Contra Costa Continuum of Care Program Models and Performance Standards

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Introduction

I. Project Purpose

The purpose of defining, formally adopting and publishing standardized program models is to enable the CoC and H3 to:

- Update the Written Standards and Policies & Procedures
- Create consistent parameters for contracting scopes
- Establish clear performance expectations, measures, and benchmarks
- Improve consistency, clarity, and coordination in service delivery within and between models
- Improve the quality of service and outcomes for people experiencing or at-risk of homelessness
- Increase accountability and transparency within the homelessness response system

II. Model Development Process

In April of 2021, H3 contracted with EdeColigny Consulting LLC to draft program model descriptions, identify performance measures for those models, and recommend templates and language for inclusion in provider contracts.

The process started with over a dozen interviews with providers and H3 staff as well as review of performance data and policy documents. Multiple stakeholders described experiencing the Contra Costa Continuum of Care as a system that is working very hard but not getting the results intended. Outcomes reported in the Calendar Year 2020 Annual Report confirm that perception. Nearly ten thousand people were served, 75% of whom were experiencing literal homelessness, yet only 11% of those were documented to have exits to permanent housing (pg. 29). Not all challenges faced by the CoC can be addressed by clearer Written Standards and contracts, but nearly everyone felt the project could help with both performance and morale.

The initial analysis, model drafts and performance measures were submitted to H3 Senior Management in October 2021. The model drafts articulated existing approaches, policies, and practices stakeholders identified as working well, were aligned with best practices and federal requirements, and/or were achieving performance results. The drafts also recommended changes to current approaches intended to address system issues that emerged during initial research and analysis. The system issues identified by this project have since been corroborated by the Coordinated Entry System evaluation report by Focus Strategies released in March 2022.

The consultant and H3 staff refined the draft models and measures to present to the CoC membership at an open community meeting on 2/1/22. That meeting launched a public comment period, that included an on-line posting of the draft models, a survey of stakeholders and four additional public meetings with contractors and community members to collect feedback and answer questions. All written comments and narrative survey responses are included in Appendix A. [Comments and questions are organized in Appendix A by program model along with sections regarding document readiness, the community queue and general comments/questions].

The models detailed in this report were revised in response to community input. Prior to describing the individual program models, the report discusses key changes to current practice along with relevant community input. The model specific input is incorporated in the revisions to the models themselves and noted in the appendix.

The seven intervention model descriptions, once adopted, are intended to be incorporated in the Written Standards as well as the provider contracts.

III. Program Model Descriptions

The report recommends adopting standardized models for seven types of programs within the CoC:

A. Permanent Supportive Housing
B. Rapid Rehousing
C. Rapid Exit
D. Emergency Shelter
E. CARE Centers
F. Outreach
G. Prevention/Diversion

Each model description is outlined as follows:

1. Purpose of the model, both what it does on behalf of the participants and its role in the system
2. Eligible and prioritized population
3. Required elements that define the model
4. Best practices or optional activities
5. Minimal operating hours and other access issues, such as virtual or site-based versus mobile
6. Referral, enrollment and exit requirements
7. Continuum of Care capacity and anticipated turnover
8. HMIS participation
9. Staffing such as kinds of positions needed and/or responsibilities of staff
10. Performance Measures include two equity measures and one data quality measure intended for all models.

The descriptions and measures reference the performance expectations embedded in the HMIS and Coordinated Entry policies and procedures, which also need updating.

Chapter 1: Key Changes to Current Practice Reflected in Program Models

As noted above, the model descriptions memorialize current approaches, policies, and practices. They also propose changes to current operations at the system and program level to improve quality of care and performance. Those changes are summarized below.

I. Resolving duplications and gaps in services between models

The *Purpose (1), Required(3) and Optional Elements(4)* of the model descriptions attempt to address the dynamic of duplication and gaps within and across models. Key clarifications include:

- **Every program model** is accountable to provide Trauma Informed Care and Housing Problem Solving (HPS) throughout a person's or family's housing crisis, not just at intake, assessment, and referral to the Community Queue.
- **CORE, CARE Centers and Emergency Shelters** are responsible for helping people secure the documents needed to move into housing. Fewer documents are needed for enrollment in CoC and ESG housing programs. Required documents are verification of homelessness, verification of chronic homelessness (if applicable), and verification of disability. Forms of identification (Government issued ID, such as Photo ID, birth certificate, or Social Security card) and verification of income are not needed for these enrollment programs, but are typically required by prospective landlords, including in scattered site programs where the participant will hold the lease. Crisis response staff will work on gathering the ESG and CoC required documents as well as at least one form of ID and proof of income.
- **Care Center Case Management** is distinguished from the drop-in function of Care Centers. Case Management is a funded part of Coordinated Entry grant and is designated for assisting unsheltered people to access temporary or permanent housing. This can include direct referrals to Rapid Exit when identified solutions require one-time financial assistance. Drop-in Centers may provide additional supports, such as meals, showers, recovery services, and/or children's programming for unsheltered people and other populations, but not using CoC Coordinated Entry grant funding.
- **Emergency Shelter Programs** will provide housing focused case management which includes problem solving, document ready work, and referrals to Rapid Exit when identified solutions require one-time financial assistance. The proposed model description included the elimination of set lengths of stay limits, such as having people leave after 60 or 90 days, in favor of pursuing the goal that all participants work on housing from day one and leave when they have an identified housing destination. This was a very popular element of the model with multiple stakeholders expressing support. The recommended, though not currently required, best practices of making more allowances for pets, possessions, and partners as well as eliminating curfew were also applauded by respondents. The CoC may want to look at how to support existing emergency shelters to embrace these best practices as well. Though popular, they remain an optional approach in this version.

- **CORE teams** serve people experiencing unsheltered homelessness and, with very few exceptions, will exit those who move into emergency shelter or housing. CORE does make direct referrals to emergency shelter and/or direct referrals to Rapid Exit when identified solutions require one-time financial assistance.

- **Rapid Exit and Prevention/Diversion** are two different program models. Rapid Exit provides one-time financial assistance for literally homeless people referred by CORE, CARE and Shelter providers after an exit to housing, temporary or permanent, has been identified. Rapid Exit will verify the option and provide financial assistance. Case Management and Housing Problem Solving will be minimal. Prevention/Diversion assists households who are not yet literally homeless, but at imminent risk. It is designed to help them avoid unsheltered homelessness or a shelter stay.

- **Permanent Supportive Housing and Rapid Rehousing** will assist participants with rental subsidy vouchers to locate housing and access move-in assistance funds as needed. The expectation is that newly enrolled households will have obtained the documents needed to move into housing during their work with CORE, CARE or Emergency Shelter Programs. Assistance with documents can be provided if this is not the case, but that should be the exception not the norm. Service staff will support housing retention while household is enrolled in the program.

- **Rapid Rehousing** staff will use the Critical Time Intervention approach for supporting participants during housing search, move-in and stabilization. CTI is a time-limited evidence-based practice that facilitates community integration and continuity of care by ensuring that a person has enduring ties to their community and support systems during these critical periods of transition such as exiting homelessness. H3 will provide training on CTI for providers required to use it.

- **Models will collaborate** when households are matched to a housing referral through the Community queue. The CORE Team, CARE Center staff or Emergency Shelter households are connected to will facilitate the warm hand-off to the RRH or PSH program and support connection with participant during enrollment, housing search and move-in.

II. Addressing the mismatch between numbers referred versus served

Many stakeholders expressed frustration with referrals. This was true for people experiencing a housing crisis, concerned community members trying to access help, and staff of both referring programs and those receiving referrals. Those making referrals in HMIS through the Triage Tool experienced the referrals as resulting in little or no help, even when a person was clearly eligible for the program. Currently providers are expected to refer people experiencing homelessness to the programs for which they are eligible without knowing what the capacity of the program is to enroll or house them.

Staff of programs getting referrals described being overwhelmed by the volume. Eligible or not, the capacity does not exist to serve every household referred. This was true for shelters, CARE Case Management and Rapid Exit as well as the housing managed by CES. This resulted in long waitlists and lots of time managing referrals rather than delivering services.

The Community Queue for housing is the most dramatic example of this dynamic. According to the Coordinated Entry System Evaluation conducted by Focus Strategies; "Among the 3,302 households in the study population who entered CES [between 10/1/20-9/30/21], only 88 were referred to housing. This indicates that there is a large backlog of households on the *community* queue with very few housing opportunities." (pg. 16). Evaluators also noted an average wait of 149 days for adults between CES enrollment and referral to housing.

Many public comment responses noted that dramatic increases to housing and services are needed to fix the mismatch between referred and assisted. This is true and beyond the scope of this report. It is within the scope to recommend that all models are transparent about who is prioritized for services and how many people can be served at a point-in-time and over the course of the year. In addition, *Referral, Enrollment and Exit Requirements (6),* the discussion of *Eligible and Prioritized Populations(2)* as well as the *CoC Capacity and Anticipated Turnover(7)* in each model description will help manage expectations of how many people/households can be served with the resources currently dedicated to a program model. The capacity and turnover will need to be updated in the Written Standards by H3 annually using the Housing Inventory Chart and the Annual Report data. The discussion of S*taffing (9)* in the model descriptions also addresses capacity by identifying a point-in-time capacity as well as thinking about how many households a full-time equivalent staff can assist over the course of the year.

Key clarifications/changes to prioritization and capacity include the following:

- Affirming the prioritization of those with the longest time homeless and highest VI-SPDAT scores for **Rapid Rehousing**. This prioritization was piloted in 2019 and maintained throughout the pandemic. National studies commissioned by both the Veteran's Administration and HUD have demonstrated that this approach is viable for achieving housing stability for high needs populations and does not lead to greater returns to homelessness. Prioritizing in this way for RRH is best supported by housing placements that are sustainable with fixed incomes such as SSI, with options to bridge to PSH if indicated, and the commitment to be prioritized for prevention assistance should a future housing crisis arise. The efficacy of this approach will continue to be assessed by the CoC.

- **Prevention/Diversion** assistance will be prioritized for those most likely to become homeless according to research-based criteria, which includes prior experience of homelessness. The prevention model includes the adoption of a standard assessment tool, a change strongly supported by community input. People currently living in Permanent Supportive Housing or Rapid Rehousing will be eligible and prioritized for prevention services.

- All unsheltered **CARE Center** clients will not automatically be referred to case management. Each CARE Center case manager will work with a case load of 25 households/persons at a time, and therefore cannot provide housing focused case management to all the eligible persons who come to the CARE Center drop-ins. Case managers will reach out to active clients of the Care Center based on the prioritization policy and enroll them when they have openings. Active is defined as a client who is enrolled in CES, has a completed housing assessment, and participates in the CARE Center at least weekly/4 times per month. When case managers have openings, they will prioritize active clients who have been homeless the longest with the highest VI-SPDAT scores to enroll in housing focused case management. Case Managers will "work the list" from the most vulnerable active drop-in client down until a new client accepts the services.

- All potentially eligible clients who are literally homeless with a VI-SPDAT score of less than 3 will no longer be automatically referred to **Rapid Exit** for Housing Problem Solving and possible financial assistance. As noted above, Housing Problem Solving will be done for people experiencing literal homelessness primarily through crisis response services (CORE, CARE and Emergency Shelters) regardless of VI-SPDAT score. Referrals to Rapid Exit will occur when there is a strategy to obtain temporary or permanent housing and one-time financial assistance is needed to implement it. Each month, households will be assisted on a first come, first served basis until funds are exhausted for that month, at which point the Rapid Exit provider will notify referring agencies not to send additional households. Households who cannot get financial assistance will continue to get Housing Problem Solving through the crisis response program they are working with.

- Prioritization for **Emergency Shelters** accessed through the CORE teams will continue to be based on those with the most acute needs as determined by the triage tool, without needing to generate a VI-SPDAT score before shelter is accessed. Shelters that manage their own intakes are not required but are strongly encouraged to prioritize based on the Triage Tool.

III. Changes designed to reduce the length of time homeless

The Calendar Year 2020 Annual Report notes that lengths of time homeless have increased by 42% since 2018. As many survey respondents and interviewees asserted, lack of affordable housing is a key driver of this phenomenon. Stakeholders describe participants with housing vouchers taking six months to a year to locate units/landlords willing to rent to them. Yet, the concurrent work of this project on program models and the evaluation of Coordinated Entry processes surfaced interrelated opportunities for improvement on this metric that are within the control of the CoC.

- **Decrease the time between CE access and assessment:** On page 7 of the CES Evaluation, the authors note: "most adult households received one or both assessments on the same day they enrolled in CES, but the average time between enrollment and the first assessment is 58 days, with the maximum being 349 days." The model descriptions reinforce the expectations H3 staff communicated starting in June of 2021 that assessments should be completed at the same time as a CE enrollment, both the Triage Tool and for those who are literally homeless, the VI-SPDAT.

- **Housing Problem Solving efforts continue after referral to the Community Queue:** Given how few housing referrals are available through the community queue, the model descriptions reiterate that all model types must do Housing Problem Solving and must assume it is the primary service most people experiencing homelessness will get.

- **Get started on document gathering during crisis services and complete before household is given a housing referral:** As noted in section I, CORE, CARE Centers and Emergency Shelter staff will work on gathering the documents needed for enrollment in CoC and ESG housing programs (verification of homelessness, verification of chronic homelessness if applicable, verification of disability if relevant to the housing plan) as well as at least one form of ID and proof of income, because those are typically required by perspective landlords, including in scattered site programs where the participant will hold the lease.

This project recommends that the CES establish a way that people in the Community Queue could have their records flagged when they are document ready, and at that point could be matched to a housing referral as openings occur. It further recommends that the CES staff review the community queue regularly to ensure that the 50 highest priority households on it are connected to a CORE team, CARE Center or Shelter staff that is working with them to get document ready.

Survey respondents were very supportive of starting document gathering as soon as possible. They expressed two concerns. First, they wanted to be sure access to crisis response services, such as shelters and CARE Centers, would not be denied because of lack of documents. It will not. Documents are required for subsidized permanent housing (Tenant Choice Vouchers, RRH, PSH, VASH, etc.) and most private landlords. They are not required for emergency shelter or other crisis response services. Second, respondents wanted to be sure people would not be given arbitrary deadlines by which to get documents or assistance would cease. Support with securing documents and other crisis assistance would not cease. Some scattered permanent housing vouchers must be leased up within a certain time frame or they get recaptured, which makes starting on document gathering even before a housing referral even more critical.

IV. Advancing racial equity

Along with other quality improvement efforts, this project seeks to advance racial equity within the CoC. All program models will be accountable for two equity-based performance measures. Equity measure 1 is about service delivery. Equity measure 2 is organizational composition. Several comments during the community input indicated that the language describing the measures or the method for measuring them was not clear. The descriptions below now include the data source for measuring the results. Equity Measure 1 has some examples of how equitable service delivery can look across the system. Each service contract will use the relevant specific measures.

Equity Measure 1--Program demonstrates racially equitable service delivery and outcomes as described in the examples below:

- Programs that gain participants through referrals, CES and other sources, accept all races into their program at comparable rates, meaning if 75% of whites referred are enrolled, a comparable % from other races and ethnicities should be as well.
- The achievement of intended program outcomes, such as retention of housing or exits to PH, should be comparable across racial groups
- No racial group should be disproportionately terminated from assistance.

Data from HMIS disaggregated by race will be used to measure this performance standard.

Equity Measure 2—Each level of an organization from frontline staff, executive leadership and board membership needs to include people with lived experience and reflect the populations being served, by race and gender.

V. Improving data quality

Many stakeholders expressed the desire for more robust data to understand program and system performance as well as service gaps. Good data supports accountability and transparency and strengthens planning and system improvement. All model descriptions include performance measures for data quality and timely data entry as reflected in the CoC HMIS Policy and Procedures' Data Quality and Monitoring Plan. The description articulates the role of the provider's HMIS administrator to go beyond program set up to include managing for data quality.

VI. Performance Standards, Measures and Benchmarks

In addition to the data quality and racial equity measures, each model has multiple performance measures specific to its role in the system, such as exits to permanent housing, retaining permanent housing, etc.

The benchmarks are consistent with national best practices, as well as expectations and performance in Contra Costa County or other CoCs. Where Contra Costa County providers are falling well below the aspirational benchmark a 10% improvement is considered meeting expectations. In cases where performance expectations have not previously been measured, such as document readiness, they will be tracked in year one and then benchmarked for the next year.

Multiple stakeholders expressed concerns about programs' ability to achieve the desired outcomes with so few affordable permanent housing units available. Several brought up the difficulties of housing people with criminal backgrounds, especially 290s, life-time registered sex offenders. These are real challenges throughout the Bay Area, requiring advocacy and additional resources. This project is charged with making sure the resources we have are clearly defined and working well together, even though they are not adequate to house everyone.

Public comments also raised examples of other circumstances that could make meeting the benchmarks more difficult. Extenuating circumstances in any given reporting period, such as rehabbing buildings, a public health crisis that requires lower occupancy, bottlenecks in other parts of the system, such as Coordinated Entry, funding cuts, etc., that impact projects' ability to meet performance benchmarks can be addressed with H3 at the time. Setting, measuring, and holding ourselves accountable to performance standards, despite the challenges they present, expresses the aspiration of our CoC to deliver quality care to people experiencing the trauma of homelessness. The intent is not to punish providers, but to improve our response.

Providers raised questions about whether new dashboards and templates will be available to report on the performance measures. Most measures draw from data that is already collected and reported on in HMIS. The Research, Evaluation and Data (RED) team has the ability to and will customize dashboards and reports based on needs.

