integrated approach for a community to connect people to housing support services.

Support with ID/Documents

Clients with complex needs may have lost their birth certificate, drivers license, or other essential documents that are necessary for housing, benefits, and employment. Support with getting these documents can speed access to services.

Legal Support

Clients with complex needs may have unpaid legal fines and fees or other legal involvement that prevents them from accessing housing and necessary services. Medical-legal partnerships have emerged to remove this barrier for clients.

Access to Benefits

It is not uncommon for people with complex needs to lose benefits or not sign up for health care and income benefits for which they qualify. Identifying services that provide support with getting benefits can be helpful for clients.

SOAR

This program accelerates access to Social Security income and Social Security disability for people who are experiencing homelessness.

Individual Input

Individual interviews with key community members or leaders will help ensure your map is complete. An opener for the initial inquiry by phone or email could be:

"Hi, my name is [your name], and I am putting together a resource with services for [asset map population and region]. I came across your organization through Internet research and am hoping you can tell me more about your services and others in your community."

Interview questions might include:

- What resources do you know of that offer primary and supporting services related to this population in our region?
- What is missing from this list of assets?
- For the organizations I've named, is the list of services accurate and complete?
- What does [this county] do well regarding [asset map topic]?
- What are the most important resources that you feel are missing in the community regarding [asset map topic]?
- Who else should I talk to?

Community Input

If there are community groups or collaboratives working with the population, consider bringing the group together virtually or in person to review the map and edit it based on their combined knowledge. It is helpful to have a baseline from Internet research for them to react to and build upon, as opposed to a blank slate.

Community Distribution

To ensure the asset map can be best utilized by the community, be sure to make it available to any providers or community leaders that might benefit from it.

Updating Process

System of care asset maps should be updated at least annually as services change frequently in communities. Make a plan for when the map should be updated and who will work on it. Updating the map entails checking that hyperlinks still work and seeing if any organizations have closed or have added or stopped services, as well as doing light Internet research to see what new organizations have emerged.

MAPPING TOOLS FOR SPECIFIC **POPULATIONS**

For each of the populations listed at right, a System of Care Asset Map template is available in an editable PowerPoint format through a QR code and link in each section.

On the next pages, you will find definitions of the service categories, as well as recommended Internet research terms and interviewees.

Service Categories Quick Links

01 Populations Experiencing Homelessness

02 Mental Health Populations

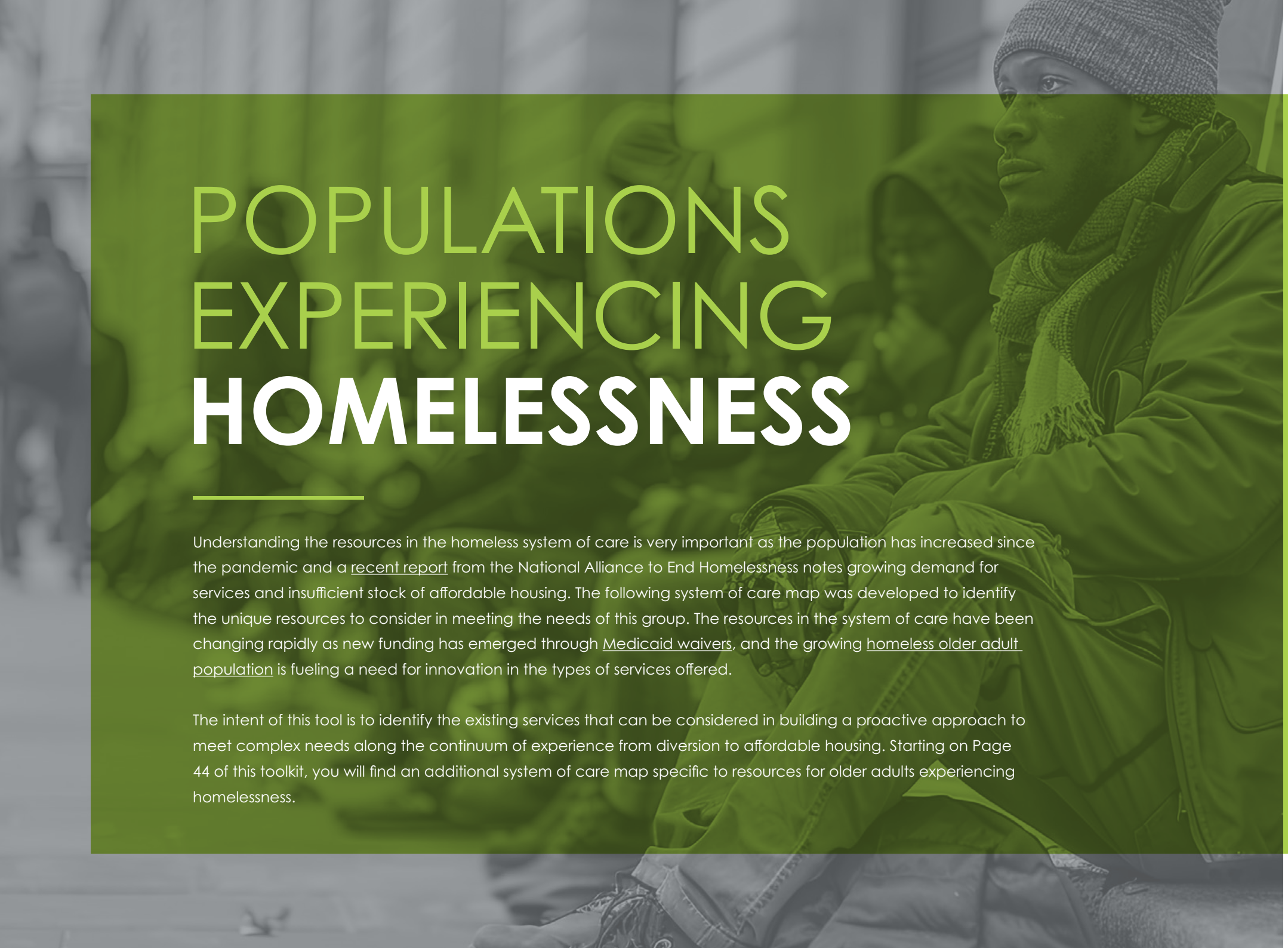
03 Substance Use Populations

04 Justice Involved Populations

05 Birth Equity Populations

06 Older Adults Experiencing Homelessness

07 Populations at End of Life



POPULATIONS EXPERIENCING **HOMELESSNESS**

Understanding the resources in the homeless system of care is very important as the population has increased since the pandemic and a recent report from the National Alliance to End Homelessness notes growing demand for services and insufficient stock of affordable housing. The following system of care map was developed to identify the unique resources to consider in meeting the needs of this group. The resources in the system of care have been changing rapidly as new funding has emerged through Medicaid waivers, and the growing homeless older adult population is fueling a need for innovation in the types of services offered.