VII. Consumer feedback and satisfaction vital to performance accountability

Multiple respondents during the public comment period noted that the Performance Standards did not include a way of gathering consumer feedback or satisfaction. That was a critical oversight that has been addressed in the revised models and standards. They now include the following language:

> **Customer Satisfaction Measure—**Consumers will indicate satisfaction with program services in multiple domains, such as helpfulness, respectful treatment, accessibility, etc. Data will be gathered using a

tool(s) or method(s) **developed or selected by a consumer lead work group**. As with other new measures, data will be gathered in year one of the contracts to establish the baseline of performance and set the benchmark for future years.

If the CoC is to hold itself accountable for providing programs that consumers experience as helpful, timely and respectful it needs to start with involving people with lived experience of homelessness in defining what criteria and method(s) should be used to measure consumer satisfaction. For example, if it is a survey, what are the questions, when how and how frequently would it get administered? Staff recommends the CoC establish a working group that is comprised of at least 50% people with lived experience to vet existing tools and metrics or develop a new tool. If the working group has not selected or developed a tool by the start of the 2022-2023 contract year (July 1, 2022), data will be collected using an existing tool for the first year, subject to change.

Chapter 2: Community Input and Survey

I. Summary of Community Input Process

The draft program models and performance standards were presented at a community meeting on 2/1/22 attended by 115 CoC members and stakeholders. Participants included people experiencing homelessness, community volunteers, existing non-profit contractors, providers without CoC funding contracts, county staff, Council on Homeless members, and CoC Oversight Committee members. After the consultant presented the models, attendees were able to participate in small group discussions on the model of their choosing to ask questions and offer feedback. That meeting launched the public comment period that lasted until 3/4/22. Public Comment mechanisms included:

- 3 topic-specific Office Hours sessions and 1 general session via Zoom
    - Emergency Shelter, CORE and CARE Center Models attended by 12 people
    - Prevention/Diversion attended by 5 people
    - PSH and RRH models attended by 9 people
    - General Office hours attended by 12 people

- A lengthy survey with both quantitative and qualitative questions on each model and the proposed system changes with links to the draft document was sent to all members with periodic reminders. It was opened by 83 people and completed by 31.

- The document is posted on-line with ways people could submit comments or questions in writing. Two providers and one community member emailed written questions and comments.

Appendix A contains all the questions and comments received by any mechanism. They are sorted by program model, unless they are broader than or unrelated to a specific model in which case they are grouped at the end as general comments. Staff has responded to specific questions in the Appendix and indicated when recommendations have resulted in changes to the models. Specific aspects of community input are discussed below or referenced in Chapter 1 as they relate to the key changes in current practices.

II. Comments on Public Planning Process

The planning process enjoyed participation from a diverse range of stakeholders. Well over 100 people participated in one or more ways to shape the system changes, model descriptions and performance standards reflected in this document. Several respondents did express concerns about the timeline and structure of the public comment period and mechanisms by which it was gathered. Examples include not having enough space to write narrative responses, frustration with the length or redundancy of the questions, and concern there was not enough time for discussion of the models in the public forums. Even with these concerns, more stakeholders articulated the benefit of moving forward and ensuring the program model descriptions and performance standards are in place by the July 1, 2022, contract year. Community input was substantive and robust, and resulted in additions and modifications to the models as presented on February 1, 2022. This performance improvement project will be iterative, with model descriptions and performance benchmarks getting reviewed and updated annually.

III. Highlights from the Quantitative Survey Data

The community survey asked survey takers to strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree with the same six statements for each of the seven models. There were also questions specific to a given model and several questions at the end about recommendations that crossed models or impacted coordinated entry. As noted above, respondents could also provide narrative responses to explain their ratings. Survey takers could answer as few or as many questions as they chose. It appears that most elected to focus on models of greatest interest to them, rather than complete the entire survey. The number of respondents per model ranged from 11-26, with PSH and RRH getting the most and Outreach and Prevention/Diversion had 11 respondents each. The six statements regarding the models were:

1. The expectations and standards in the model were communicated clearly across the 10 description domains (Purpose, Eligibility, Required Elements, Best Practices, Operating hours and access, Referral/enrollment/exits, CoC capacity and turnover, HMIS participation, Staffing, and Performance standards).
2. The standards developed across the 10 description domains in the model were reasonable.
3. The performance standards outlined in the model are achievable (either by meeting the benchmarks outlined within the model or the ability to show 10% improvements each year).
4. I believe that the expectations and standards developed in the model will improve the quality-of-care consumers will receive when participating in these programs.
5. I believe that the expectations and standards developed in the model will improve the outcomes consumers experience when participating in these programs.
6. I believe that the expectations and standards developed in the model will improve providers abilities to implement programs consistently.

Across all models, respondents agreed most strongly with the statement that a model would improve quality of care consumers will receive, with range of 58-82% agreeing or strongly agreeing and an average of 69%, compared to a disagreement range of 0-16% with an average of 10%.

The second highest average area of agreement was that the standards will improve client outcomes with an average agreement of 64%, but a much wider range of 33-91%, with 2 models below 50% agreement. One of those is PSH, where client outcomes are already very high, so disagreement with the survey statement could be an indication that respondents were aware of that.

Five of the seven models, PSH, RRH, Shelter, Care Centers and Prevention/Diversion had most respondents agreeing or strongly agreeing with five of the six statements above. When the level of agreement was less than 50% it remained above the level of disagreement by 10% or higher.

Rapid Exit had the highest proportion of respondents who neither agreed nor disagreed with the statements. Respondents were not as clear about the purpose and performance standards of this model. Comments indicated that as a newer model, they didn't feel as though they knew enough about it to give an opinion.

Just over 50% of respondents to Outreach disagreed that the model description was clear, reasonable, or would lead to greater consistency. Conversely, 75% agreed the standards were achievable and would improve the quality of care, with 91% agreeing it would achieve improved consumer outcomes. Comments indicated frustration with recent experiences during an encampment sweep in East County, which may have shaped responses to this model.

IV. Feedback for Future Consideration or Beyond the Scope of this Project

Community members provided feedback that staff determined was beyond the current scope of this project at this time. Some of it related to current or potential future program models. Other input did not, but is summarized here and documented in Appendix A.

A. Feedback Related to Current or Potential Program Models

1. Operationalizing a way that for RRH participants who need it to transition to PSH

The CoC does have a transfer policy that allows for moving from one type of housing program to another, but the criteria and procedures for this transfer need to be detailed in the revised Coordinated Entry Policies and Procedures

2. Mechanism for Private Contributions to Rapid Exit and Diversion Resources

Several community members thought the funding available for Prevention, Diversion, and Rapid Exit was very small compared to the need and one suggested creating a private fund that the public could contribute to in support of helping more people exit or avoid homelessness

3. Supporting Emergency Shelters to Adopt Best Practices and Reduce Barriers

As noted in Chapter 1, the elimination of curfews, along with the ability to enter shelter with partners, pets and more possessions were very popular. Understanding technical assistance might be needed to incorporate them successfully, they remain optional best practices in this iteration of the program model standards.

4. Explore ways to incorporate more peer staffing into program models

The feedback included suggestions for ways people with lived experience could support implementation of the models, especially in helping people secure the documents needed for housing. All contractors are strongly encouraged to utilize the expertise of people with lived experience as employees, interns, volunteers, and board members. There may also be a benefit to creating a CoC-wide mechanism for doing so.

5. Consider New Program Models for Unsheltered People

Several commenters recommended the CoC include Sanctioned Encampments and Safe Parking programs in what it offers people experiencing unsheltered homelessness.

B. Feedback Beyond the Scope of this Project

1. Support the Creation of More Affordable Housing

H3 is committed to working with local cities and stakeholders to apply for funding to create more safe and affordable housing for people in our community. Are there other ways for the CoC to strengthen its advocacy for expanding units and targeting them to housing those experiencing homelessness?

2. Update Encampment Abatement Protocol

Several comments expressed frustration and outrage over current practices in the CoC's geography when it comes to addressing encampments. H3 has a suggested encampment protocol that was last updated in 2018. This protocol could be updated with community input and integrated into the relevant model standards in future yea

Chapter 3: Revised Program Models

I. Permanent Supportive Housing (PSH)

1. **Purpose:** Permanently house the Continuum of Care's most vulnerable individuals and families with long histories of homelessness by providing permanently subsidized housing and trauma-informed supportive services to ensure housing retention and improved quality of life for participants.

2. **Eligible Population and Prioritization**: Households assisted by PSH must be literally homeless and living with a documented disabling condition. Whether or not the project is dedicated to or prioritized for chronically homeless individuals, the Written Standards prioritize those with the longest history of homelessness and most severe service needs.

3. **Required Elements:** All aspects of the program from enrollment through housing retention must be Housing First, meaning no sobriety requirement, treatment compliance, criminal justice history exclusions or minimum income requirements for enrollment, and all services participation is voluntary for tenants, and non-participation cannot be a basis for terminating tenancy. PSH can be scattered-site or project-based. PSH must include:

    - Rent subsidy such that the participant household pays no more than 30% of adjusted income for rent.
    - Proactive Housing First based supportive services focused on housing retention and improved quality of life, which can include recovery support and behavioral health care. Beyond regular check ins that may be required by a funder, participation in services cannot be mandated for any program participant. Staff are required to be proactive in reaching out to participants to identify and provide supportive services that meet their needs.
    - Each project must assist participant with locating and applying for housing.

4. **Optional Elements or best practices:** People stabilize in PSH and may not always need wrap around services. Supporting participants who wish to "move-on" to less intensive permanent housing, such as a Housing Choice Voucher or an affordable housing development, improves system flow by opening more PSH slots.

    The system is designed to enroll households in PSH programs when they have the documents needed for CoC program enrollment, such as verification of homelessness, chronic homelessness, and disability, as well as the documents that are likely to be required by a landlord (I.e., government issued photo ID and proof of income). In situations where a household is at the top of the Community Queue and still needs documents, the PSH program staff can assist if they have capacity.

5. **Access and Operating Hours:** Housing must be available twenty-four hours per day, 365 days per year. Services must be available at a minimum of regular business hours (for example, Monday through Friday from 9:00 am to 5:00 pm). Evening and weekend hours are encouraged if resources allow. In scattered

site programs, access cannot be restricted by requiring participants to travel to centralized service sites; support must also be delivered through home visits as appropriate.

6. **Referrals to and from, Enrollment and Exit:** Eligible households must be referred to the community queue by providers who conduct the Housing Needs Assessment (VI-SPDAT), CORE, CARE Center Case Management and Emergency Shelters. Except for VASH vouchers, PSH openings are filled by drawing from the community queue in order of priority.

   Participants enrolled in PSH can be co-enrolled with CORE, CARE, or emergency shelters while still in the housing search phase of program enrollment. Once moved into housing, they should be exited from crisis response services.

   Prior experience of homelessness is the highest risk factor for future homelessness. Participants who have fallen behind on their portion of the rent should be referred to Prevention programs.

   Housing retention is the goal of PSH; exits should be to other permanent housing when they do occur. Participants who must be exited for unresolved lease/program violations must get written notice and have the right to appeal per 24 CFR 578.91(b)&(c), HUD's termination of assistance policy as well as all legal rights of tenants. Participants who exit PSH are typically exiting the system of care.

7. **Continuum of Care Capacity and Anticipated Turnover:** The CoC has 838 PSH units/vouchers filled through CE and another 367 VASH vouchers. Approximately 5% (41 slots) of current non-VASH capacity turns over each year. In the program year July 1, 2022-June 30, 2023, the CoC anticipates 35 new units to become available for a total of approximately 75 PSH openings.

8. **Staffing:** Minimum staffing for PSH supportive services equals one full-time housing focused case manager/other support services staff for every 15 households. Property management staff varies in site-based and scattered site programs and may or may not be funded directly by the CoC. They are not part of the support services staff ratio. Agreements between landlords/property management and service providers should specify when and about what services staff will be notified concerning problems with the tenancy. Clinical staff and supervisory ratios may vary across projects and funding sources for the housing.

9. **HMIS Participation:** All federally and state funded PSH projects are required to participate in HMIS per the HUD standards and CoC HMIS Policies and Procedures adopted May 6, 2021. Participation includes identifying an HMIS administrator within each agency, who not only helps to set up programs, but monitors the project to ensure data accuracy, completeness, and security ongoing.

10. **Performance Standards:** PSH program operators will be accountable to achieving the following benchmarks.

    a) Program declines less than 5% of eligible CE referrals.

    b) Maintain 95%-unit occupancy/voucher utilization unless the program is in lease up phase.

    c) Time between program enrollment and move into housing is 120 days or less.

    d) Housing retention and exits to permanent housing combined is 96% or greater.

    e) 80% of those who enroll in the program without health insurance, have acquired it by program exit/annual update, or project shows a 10% improvement from prior year if rate is below 70%.

f) 80% of those who enroll in the program without non-cash benefits, for which they would be eligible, have acquired those benefits by program exit/annual update, or project shows a 10% improvement from prior year if rate is below 70%.

g) *Equity Measure 1*--Program demonstrates racially equitable service delivery and outcomes as described below:

   a. CE referrals are accepted and enrolled in rates comparable across racial groups.

   b. The time between enrollment and move-in and the rates of housing retention and securing of benefits are comparable across racial groups.

   c. No racial group should be disproportionately terminated from assistance.

   Data from HMIS disaggregated by race will be used to measure this performance standard.

h) *Equity Measure 2*--Each level of an organization from frontline staff, executive leadership and board membership needs to include people with lived experience and reflect the populations being served, by race and gender.

i) Meet data quality standards as outlined in CoC HMIS Policy and Procedures' Data Quality and Monitoring Plan.

   a. An error rate of no more than 5% for null/missing and unknown/don't know/refused responses for all UDEs and program specific data elements excluding Domestic Violence and Social Security Number.

   b. Data entered within three days of service event including entry and exit.

   Evidenced by submission of the Enrollment Report monthly and Data Quality Report quarterly.

j) *Customer Satisfaction Measure*—Consumers will indicate satisfaction with program services in multiple domains, such as helpfulness, respectful treatment, accessibility, etc. Data will be gathered using a tool(s) or method(s) **developed or selected by a consumer lead work group**. As with other new measures, data will be gathered in year one of the contracts to establish the baseline of performance and set the benchmark for future years.

II. Rapid Rehousing

1. **Purpose:** Permanently house vulnerable individuals and families who are unsheltered, with long histories of homelessness and severe service needs by providing housing location and move-in assistance, medium-term subsidy of rents that taper down over time, and trauma informed supportive services in the mold of Critical Time Intervention, which seeks to connect participants with community supports that will help sustain their housing after the program ends its support.

2. **Eligible Population and Prioritization:** Households assisted by RRH must meet HUD's definition of homelessness under category 1 or 4 (24 CFR578.3). The CoC Standards of Service prioritize those who are unsheltered, with the longest histories of homelessness and severe service needs.

3. **Required Elements:** All aspects of the program from enrollment through housing retention must be Housing First, meaning no sobriety requirement, treatment compliance, criminal justice history or minimum income requirements for enrollment, and all services participation is voluntary and cannot be a basis for terminating participation. It is generally scattered site. Must include:

    - Medium-term rental assistance, meaning 6-24 months depending on the requirements of the funding source.
    - Use of Critical Time Intervention (CTI) approach to the delivery of supportive services. CTI focuses on connecting participants to services in the community that will support housing retention and improved quality of life. Starts with a housing stability plan that includes a strategy for reducing and eventually ceasing project assistance to the household.
    - Assisting households to secure any cash and non-cash benefits for which they are eligible and/or increase income.
    - Quarterly assessment, documented in HMIS, of participants continued need for financial assistance as well as Case Management services, document a plan for taper off both rental assistance and supportive services.
    - Each project must assist participant with locating and applying for housing.
    - Follow-up at 30-, 60-, 90- and 180-days post housing subsidy to confirm housing is stable and make additional referrals if needed.

4. **Optional Elements or best practices:** Staff positions dedicated to housing location, i.e., landlord facing, distinct from case managers, who are client facing.

    The system is designed to enroll households in RRH programs when they have the documents needed for CoC program enrollment, such as verification of homelessness, as well as the documents that are likely to be required by a landlord (I.e., government issued photo ID and proof of income). In situations where a household is at the top of the Community Queue and still needs documents, the RRH program staff can assist if they have capacity.

5. **Access and Operating Hours:** Housing must be available twenty-four hours per day, 365 days per year. Services must be available at a minimum of regular business hours. Evening and weekend hours are encouraged if resources allow. Projects funded by two or more staff are required to have some weekend/evening hours available. In scattered site programs access cannot be restricted by requiring participants to travel to centralized service sites; support must also be delivered through home visits as appropriate.

6. **Referrals to and from, Enrollment and Exit:** Eligible households must be referred to the community queue. RRH openings are filled by drawing from the community queue in order of priority.

   Participants enrolled in RRH can be co-enrolled with CORE, CARE or emergency shelters while still in the housing search phase of program enrollment. Once moved into housing they should be exited from crisis response services.

   Prior experience of homelessness is the highest risk factor for future homelessness. Participants who have fallen behind on their portion of the rent can be referred to any prevention assistance for which they are eligible.

   Participants who must be exited for unresolved lease/program violations must get written notice and have the right to appeal per 24 CFR 578.91(b)&(c), HUD's termination of assistance policy. Support services are voluntary and non-participation is not a reason for terminating a participant. Persons exiting RRH are typically, though not exclusively, exiting the system of care. For example, they may exit RRH to PSH, but that would be less common.

7. **Continuum of Care Capacity and Anticipated Turnover:** The CoC has 243 RRH slots filled through CE and another 64 filled directly by funders, SSVF, and Probation. An estimated 100% (360 slots) of current capacity turns over each year. In the program year July 1, 2022-June 30, 2023, the CoC anticipates 120 new RRH slots to become available through Coordinated Entry.

8. **Staffing:** Minimum staffing for RRH supportive services equals one (1) full-time housing focused case manager for every 25 households. Property management staff varies in site-based and scattered site programs and may or may not be funded directly by the CoC. Agreements between landlords/property management and service providers should specify when and about what services staff will be notified concerning problems with the tenancy. Clinical staff and supervisory ratios may vary across projects and funding sources for the housing.

9. **HMIS Participation:** All federally and state funded RRH projects are required to participate in HMIS per HUD standards and CoC HMIS Policies and Procedures adopted May 6, 2021. Participation includes identifying an HMIS administrator, within each agency, who not only helps to set up programs, but monitors the project to ensure data accuracy, completeness, and security ongoing.

10. **Performance Standards:**

    a) Provider declines less than 5% of eligible CE referrals.

    b) 75% of program participant households at a point-in-time are in permanent housing receiving housing rental assistance. Or no more than 25% of participant households at a point-in-time are in active housing search unless the program is in year one (lease up phase) of operations.

    c) Time between program enrollment and move into housing is 120 days or less.

    d) Exits to permanent housing are 80% or greater or show a 10% improvement from if rate was below 70% in previous program year.

    e) 80% of those who exited program with permanent housing and could be reached through follow-up will continue to be permanently housed at the time of 180-day follow-up contact, or project shows a 10% improvement from if retention rate was below 70% in previous program year.

    f) 80% of those who enroll in the program without health insurance, have acquired it by program exit/annual update, or project shows a 10% improvement from prior year if rate is below 70%.

g) 80% of those who enroll in the program without non-cash benefits, for which they would be eligible, have acquired those benefits by program exit/annual update, or project shows a 10% improvement from prior year if rate is below 70%.

h) 50% of adults who enroll in the program without fixed incomes (for example, SSI) have increased their income by program exit or show a 10% improvement from if rate was below 40% in previous program year.

i) *Equity Measure 1*-- Program demonstrates racially equitable service delivery and outcomes as described below:

   a. CE referrals are accepted and enrolled in rates comparable across racial groups

   b. The time between enrollment and move-in, the rates of obtaining and retaining housing, and securing of income and benefits are comparable across racial groups

   c. No racial group should be disproportionately terminated from assistance

   Data from HMIS disaggregated by race will be used to measure this performance standard.

j) Equity Measure 2--Each level of an organization from frontline staff, executive leadership and board membership needs to include people with lived experience and reflect the populations being served, by race and gender.

k) Meet data quality standards as outlined in CoC HMIS Policy and Procedures' Data Quality and Monitoring Plan.

   a. An error rate of no more than 5% for null/missing and unknown/don't know/refused responses for all UDEs and program specific data elements excluding Domestic Violence and Social Security Number.

   b. Data entered within three days of service event including entry and exit.

   Evidenced by submission of the Enrollment Report monthly and Data Quality Report quarterly.

l) *Customer Satisfaction Measure*—Consumers will indicate satisfaction with program services in multiple domains, such as helpfulness, respectful treatment, accessibility, etc. Data will be gathered using a tool(s) or method(s) **developed or selected by a consumer lead work group**. As with other new measures, data will be gathered in year one of the contracts to establish the baseline of performance and set the benchmark for future years.

III. Rapid Exit

1. **Purpose:** To assist those who are literally homeless to exit the homeless services system to temporary or permanent housing (can be independent or with family/friends), using housing problem solving and one-time financial assistance if needed.

2. **Eligible Population and Prioritization**: Households assisted must be literally homeless with an identified housing solution.

3. **Required Elements**: Rapid Exit is a Support Services Only project type. Its primary responsibility is to implement the housing solution identified by referred households. Providers referring households for Rapid Exit will have done an initial vetting of the solution and completed a financial request form. Rapid Exit will verify the viability of the solution and funds needed. The program is Housing First and Trauma-Informed, meaning there are no sobriety requirements, treatment compliance, criminal justice history exclusions or minimum income requirements for enrollment. Must include:

    - Trauma Informed Housing Problem Solving with participants to verify the viability of solution identified or adjust the solution as indicated, making every effort to re-house the household quickly.
    - Financial assistance for one-time costs such as back rent or utility payments, unit or utility deposits, first and last month's rent, moving costs, household supplies, or other expenses that impact a person's ability to obtain or return to housing.

4. **Optional Elements or best practices**: The Housing Security Fund is a flexible source that is not limited to payments to utility companies and formal landlords. It can include travel vouchers, food vouchers, repairs to residences, and a range of other costs that can be reasonably tied to ensure the participant obtains temporary or permanent housing.

5. **Access and Operating Hours**: Services must be available a minimum of regular business hours. Evening and weekend hours are strongly encouraged. Since the program serves both sheltered and unsheltered people, staff can provide services over the phone or at the centralized service site.

6. **Referral, Enrollment and Exit:** Each month CORE, CARE Centers, Emergency Shelters, or Prevention services that were unable to help the household avoid homelessness, can refer eligible households. Rapid Exit will assist as many households as the monthly allocation of funds allow with one-time assistance per household. Referring agencies must indicate what potential housing solution has been identified for Rapid Exit to follow through. Staff at Rapid Exit will complete or update HMIS intake and housing assessment during enrollment.

    Participants enrolled in Rapid Exit can be co-enrolled with CORE, CARE or emergency shelters while crisis is resolving. Participants cannot be co-enrolled in Rapid Rehousing or PSH. Once moved into housing they should be exited from crisis response services.

    Participants are exited from Rapid Exit after the 30-day, post-move-in follow up contact has occurred. Households exited from Rapid Exit are typically exited from the system of care.

7. **Continuum of Care Capacity and Anticipated Turnover**: Rapid exit served 65 households in 2020. It is anticipated they will have the capacity to serve up to 100, or 8-10 households/month, in the program year July 1, 2022-June 30, 2023. The program can provide up to $3,000 for individuals and $5,000 for

families of assistance on a first come first serve basis. Rapid Exit will notify referring agencies if monthly funds have been fully expended.

8. **Required Staffing:** Rapid Exit Specialist: Conducts intakes and housing problem solving as needed, primary responsibility is to evaluate and approve recommend financial assistance from crisis response programs making the referral. Estimated capacity will be 8-10 households per month per full-time-equivalent.

9. **HMIS Participation:** All federally and state CoC funded projects are required to participate in HMIS per the HUD standards and CoC HMIS Policies and Procedures adopted May 6, 2021. Participation includes identifying an HMIS administrator, within each agency, who not only helps to set up programs, but monitors the project to ensure data accuracy, completeness, and security ongoing.

10. **Performance Standards:**

    a) Provider declines less than 5% of eligible referrals.

    b) Time between program enrollment and exiting homelessness is 30 days or less.

    c) Exits from literal homelessness to housing (permanent or temporary) is 75% or greater, or project shows a 10% improvement if placements are below 64% in prior program year.

    d) Exits to unknown destinations are 20% or less or show a 10% improvement if exits were above 30% in previous program year.

    e) Program demonstrates that that all participants exited to housing receive a minimum of one follow-up contact attempt.

    f) *Equity Measure 1*-- Program demonstrates racially equitable service delivery and outcomes as described below:

        a. Referrals are accepted and assisted in rates comparable across racial groups

        b. The time between enrollment and move-in and the rates of obtaining housing are comparable across racial groups

    Data from HMIS disaggregated by race will be used to measure this performance standard.

    g) *Equity Measure 2*--Each level of an organization from frontline staff, executive leadership and board membership needs to include people with lived experience and reflect the populations being served, by race and gender.

    h) Meet data quality standards as outlined in CoC HMIS Policy and Procedures' Data Quality and Monitoring Plan.

        a. An error rate of no more than 5% for null/missing and unknown/don't know/refused responses for all UDEs and program specific data elements excluding Domestic Violence and Social Security Number.

        b. Data entered within three days of service event including entry and exit.

    Evidenced by submission of the Enrollment Report Monthly and Data Quality Report quarterly.

    i) *Customer Satisfaction Measure*—Consumers will indicate satisfaction with program services in multiple domains, such as helpfulness, respectful treatment, accessibility, etc. Data will be gathered using a tool(s) or method(s) **developed or selected by a consumer lead work group**. As with other

new measures, data will be gathered in year one of the contracts to establish the baseline of performance and set the benchmark for future years.

IV. Year-Round Emergency Shelter/Interim Housing

1. **Purpose:** To provide Trauma-Informed, safe interim housing for people experiencing literal homelessness while supporting their access to permanent housing opportunities through Housing Problem Solving, which includes assisting residents to secure benefits and income and obtain the documents needed for ESG or CoC PH program enrollment, such as verification of homelessness, and if applicable, chronic homelessness and/or disability, as well as the documents that are likely to be required by a landlord (I.e., government issued photo ID and proof of income).

2. **Eligible Population and Prioritization**: Households assisted must be literally homeless. Open beds in shelters who receive funding through Contra Costa County Health, Housing, and Homeless services will be filled by CORE teams who will prioritize those with most acute needs first. High priority people are seniors, families with children, or people with acute medical or mental health issues as determined by CORE team members, in partnership with dispatch staff. Programs that manage their own intakes are strongly encouraged to prioritize based on the Triage Tool.

3. **Required Elements**: Emergency Shelter/Interim Housing programs operate year-round and are focused on helping participants exit to permanent housing. Housing Problem Solving begins at intake and continues throughout a stay. The model is Trauma-Informed and Housing First. It has no sobriety requirement, treatment compliance, criminal justice history exclusions or minimum income requirements for enrollment or continued stay. Must include:

    - A structure(s) that meets the ESG's minimum habitability standards for Emergency Shelters
    - Provides Housing Focused Case Management that helps participants to develop and pursue a housing plan; provides information and referrals; housing problem-solving; obtain the documents needed for ESG or CoC PH program enrollment, such as verification of homelessness, and if applicable, chronic homelessness and/or disability, as well as the documents that are likely to be required by a landlord (I.e., government issued photo ID and proof of income); connecting to public benefits and income.
    - Serves as a point of contact for Rapid Exit, RRH and PSH during enrollment and housing search.
    - A trauma-informed care approach.
    - Provides a minimum of 2 meals per day. Three meals a day is a best practice.
    - No set lengths of stay in favor of pursuing the goal that all participants work on housing from day 1 and leave when they have it. Relocating to another shelter because time is up in the program is an outdated practice that negatively impacts system performance. Participants are expected to actively participate in a housing plan while in shelter.

4. **Optional Elements or best practices**: Reduces barriers further by accommodating partners, pets and possessions and eliminating curfews and other restrictions more appropriate for adolescents than adults.

    Connect participants to health, behavioral health, and substance use services whenever possible and desired by resident.

5. **Access and Operating Hours:** Shelters are expected to be accessible to participants 24/7 and must have staff on-site whenever the facility is occupied. Security may vary based on site location and population served.

6. **Referral, Enrollment and Exit:** The CoC seeks to fill an increasing portion of beds through CORE teams moving the most vulnerable indoors. It also wants to be sure all shelter capacity is utilized. Contracts will indicate whether beds are to be filled through CORE or more broadly. Those filled by CORE must adhere to that agreement.

   Shelters can make referrals to the Community Queue after completing the housing needs assessment (VI-SPDAT). Staff should continue Housing Problem Solving and document readiness even after referrals to Community Queue have been made.

   Participants enrolled in Emergency Shelters can be co-enrolled with Rapid Exit or RRH and PSH during the housing search period. Participants should not be co-enrolled in CORE or CARE Center case management. Once moved into housing, they should be exited from Emergency Shelter. Participants exited from a shelter program may continue to be assisted by other CoC and ESG programs.

   Participants who are being terminated must get written notice and have the right to appeal per 24 CFR 578.91(b)&(c), HUD's termination of assistance policy.

7. **Continuum of Care Capacity and Anticipated Turnover:** In 2020, Emergency Shelters served 2,448 people (1,599 households) in 600 beds. It is anticipated they will have the capacity to serve a minimum of 2,400 people in program year July 1, 2022-June 30, 2023. This assumes each shelter bed is used by 4 people each year. There are not enough shelter beds to offer one to every person experiencing homelessness at any point in time. The gap between need and availability is greater for singles and transition aged (?) youth than families with minor children. Turning over shelter beds more frequently because people exit to housing is the most efficient way to expand shelter capacity.

8. **Staffing:** Shelter Attendant/Peer Advocate/Shift Coverage: Provides day to day, operational support such as welcoming incoming clients, providing and ensuring a safe environment, milieu management, meals and security and crisis de-escalation as needed.

   Housing Focused Case Manager: Conducts shelter intake, enrolls in CES, conducts Triage Tool, and the Housing Needs Assessment (VI-SPDAT) if not already completed by CORE or CARE Center. Provides Housing Problem Solving beginning at intake and continuing throughout stay, which includes working with the resident to develop a housing plan and remove barriers to housing such as acquiring documents as described above. Refers to Community Queue. Connects to public benefits and other needs. Assists RRH and PSH programs when participant is in housing search. Each FTE would carry an active caseload of 25-30 participants.

9. **HMIS Participation:** All federally and state funded shelter projects are required to participate in HMIS per the HUD standards and CoC HMIS Policies and Procedures adopted May 6, 2021. Participation includes identifying an HMIS administrator, within each agency, who not only helps to set up programs, but monitors the project to ensure data accuracy, completeness, and security ongoing.

10. **Performance Standards:**

    a) Less than 5% of eligible referrals are declined

    b) Maintain 85% occupancy in family shelters and 90% in adult only shelters. This will be adjusted when shelters need to function at reduced capacity for public health reasons.

c) Exits to housing (permanent or temporary), using the destinations in HMIS, are 40% or greater or show a 10% improvement if placements were below 30% in previous program year. Excludes exits to TH except for TAY. Excludes exits to other shelters. Includes temporary housing not funded by system of care and exits to RRH and PSH.

d) Year 1 will track % of people who enter program without housing documents and % who have them by exit to set performance benchmarks for 2023-2024 contracts.

e) 40% of those who enroll in the program without health insurance, have acquired it by program exit/annual update, or project shows a 10% improvement from prior year if rate is below 30%.

f) 40% of those who enroll in the program without non-cash benefits, for which they would be eligible, have acquired those benefits by program exit/annual update, or project shows a 10% improvement from prior year if rate is below 30%.

g) Fewer than 20% of participants exit to unsheltered homelessness, or project shows a 10% improvement if exits are above 30%

h) Exits to unknown destinations are 20% or less, or project shows a 10% improvement if exits are above 30%

j) *Equity Measure 1*-- Program demonstrates racially equitable service delivery and outcomes as described below:

   a. CORE referrals and other intakes are accepted in rates comparable across racial groups

   b. The rates of obtaining housing and securing needed documents and benefits are comparable across racial groups

   c. No racial group should be disproportionately terminated from assistance

   Data from HMIS disaggregated by race will be used to measure this performance standard.

i) *Equity Measure 2*--Each level of an organization from frontline staff, executive leadership and board membership needs to include people with lived experience and reflect the populations being served, by race and gender.

j) Meet data quality standards as outlined in CoC HMIS Policy and Procedures' Data Quality and Monitoring Plan.

   a. An error rate of no more than 5% for null/missing and unknown/don't know/refused responses for all UDEs and program specific data elements excluding Domestic Violence and Social Security Number.

   b. Data entered within three days of service event including entry and exit.

   Evidenced by submission of the Enrollment Report monthly and Data Quality Report quarterly.

j) *Customer Satisfaction Measure*—Consumers will indicate satisfaction with program services in multiple domains, such as helpfulness, respectful treatment, accessibility, etc. Data will be gathered using a tool(s) or method(s) **developed or selected by a consumer lead work group**. As with other new measures, data will be gathered in year one of the contracts to establish the baseline of performance and set the benchmark for future years

V. CARE Centers and CARE Center Case Management

1. **Purpose:** To serve as a Coordinated Entry access point for people experiencing unsheltered homelessness by providing a safe, accessible place for people to access basic needs such as showers, laundry, mail, meals, hygiene kits, information, and referral, and for a limited subset of participants—housing focused case management. As a CE access point, CARE Centers and CARE Center Case Management also conduct intakes and enrollments into the CES program, triage tools and the Housing Needs Assessment (VI-SPDAT) and refers to the Community Queue.

2. **Eligible Population and Prioritization:** CARE Centers are intended to serve people who are experiencing unsheltered homelessness, though people at risk of homelessness are not turned away from the drop-in services. Housing focused case management is limited to people experiencing unsheltered homelessness. Case Managers will prioritize persons who have been homeless the longest and with the most acute needs for case management support.

3. **Required Elements:** CARE Centers are a low barrier, low demand resource center for people experiencing unsheltered homelessness. All services are voluntary. The model is Housing First and has no sobriety requirement, treatment compliance, criminal justice history exclusions or minimum income requirements for enrollment or continued participation. The model has two distinct components:

    - Drop-In Centers—low barrier location where participants can get out of the weather, receive mail, hygiene kits, showers, laundry, and meals. Staff conducts CARE Center intakes, enrollments into the CES program and triage tools.