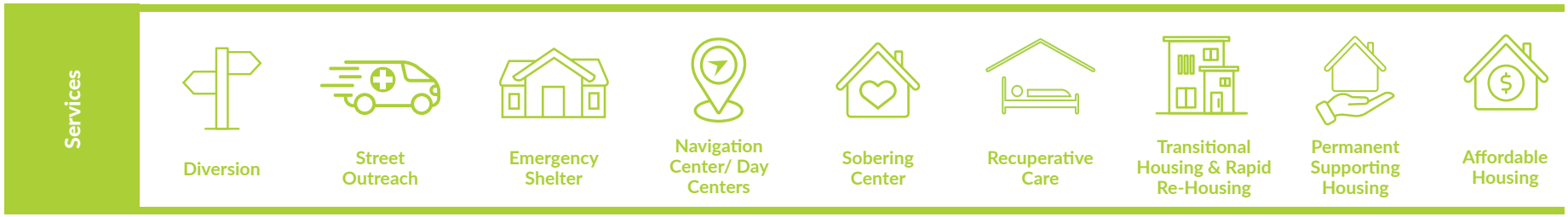
The intent of this tool is to identify the existing services that can be considered in building a proactive approach to meet complex needs along the continuum of experience from diversion to affordable housing. Starting on Page 44 of this toolkit, you will find an additional system of care map specific to resources for older adults experiencing homelessness.

We've been homeless now for almost four years. I mean, I get money every month, but I can't afford housing right now because it's so expensive. And when you're out here and you can't get your ID or your Social to try to even make it to get a job, how can we do it when we can't even take a shower to be presentable for work?

Source.

System of Care for Populations Experiencing Homelessness Category Definitions

SCAN ME OR USE THIS LINK TO ACCESS ASSET MAP TEMPLATES & SOURCES.



Diversion & Prevention Services

Diversion services address housing crises at their onset by helping individuals/families find immediate, temporary housing alternatives while working toward a long-term housing plan, targeting those at risk before they enter shelters. Source *Homelessness prevention* services include housing relocation and stabilization services and short- and medium-term rental assistance, which are designed to help at-risk individuals and families maintain their current housing or transition to new permanent housing. Source

Street Outreach

Direct outreach activities meet the urgent needs of unsheltered individuals by connecting them to emergency shelters, housing, or critical services and providing medical care, health care services, shower trailers, and necessities such as food, water, and crisis intervention. Source

Emergency Shelter

Facilities offer temporary housing with minimal supportive services to individuals who are experiencing or are at risk of homelessness, with stays limited to six months or less and no cost barriers. Source

Navigation Center/Day Center

At this low-barrier facility, unhoused individuals can access essential services, supportive services, and a safe place to rest without any requirements while case managers work to connect them to benefits, services, and/or housing. Source

Sobering Center

This facility or setting provides short-term (less than 24 hours) recovery or recuperation from the effects of acute alcohol or drug intoxication, primarily for individuals who are experiencing homelessness or those with unstable living situations. Source

Recuperative Care

Also known as "medical respite," these programs offer health care providers a safe place to discharge homeless patients when they no longer require hospitalization but still need to heal from an illness or injury. Source

Transitional Housing & Rapid Re-Housing

Transitional housing provides temporary housing with supportive services to individuals and families experiencing homelessness, typically lasting up to 24 months. Source *Rapid re-housing* is permanent housing that provides short-term (up to three months) and medium-term (4-24 months) tenant-based rental assistance and supportive services to households experiencing homelessness. Source

Permanent Supportive Housing (PHS)

Long-term, stable housing is paired with supportive services to help individuals/families experiencing chronic homelessness. This is designed to help people who have disabilities, mental health challenges, or substance use disorders maintain housing stability and improve their quality of life. Source

Affordable Housing

Long-term, stable housing is paired with supportive services for low-income individuals or families. This housing costs no more than 30% of gross income, including utilities. Source

Internet Research Recommendations

- Start with the Continuum of Care (CoC) site to gather resources.
- Next search 211.
- Next search for Homeless Task Force – any reports that would inform the assets.
- Use search terms "coordinated entry" and "coordinated access" (CAS, CES) and "Homeless Management Information System."
- The population may be described as unhoused, homeless, or high utilizer.
- Next search by service category – i.e. recuperative care in [county] or homeless shelters in [county].

Interview Recommendations

- Executive director or leader from a local homeless coalition, housing authority, or homeless task force.

MENTAL HEALTH
POPULATIONS

Mental health continues to be an area of critical public health concern affecting millions of Americans across the age spectrum. Following the pandemic, many initiatives across the country have moved forward and are focusing on building a more connected system of care. The following system of care map was developed to identify the unique resources to consider in meeting the needs of this group

The intent of this tool is to identify the existing services that can be considered in building a proactive approach to meet complex needs along the continuum of experience from peer support to inpatient psychiatric settings. The tool is primarily focused on adult populations but could be adapted for the pediatric population.

It feels like being severely overwhelmed without a way to release… But I can't tell my friends and family how I feel. Telling people means I'm weak; it means I can't; it means I've failed.

Raynique Source

System of Care for Mental Health Populations Category Definitions

SCAN ME OR USE THIS LINK TO ACCESS ASSET MAP TEMPLATES & SOURCES.

Support Groups, Peer Support Clubhouse

Support groups provide opportunities for people to share personal experiences, feelings, or coping strategies. Source
A Peer Support Clubhouse is a community-based location that is designed to support the recovery of people living with serious mental illness. Clubhouses offer opportunities for friendship, employment, housing, education, and access to medical and psychiatric services. Source

CCBHC, FQHC for BH, Specialized BH Clinics

A Certified Community Behavioral Health Clinic (CCBHC) is a specially designated clinic that provides comprehensive mental health and substance use services, regardless of an individual's diagnosis or insurance status. Source *A Federally Qualified Health Center (FQHC) for Behavioral Health (BH)* is a community health center that provides mental health care to underserved populations. Source A *specialized BH clinic* treats mental health conditions and substance use disorders.