    - Housing Focused Case Management for a sub-set of CARE Center participants who are active. Active is defined as coming to the CARE center at least 1 time per week. Helps participants to develop and pursue a housing plan; assists in applying for benefits and increasing income, housing problem-solving; supports with obtaining the documents needed for ESG or CoC permanent housing program enrollment, such as verification of homelessness, and if applicable, chronic homelessness and/or disability, as well as the documents that are likely to be required by a landlord (I.e., government issued photo ID and proof of income).

    - Serves as a point of contact for Rapid Exit, RRH and PSH during enrollment and housing search.

    - Employ trauma-informed care practices.

6. **Optional Elements or best practices:** All drop-in participants, whether or not they get case management, get information about housing documents needed and where to find them, information about and referrals to public benefits including CalFresh and Medical, and any open housing lists to register for.

5. **Access and Operating Hours:** Services must be available during regular business hours for at least 40 hours per week. Evening and weekend hours are strongly encouraged as part of the 40 hours. Staff must be present when program is operating. Case managers can provide services over the phone or at the centralized service site.

7. **Referral, Enrollment and Exit:** 211 and CORE are the primary referral sources to CARE Centers. Self-referrals to drop-in centers are okay. Housing Focused Case Management selects literally homeless participants to work with from within the active drop-in population, based on the prioritization above.

   CARE Centers can make referrals to Rapid Exit if access to temporary or permanent housing outside the CoC has been identified and can be implemented with one-time assistance. Referral to the Community Queue occurs after completing the housing assessment/VI-SPDAT. Staff should continue h\Housing Problem Solving and document readiness even after referrals are made. Centers can also make referrals to Emergency Shelters that are not filled through CORE referrals.

   Participants enrolled in CARE Center Case Management can be co-enrolled with CORE, Rapid Exit, RRH or PSH during the housing search period. Participants should not be co-enrolled in Emergency Shelter. Once moved into housing or shelter they should be exited from CARE Center programs. Participants exited from CARE Centers may continue to be assisted by other CoC and ESG programs.

   Participants who are being terminated must get written notice and have the right to appeal per 24 CFR 578.91(b)&(c), HUD's termination of assistance policy.

8. **Continuum of Care Capacity and Anticipated Turnover**: In 2020, CARE Centers served 825 households. It is anticipated they will have the capacity to serve 800 households in the program year July 1, 2022-June 30, 2023. Up to 150 clients will be assisted by Housing Focused Case Management.

9. **Staffing:** Intake Specialist/Member Advocate— Ensures the smooth operations of the project in terms of welcoming safe environment, meals, and security. Creates HMIS record and conducts CARE Center intake (shortened version), enrolls client in the CES program in HMIS, and conducts Triage Tools. Determines whether someone is literally homeless and interested in Housing Case Management, makes referral in HMIS to Case Manager, reviews attendance for referring active clients and schedules appointments with Case Manager to begin housing Focused Case Management.

   Housing Focused Case Manager: Conducts intakes into the Housing Focused Case Management program, tracks services and case notes, Housing Needs Assessments (VI-SPDATs), makes referrals to Community Queue, Housing Problem Solving, works with participant to develop a housing plan and assists in applying for benefits and increasing income, housing problem-solving; supports with obtaining the documents needed for ESG or CoC PH program enrollment, such as verification of homelessness, and if applicable, chronic homelessness and/or disability, as well as the documents that are likely to be required by a landlord (I.e., government issued photo ID and proof of income), provides information and assists in applying for public benefits and other needs, assists Navigation, RRH and PSH programs when participant is in housing search. Each FTE would carry an active caseload of 25 participants for an average of 4 months.

10. **HMIS Participation:** All federally and state funded projects are required to participate in HMIS per the HUD standards and CoC HMIS Policies and Procedures adopted May 6, 2021. Participation includes identifying an HMIS administrator, within each agency, who not only helps to set up programs, but monitors the project to ensure data accuracy, completeness, and security ongoing.

11. **Performance Standards for Housing Focused Case Management Services:**

    a) Exits to housing (permanent or temporary) are 35% or greater or show a 10% improvement if placements are below 24%. Includes temporary housing not funded by system of care and exits to Emergency Shelter, TH and RRH and PSH.

b) Year 1 will track % of people who enter program without housing docs and % who have them by exit to set performance benchmarks for 2023-2024 contracts.

c) 35% of those who enroll in the program without health insurance, have acquired it by program exit/annual update, or project shows a 10% improvement from prior year if rate is below 24%.

d) 35% of those who enroll in the program without non-cash benefits, for which they would be eligible, have acquired those benefits by program exit/annual update, or project shows a 10% improvement from prior year if rate is below 24%.

e) Exits to unknown destinations are 30% or less or show a 10% improvement if exits are above 40%

f) *Equity Measure 1*-- Program demonstrates racially equitable service delivery and outcomes as described below:

   a. Intakes are done in rates comparable across racial groups represented at the drop-in program

   b. The rates of obtaining housing and securing needed documents and benefits are comparable across racial groups

   c. No racial group should be disproportionately terminated from assistance

   Data from HMIS disaggregated by race will be used to measure this performance standard.

g) *Equity Measure 2*--Each level of an organization from frontline staff, executive leadership and board membership needs to include people with lived experience and reflect the populations being served, by race and gender.

h) Meet data quality standards as outlined in CoC HMIS Policy and Procedures' Data Quality and Monitoring Plan.

   a. An error rate of no more than 5% for null/missing and unknown/don't know/refused responses for all UDEs and program specific data elements excluding Domestic Violence and Social Security Number.

   b. Data entered within three days of service event including entry and exit.

   c. 90% or greater of participants have been exited who have not had a service encounter within 120 days. Requires a minimum of 3 documented attempts to contact before exiting. Attempts to contact should be varied, including calls, texts, email, messaging through other providers in HMIS record, mail, etc.

   Evidenced by submission of the Enrollment Report Monthly and Data Quality Report quarterly.

i) *Customer Satisfaction Measure*—Consumers will indicate satisfaction with program services in multiple domains, such as helpfulness, respectful treatment, accessibility, etc. Data will be gathered using a tool(s) or method(s) **developed or selected by a consumer lead work group**. As with other new measures, data will be gathered in year one of the contracts to establish the baseline of performance and set the benchmark for future years.

VI. Outreach/CORE Teams

- **Purpose:** To serve as a Coordinated Entry access point to connect people experiencing unsheltered homelessness to the system of care, address their immediate health and safety needs, and assist them to move indoors. CORE teams are mobile and go where clients are, providing food, hygiene kits, blankets, rain gear and information and referral. As a CE access point, CORE outreach also conducts intakes and enrollments into the CES program, Triage Tools, and the Housing Needs Assessment (VI-SPDAT) and refers to the Community Queue in the field.

- **Eligible Population and Prioritization:** CORE Teams serve people who are experiencing unsheltered homelessness. People with the most acute needs and longest time homeless are prioritized for emergency shelter and/or ongoing engagement from the team.

- **Required Elements:** CORE Teams are a primary access and enrollment point for CES for people experiencing unsheltered homelessness. They are mobile, going to persons outdoors and providing transport to appointments as needed. The model is Housing First and has no sobriety requirement, treatment compliance, criminal justice history exclusions or minimum income requirements to receive assistance. Staff work with participants in three ways:

    - Engagement, enrollment, and warm hand-off to other interventions—this includes housing triage, establishing an HMIS record and information and referral. It can include Housing Problem Solving, conducting a Housing Assessment/VI-SPDAT, referring to the Community Queue and facilitating access to Emergency Shelter or Rapid Exit.

    - Continued work with participants who cannot or are not willing to access other services, continuing to meet survival needs, building trust and low-pressure housing problem solving.

    - Continued work with persons who are in the Community Queue for RRH or PSH but cannot access a CARE Center or Emergency Shelter in the interim. CORE Teams help participants to develop and pursue a housing plan; including support with obtaining the documents needed for ESG or CoC PH program enrollment, such as verification of homelessness, and if applicable, chronic homelessness and/or disability, as well as the documents that are likely to be required by a landlord (I.e., government issued photo ID and proof of income).

    - Link participants who are living unsheltered to health and behavioral health care services.

    - Assist participants who are unsheltered in applying for cash and non-cash benefits (medical, CalFRESH, CalWORKS, GA, etc.)

- **Optional Elements or best practices:** Though not always possible due to resource constraints, it is a best practice to provide transportation to and from appointments as needed for participants who are unsheltered and are unable to access other transportation services.

  Incorporate Licensed Clinical Social Workers on staff teams when possible. Provide comprehensive strengths-based, trauma informed, case management services to engage unsheltered and chronically homeless individuals and families in services.

5. **Access and Operating Hours:** Services must be available during regular business hours. Evening and weekend hours are strongly encouraged. Staff stay connected to participants primarily through visits to their unsheltered location but can use phone and drop-in sites as appropriate.

6. **Referral, Enrollment and Exit:** 211 is the primary referral source and callers are transferred to the CORE dispatch line. Cities that fund a CORE Team have direct and prioritized access to the team(s) they fund as well as privately funded teams (HDAP, HSP, Public Works).
   CORE makes referrals to CARE Centers and Emergency Shelters after enrolling them in CES program in HMIS. CORE can make referrals to Rapid Exit if access to temporary or permanent housing outside the CoC has been identified and can be implemented with one-time assistance. Referral to the Community Queue occurs after completing the Housing Assessment/VI-SPDAT. Even after referrals are made, staff should continue housing problem solving and document readiness (obtaining the documents needed for ESG or CoC PH program enrollment, such as verification of homelessness, and if applicable, chronic homelessness and/or disability, as well as the documents that are likely to be required by a landlord (I.e., government issued photo ID and proof of income)).

   Participants working with CORE teams can be co-enrolled in CARE Centers (meaning they can use the drop-in centers), Rapid Exit, and RRH or PSH during the housing search period. Participants should not be co-enrolled in Emergency Shelter or CARE Center Case Management. Once moved into housing or shelter they should be exited from CORE. Participants exited from CORE program may continue to be assisted by other CoC and ESG programs.

7. **Continuum of Care Capacity and Anticipated Turnover:** In 2020, CORE Teams served 3,755 households. It is anticipated they will have the capacity to serve at least that number in program year July 1, 2022-June 30, 2023.

8. **Staffing:** Outreach Workers: Participate in teams that include one Outreach Worker who serves as the team lead. Travel to unsheltered individuals to do health and welfare checks, pass out supplies, triage, screen, and connect people to services and places to stay indoors. Can work on document readiness if not connected to CARE case management. Must include HMIS data collection and entry.

   Dispatch staff: Screen referral calls and assign teams to go and locate unsheltered people and offer assistance.

   Coordinators: Provides leadership and direct supervision of staff for county-wide mobile and street outreach and develops and facilitates outreach strategies that will support those living outside to find and sustain housing.

9. **HMIS Participation:** All federally and state funded CoC projects are required to participate in HMIS per the HUD standards and CoC HMIS Policies and Procedures adopted May 6, 2021. Participation includes identifying an HMIS administrator, within each agency, who not only helps to set up programs, but monitors the project to ensure data accuracy, completeness, and security ongoing.

12. Performance Standards:

a) Exits to housing (permanent or temporary) are 35% or greater of those served. Includes temporary housing not funded by system of care and exits to Emergency Shelter, TH and RRH and PSH.

b) Year 1 will track % of people who enter program without housing docs and % who have them by exit to set performance benchmarks for 2023-2024 contracts.

c) 35% of those who enroll in the program without health insurance, have acquired it by program exit/annual update, or project shows a 10% improvement from prior year if rate is below 24%.

d) 35% of those who enroll in the program without non-cash benefits, for which they would be eligible, have acquired those benefits by program exit/annual update, or project shows a 24% improvement from prior year if rate is below 30%.

e) Exits to unknown destinations are 30% or less or show a 10% improvement if exits are above 40%.

f) *Equity Measure 1*-- Program demonstrates racially equitable service delivery and outcomes as described below:

   a. Different racial groups are assisted in rates comparable to their presence in the PIT Count

   b. The rates of obtaining housing and securing needed documents and benefits are comparable across racial groups

   c. No racial group should be disproportionately terminated from assistance

   Data from HMIS disaggregated by race will be used to measure this performance standard.

g) *Equity Measure 2*--Each level of an organization from frontline staff, executive leadership and board membership needs to include people with lived experience and reflect the populations being served, by race and gender.

h) Meet data quality standards as outlined in CoC HMIS Policy and Procedures' Data Quality and Monitoring Plan.

   a. An error rate of no more than 5% for null/missing and unknown/don't know/refused responses for all UDEs and program specific data elements excluding Domestic Violence and Social Security Number.

   b. Data entered within five days of service event including entry and exit.

   c. 90% or greater of participants have been exited who have not had a service encounter within 120 days. A minimum of 3 documented attempts to contact before exiting. Attempts to contact should be varied, including calls, texts, email, or messaging through other providers in HMIS record.

   Evidenced by the monthly submission of the enrollment report and quarterly Data Accuracy Report.

i) *Customer Satisfaction Measure*—Consumers will indicate satisfaction with program services in multiple domains, such as helpfulness, respectful treatment, accessibility, etc. Data will be gathered using a tool(s) or method(s) **developed or selected by a consumer lead work group**. As with other new measures, data will be gathered in year one of the contracts to establish the baseline of performance and set the benchmark for future years.

VII. Homelessness Prevention/Diversion

1. **Purpose:** To keep people from experiencing literal homelessness for the first time or returning to it after being permanently housed.

2. **Eligible Population and Prioritization**: Eligible households meet HUD's definition of "at-risk of homelessness" in 24 CFR 576.2. Assistance will be prioritized for those most likely to become homeless according to research-based criteria, which includes prior experience of homelessness. The prevention model includes the adoption of a standard assessment tool.

3. **Required Elements:** Those that meet the criteria for the most at risk are supported with Housing Problem Solving and, if needed, financial assistance to avoid time in Emergency Shelter or unsheltered homelessness. Homelessness prevention is provided based on need rather than proof of sustainability post assistance.

    - Housing Problem Solving to stabilize existing housing through non-financial means such as conflict resolution, landlord/tenant mediation, information and referral, and use of the household's natural supports.
    - Financial assistance can help with utility or rent arrears, first month's rent or deposit, other costs associated with relocating to more stable housing and/or other expenditures to help household stay in current housing, such as food vouchers or repairs. Holding a lease is not a requirement for homelessness prevention financial assistance. Financial assistance is capped at $3,000 for individuals, $5000 for families. Anything beyond that limit requires a consultation with the Coordinated Entry Manager.

4. **Optional Elements or best practices**: Secure commitment from landlord not to pursue eviction/canceling of the lease after payment.

5. **Access and Operating Hours:** Services must be available during regular business hours, though a full 40 hours is not required. Evening and weekend hours are strongly encouraged. Staff can provide services over the phone or at the centralized service site.

6. **Referral to and from, Enrollment and Exit**: Homelessness Prevention/Diversion may receive referrals from 211 or RRH or PSH programs. Referrals are made directly to the program, not through Coordinated Entry.

    Participants enrolled in Homelessness Prevention/Diversion can be co-enrolled with PSH and RRH. Participants should not be co-enrolled in programs that require participants to be literally homeless, CORE, CARE, Emergency Shelter, and Rapid Exit.

    Participants are exited from Homeless Prevention/Diversion after the 30-day, post-housing stabilization follow up contact has occurred. Households exited from this model are typically exited from the system of care.

7. **Continuum of Care Capacity and Anticipated Turnover:** In 2020, Homelessness Prevention and Diversion served 129 households. It is anticipated the model with have the capacity to serve an estimated 240 households in program year July 1, 2022-June 30, 2023.

8. **Staffing:** Prevention/Diversion Specialist: Conducts screening, intakes/assessments, housing problem solving, evaluates and approves financial assistance. Each full-time equivalent can assist up to 180-240

households a year, or an average of 15-20 per month. The number of households who will get financial assistance will be fewer.

9. **HMIS Participation:** All federally and state funded prevention/diversion projects are required to participate in HMIS per the HUD standards and CoC HMIS Policies and Procedures adopted May 6, 2021. Participation includes identifying an HMIS administrator, within each agency, who not only helps to set up programs, but monitors the project to ensure data accuracy, completeness, and security ongoing.

10. Performance Standards:

a) Fewer than 20% of those assisted fall outside of the priority populations per the selected screening tool.
b) Exits with a permanent or temporary housing solution that divert household from homelessness are 70% or greater or a 10% improvement over prior year if it is less than 60%.

c) Fewer than 10% of participants exit to unsheltered homelessness.

d) Exits to unknown destinations are 30% or less or show a 10% improvement if exits are above 40%

e) *Equity Measure 1*-- Program demonstrates racially equitable service delivery and outcomes as described below:
   a. Different racial groups are assisted at rates comparable to their rates in the extremely low-income renter population per American Community Survey data
   b. The rates of retaining housing are comparable across racial groups
   c. No racial group should be disproportionately denied assistance

   Data from HMIS disaggregated by race will be used to measure this performance standard.

f) *Equity Measure 2*--Each level of an organization from frontline staff, executive leadership and board membership needs to include people with lived experience and reflect the populations being served, by race and gender.

g) Meet data quality standards as outlined in CoC HMIS Policy and Procedures' Data Quality and Monitoring Plan.
   a. An error rate of no more than 5% for null/missing and unknown/don't know/refused responses for all UDEs and program specific data elements excluding Domestic Violence and Social Security Number.
   b. Data entered within three days of service event including entry and exit.

   Evidenced by the monthly submission of the enrollment report and quarterly Data Accuracy Report.

h) *Customer Satisfaction Measure*—Consumers will indicate satisfaction with program services in multiple domains, such as helpfulness, respectful treatment, accessibility, etc. Data will be gathered using a tool(s) or method(s) **developed or selected by a consumer lead work group**. As with other new measures, data will be gathered in year one of the contracts to establish the baseline of performance and set the benchmark for future years.

Conclusion and Next Steps

The revised program models and performance standards incorporate the community feedback and have been improved by it. For example, clarifying the meaning of the racial equity measures and how they would be measured as well as including a performance metric related to consumer satisfaction will enhance the transparency and accountability of the CoC and its providers. In general, community members felt strongly that the models as described would improve the quality of care and outcomes experienced by consumers. Providers also expressed optimism that these standards would make their jobs clearer and collaboration across the system more seamless. The community also had recommendations for future work to improve the system.

Staff recommends the CoC Oversight Committee adopt and publish the models as revised in this report. Staff will then facilitate:

- Incorporating the models and performance measures into provider contracts
- Developing and training on HMIS report templates for documenting performance
- Selecting or developing tools such as the Prevention Assessment and the Consumer Satisfaction survey
- Training on new model components or refreshing on existing ones such as:
    - Critical Time Intervention (CTI) (NEW)
    - Trauma-Informed Care (REFRESH)
    - Harm Reduction (NEW)
    - Document Readiness & Housing Focused Case Management (REFRESH)
    - Referrals to Rapid Exit (NEW)
    - Problem Solving (REFRESH)
    - Triage Tool (REFRESH)
    - Housing Needs Assessments (VI-SPDAT) (REFRESH)
    - Follow ups after exit (NEW)
    - Community Queue Referrals (NEW)
    - Accepting & Denying Referrals (REFRESH)
- Continuing work to align CES and HMIS policies and procedures with these and other system improvements
- Providing other ongoing technical assistance
- Implementing, evaluating, and refining these models in future years

The CoC Oversight Committee can consider how and when it wants to address feedback that was beyond the scope of this project for this year including:

- Operationalizing a way for RRH participants who need it, to transition to PSH
- Mechanism for private contributions to Rapid Exit and Diversion Resources
- Supporting Emergency Shelters to adopt best practices and reduce barriers
- Explore ways to incorporate more peer staffing into program models
- Consider new Program Models for people experiencing unsheltered homelessness—Safe Parking and Sanctioned Encampments
- Build more affordable housing
- Address encampment sweeps

Appendix A
Consolidated Community Feedback

Appendix – Cataloging of Comments

We received comments from a variety of sources and channels. Contracted providers, non-contracted providers, community members, people with lived experience and other various stakeholders provided feedback via a community meeting, office hours, email, and survey. All comments were received, reviewed, and responded to accordingly. In this appendix, comments are ordered by model and categorized by clarification, modification to existing models, parking lot, systems issues, and general comments.

Permanent Supportive Housing

Community Meeting Comments and Questions

Anything that was unclear?

Question: "Eligibility for folks with that don't qualify for PSH due to charges."

Response: CoC and ESG funded programs are not required by HUD to exclude applicants with criminal backgrounds, and HUD encourages CoCs to adopt the Housing First approach noted here. Housing Authorities and Non-profit developers may be required or choose to exclude applicants with criminal convictions, limiting access to units for which PSH vouchers are accepted. This reality requires advocacy and resourcefulness from staff. No changes to model language.

Question: "Are these outcomes aligning with what HUD is looking at for this program model?"

Response: "Yes, all outcomes align with HUD expectations as well as best practices for the particular model."

Question: "When we talk about PSH, what exactly does that mean? Which programs, locations, funding programs, etc.?"

Response: Permanent Supportive Housing (PSH) in the program models refers to all PSH programs that receive CoC funds and/or are contracted with the CoC. Some PSH units are scattered site and some PSH programs are site-based.

Question: "is the Shelter Plus Care PSH program included here? And if so, the staffing ratio is off and what is the system prepared to do to meet the 1:15 staffing ratio?"

Response: Yes, the Shelter Plus Care program is included in the permanent supportive housing program model. Each contracted provider will have an opportunity to conduct a self-assessment to ask for additional resources needed to align with the program model.

Question: "Does the PSH model include strategies to create more units?"

Response: Outside of the scope of this project. See comments in Chapter One, Section Six.

Question: "Are we talking about PSH as an overall for the county or for individual organizations?"

Response: Permanent Supportive Housing (PSH) in the program models refers to all PSH programs that receive CoC funds and/or are contracted with the CoC.

Question: *"*Will HMIS be set up to have a dashboard and/or canned report based on these standards? And will we enter data regarding every standard in HMIS?"

Response: Addressed in Chapter One, Section Six.

Question: "Will paper report templates due to the County be revised to reflect/capture these outcomes? For a few of our programs, we must run five different HMIS reports and count by hand from internal spreadsheets to complete the quarterly reports (which do not mention or list the contract's performance standards)."

Response: Addressed in Chapter One, Section Six.

Question: "PSH page 7, X.g: and RRH page 10, X.1: *"Staff, Leadership, and board membership include people with lived experience…reflective of populations being served..."* How will this target be set? How will it be measured?"

Response: Addressed in Chapter One, Section Four.

Question: "Page 7, X.a: *"Less than 5% of eligible CE referrals are declined"* Is it possible to add the word "appropriate" in the language? For example, we may get an eligible referral to fill a vacant unit on the second floor, but the client is not physically able to walk up and down stairs every time they enter/exit the unit."

Response: Language in the program models is unchanged. However, the matching process between the housing provider, current provider and the coordinated entry team will take this into consideration and match accordingly.

Question: "Page 7, X.b: *"Maintain 95%-unit occupancy/voucher utilization unless program is in lease up phase."* We have had trouble maintaining occupancy due to delays getting appropriate referrals for the open vacancies. And sometimes we get only one referral at a time for an opening, which means if that first applicant doesn't work out, we have to wait for a second referral, which stretches out the time a unit may be vacant*."*

Response: The coordinated entry team will work with housing providers to provide up to 3 referrals per open unit.

Question: "Page 7, X.d: *"Housing retention and exits to permanent housing combined is 96% or greater."* Will this be adjusted according to program size? In one program, if only one household exits to a non-permanent destination, we won't meet this standard. In another program, only two individuals could exit to a non-permanent destination. And if/how will discharges to higher levels of medical care (that may be required for some of our senior residents) be counted? As of now, these are exits to non-permanent destinations."

Response: Because persons housed in PSH are disabled and often older, there may be times tenants exit the program to institutional care, which HUD has classified as non-permanent. The CoC cannot change that exit destination. H3 can, in conversation with providers, use its discretion when determining if smaller programs that have 1-2 exits to non-permanent destinations, causing their performance on PH retention/exits to drop below 96% can still be considered to have met the benchmark.

Question: "Page 7, X.f: *"Program demonstrates equitable service delivery…"* How will this target be set? How will it be measured? This is directly influenced by the demographics of the referrals each provider receives – how will this be accounted for?"

Response: See Chapter One, Section Four regarding equitable service delivery.

What aspects of the description confirmed what is already happening?

Comment: "All the required elements are happening, but optional elements are not happening. Moving on is available for the first time but it's unclear whether it will continue. Not sure if all referrals are coming document ready."

Response: Optional elements are optional in the upcoming contract year. Moving on is not currently part of the Permanent Supportive Housing (PSH) program model. Moving on policies can be found in the CoC Written Standards. H3 will continue to pursue moving on strategies and projects whenever possible. As for document readiness, referrals to PSH are required to be document ready upon referral. The emphasis is on crisis response service providers to work on document readiness immediately.

Comment: "Unsure about how we are prioritizing in PSH"

Response: PSH prioritization is by housing needs assessment score and length of time homeless.

Comment: "With wrap around case management, may also come in with other goals, and other care may not be set up, goals of family reunification."

Response: Permanent Supportive Housing (PSH) program model unchanged. Case management may include family reunification though not a requirement.

What aspects of the model description were new or different from current operations?

Comment: "PSH is a wide umbrella term with varying case management, some programs require a lot of case management while others require very little."

Response: PSH programs are required to provide supportive services like case management to consumers who want to service. The level of case management will be dependent both on consumer need and grant/funding requirements.

Comment: "Housing retention of 96% can be tricky for small provider. IE our adult PSH program houses 48 highly vulnerable singles would fall below if more than 2 move into medical facility (not considered permanent)."

Response: See Permanent Supportive Housing (PSH) performance standards for updated language. Because persons housed in PSH are disabled and often older, there may be times tenants exit the program to institutional care, which HUD has classified as non-permanent. The CoC cannot change that exit destination. H3 can, in conversation with providers, use its discretion when determining if smaller programs that have 1-2 exits to non-permanent destinations, causing their performance on PH retention/exits to drop below 96% can still be considered to have met the benchmark.

Any comments on the staffing ratio and functions?

Comment: "The staffing ratios do not seem to be universally in place across programs. And it seems like 1:15 should vary depending on if we are working with singles or families."

Response: The staffing ratio of 1 staff per every 15 is referring to households. Please see staffing description in the Permanent Supportive Housing (PSH) model. Model unchanged.

Comment: "How to achieve staffing ratios due to funding."

Response: During the self-assessment phase, contracted providers can ask for additional resources to fulfill the obligations set in their program model prior to contracts starting on July 1st, 2022.

Comment: "Suggest not just case management but support services staff ratio for programs, because property management team will impact ratios."

Response: See Permanent Supportive Housing (PSH) model description of staffing which includes both case management and property management staff.

Any comments on the performance measures?

Comment: "Occupancy rate of 95% is highly dependent on appropriate and referrals, providers can't always control vacancies due to the CE system and HA partnership, needs to be built into performance measures."

Response: See Chapter One, Section Six regarding occupancy rates.

Comment: "Percentage reflecting current capacity is very different for larger programs vs smaller programs, ex: site-based programs may need time to rehab units for new clients, need to factor in the different types of programs +1."

Response: Performance standards are unchanged in the PSH model, however, rehabbing of units and other factors will not be held against providers.

Comment: "I like the idea that performance measures are tied to Funding program targets and goals. Whether they are realistic in our market is the challenge."

Response: Thank you for your feedback and noted. That's why it will be important for H3 and contracted providers to evaluate the effectiveness of this iteration of the program models after year one.

Comment: "I'm not sure the 'optional' elements of best practices can be accomplished without additional funding."

Response: Optional elements are optional however, if providers need additional resources, it is encouraged to ask for what you need during the self-assessment phase prior to contract implementation starting on July 1st, 2022.

Comment: "timelines can be a challenge at times during the pandemic."

Response: Thank you for your feedback and noted.

Survey Comments

Do you have any other comments you would like to add about the PSH model?

Comment: "1- The outcomes were not clearly identified in the pdf to answer item #6. It needs its own section to be clear on how those outcomes will be measured. 2- There are no measurements that include asking the clients how the program works for them. 3-Permanent Housing should be offered for 1-2 years to individuals who are chronically ill and recovering from surgeries or illness as prescribed by a medical professional (not necessarily a state disability department) allowing the individual to get to full recovery, and exit into different programs once they can gain employment again. 4) It is not clear enough if PSH being offered to families, where the main household member is disabled. Homelessness separates families, and PSH should allow families to be reunited where the main parent/household guardian can get help. Households should not be limited to families with children, families can be of different mixed status and ages with adult children who are also trying to recover from the impacts of homelessness having experienced it with their family members. Families should not be discriminated against, and it should be clear that families can be of all ethnicities and from the LGBTQ+ community. 5) In all application forms, include an option for race and ethnicity "indigenous." Not all individuals identify as Hispanic or Latino/a. Use indigenous, Chicano/a/e as well."

Response: See the equity measure (#6) in Chapter One, Section Four for clarification. For consumer satisfaction, see Chapter One, Section Seven. Permanent Supportive Housing is offered for as long as the household needs assistance. See the Rapid Rehousing (RRH) model description regarding time limited assistance. A family who enters a permanent supportive housing (PSH) program must have a permanent disability to qualify. In most cases, the head of the household must have a permanent disability for the household to qualify for assistance. PSH does not require a household to be physically healthy or work. PSH is permanent rental assistance which is different from Rapid Rehousing (RRH). See the RRH program model description for clarification. The kind of family a particular PSH program can serve is dependent on the grant requirements. Families with mixed status or composition are served whenever possible. Application forms are outside of the scope of this project.

Comment: "Housing First must be enforced since PSH programs do not currently support Housing First models."

Response: Housing First is a requirement for all HUD/CoC funded PSH programs. Providers are trained yearly on the Housing First model. Providers are encouraged to reach out to the Coordinated Entry Manager at H3 if issues related to Housing First arise.

Comment: "Recommendation to separate Performance Standard e. so the measure for health insurance and non-cash benefits are separate as on the APR."

Response: See the Permanent Supportive Housing (PSH) model under performance standards to reflect this change.

Comment: “Research has shown this to be the most effective model to reduce homelessness.”

Response: Thank you for your feedback and we agree.

Comment: “Section III (required elements) part B: "Staff are required to be proactive in reaching out to participants to identify and provide supportive services" I feel this doesn't happen. Staff needs support to get this kind of service.”

Response: Thank you for your feedback. During the self-assessment phase, contracted providers can ask for what they need to fulfill their contract obligations including any support or training.

Comment: “There should be a measurement which includes how the client thinks the program is working. The outcomes need to be more clearly defined in #6. Permanent Housing should be offered for 1-2 years to those who are chronically ill or recovering from surgeries or illness. Families need to be kept together and that can include adult children.”

Response: Consumer satisfaction is addressed in Chapter 1, Section 7 and PSH model description. The equity outcome (#6) is addressed in Chapter 1, Section 4 and in the PSH model description. Permanent Supportive Housing is offered for as long as the household needs assistance. See the Rapid Rehousing (RRH) model description regarding time limited assistance.

Comment: “Under Performance Standards, I don't see any measure that involves asking clients how the program works for them.”

Response: See Chapter One, Section Seven and Permanent Supportive Housing model description.

Comment: “Very much appreciate the "housing first" focus. I hope eligibility is structured to apply to families and couples where one family member's disability has affected the whole family's ability to remain housed, and that the family could get PSH together in that case. I also hope it would be offered to people recovering from serious injury or illness until they become able to work again.”

Response: A family who enters a permanent supportive housing (PSH) program must have a permanent disability to qualify. In most cases, the head of the household must have a permanent disability for the household to qualify for assistance. PSH does not require a household to be physically healthy or work. PSH is permanent rental assistance which is different from Rapid Rehousing (RRH). See the RRH program model description for clarification.

Rapid Rehousing

Question: “Page 9, iii.b-f: *“Required elements - use of CTI, securing non-cash benefits, quarterly assessment, locating housing, and post housing follow up”* We would like to hear more about how the CoC wants this implemented. We currently utilize most of the methods but aren’t calling it CTI.”

Response: Program models that are required to use Critical Time Intervention (CTI) will be provided training on that approach. This is addressed in Chapter One, Section One.

Question: "How will letter "b" be measured? And as we understand CTI, letters "c, d, and e" are part of the CTI model – curious why they are listed separately."

Response: See Rapid Rehousing (RRH) model description for clarification regarding CTI.

Question: "A CTI element that we don't yet adhere to are caseload sizes of 20 (our contract states 25 – and our contract targets are loosely based on that ratio). Will contract targets be adjusted to fit the model?"

Response: 2022-2023 contracts will be adjusted to reflect what is in the performance standards including caseload sizes.

Question: "Regarding letter "f", how is this work accounted for in caseload ratio size? In our experience, after-care and program follow ups are not allowed for in the resources or funding – it is on the provider to add that to our plates as a free service."

Response: Every contracted provider will have the opportunity to complete a self-assessment on your current program model. In that assessment, providers are encouraged to ask for what resources they might need to successfully implement these changes within the program models. After-care is not part of letter "f" in the RRH program model. Six months of follow ups post subsidy is part of HUD and ESG funded RRH models. Model description has not changed.

Question: "Page 10 VI.d: *"Participant who must be exited…""* We see a conflict as our contract/program agreement set by the funder states that clients can be exited for continued non-engagement – how does the CoC expect a program to work with someone who is not in communication with the program?"

Response: There will be times where the expectations laid out by your funder and these new program models might not match. Address that during H3 contract negotiations. Regarding program engagement, it is necessary to engage in some level to obtain and maintain housing. The Rapid Rehousing program model simply reiterates that services such as on-going case management are in fact voluntary. The RRH program model did not change.

Question: "Re: "*participants exiting RRH are typically exiting the system of care*" – is it possible to list instances of when a client may exit RRH but go to another model/level in the CoC/"

Response: Yes, absolutely. This is referred to as a transfer and will be reflected in the Written Standards and Policies and Procedures. See RRH model description for clarification.

Question: "Page 10, X.b: *"75% of participants have moved into housing…"* This is the only standard we have not yet seen - how this will be measured? Would it be per fiscal year…so if 100 clients were enrolled in a fiscal year, 75 of those 100 clients would need to be housed in the same fiscal year? would the 120 days from enrollment to housing be figured in (so referrals received in the last few months of the fiscal year would not be counted)?"

Response: 75% of participants have moved into housing refers to any point-in-time during contract year. The goal of this measure is to ensure subsidies are being utilized and consumers are being housed. It is the RRH equivalency of an occupancy measure.