Behavioral Health Care Managers (BHCM) / Medication Management

These services support individuals with mental illness and substance use issues in navigating the health care system by assessing client needs, developing treatment plans, connecting clients to appropriate resources, and providing ongoing support, advocacy, and medication management. Source 1, Source 2

Assertive Community Treatment Teams (ACT)

This team of specialists may include psychologists, psychiatrists, dual diagnosis treatment specialists, social workers, or registered nurses who work together to support people with severe mental health conditions who are most at risk of psychiatric crisis leading to hospitalization, the criminal justice system, or homelessness. Source

Mobile Crisis, Crisis Line, Crisis Housing

Mobile crisis services are a community-based intervention designed to provide de-escalation and relief to individuals experiencing a behavioral health crisis in any setting. Source A *crisis line* is a phone number, operating 24/7, that people can call to get immediate emergency telephone counseling. Source *Crisis houses* offer intensive, short-term support to help an individual manage a mental health crisis in a residential setting. Source

Day Treatment Center

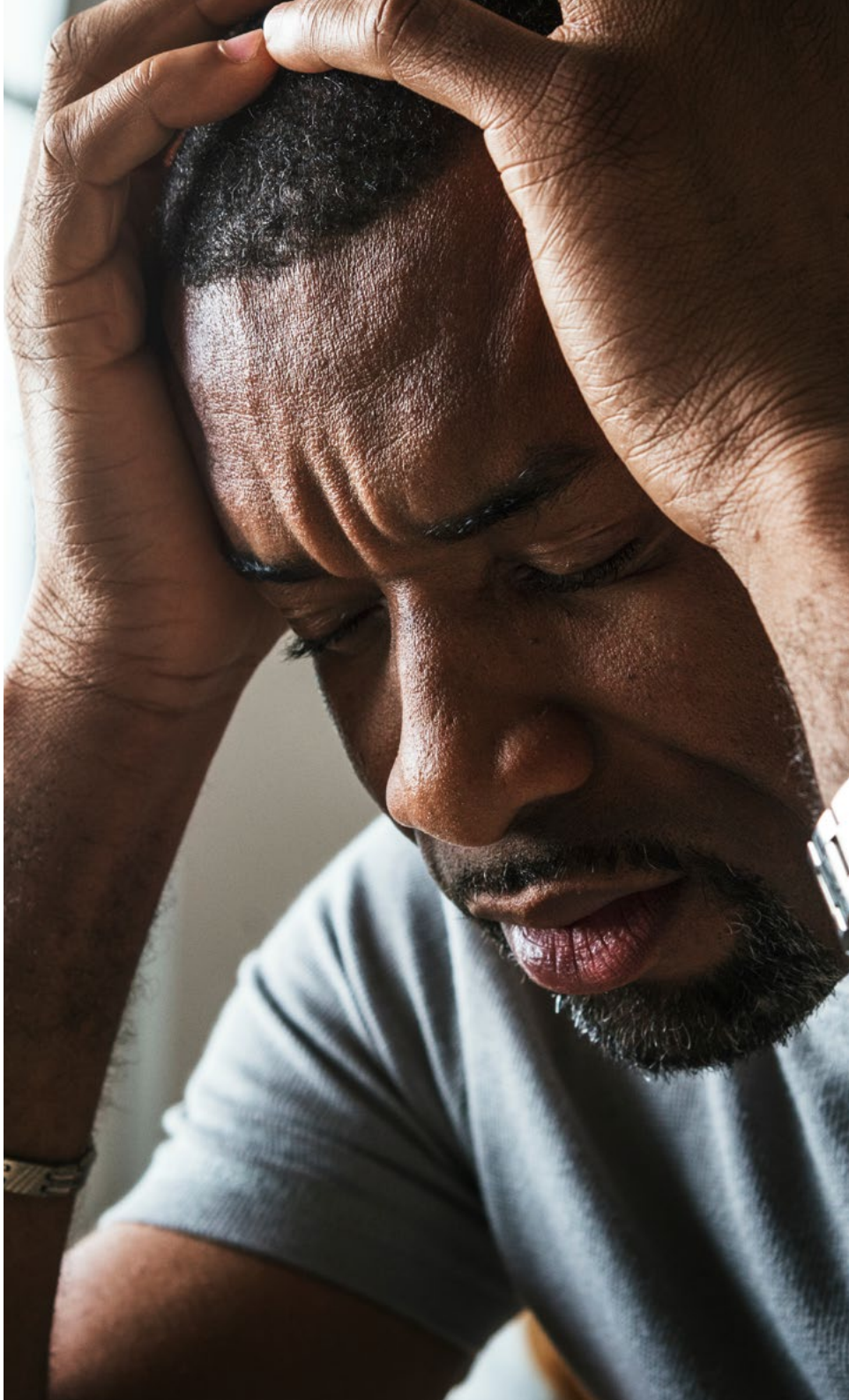
This facility offers a structured, mental health treatment program during the day for individuals with mental or substance use disorders who do not require 24-hour care. Source

BH Residential Housing Board and Care

The structured living environment provides 24/7 support for individuals needing mental health or substance use recovery assistance before transitioning to independent living, without requiring inpatient treatment. Care is provided for limited periods of time with the goal of preparing people to move into the community at lower levels of care. Source

Psych EDs/Urgent Care

Facilities are specifically designed to provide immediate assessment and treatment for individuals experiencing mental health crisis. While some urgent care operates 24/7, others have set hours. These centers provide prompt mental health support but refer individuals to emergency rooms for severe cases requiring higher levels of care, such as suicidal threats, self-harm, or severe psychiatric symptoms. Source

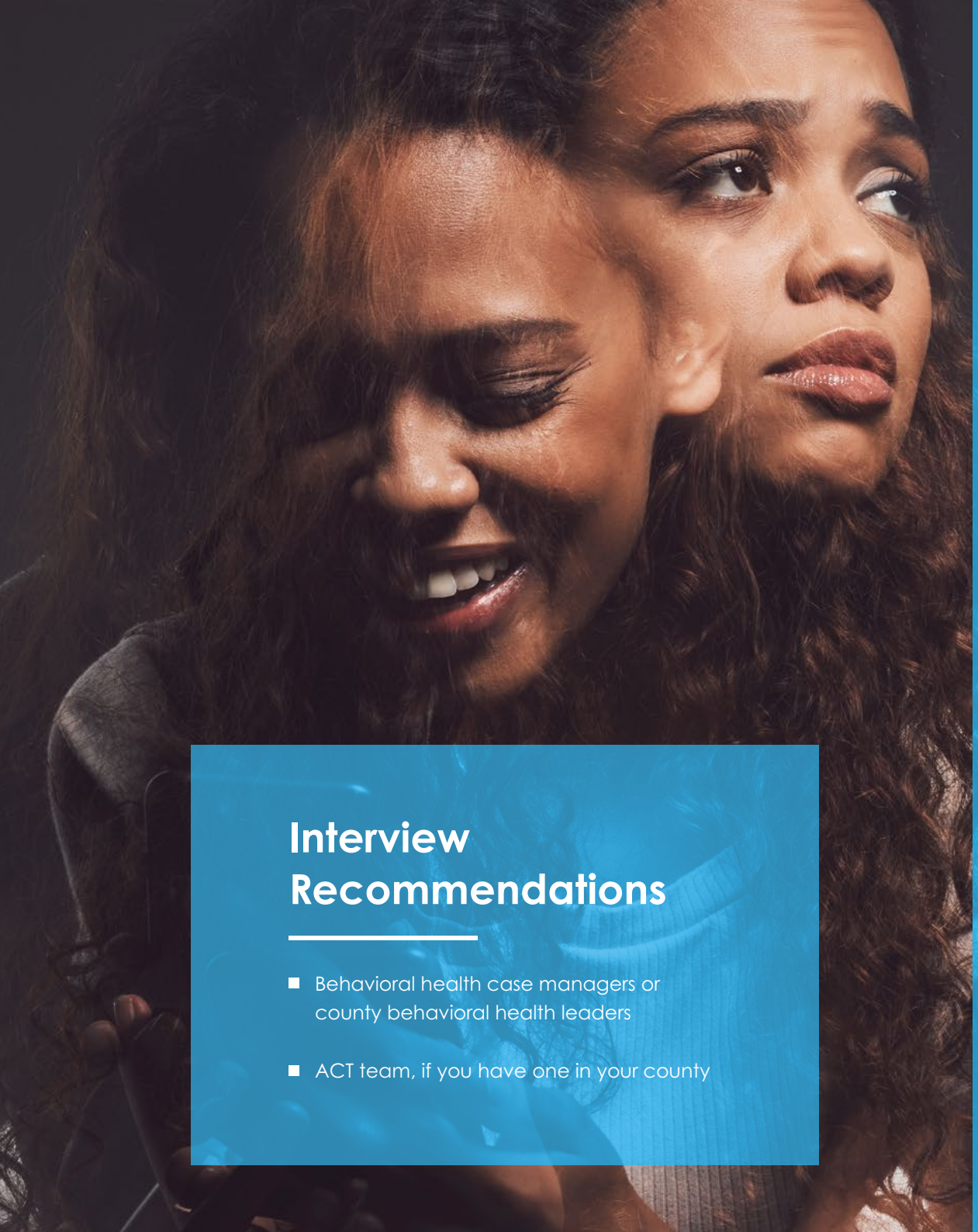


Psych/Med Inpatient Units

Hospital care is provided for patients presenting with acute psychiatric disorders and medical conditions requiring hospitalization. These units offer a secure setting where medical and mental health professionals work together to deliver comprehensive care. Source

Psych Inpatient Hospitals

Stays in a psychiatric hospital provide a safe place for people to receive intensive treatment for mental health conditions. They are intended to last only long enough to resolve the most urgent issues based on the recommendation of a doctor or health care professional – generally a few days to a few weeks. Source



Interview Recommendations

- Behavioral health case managers or county behavioral health leaders
- ACT team, if you have one in your county

Internet Research Recommendations

- Search "county behavioral health" for a directory.
- Search 211/Find Help.
- Check the NAMI website.
- Search these categories:
  - Psychiatric hospitals (and capture number of beds)
  - Behavioral health residential settings
  - Psychiatric inpatient units (these are in regular hospitals)
  - Psychiatric emergency departments
  - Behavioral health case management
  - ACT (assertive community treatment) teams
- Next, search by service category – i.e. support groups in [county] or day treatment center in [county].

SUBSTANCE USE **POPULATIONS**

With more than 47 million Americans ages 12 and over reporting current use of illegal substances, this remains an area of critical public health concern. Understanding the intersection between mental health and substance use is key to meeting the needs of the population. The following system of care map was developed to identify the unique resources to consider in meeting the needs of those with substance use. Partnering this with completion of the system of care map for mental health will provide a holistic picture of key resources for the population.

The intent of this tool is to identify the existing services that can be considered in building a proactive approach to meet complex needs along the continuum of experience from support groups to residential housing settings. While primarily focused on adult populations, the tool could be adapted for children and youth.

I didn't want to be clean... I didn't want to be anywhere really. I was just in a cloud. I was depressed. Really depressed. Scared, I just felt alone.

44-year-old female about her substance use disorder *Source*

System of Care for Substance Use Populations Category Definitions

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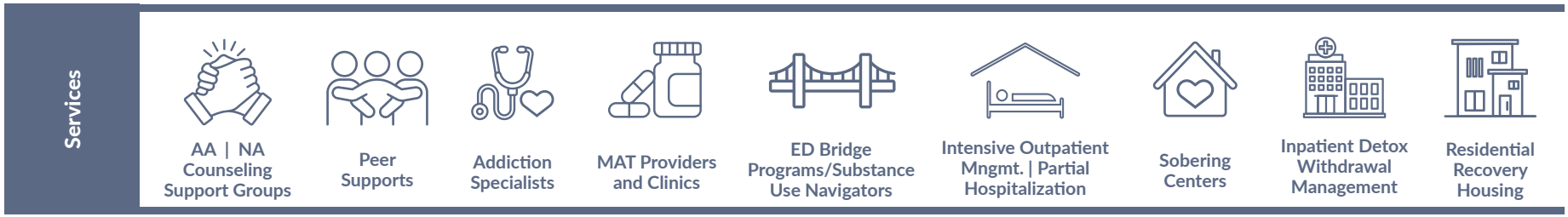


AA/NA Counseling Support Groups

Alcoholic Anonymous (AA) is a free gathering of people who come together to address alcohol use disorder. Source *Narcotics Anonymous* is a support group for those attempting to recover from opioid use disorder. Source

Peer Supports

Support is provided by people who share similar experiences with mental health conditions, substance use disorders (SUDs), or both. Source

Addiction Specialists

This physician subspecialty is focused on preventing, diagnosing, and treating substance use disorders and related health conditions. These specialists also support affected family members and serve as educators, researchers, and advocates for change. Source

MAT Providers and Clinics

A *medication-assisted treatment (MAT) facility* offers an evidence-based, whole-person approach to treating substance use disorders by combining medication with counseling, behavioral therapies, and peer support. Source

ED Bridge Programs/Substance Use Navigators

An *Emergency Department (ED) Bridge program* connects ED patients with opioid use disorders (OUD) to follow-up care, providing medication, prescriptions, and care coordination with support from an ED clinician champion, outpatient provider, and hospital leadership. Source A *substance use navigator (SUN)* is a care coordinator who is embedded in emergency or inpatient settings under the Bridge model and connects patients with SUDs to treatment while providing coaching, care coordination, and access to community resources and services. Source

Intensive Outpatient Management/Partial Hospitalization

These mental health treatment programs provide more than once-weekly support to individuals struggling with serious mental health conditions but offer less supervision than inpatient care. *Intensive outpatient management (IOP)* is designed to provide structured, focused treatment to individuals for several hours a day, multiple days a week, while allowing them to maintain their daily responsibilities and routines. Treatment may include individual and group therapy, medication management, and other evidence-based interventions. *Partial hospitalization programs (PHP)* offer more intensive mental health treatment than IOP, including therapy and medication management, for several hours a day, multiple days a week, without requiring 24-hour inpatient care. Source