Question: "Page 10, X.e: *"80% of those who have exited will be housed at 180 day follow up"* This is a higher target than we have seen elsewhere. What is the national average? And how will providers be held accountable for circumstances after program and beyond our control that may cause people to lose housing?"

Response: 80% is the national average. However, it is understood and noted that there will be circumstances beyond the control of the program that could cause participants to lose their housing.

Question: "Many clients change phone numbers and/or don't respond to follow up attempts, despite our best efforts. How will this be factored into the measurement? Would we be able to provide $100 gift cards as incentive for replying?"

Response: The follow up attempts can be tracked in HMIS and if participants are not reachable, the program will simply document that and that the attempt was made. The Rapid Rehousing (RRH) model language has been changed to clarify follow-up attempts, see RRH model performance standards. The gift card incentives will be up to each program whether they want to provide or not.

Community Meeting Questions and Comments

Anything that was unclear?

Question: "The expiration of housing certifications. Do these certifications expire? People have been denied perm housing when enrolled RRH."

Response: Documents needed for housing such as an application, proof of income, verification of homelessness can all expire and usually need to be dated within 30 days. The case manager working with the applicant can assist in providing the most up-to-date documents. Eligibility for permanent housing when enrolled in Rapid Rehousing is on a case-by-case basis.

Question: "Is there a difference between support and navigation services because this doesn't align with some program guidelines."

Response: Support services refers to case management services and navigation services refers to housing location services.

Question: "Challenges with CTI, finding the resources, where are we going to find these resources, where do we connect folks to prepare them for stable housing?"

Response: There will be critical time intervention training for all providers who are required to implement this approach.

What supports are needed to ensure the success of prioritizing those with the severe service needs and longest histories of homelessness for Rapid Rehousing?

Comment: "CTI model and after care to sustain housing. Additional funding to help house the 290's."

Response: We agree. Regarding serving households who may be on the sex offender registry, see Chapter 1, section 6.

Comment: "The pitch to clients about RRH may be interpreted as they are not able to be housed without a job."

Response: Thank you for your feedback. We want to reiterate that employment is not a prerequisite for enrolling or being housing in a Rapid Rehousing (RRH) program. The ability to obtain and maintain steady income is essential for participants success in a RRH program overall and RRH case managers will work with consumers towards that effort.

Survey

What resources or additional support may be needed to ensure households with the greatest needs and longest histories of homelessness are prioritized for RRH?

Comment: "Under Best Practices, Unhoused needed RRH, should recessive assistance with attaining their documents should they become complicated for the individual to physically or experience transportation issues. Under Performance standards, no mention of connecting unhoused in program enrollments with social work and mental health services. Currently, in RRH program unhoused are only sought after to participate if they have a job; interestingly, this model now says they will provide RRH even to those experiencing chronic homelessness/having been unhoused for a long period. So, the change is a good one, and I hope the person gets help with job search and resume support through the 24 months of being in the program to ensure they are successful."

Response: See Chapter One, Section Three for clarification under best practices for Rapid Rehousing (RRH). The Critical Time Intervention (CTI) model assists participants with accessing appropriate resources. Rapid Rehousing (RRH) operates under a Housing First model where having income is not a requirement to enrollment. The RRH model will continue to serve those who are chronically homeless, with no change in the program model. The RRH program is not a set 24 months but generally 6-12 months of assistance, on a case-by-case basis.

Comment: "Document Readiness and better communication from RRH providers"

Response: Document readiness is the primary responsibility of crisis response service providers such as CORE, CARE Centers and Emergency Shelters. Rapid Rehousing providers should continue to communicate with the referring provider during the intake process.

Comment: "Landlord education about the population that they are renting to."

Response: While the Rapid Rehousing model remains unchanged, the case manager/housing navigator can provide landlord supports to help mitigate any issues that might arise.

Comment: "so many moving pieces outside of the programs control from referral to housing availability."

Response: Thank you for your feedback. H3 recognizes the challenges providers face that are often outside of their control.

Comment: "Mental health assessment and support, substance abuse assessment and support, physical health assessment and support, wrap around services, family therapy."

Response: Critical Time Intervention (CTI) can help individuals access appropriate services. The model description for Rapid Rehousing (RRH) has not changed.

Comment: "Households with extensive needs and long histories of homelessness, may need to be identified around month 9 or 12 for PSH opportunities if it does not appear they will maintain a sustainable permanent housing outcome from RRH programs."

Response: All households are evaluated month by month to determine continued need regardless of needs or length of time homeless. Households who entered Rapid Rehousing chronically homeless and have a permanent disability are eligible for Permanent Supportive Housing (PSH). The CoC Written Standards have a transfer policy

between RRH and PSH. However, more work will need to be done in the Coordinated Entry Policies & Procedures to operationalize that practice. See Chapter Two on community feedback regarding this topic.

Comment: “This program does not seem to prioritize households with the longest history of homelessness.”

Response: The Rapid Rehousing (RRH) program currently prioritizes the highest housing needs assessment score and highest length of time homeless. While also utilizing dynamic prioritization where households are matched based on individual need and availability of housing programs.

Comment: “Look at routines of individuals. The why behind chronic homelessness and address that. Mental health services by way of peer support, building a peer community.”

Response: While peer support is not part of this iteration of the program models, H3 is committed to continue exploring models of peer support in future iterations. See Chapter Two on community feedback regarding this topic.

Comment: “H3 Staff that fully understand all the programs, contact people, and process.”

Response: Thank you for your feedback.

Comment: “Need to connect unhoused with social work & mental health services.”

Response: Outside of the scope of the Rapid Rehousing program model (RRH).

Comment: “Regarding being "document ready": "in situations where a household is at the top of the Community Queue and still needs some documents, the RRH program staff can assist if they have capacity." I suspect this assistance will need a higher priority than "if they have capacity."

Response: Gathering documents can be difficult. That is why it is required that crisis response service providers such as CORE, CARE Centers and Emergency Shelters work immediately on document readiness and suggested documents get uploaded into the Homeless Management and Information System (HMIS) for the Rapid Rehousing provider to access.

Comment: “Some of those most in need will need assistance with application processes/paperwork for this and associated services.”

Response: All individuals and families referred to a Rapid Rehousing program will receive assistance in gathering their documents and completing any necessary paperwork. If applying for housing within the Rapid Rehousing program, the case manager/housing navigator will work with the consumer to complete all necessary applications and paperwork.

Comment: “Don't think any of it is reasonable nor should just one set of conditions be prioritized.”

Response: Thank you for your feedback. The Rapid Rehousing (RRH) model is unchanged.

Comment: “More workers less case load.”

Response: Thank you for your feedback. The Rapid Rehousing (RRH) model is unchanged.

Comment: “The time between entering the program and getting housed is not correct. I have been on the list for over a year. Still living in a tent, still employed. I am not satisfied with Core.”

Response: Thank you for your feedback and we apologize you are not satisfied. The time between enrollment and housing is a new requirement that will be a performance standard in the 2022-2023 contracts. Should you wish to make a complaint, please see the CoC Complaint process here: https://cchealth.org/h3/coc/pdf/Complaint-Form-Process.pdf.

Comment: "Help with child care, possibly tutor."

Response: Connecting families to childcare and tutoring in their new housing is an appropriate resource link to be made in the CTI model.

How would you recommend programs document follow up attempts and results?

Comment: "Document individuals challenges and successes Document the individuals' reasons for hiccups in the programs Document the individuals' experiences with staff, leadership, and CTI - programs services they were connected to. Document the individuals' complaints, and improve services asap to adjust to the client Share documented challenges and successes with funders Document the client's journey, pre-program and during to show progress."

Response: See Chapter One, Section 7 on consumer satisfaction.

Comment: "They need to provide multiple ways they attempted to contact it seems that if someone does not answer the phone the attempt stops and it is looked at if the client is not responding."

Response: Yes, follow up attempts should be varietal whenever possible. Via phone, email, text in person or in HMIS whenever possible. See revised program models to reflect this change in program models that require follow up attempts.

Comment: "Salesforce."

Response: Thank you for your feedback. Contra Costa County and its homeless service providers utilize the Homeless Management and Information System (HMIS) as its database.

Comment: "case notes"

Response: Thank you for your feedback.

Comment: "Use the follow up assessment screen in HMIS to document attempts and results. 2 parts for Performance measure e.: e1) 80% of those who have exited will continue to be housed e2) 80% of those who have exited and were contacted continue to be housed."

Response: See the Rapid Rehousing program model to reflect the suggestion to utilize the follow up assessment screen in HMIS to document attempts and results of attempts as well as language in the model to address 80% of those who have exited and were contacted continue to be stably housed.

Comment: "I would recommend that a team should follow the clients through the process and in follow up. That way the clients will already know the providers and new relationships will not have to be established."

Response: Although changing staff can be disruptive during the housing process, Rapid Rehousing (RRH) providers are not required to have a team assigned to each individual household though maintaining the same staff member(s) makes sense. Model unchanged.

Comment: “in HMIS”

Response: Thank you for your feedback.

Comment: “centralized computer system across the County.”

Response: The Homeless Management and Information System (HMIS) is the centralized data system that homeless service providers use in Contra Costa County.

Comment: “some ideas are to 1) document the successes & challenges for individuals; 2) document the individuals' experiences with staff; 3) document the individuals' complaints; 4) Share documented challenges and successes with funders.”

Response: See Chapter One, Section 7 on consumer satisfaction. Although not required, sharing challenges and successes with funders is something providers can do.

Comment: “I would like to see much more focus on evaluation of programs by clients themselves. I don't see much of that in the Performance Standards. They seem to focus more on other people deciding how things have turned out for clients.”

Response: See Chapter One, Section 7 regarding consumer satisfaction.

Comment: “Gather details of individual experiences--successes, roadblocks, complaints--through a process that centers the voices/experiences of applicants.”

Response: See Chapter One, Section 7 regarding consumer satisfaction.

Comment: “Feel like no follow ups are really attempted. I have experienced nothing but failure in the entire system”.

Response: Thank you for your feedback and we apologize that you have not had a good experience within our system of care. We will have an opportunity for consumers to provide feedback and encourage you to do so. See Chapter One, Section 7 regarding consumer satisfaction.

Comment: “Every month for 1st 3 months then every 3 months for 6 to 9 months depending on their situations at those times and then after 6 months and then yearly.”

Response: The Rapid Rehousing (RRH) program model requires follow up attempts occur 30, 60, 90 and 120 days post housed. HUD and ESG funded RRH programs require 6 months of follow up.

Comment: “Centralized shared database - -but access to sharing information between agencies where applicable.”

Response: The Homeless Management and Information System (HMIS) is the centralized database that homeless service providers use in Contra Costa County. Much of the information tracked in HMIS is visible across agencies and programs.

Comment: “Electronic records or some type of written plan.”

Response: Electronic records can be in the form of case notes and follow up attempts documented in HMIS.

Do you have any other comments you would like to add about the RRH model?

Comment: “Unhoused individuals often experience being put on this program and being taken off the program because they are not employed, and their status changes often as they find employment stability. In this process they continue to be unhoused and are not connected to other housing programs that work for that person; they are left without hope and distrust of the County H3 programs.”

Response: Thank you for your feedback. Consumers in Rapid Rehousing (RRH) programs do not lose their eligibility due to not keeping employment. If a consumer cannot maintain some form of income, success in an RRH program will be difficult and will be evaluated on a case-by-case basis. If RRH is not the appropriate fit, the consumer will be referred to the Community Queue and the RRH program will inform both the Coordinated Entry team and referring provider.

Comment: “Being homeless makes it difficult to contact folks and attempts are not really made to find the individuals. As providers we should be able to flag and talk to each other in HMIS looking for the client.”

Response: Public Alerts can be posted in the consumer profile in the Homeless Information and Management System (HMIS). For training on how to use public alerts or other HMIS functions, please email H3’s Research, Evaluation and Data (RED) team at: h3redteam@cchealth.org.

Comment: “Success of the model overall depends on appropriate referrals, employment market and housing market as much or more than the actual programming.”

Response: Thank you for your feedback. See Chapter One, Section Six where this comment is addressed.

Comment: “Performance Standards recommendations: b) Recommend changing language to households because usually the HoH receives financial assistance. f) separate non cash benefits from health insurance because non cash benefits are only recorded for adults and health insurance is recorded for everyone.”

Response: Thank you for your feedback. See language in the performance standards in the Rapid Rehousing model to reflect this change.

Comment: “I think this model would be helpful for a limited number of individuals. However, it is not designed to help the chronically homeless.”

Response: The Rapid Rehousing (RRH) program model is designed to assist consumers, regardless of length of time homeless in obtaining and maintaining housing on their own. Because this program is short term in assistance, it is correct in saying this model will not serve most people in our system of care.

Comment: “there are some conflicts between what CTI recommends and what is in the performance standards and what is in our current contracts. To me, this is an indicator that this design and implementation process is moving too fast, and was designed to meet funders' needs and not provider needs.”

Response: Thank you for your feedback. Contracted providers will have the ability to address these concerns during contract negotiations. We encourage all providers to also complete the self-assessment prior to the 2022-2023 contract year to voice concerns such as these. Language in the Rapid Rehousing program model and in Chapter One, Section 1 has more detail regarding Critical Time Intervention (CTI).

Comment: “I have been told experiences of some unhoused clients being removed from this program for volatility in their job situation. This kind of experience is highly destructive of trust which programs depend on for success.”

Response: Consumers in Rapid Rehousing (RRH) programs do not lose their eligibility due to not keeping employment. If a consumer cannot maintain some form of income, success in an RRH program will be difficult and will be evaluated on a case-by-case basis.

Comment: "This appears to be a change from past policy in which people have lost their eligibility for the program if they can't keep consistent employment--losing a job and then losing assistance as a double whammy. I hope this is indeed changing and that residents could continue to be housed and receive assistance with seeking new employment."

Response: Consumers in Rapid Rehousing (RRH) programs do not lose their eligibility due to not keeping employment. If a consumer cannot maintain some form of income, success in an RRH program will be difficult and will be evaluated on a case-by-case basis. If a consumer loses their income while they are housed in RRH, the RRH program can flex the level of assistance provided and continue to support the participant in regaining income.

Comment: "Some issues that are unclear regarding requirements for participants - housing first is ideal but there are income requirements for housing; employment and income is needed for stability and it sates (this may be a clarity issue) that housing is regardless of participation or employment, and it sates something to the effect that communication and participation is not required. Following protocol of communication with staff and following up on support systems is what leads to stability; an expectation of gaining employment in order to increase income is very important. Where is the housing coming from that does not have a minimum income eligibility in a scattered site RRH model."

Response: Housing First is a requirement for all Rapid Rehousing (RRH) programs that received CoC funds or are contracted with the CoC to provide RRH. Income of any source whether earned or benefits or both are needed for long term stability and are not a requirement for referral and enrollment into RRH. Some level of engagement is required during the enrollment and housing process, however, participation in on-going case management services is in fact voluntary in a Housing First model. To be clear, the RRH program model does not have a minimum income requirement for referral and enrollment as that goes against Housing First. Some level of income will be necessary for households to maintain rent on their own after the RRH subsidy ends.

Rapid Exit

Community Meeting Questions and Comments

Anything that was unclear?

Question: "Why is the program named rapid exit? What about diversion? Are we artificially creating discrete categories?"

Response: This program model was previously called Rapid Resolution which encompassed both diversion and rapid exit. Diversion serves at-risk population and rapid exit serves literally homeless population. These are very different populations and cannot be mixed in HMIS.

Question: "What are the eligibility criteria?"

Response: Please see eligibility section in the Rapid Exit program model.

Question: “Concern about identified housing solution - shouldn't this happen through problem solving?”

Response: Yes, identifying a housing solution happens during problem solving prior to being referred to Rapid Exit.

Question: “How does this program model intersect with prevention? If a person becomes literally homeless, then they can participate?”

Response: Rapid Exit serves those who are literally homeless. Prevention/Diversion serves those who at at-risk.

Question: “Does this practice only live in rapid exit, or do the problem-solving principles carry over as best practices into other models?”

Response: Problem solving conversations happen at every entry point into our system of care.

Question: “Is there a natural backstop that people can be prioritized for? If we start with minimal intervention, how do we ensure there is more than one time assistance?”

Response: The Rapid Exit program model can only provide households with one time assistance. Households who need assistance more than one time can be served in other programs within our system of care such as Rapid Rehousing.

Comment: “Problem solving should be incorporated into all approaches. Diversion is where we should stop inflow into homeless response system.”

Response: Problem-solving is part of front door, crisis response services such as CORE, CARE Centers and Emergency Shelters, that is correct. Diversion is not the same program as Rapid Exit. Please see program model, Prevention/Diversion to learn more about how we can stop inflow into our system of care.

Comment: “Need for collective understanding and agreed-upon definitions.”

Response: Thank you for your feedback. We agree and hope that these program models create both collective understanding and agree-upon definitions.

What will the impact be of having Rapid Exit shift its emphasis from helping people to identify solutions to verifying solutions they have located while working with CARE, CORE or a Shelter?

Question: “Clarify what is shifting in the proposed model. Will rapid exit program be administering the financial assistance program?”

Response: Rapid exit will continue to provide one-time financial assistance. The proposed model shifts the problem-solving work from Rapid Exit to the entry points (CORE, CARE and Shelter) to identify a housing solution.

Comment: “Concern that there will be less people assisted through this program.”