Sobering Center

Facility or setting provides short-term (less than 24 hours) recovery or recuperation from the effects of acute alcohol or drug intoxication, primarily for individuals experiencing homelessness or those with unstable living situations. Source

Inpatient Detox Withdrawal Management

In this medically supervised process, individuals with SUD receive 24-hour care in a hospital or treatment facility to safely withdraw from substances. Treatment involves managing withdrawal symptoms, providing medical interventions, and offering emotional and psychological support to ensure the patient's safety and comfort during detoxification. Source 1, Source 2

Residential Recovery Housing, AKA Sober Living

This supportive living environment is designed for individuals in recovery from alcohol or drug use disorders, offering a safe, stable, and substance-free space to promote long-term health and sobriety. Source

Internet Research Recommendations

- Detoxification units (these are in regular hospitals).
- Sobering Centers.
- Medication-assisted treatment (MAT) providers (for substance use disorders).
- ACT (assertive community treatment) team.

Interview Recommendations

- Behavioral health case managers or county behavioral health leaders.
- ACT team, if you have one in your county

JUSTICE INVOLVED **POPULATIONS**

Justice involved individuals have some of the most complex health and social needs, including a higher burden of complex health conditions, behavioral health diagnoses, and community resource needs than the general population. The following system of care map was developed to identify the unique resources to consider in meeting the needs of this group.

There isn't an established integrated system of care to meet the needs of justice involved individuals. The intent of this tool is to identify the existing services that can be considered in building a proactive approach to meet complex needs along the continuum of experience from diversion to within the justice system and post release. As multiple initiatives move forward nationally to work on building an integrated system of care, this tool may inspire ideas of what could be built within communities.

The California Department of Rehabilitation] have all these things that help you get clothing for when you find a job… they give vouchers for transportation for food- they help you with housing. They have programs that will pay first and last month's rent for you. I didn't know any of that.

***Female interviewed after her release following a sentence of life without the possibility of parole** Source*

System of Care for Justice Involved Populations Category Definitions

SCAN ME OR USE THIS LINK TO ACCESS ASSET MAP TEMPLATES & SOURCES.

Services

Diversion/Prevention

- Specialty Courts (Mental Health, Drug, CARE, Homeless, Reentry) & Sentencing
- Police Crisis Intervention Team (CIT)
- 911 Diversion
- Ride-along Programs with Social Work or Nursing Care Management

Within the Jail

- Facilities: Jails, Prisons, Juvenile Facilities, Other
- Health Care Providers
- Behavioral Health
- Medication-Assisted Treatment
- Access to Insurance Prior to Release

Post-Release

- JI Community Housing: Transitional Housing / Halfway House
- Affordable Housing for JI Population with Felony Records
- Employment for JI
- Reentry Organizations
- Felony Expungement/ Advocacy Organizations

Specialty Courts & Sentencing (Mental Health, Drug, Care, Homeless, Reentry)

Specialty courts–including mental health courts, drug courts, CARE courts, and homeless courts–are collaborative judicial models that address the underlying causes of justice involvement, such as mental illness, substance use, and homelessness. These courts connect individuals to treatment, housing, and support services, with the goal of reducing recidivism and promoting long-term stability. Source *Mental health courts* provide specific services and treatment to defendants dealing with mental illness. Source *Drug courts* are specialized court docket programs that target criminal defendants, juveniles who have been convicted of a drug offense, and parents with pending child welfare cases who have alcohol and other drug dependency problems. Source *CARE courts* provide court-ordered care plans for individuals with severe mental illness, focusing on community-based recovery. Source *Homeless courts* resolve low-level offenses for unhoused individuals while connecting them to supportive services. Source A *reentry court* is a collaborative program for individuals who have been released from prison, have violated a term or condition of parole, and have a history of substance use disorder and/or a history of mental health illness; successful completion can result in early discharge from parole. Sentencing includes court-ordered alternative programs in place of jail time as well as restorative justice initiatives. Source

Police Crisis Intervention Team (CIT):

This community partnership between local law enforcement, county health services, mental health advocates, and mental health consumers is designed to address the needs of mental health consumers who enter the judicial system during a crisis state. Source

911 Diversion

Diversion provides alternative responses to emergency calls involving behavioral health needs, substance use, or social challenges such as homelessness. Instead of relying solely on law enforcement, these programs direct calls to trained professionals—such as crisis counselors, medical personnel, or outreach workers—who can provide immediate support and connect individuals to appropriate community-based services. Source

Ride-Along Programs with Social Work or Nursing Care Management

Law enforcement or outreach teams are paired with social workers, nurses, or care managers to provide coordinated, on-the-ground support for justice-involved individuals experiencing a behavioral health crisis, homelessness, or complex medical needs. Source

Facilities: Jails, Prisons, Juvenile Facilities, Other

Jails are locally operated facilities that hold individuals before trial or for short-term sentences (typically one year or less). Source *Prisons* are state or federally operated institutions that confine individuals convicted of serious offenses, usually felonies, serving sentences longer than one year. Source *Juvenile facilities* are secure facilities that provide temporary detention for adjudicated youth awaiting court proceedings or longer-term confinement, with an emphasis on rehabilitation, education, and treatment. Source This category also includes other facilities that serve the justice-involved population.

Health Care Providers

Licensed professionals deliver medical, behavioral health, and dental services to incarcerated individuals.

Behavioral Health

Incarcerated individuals receive treatment for mental health and substance use disorders. This includes screening, therapy medication, and crisis intervention.

Medication-Assisted Treatment (MAT)

This clinical intervention combines medication with behavioral therapy to treat substance use disorders among incarcerated individuals. Source

Access to Insurance Prior to Release

Incarcerated individuals are enrolled in health insurance programs, such as Medi-Cal (California's Medicaid), before their release. Source

JI Community Housing: Transitional Housing/ Halfway House

A residential center provides transitional housing for individuals who are moving from a restrictive setting such as prison into independent living. Also known as a sober living home or transitional living facility, the center offers a structured environment where residents pursue job training or employment, attend therapy, or reconnect with the community while staying substance free. Source

Affordable Housing for JI Population with Felony Records

This housing is designed to be accessible and affordable for individuals with felony convictions. The programs address barriers to housing caused by criminal records by offering low-cost rental units, supportive services, and policies that reduce discrimination, helping individuals reintegrate into the community and maintain stability. Source

Employment for JI

Programs and initiatives support people with criminal records in finding and retaining employment, reducing recidivism, and supporting successful reentry into the community. These efforts include education, job training, work experience, and partnership with employers to reduce stigma and legal barriers. Source 1, Source 2

Reentry Organizations

These organizations give individuals support to successfully return to their communities after incarceration. The programs can be delivered in a correctional institution or in the community upon release. They offer a range of services such as housing, employment, family unification, and treatment for substance use and mental and physical health as needed. Source

Felony Expungement/Advocacy Organizations

Individuals with felony convictions receive assistance in clearing or reducing the impact of their criminal records so they can become or stay employed. The organizations offer legal support, rights education, and policy advocacy to promote second chances and reduce barriers to housing, employment, and civic engagement. Source 1, Source 2

Internet Research Recommendations

- Search search each service category listed above and the county/community.

Interview Recommendations

Interviews are important for information gathering with this population of focus.

- Reentry organization
- Health care provider in the prison
- Case management for the hospital that provides hospital-based care for the prison (if known)

BIRTH **EQUITY**

Birth equity has been an area of focus nationally as stark racial disparities in maternal and infant health persist despite many improvement initiatives. The following system of care map was developed to identify the unique resources to consider in meeting the needs of this population. The focus of this system of care map is thinking beyond the site of care and considering the client experience as a whole throughout the prenatal, birth, and postnatal process." Prenatal and postnatal do not take hyphens.

From a place of respect, from a place of support, from a place of ensuring the centering of that woman, that patient, that person. The centering therefore allows for all the care plans, all the decisions, all of the policies, procedures, protocols, to be safely delivered and supported for the patient herself and her autonomy; her agency is respected."

Jennie Joseph, Midwife and Founder of Commonsense Childbirth, Inc.
Source

System of Care for Birth Equity Category Definitions

SCAN ME OR USE THIS LINK TO ACCESS ASSET MAP TEMPLATES & SOURCES.

Services

Prenatal

- Public Health Services (WIC, TANF, Black Infant Health)
- In-Home Visiting Programs & Nurse Family Partnerships
- Clinics, Providers, CHWs, & CPSP
- Substance Use and Mental Health Services
- Medical-Legal Partnerships

At Birth

- Baby-Friedly Hospitals & Birth Centers
- Doulas & Midwives
- High-Risk OB Services

Postnatal

- Public Health Services (WIC, TANF, Black Infant Health, In-Home Visiting)
- Clinics, Providers, CHWs, & CPSP
- Substance Use and Mental Health Services
- Medical-Legal Partnerships
- Breastfeeding / Lactation Services
- Education and Social Support Services

Colored squares shown in each service definition represent services that are also available in the two service categories. Refer to the legend above for color reference.

Public Health Services (WIC, TANF, Black Infant)

Public health services encompass programs such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); Temporary Assistance for Needy Families (TANF); and Black Infant Health (BIH). These programs aim to support low-income families by providing nutritional assistance, financial aid, and personalized care to address disparities in maternal and infant health outcomes, particularly among Black communities. Specifically, *WIC* provides free health foods, breastfeeding support, nutritional education, and referrals to other services to support families. Source *TANF* is a federally funded, state-run program that helps families pay for food, housing, home energy, and childcare. In addition to cash assistance, many states offer job training and help with tuition payments for work-related education. Source *BIH* is a health equity program that is designed to enhance participants' life skills within a culturally affirming and supportive environment that honors the unique history of Black women and birthing people. Source

In-Home Visiting Programs & Nurse Family Partnership

In-Home visiting programs are designed for overburdened families who are at risk for Adverse Childhood Experiences (ACEs). Home visiting gives parents the tools and know-how to independently raise their children . Source *Nurse Family Partnership (NFP)* is an evidence-based home visiting program that pairs first-time, low-income pregnant individuals with registered nurses from early pregnancy through the child's second birthday. Source

Clinics, Providers, CHWs, & Medicaid Perinatal Services

Clinics and health care providers are primary access points for prenatal, perinatal, and postpartum care. *Community health workers (CHWs)* are trusted frontline public health workers who provide health education, advocacy, and linkage to services. Source They play a critical role in bridging gaps in care, building trust, and supporting pregnant and parenting individuals. *Medicaid Perinatal Services* typically cover prenatal care, delivery, and postpartum care. For example, the Comprehensive Perinatal

Services Program (CPSP) in California provides a wide range of culturally competent services to pregnant individuals from conception through 60 days' postpartum. In addition to standard obstetric services, patients receive enhanced services in the areas of psychosocial care, health education, and nutrition. Source

Substance Use and Mental Health Services

These services include screening, treatment, counseling, and recovery support for individuals experiencing mental health challenges or substance use disorders during the perinatal and postpartum periods. Source

Medical-Legal Partnerships (MLP)

Medical-Legal Partnerships (MLPs) are evidence-based, interdisciplinary collaborations between health systems and legal service organizations designed to address health-harming legal needs among low-income patients and their families. MLPs are typically composed of medical champions, attorneys, and social workers, and aim to improve health through legal interventions that target health-harming social and legal needs, such as substandard housing, food insecurity, benefit denials, education and employment barriers, legal status, custody issues, and child support. Source1, Source 2

Baby-Friendly Hospitals & Birth Centers

Baby-Friendly Hospitals are health care facilities that meet the standards of the Baby-Friendly Hospital Initiative (BFHI), a global program launched by WHO and UNICEF to encourage broadscale implementation of the Ten Steps to Successful Breastfeeding and the International Code of Marketing Breast-milk Substitutes. These standards have been shown to significantly improve breastfeeding rates. These institutions play a role in promoting evidence-based care for all birthing people. Source A *birth center or birthing center* is a free-standing health care facility for childbirth where care is provided in the midwifery and wellness model.
Source 1, Source 2

Doulas & Midwives

Doulas are trained non-clinical professionals who provide continuous physical, emotional, and informational support to their client before, during, and shortly after childbirth to help them achieve the healthiest, most satisfying experience possible. Source *Midwives* are licensed health care providers who offer comprehensive reproductive, pregnancy and postpartum care, often using a holistic, person-centered model. They are licensed in many states and are severely restricted in others. Source

High-Risk OB Services

High-risk OB services provide specialized care to individuals with pregnancies that carry increased medical or social risks, such as pre-existing health conditions or pregnancy-related health conditions such as pre-eclampsia or gestational diabetes, maternal age, or lifestyle factors including smoking, substance use disorder, and alcohol use disorder Source. These services are usually delivered by specialized clinics that provide full scope obstetric care for high-risk pregnancies, including preconception counseling, ultrasounds, advanced genetic testing, and fetal monitoring. Individuals may be referred to a maternal-fetal medicine specialist who will coordinate care during pregnancy and at delivery with the help of a pediatric care team. Hospitals with a neonatal ICU typically provide high-risk OB services.