Response: The switch from Rapid Exit conducting the problem solving and identifying the housing solution to providing one time assistance once the housing solution has already been identified will allow the program to serve more households than ever before.

Question: “Can this be an expansion to build on what other teams who have identified housing solutions?”

Response: Rapid Exit will continue to provide one-time financial assistance to participants who have an identified housing solution.

Question: "What distinguishes whether they need full program or verification to use full funds?"

Response: All housing solutions will be verified by Rapid Exit before release of funds.

Survey

How should Rapid Exit manage the flow of accepting referrals so that consumers are not being referred to services that are not able to assist them? For example, take referrals at the start of the contract until the funds run out; divide the assistance amount over 12 months or over 52 weeks; etc.?

Comment: "Have a LIVE funding allotment available on H3s website so service providers know when the client has a good chance of getting assistance if they apply for assistance quickly."

Response: Thank you for your feedback.

Comment: "This would allow more capacity to serve the right populations"

Response: Thank you for your feedback. We agree.

Comment: "Not sure what the total budget is, but if 100 households get $3000/household, seems like managing 8-10 households/month would work."

Response: Thank you for your feedback. We agree.

Comment: "I just don't see this program as providing much beyond the county's current capacity."

Response: Thank you for your feedback. The Rapid Exit program is not intended to serve a large portion of the total population served in the homeless system of care.

Comment: "Find more funding and build a foundation/trust that'll also help compensate those with lived-experience who come to the table. There needs to be an ongoing bucket to donate funds to those who are literally homeless. Referrals to nowhere happen because we don't meet people who are experiencing homelessness where they are."

Response: Outside of the scope of the Rapid Exit program model. However, H3 is committed to continuing to compensate people with lived experience for their time. Should you or someone you know be interested in donating to our CoC's Housing Security Fund (HSF), please visit: https://cchealth.org/h3/coc/donate.php. See the conclusions and next step section after the program models.

Comment: "Provide a live alert of funding available on H3s' website so service providers know when the client has a good chance of getting assistance if they apply."

Response: Thank you for your feedback.

Comment: "H3 website or other 24/7 publicly available place could let potential referrers know what is available at a given time. This would critically depend on such information being kept accurate and up to date at all times."

Response: Thank you for your feedback. We agree accurate and up-to-date information is critical.

Comment: “I don't understand the question. Consumers are not being referred to services that are not available?”

Response: When providers do not have a full understanding of openings and eligibility, consumers may have been referred to programs that aren’t available to them. This illustrates a need for continued training through our system of care.

Comment: “Take referrals until funds are out and divide funds over 52 wks.”

Response: Thank you for your feedback.

Comment: “Divide assistance over 12 months.”

Response: Thank you for your feedback. We have incorporated into the Rapid Exit program model to reflect assistance being divided over 12 months.

How should providers be notified of openings?

Comment: “Have a weekly alert system emailed to them of remaining funds available. As well as put, it on the H3 website.”

Response: Thank you for your feedback.

Comment: “In the system.”

Response: Thank you for your feedback.

Comment: “Food resources, churches, County meetings, county website, shelters, welfare offices, benefit offices.”

Response: Thank you for your feedback. Because Rapid Exit is open to referrals from CORE, CARE Centers and Emergency Shelters, notifying programs outside of our system of care won’t be possible.

Comment: “All avenues of communication should be utilized from phone calls to face to face to emails, etc.”

Response: Thank you for your feedback.

Comment: “I don't have much feedback on this as I don't see this program as providing much value added.”

Response: Thank you for your feedback.

Comment: “Have a weekly alert system emailed to them of remaining funds available.”

Response: Thank you for your feedback.

Comment: “Website, email list, etc. Usefulness depends on accuracy and very frequent updates.”

Response: Thank you for your feedback. We agree frequency of updates is important.

Comment: “When they enroll an automatic notification of openings should be sent.”

Response: Thank you for your feedback.

Comment: “Email USPS and flyers hand delivered.”

Response: Thank you for your feedback.

Comment: “Email/Zoom meetings.”

Response: Thank you for your feedback.

Do you have any other comments you would like to add about the Rapid Exit model?

Comment: “1- It’s not clear what EXIT means, what system are they in as identified in the purpose? As read in the purpose, it sounds like a client could be part of RRH, and then qualify for Rapid Exit, but later in Eligibility and Prioritization, it says the person must be unhoused to qualify. So, the term EXIT is confusing, because you’re preventing a person from entering the system by providing 1x funds, right? 2 - As part of Referral, Enrollment and Exit: What is the follow through requirements of a provider? 3 - Why are Exits to unknown destinations why can’t this be tracked by a case worker at the provider location with a 30, 60, 80, and 180 day follow up to ensure clients don’t need more support to ensure they are successful in staying housed. 4 - clients should receive more than 1 follow-up attempt to ensure they are successful in staying housed. 5- Most individuals that need 1x assistance, really need 2-3 months of assistance because they are living pay-check to paycheck, and/or loss their employment, trickling unpaid bills that go back possibly month and need assistance for 1-3 months to gain stability.”

Response: The system refers to the homeless system of care or the Continuum of Care (CoC) which has been modified to make clearer in the model language. Consumers in Rapid Rehousing projects could potentially be referred to Prevention/Diversion if they are at risk of losing their housing but not Rapid Exit. Rapid Exit is for those who are not yet housed. The Rapid Exit provider is encouraged to provide multiple follow-up attempts should the referral be unreachable during the enrollment period. The Rapid Exit provider is required to verify whether the proposed housing solution is a safe and stable destination for the incoming referral. Exits to unknown destinations are not able to be followed up on since they are unknown. The Rapid Exit provider is required to conduct one follow up attempt for those who exited to housing and not intended to provide multiple follow up attempts upon exit to housing. Consumers who need more than one month of financial assistance are not appropriate referrals for the Rapid Exit model and instead would be better served in a Rapid Rehousing program model.

Comment: “This model can work as long as all providers do their part to refer and prepare folks before referral.”

Response: Thank you for your feedback and we agree that is why it is a requirement of the referring provider to refer once a housing solution has been identified.

Comment: “Such a hopeful model, too bad such a small program.”

Response: Thank you for your feedback. The intention of Rapid Exit is not to serve a large percentage of the total population within the CoC. If there is a demonstrated need for this program to expand, H3 will look into expansion.

Comment: “1) As part of Referral, Enrollment and Exit--what are the "follow through" requirements of a provider? 2. Should Exits to "unknown destinations" be followed up to be sure they are successful in staying housed?”

Response: The Rapid Exit provider is encouraged to provide multiple follow-up attempts should the referral be unreachable during the enrollment period. The Rapid Exit provider is required to verify whether the proposed housing solution is a safe and stable destination for the incoming referral. Exits to unknown destinations are not able to be followed up on since they are unknown. The Rapid Exit provider is required to conduct one follow up attempt for those who exited to housing and not intended to provide multiple follow up attempts upon exit to housing.

Comment: “One follow-up seems inadequate--suggest that it should be multiple over a period of several months.”

Response: Thank you for your feedback. Rapid Exit is designed to be a one-time service therefore more than one follow up is not within this program model. Model unchanged.

Comment: “Why not provide life sobriety classes, therapy and life skill programs. It would help keep them in the homes.”

Response: Outside of the scope of the Rapid Exit program model.

Emergency Shelters

Community Meeting Questions and Comments

Anything that was unclear?

Comment: “Shelter referrals - having the opportunity to bring in their own referrals or working with other agencies/providers vs having CORE placements.”

Response: Thank you for your feedback. There are some shelters that do take their own referrals, some a mix between their own and CORE and some solely through CORE. While not part of this iteration of the program models, future work and iterations can consider the idea of centralized shelter placements.

Comment: “Capacity concerns - limiting belongings for consumers. ~2 bag limit; introducing more personal items that could lead to health or storage issues.”

Response: Thank you for your feedback. While we recognize limiting belongings can present as a barrier for some, at this time, the model is unchanged.

Question: “continued partnership with non-CoC or shelters that don't fit these standards - how do we continue partnerships if standards are significantly different? ES may continue to be defined differently”

Response: Emergency shelters that are not contracted or funded through the CoC will not be held to these standards although strongly encouraged to prioritize bed placements based on acute needs identified on the triage tool.

Comment: “arguments for different standards within some ES program types - leads to stronger sustainability and long-term success in exiting homelessness.”

Response: Thank you for your feedback. All contracted Emergency Shelter providers will be held to these performance standards starting July 1, 2022, in hopes of creating more accountability and success for both providers and consumers receiving services.

Question: “what about standards for seasonal programs or night by night shelters? How do they fit into these program models?”

Response: Night by night and seasonal shelters are not held by these same standards unless funded or contracted with the CoC. It is encouraged to prioritize bed placements based on acute needs identified on the triage tool.

Question: “Error rate of data (null, missing, don't know, refused) - ability to gather that data may need trust/rapport/time - is 5% realistic understanding this population?”

Response: The 5% error rate is set by HUD data standards and unable to be changed. We acknowledge the difficulty in meeting this standard.

Question: “Wrap around services assumption - does this presuppose the ability to do case management throughout the day vs the evening when the sheltering is taking place?”

Response: CoC funded and contracted shelters operate 24 hours a day, 7 days a week. It is encouraged to have evening and weekend case management support to accommodate shelter resident’s schedules.

Question: “Do we have resources/other programs to help people who are homeless store their belongings? If they aren't able to be brought to the shelter, is that a barrier to shelter access?”

Response: We acknowledge that limiting the number of belongings a person can bring into shelter may cause barriers for some. However, identifying storage resources in the community is outside of the scope of this project.

Question: “What about consumers with children? Services and support or other resources? Rides to school/other resources?”

Response: Transportation is not a requirement for contracted emergency shelters, however, those that serve families are encouraged to provide relevant resources to families.

Question: “How are standards and non-HMIS participants held/considered against these standards? what are the supports/repercussions?”

Response: Non HMIS participating providers are not held to these performance standards as they are not contracted or CoC funded providers.

Question: “guidelines and requirements to protect women and children - i.e., requirements around 290s?”

Response: Serving people on the sex offender registry and families can be served at the discretion of the shelter and rules and requirements of the person’s tier status on the registry.

Survey

What support do shelters need to eliminate lengths of stay policies and instead focus on exiting people to permanent housing as quickly as possible?

Comment: "Problem Solving conversations are important to have at multiple levels."

Response: We agree that's why crisis response service providers are required to provide problem solving and housing focused case management on-going.

Comment: "I think rethinking rules like curfew for working people, on-site aod programs."

Response: Emergency shelters are encouraged to eliminate curfews whenever possible and accommodate work schedules. On-site substance use services are also important though not required in this model.

Comment: "probably more beds."

Response: Outside of the scope of this project and we agree.

Comment: "Increased problem solving and rapid exit opportunities."

Response: Through housing focused case management and problem-solving conversations the goal would be to increase referrals to rapid exit whenever possible.

Comment: "This program does not seem to improve access to permanent housing. Focusing on exiting people to permanent housing without increasing availability does not seem very effective."

Response: Access to permanent housing is outside of the scope of the Emergency Shelter program model. Emergency shelters are not able to increase permanent housing opportunities though they are required to provide housing focused case management including document readiness, all essential pieces of preparing consumers for housing opportunities.

Comment: "There needs to be a self-reflective moment for those in shelters. Workshops that provide Wellness Recovery Action Plan (WRAP) because being in a shelter is the recovery process of homelessness. There was a crisis before homelessness and that trauma needs to be addressed. Add the Peer Respite Model to the Shelters!"

Response: Thank you for your feedback. No changes were made to the emergency shelter model however, peer support and wrap around services can be part of the services shelters provide.

Comment: "The curfew."

Response: Shelters are encouraged to eliminate curfews, though not required.

Comment: "Housing classes, how to be a tenant."

Response: Although not required, classes and workshops to prepare consumers for housing are encouraged.

Do you have any other comments you would like to add about the Year-Round Emergency Shelter/Interim Housing model?

Comment: "1- As to eligibility, while having a central group like CORE do the referrals and assessments is a good idea, unhoused people should be able to call the shelter directly, and get assistance and have CORE come to

them there once they are in, or waiting to get in, as well. CORE should connect with people where they are at, sheltered or unsheltered, or becoming sheltered, but become part of the immediate assessment process regardless of where the person is at. 2 - CORE team can't be the only one making the referrals, as CORE has limited weekday day, evening, midnight and weekend availability and the person needs to be able to call the shelters on their own and be allowed to walk-in and seek service. Obviously, we need more room in the shelters to allow for a walk-in area, or allow people to park in their vehicles or stay nearby in a temporary camp while they are allowed inside the shelter. 3 - AT THE MOMENT, THE SERVICES ARE VERY RATIONED, AND THERE ARE LONG WAITING LISTS THAT MAKE UNHOUSED GIVE UP ON THE PROCESS, CAUSING THEM TO BECOME CHRONICALLY HOMELESS. 4 - No mention in performance Standards that clients are offered FEEDBACK SURVEYS for all the services they receive and asked about improvements that could be made/enacted quickly. 5. there is no mention on how they hold each provider accountable during triage or transfer of services 6 - Curfew are being eliminated, Yay!! I'm also excited to read that one of the purposes is to remove barriers of pets and possessions? But there is no mention of how that is done. For example, unhoused who have service animals need to sleep with them, not in a kennel. Also, people should be allowed to take more than 2 bags of belongings. Two large suitcases are more adequate, and storage should be adjacent to the shelter and accessible so they can grab items they need. At present, Concord PD stores their stuff in an open field that is gated and locked, but it is often breached and broken into; and their stuff is stolen causing anxiety of going into shelter out of fear of losing personal belongings like pictures of their family. 7 - There is no performance standard for how outreach is conducted, implemented and followed through - from the 1st point of contact, providing accurate information, all the way to transferring the client to shelter or another provider for care."

Response: Some emergency shelters take their referrals solely from CORE, some from CORE and direct referrals and some all-direct referrals. Emergency shelters that take their referrals solely from Coordinated Entry cannot take walk-ins or self-referrals. Emergency shelters are not available for walk in services however the Concord Service Center and two CARE Centers are as well as safe parking programs in the community for consumers to safely park their vehicles. See Chapter One, section 7 regarding consumer satisfaction. Provider accountability across models and additional storage for shelter facilities is outside of the scope of this project. Performance standards for Outreach remain unchanged.

Comment: "Communication and follow up and warm hands offs are very important to exiting folks quicker."

Response: Thank you for your feedback. We agree.

Comment: "good to see the lived experience on the board expectation."

Response: Thank you for your feedback. We agree.

Comment: "Performance Standards recommendations: c) specifically identify which exit destinations to be included in the temporary category using the destinations in HMIS. Also, recommend using the exit destination categories as displayed in Appendix A of the HMIS Data Standards manual instead of the categories in the APR. For example, the APR categorizes Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter a temporary destination, whereas the Data Standards manual categorizes this as a homeless destination. d) separate non-cash benefits, income, and health insurance outcomes."

Response: Performance standard c) exit destinations will be categorized using the destinations in HMIS. For purposes of the performance standards, all outcomes are measured using the HMIS Data Standards not the APR.

Non-crash benefits, income and health insurance outcomes have been separated out across all performance models. Please see performance standards in the models.

Comment: “Section III (Required Elements) part E and section IV parts a&b need to be added to ALL models! The trauma informed; crisis prevention is missing in all the other models.”

Response: See revised program models on how Trauma Informed Care will be incorporated in each model.

Comment: “There needs to be more than the CORE team making the referrals, as CORE has limited availability and the person needs to be able to call the shelter on their own and be allowed to walk-in and seek service. I called about a woman, very worried about her during the freeze, but was told that CORE only brings people to the Warming Center and it was full. So, no one checked on her. Also, we need more room in the shelters to allow for a walk-in area or a place for people to park their vehicles or stay nearby in a temporary camp. Also, the unhoused should be able to give feedback on the services they receive and they should be asked about improvements that they can think of. Getting rid of some of the barriers such as curfews and keeping pets, is great. They do still need a safe place to store their belongings.”

Response: Some emergency shelters take their referrals solely from CORE, some from CORE and direct referrals and some all-direct referrals. Emergency shelters that take their referrals solely from Coordinated Entry cannot take walk-ins or self-referrals. Emergency shelters are not available for walk in services however the Concord Service Center and two CARE Centers are as well as safe parking programs in the community for consumers to safely park their vehicles. See Chapter One, section 7 on how H3 will evaluate and solicit feedback from consumers.

Comment: "Accommodating partners, pets and possessions and eliminating curfews and other restrictions more appropriate for adolescents than adults" is a VERY good improvement, likely to increase trust in the system from potential clients. Referrals and admissions to emergency shelter must be available 24/7, and this cannot depend on CORE as long as CORE continues to have limited hours of availability.”

Response: Thank you for your feedback. Referrals and admissions to emergency shelters are not available 24/7 but available depending on shelter staff capacity.

Comment: “Is this model eliminating shelter curfews? That would be excellent if so.”

Response: Emergency Shelter model is recommending shelter’s eliminate curfews however not requiring them to do so.

CARE Centers

Question: “The intake specialist will take care of a shortened version of the intake. How short is this? Will we be part of the process of creating this?”

Response: The Research, Evaluation and Data (RED) team will provide the CARE Center providers with a shortened version of the standardized intake and if possible, will work with CARE Center providers to develop that intake.

Question: “What is the length of time a member can be on the Active caseload for the housing focused case manager?”

Response: The length of time a member can be active on a caseload for housing focused case management is a case-by-case basis so long as the member is engaged on a weekly basis and/or until member has exited to temporary or permanent housing.