Lactation Consultants

Lactation consultants are health care professionals who specialize in breastfeeding and in offering breast milk to infants. Source Individuals can visit a lactation consultant while they are pregnant, right after delivery, or several months into breastfeeding.

Education and Social Support Services

Social support services, or the exchange of practical and emotional supports through care providers and social networks, are an important factor in improving mental health during pregnancy and the postpartum period. Source *Education services* during pregnancy or the postpartum period can foster empowerment, confidence in navigating newborn care, and awareness during physical and emotional recovery. Source

Interview Recommendations

- Hospital obstetric unit managers
- WIC leaders

Internet Research Recommendations

Birth Equity search terms:

- Search "[county name] birth equity programs" and explore what comes up
- Search "[county name] Mmaternal health care"
- Search "[county name] Pprenatal and postpartum care"
- Search "[state name] Medicaid prenatal and postpartum care]"
- Search "[county name] prenatal or postpartum [substitute with health care facility type ie. clinic, providers, hospitals, birth centers]"
- Search "[county name] labor and delivery care"
- Search "[county name] neonatal ICU"

Useful links for California Services:

- CSPS Programs by County
- SUD treatment programs for women perinatal directory by County
- Medi-Cal Managed Care Health Plen Directory by County (useful when looking for provider directories)
- Enhanced Care Management Birth Equity Population of Focus: FAQ

OLDER ADULTS EXPERIENCING **HOMELESSNESS**

Older adults (those 50 years and older) are the fastest-growing group of people experiencing homelessness. Recent reports cite growth from 20% to almost 50% of the unhoused population. The numbers are predicted to double by the year 2030. The following system of care map was developed to identify the unique resources to consider in meeting the needs of this group.

There isn't an established integrated system of care to meet the needs of older adults experiencing homelessness. The intent of this tool is to identify the existing services that primarily will accept and serve those who are homeless. For example, there may be many Area Agency on Aging services in the community, but asking if they serve the homeless population will be important. For long-term care and assisted living/board and care facilities, it's important to identify which ones will admit those who are unhoused and which facilities have the specialized care, such as behavioral health or memory care, to serve the unique needs of some of the population. To gather a well-rounded picture of the services that could meet the needs of older adults experiencing homelessness, it can be helpful to also complete the homelessness and end of life system of care maps.

"I've felt like walking in front of the train every day for the last three years since I lost my house... It's the first time I've ever contemplated suicide ever in my life. I'm always upbeat and I'm such a positive person until I got out here… Everything is so hard, just my age and just physically... I hurt all the time and I'm in pain and everything is just a struggle, just to do laundry, just to, you know, food. The younger crowd seems to do better, but I'm older and it's hard. It's just hard."

57-year-old woman Source

System of Care for Older Adult Experiencing Homelessness Populations Category Definitions

SCAN ME OR USE THIS LINK TO ACCESS ASSET MAP TEMPLATES & SOURCES.

Services


Area Agency on Aging/ Guardians


Day Centers


Health Care for the Homeless


LTSS/CM/PACE Medication Management


Service–Enriched PSH


ASL/Board and Care


Long Term Care (LTC)


LTC w BH/SUD Focus


LTC w Memory Care Units


Hospice Homes

Area Agency on Aging (AAA)/Guardians

AAA is a public or nonprofit organization that is designated by the state to support older adults at the local level. They provide many home- and community-based services to help older adults live independently, such as home-delivered meals, homemaker assistance, and other essential support. Source *Guardians or conservators* may be appointed to attend to the needs of someone who has been deemed incapacitated (by medical condition, mental illness, or substance use) by the court. The appointee may be a family member or a community program typically managed by the county. Source

Day Centers

Adult day services programs provide community-based care for individuals who do not require 24-hour nursing, offering activities that promote mental and physical well-being, reduce isolation, and prevent functional decline. These programs support working and full-time caregivers by offering flexible attendance options, transportation assistance, and caregiver support services. Services vary but may include therapeutic activities, health monitoring, meals, and specialized care for specific populations. Source 1 Source 2

Health Care for the Homeless

Some communities have primary care or an FQHC (Federally Qualified Health Center) focused on serving unhoused populations. Street medicine or mobile clinic providers also may be serving older adults experiencing homelessness. Source

Long-term Services and Support (LTSS)/Care Management (CM)/Medication Management/ PACE Programs

LTSS programs care for older adults and people with disabilities who need support because of age, cognitive development, or

chronic health conditions; or other functional limitations that restrict their ability to care for themselves. This care is provided in the home, in community-based settings, or in facilities such as nursing homes. Source *Care management* assists older adults with complex care needs by coordinating services and developing care plans to help them remain safely at home through assessment, monitoring, advocacy, and ongoing support. Source *Medication management* refers to a program or service designed to help older individuals experiencing homelessness properly manage their medications. Source *PACE* is a comprehensive program to support those over 55 who may qualify for nursing home care but prefer to receive care where they live. It includes medical and social needs services and is covered by Medicare and Medicare/Medicaid in several states. Innovative programs are providing this for the homeless population to expand supportive housing options. Source

Service-Enriched Permanent Supportive Housing (PSH)

Housing is designed for households experiencing homelessness in which social services are available on-site or by referral through a supportive services program or service coordinator. Source

ASL/Board and Care

Nonmedical facilities provide 24-hour care, supervision, and assistance with activities of daily living (ASLs), such as bathing, dressing, and grooming. Source

Long Term Care (LTC)

A long-term care (LTC) or skilled nursing facility (SNF) is a residential setting that provides a range of medical and personal care services for individuals who are unable to live independently due to chronic illness, disability, or aging. Source

LTC with BH/SUD Focus

LTC with BH/SUD Focus provides comprehensive, long-term support and services for individuals who require ongoing assistance with daily living activities and have co-occurring behavioral health conditions or substance use disorders. This specialized care integrates medical, psychological, and addiction treatment services, addressing both physical and mental health needs to promote recovery, stability, and improved quality of life. Source 1, Source 2, Source 3

LTC with Memory Care Units

LTC with Memory Care Units provides specialized long-term support and services for individuals with memory-related conditions, such as Alzheimer's disease and other forms of dementia. These units are designed to offer a safe, structured environment with trained staff who provide personalized care. Source Because of the prevalence of traumatic brain injury in the homeless population, it's important to identify supportive environments for this care.

Hospice Homes

Terminally ill patients receive hospice care in a peaceful, home-like residence. Hospice care is available to people with a life expectancy of six months or less and focuses on pain relief to keep them comfortable during their remaining time. Source 1 Source 2

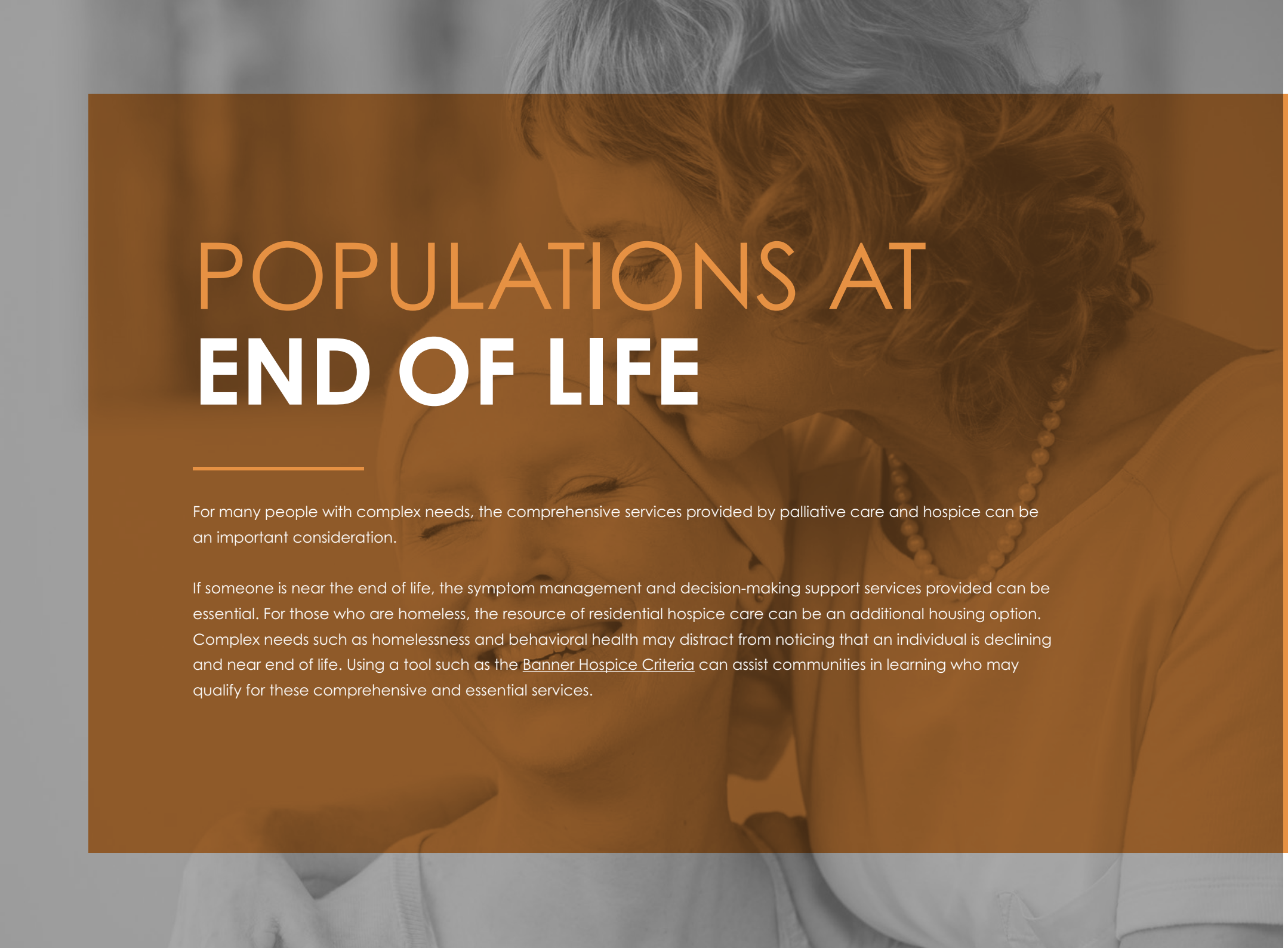
Internet Research Recommendations

- Search each service category listed above and the county/community.

Interview Recommendations

Interviews are important for information gathering with this population of focus.

- Emergency room or hospital case managers
- Area Agency on Aging
- CoC representative
- Street medicine providers



POPULATIONS AT **END OF LIFE**

For many people with complex needs, the comprehensive services provided by palliative care and hospice can be an important consideration.

If someone is near the end of life, the symptom management and decision-making support services provided can be essential. For those who are homeless, the resource of residential hospice care can be an additional housing option. Complex needs such as homelessness and behavioral health may distract from noticing that an individual is declining and near end of life. Using a tool such as the Banner Hospice Criteria can assist communities in learning who may qualify for these comprehensive and essential services.

No pain, he said. I'm just tired. — Henry Hunt, reflecting on his peaceful state in hospice care, speaking to a visitor shortly before his passing.

Source

System of Care for Populations at End of Life
Service Category Definitions

SCAN ME OR USE THIS LINK TO ACCESS ASSET MAP TEMPLATES & SOURCES.

Services			
			
	Palliative Care	Hospice	Hospice Homes

Palliative Care

This interdisciplinary approach aims at improving the quality of life for individuals with serious illnesses. Source

Hospice

Care focuses on the comfort and quality of life for individuals with serious illnesses who are approaching the end of life. Hospice is typically provided to individuals with a terminal illness whose doctor believes they have six months or less to live. Services are offered in various settings, including one's home, an apartment, a nursing home, a hospital, or a dedicated hospice center. Source

Residential Hospice

Hospice services are provided specifically in a residential care facility. Source

Interview Recommendations

- Largest hospice and largest palliative care programs in your area
- Emergency room or inpatient case managers

Internet Research Recommendations

Hospice search terms:

- Search "[county name] hospice programs," and explore what comes up.
- Visit the site for "National Hospice Locator."
- Visit the site for "Alliance for Care at Home and Find a Provider"; they have a directory page where you can search by zip code or find services on a map.

Palliative care search terms:

- Search "[county name] palliative care for the homeless."

Residential Hospice search terms:

- Search "[county name] hospice residential programs" — check to make sure that they're actually residential.
- Search "[county name] hospice inpatient programs."
- Search "[county name] hospice home programs."
- Search "[county name] hospice for the homeless."

CLOSING THOUGHTS

Every community has their own unique system, context, and environment.

We welcome you to take these tools as they are useful and adapt them to meet your needs. For instance, you may create a new primary service category or remove one that is not relevant to your setting. We encourage you to have discussions in your community about the benefit of regularly reviewing and updating your System of Care Asset Map and who may "own" the process moving forward in a sustainable way.

In the spirit of learning and improvement, we would love to hear about your experience using this tool.
To share with us, please fill out this form.

SCAN THE QR CODE OR CLICK THE LINK TO OPEN THE FORM

HC² Strategies, Inc. (2025). *Asset Map Guide: Building Systems of Care.*

HC² STRATEGIES
HEALTHY CONNECTED COMMUNITIES

hc2strategies.com