Question: "Do you have any guidance for us that can help us determine vulnerability for referrals to the housing focused case manager? For example: How long does someone need to use TC services, ones a week, to get qualified for a referral?"

Response: Case Managers will prioritize people who have been homeless the longest and with the most acute needs for case management support. Consumers must be active with CARE Center services. Active is defined as once weekly engagement or more. The model language was modified to clarify this change.

Question: "How was the amount of 30 participants per caseload determined? What is it based on?"

Response: To account for concerns with the caseload numbers, the CARE Center program model has been edited to 25 participants per caseload.

Community Meeting Questions and Comments

Anything that was unclear?

Question: "Co-enrollment with CARE Centers and Shelters. We have members who have relationships with CARE Centers and want to continue accessing services such as meals and meeting with staff they have a relationship with."

Response: Thank you for your feedback. We recognize that for some, the CARE Center drop-in services provide on-going support and stability. Language has been revised in the CARE Center model to apply this only to consumers enrolled in CARE Center case management services. Those receiving basic needs services may continue to do so until they are housed.

Is the relationship between CARE Centers and CARE Center Case Management clear in the model descriptions and performance measures? How can it be clearer?

Comment: "It's clear on paper, now we have to see how to make it clear in real life. We have folks with substance use, how do we continue offering those supports and services."

Response: Thank you for your feedback. Substance use services are outside the scope of housing focused case management and CARE Centers can provide this service using other funding should they wish to do so.

Is more detail needed on how should Case Managers fill openings in their caseloads?

Comment: "Like that it leaves it up to the CARE Centers to fill but still will be challenging."

Response: The model description has been modified to describe how CARE Center case managers are to fill their openings.

Survey

I believe the detail described within the model is clear on how case managers fill openings in their caseloads. How can it be clearer?

Comment: "It is open for workers to select who is most vulnerable or most in need of the service. This has its pros and cons. For an even more structured system I think guidelines will be good. Or to match is best to the different program, some help (per location) determining the guidelines."

Response: Case Managers will prioritize people who have been homeless the longest and with the most acute needs for case management support. Consumers must be active with CARE Center services. Active is defined as once weekly engagement or more.

Do you have any other comments you would like to add about the CARE Center model?

Comment: "1 - CARE Centers should be open on weekends to allow the community volunteers to bring unhoused to get triaged and accessed for services, to allow unhoused to get mail, do laundry, as well to triage unhoused that are dispatched from the hospital on weekends. 2 - Under referrals, 211 and CORE should not be the only ones referring to CARE Centers, because they don't always answer the phones, and CORE isn't always open to support unhoused, they are very limited in capacity. 3 - Under Access and Operating Hours, CARE Centers should increase their hours and open a new site to be more accessible to the unhoused in different parts of the county. CARE centers should be open on weekends to allow the unhoused to do laundry, and get mail, and to triage unhoused people that are released from the hospital. Often CORE and 211's is limited in capacity, or they are closed. Also, unhoused work, and they need weekends to do laundry and check mail. 4 - Under performance standards, it's great if people are exited from a CARE center to a housing but it is not clear if that's what's happening. Due to limited # to serve, unhoused will need access to CARE centers possibly for several years. So, this 90% measurement of exiting is confusing. Also, there is no mention that unhoused are surveyed and solicited for feedback."

Response: One of the two CARE Centers, GRIP in our community is open 7 days a week. Weekend hours are 8am-2pm. Please visit H3 website at: https://cchealth.org/h3/coc/help.php for more information regarding CARE Centers. CARE Centers operate on a drop-in basis, meaning anyone who is experiencing homelessness, or a housing crisis may access services. 211 and CORE are main referral sources for CARE Centers. Should community members wish to volunteer at a CARE Center, they can contact the CARE Centers directly. Please visit their websites: Trinity: https://trinitycenterwc.org/ and GRIP: https://gripcares.org/. One of the performance standards CARE Centers will be held to is assisting consumers who are case managed in exiting them to housing. CARE Centers is one of multiple places where people experiencing a housing crisis can access case management and work on a housing plan. See Chapter One, section 7 on how H3 will evaluate and solicit feedback from consumers.

Comment: "Document readiness and exploring and connecting to more agencies while working with clients is important."

Response: Document gathering work is a requirement of the CARE Center providers. CARE Centers will continue to partner and connect consumers to outside agencies when needed.

Comment: "Transportation to and from, lockers, po boxes or mail service."

Response: Thank you for your feedback. We recognize transportation as a barrier across our system of care. Lockers and mail service is provided at Trinity Center and mail service is offered at GRIP.

Comment: "III A (Drop-in Centers) should also provide services for employment and skills training - or at least partner with someone who does that stuff."

Response: Outside of the scope of this project. The CARE Center program model is focused on the case management aspect of the CARE Center. CARE Centers are welcome to provide employment services and both CARE Centers currently offer employment support as well as partner with agencies in the community who offer employment support.

Comment: "CARE Centers should be open on weekends to allow community volunteers to help out. Under referrals, there needs to be more than 211 or CORE because they are not always available to support the unhoused. CARE centers should increase their houses & open a new site. They should be open on weekends--which would allow volunteers to be able to help the unhoused."

Response: One of the two CARE Centers, GRIP in our community is open 7 days a week. Weekend hours are 8am-2pm. Please visit H3 website at: https://cchealth.org/h3/coc/help.php for more information regarding CARE Centers. CARE Centers operate on a drop-in basis, meaning anyone who is experiencing homelessness, or a housing crisis may access services. 211 and CORE are main referral sources for CARE Centers. Should community members wish to volunteer at a CARE Center, they can contact the CARE Centers directly. Please visit their websites: Trinity: https://trinitycenterwc.org/ and GRIP: https://gripcares.org/.

Comment: "Referrals and admissions must be available 24/7; CORE is currently unable to meet this standard, so it should not depend on CORE. CARE centers should be open on weekends, not just 40 hours/wk, to allow life tasks such as laundry. As with all the models, I want to see more performance standards focused on evaluation of programs by clients themselves; these are lacking."

Response: CARE Centers are drop-in centers, not overnight shelters. CARE Centers operate during daytime hours, including weekends. Weekend hours are 8am-2pm. Please visit H3 website at: https://cchealth.org/h3/coc/help.php for more information regarding CARE Centers. See Chapter One, section Seven on how H3 will evaluate and solicit feedback from consumers.

Comment: "CARE centers need expanded hours and locations, especially weekend hours. Those who are homeless with jobs need weekend time for laundry etc., and working people who are assisting a homeless person need access to the system outside business hours."

Response: One of the two CARE Centers, GRIP in our community is open 7 days a week. Weekend hours are 8am-2pm. Please visit H3 website at: https://cchealth.org/h3/coc/help.php for more information regarding CARE Centers.

Comment: "I want to express that the caseload of 30 may be difficult to handle for case managers. There are many responsibilities for case managers and limited staff to support the amount of people at CARE centers. I suggest 20 or fewer clients on a caseload would improve quality of assistance."

Response: To account for concerns with the caseload numbers, the CARE Center program model has been edited to 25 participants per caseload.

Comment: "I think the model has great goals, but it is difficult to successfully house 1 out of every 3 persons on the caseload. There are a variety of factors which make this difficult. One of which is simply supply and

demand, along with the cost of housing in our area. Supportive services are vital for a lot of the consumers of the CE system. MH and SUD often need to be simultaneously addressed for success."

Response: Noted and thank you for your feedback. CARE Centers are not expected to house consumers only using their own resources but also through other programs in the community such as rapid exit, rapid rehousing, permanent supportive housing, and other permanent housing options. H3 recognizes the need for more affordable housing in our community. Although outside the scope of this project.

Outreach

Community Meeting Questions and Comments

Anything that was unclear?

Comment: "Feasibility of storing documents for consumers?"

Response: Thank you for your feedback. CORE staff can upload digital copies of consumer documents in the Homeless Management and Information System (HMIS) without having to store consumer documents.

Comment: "The Final document should refer to "Outreach," not just CORE."

Response: This program model refers to outreach providers that are CoC contracted and/or funded providers. CORE mobile outreach is the only contracted provider to provide outreach currently. Thus, this program model only refers to CORE mobile outreach.

What aspects of the description confirmed what is already happening?

Comment: "CORE Plus Model in Concord/Richmond."

Response: Glad to hear there are teams with clinical social work already embedded in the outreach model.

Comment: "Staffing is already in place."

Response: Glad to hear staffing is already in place.

Any comments on the staffing ratio and functions?

Comment: "after-hours could be boosted."

Response: Noted. Each contracted provider will have the ability to ask for what they need to fit the program model during the self-assessment process prior to implementation on July 1st.

Comment: "Could use more staff to help get people document ready."

Response: Noted. Each contracted provider will have the ability to ask for what they need to fit the program model during the self-assessment process prior to implementation on July 1st.

Comment: "3700 clients, 29 staff in the field, 3 dispatchers."

Response: Noted. Thank you for your feedback.

Comment: "Is staffing sufficient based on the roles laid out in the model."

Response: We believe so, yes.

Comment: "Adding clinical case managers helps with capacity quite a bit."

Response: Noted and thank you for your feedback. H3 is committed to continue building out the CORE outreach teams and agrees there is a need for clinical social workers.

Comment: "More resources not related to outreach would be critical. Shelters, places to refer."

Response: Thank you for your feedback. Outside of the scope of this program model.

Any comments on the performance measures?

Comment: "We have shelter for only 30% of the people we serve. This impacts performance (pre-COVID numbers)."

Response: Noted and thank you for your feedback.

Comment: "Performance measures are only as good as the resources we have."

Response: Noted and thank you for your feedback. See comments in Chapter 1.VI.

Comment: "Families need more resources as well."

Response: H3 will continue to apply for funding to expand CORE teams for families.

Survey

Do you have any other comments you would like to add about the Outreach model?

Comment: "Need to be more communicative with the unhoused. I have experienced judgmental responses from core personnel."

Response: Noted and thank you for your feedback. We are sorry to hear about your experience with CORE and H3 is committed to continuous improvement and welcome feedback regarding services.

Comment: "CORE should have a role in making sure people have somewhere to sleep, and communicate with police when there are no shelter space and people need to be allowed to continue to camp. They also need to be able to provide emergency self-sheltering items such as tents when shelter beds aren't available, especially since these items are often taken from people during sweeps. Performance standards should include feedback from those seeking help through CORE."

Response: CORE does not have authority in stopping law enforcement from sweeping encampments. H3 is committed to continue to advocate against encampment sweeps whenever possible. CORE provides tents and other emergency supplies when available. See Chapter One, section Seven on how H3 will evaluate and solicit feedback from consumers.

Comment: “CORE should not assist in sweeping homeless residents when unable to place them in immediate shelter. CORE should develop agreements with law enforcement for where they can place people in such circumstances, rather than leaving people to choose a new illegal location.”

Response: CORE does not have authority in stopping law enforcement from sweeping encampments. H3 is committed to continue to advocate against encampment sweeps whenever possible. CORE makes every effort to offer shelter when shelter is available. Everyone has the right to accept or decline the shelter option(s) provided.

Comment: “Core teams don’t always offer items listed in the Purpose, and they should offer additional items often taken from police in a sweep like tents, clothing, shoes. When things are stolen or taken from them, CORE should help the individual get assistance with acquiring important documents and finding a service agency to pay for the document copy fee. When harm is done to them, CORE should help the unhoused person file a police report, and continue to be an advocate. CORE should know when there is shelter available and inform the police they can’t be swept because the type of shelter that is adequate for that person is not available. Unhoused people should be able to report to police Yellow Tags to CORE and get help with moving to a new spot, and/or stop the sweep when adequate shelter is not available. CORE should provide training to community volunteers and allow them to participate in outreach and assessment after signing confidentiality agreements. Under performance standards, there is no mention that unhoused are surveyed and solicited for feedback. There should be measurement standards based on feedback received from clients accessing CORE, or being transitioned into other programs.”

Response: Noted and thank you for your feedback. CORE offers items upon availability including tents. As a crisis response service provider, CORE is required to assist consumers with document gathering. CORE assists consumers in filing a police report should the consumer express interest in doing so. CORE does not have authority in stopping law enforcement from sweeping encampments. H3 is committed to continue to advocate against encampment sweeps whenever possible. CORE is unable to provide training or any information regarding consumers without a signed release of information and consent from the consumer. See Chapter One, section Seven on how H3 will evaluate and solicit feedback from consumers.

Comment: “CORE. teams need to offer help when individuals have lost items during a sweep; CORE should know when there is shelter available and inform police that they can't be swept because the type of shelter that is adequate for that person is not available. Unhoused people should be able to report to police Yellow Tags to CORE and get help moving to a new spot.”

Response: CORE teams make every effort to work with community members who are asked to relocate. When shelter beds are available, shelter is offered to those who are asked to relocate.

Comment: “Outreach should be for all not one group. I have not been able to obtain any help & will be a senior this month but it won't help because I have no medical issues nor any other needs besides housing & it is not right.”

Response: Thank you for your feedback and we are sorry to hear about your experience with our services. Outreach can serve anyone in our community who is unsheltered. However, prioritization for shelter is dependent on vulnerability and availability of beds. Due to the limited number of shelter beds, outreach must prioritize the most vulnerable for a small number of beds. H3 recognizes there is a greater need than there is availability for shelter in our community. Should you wish to be contacted, please email: ContraCostaCoC@cchealth.org.

Comment: “The approach that core has is incorrect. They do not go where the unhoused are completely. They have a certain few who they deal with and that is it. There is documented proof that they only approach a certain persons”

Response: Thank you for your feedback. Providers and community members are encouraged to reach out to CORE whenever they encounter a consumer unsheltered so CORE can outreach.

Comment: “There needs to be more core staff I am a front-line worker who has had a lot of trouble utilizing services.”

Response: Noted and thank you for your feedback. H3 is committed to improving services and applying for funding for additional CORE teams whenever possible.

Prevention/Diversion

Community Meeting Questions and Comments

Anything that was unclear?

Question: “Where does Couch Surfing fit into this within HUD guidelines?”

Response: Prevention/Diversion program model is intended to serve people at imminent risk of losing their housing (within two weeks). This program does not operate under HUD’s definition of literal homelessness.

Question: “People timing out of Sober Living Events?”

Response: People who are going to lose their housing within two weeks and have an identified housing solution are eligible for Prevention/Diversion.

Question: “Can this apply also to people already experiencing literal homelessness. What's the difference between this and Rapid Exit?”

Response: Prevention/Diversion serves people who are at risk of losing their housing and Rapid Exit serves people who are already experiencing homelessness.

Question: “Is car literal homelessness or housed for the purposes of this program?”

Response: Sleeping in a vehicle is considered a place not meant for human habitation or literally homeless. Someone staying in their car would not be referred to Prevention/Diversion, but Rapid Exit should they have a housing solution.

Are there any assessment tools or platforms that could support implementation of prioritization?

Comment: “HMIS doesn't have capacity but- maybe get to do an online screening tool for people to apply/be prioritized online.”

Response: Noted and thank you for your feedback. H3 is committed to working with the community to adopt a tool that has been vetted, well researched and the community agrees upon.

Comment: “SSVF program has assessment tool.”

Response: Noted and thank you for your feedback. H3 is committed to working with the community to adopt a tool that has been vetted, well researched and the community agrees upon.

Comment: “SPDAT has own module that could be used.”

Response: Noted and thank you for your feedback. H3 is committed to working with the community to adopt a tool that has been vetted, well researched and the community agrees upon.

Comment: “All Home: Have platform and tool used in SF/Oakland/Fremont. Looks at 4-5 other prevention tools and worked with academics to develop.”

Response: Noted and thank you for your feedback. H3 is committed to working with the community to adopt a tool that has been vetted, well researched and the community agrees upon.

Comment: “SHELTER, Inc. doesn't have a specific tool. Based on documentation, crisis and need and determine funding stream, LOT and amt of support needed.”

Response: Noted and thank you for your feedback. H3 is committed to working with the community to adopt a tool that has been vetted, well researched and the community agrees upon.

Comment: “Problem solving convos at very beginning.”

Response: Agreed. Problem solving conversations should exist at every entry point and crisis response service provider level. H3 is committed to working with the community to adopt a tool that has been vetted, well researched and the community agrees upon.

Comment: “Be cautious about tool implicitly assessing "success" b/c can't accurately predict success.”

Response: Noted and thank you for your feedback. H3 is committed to working with the community to adopt a tool that has been vetted, well researched and the community agrees upon.

Survey

Do you have any other comments you would like to add about the Prevention/Diversion model?

Comment: “1 - The question around expanding the prevention prioritization recommendations in CoC was not clear. This did not have its own section; it was hard to find. I assumed it was the language under CoC Capacity and Turnover. If this is the correct place to review under the model, then I believe it’s not clear how prevention prioritization will be expanded and prioritized in what areas of the county? 2 - Under performance standards, there is no mention that unhoused are surveyed and solicited for feedback. There should be a performance standard or evidence-based measurement to evaluate the feedback received from clients who assess how the prevention/diversion model helped them.”

Response: Noted and thank you for your feedback. The prevention prioritization recommendation is referenced in chapter one, section five. See Chapter One, section Seven on how H3 will evaluate and solicit feedback from consumers.

Comment: “Again, performance standards need to include feedback from clients themselves.”

Response: See Chapter One, section Seven on how H3 will evaluate and solicit feedback from consumers.

Comment: "As with all the models, I want to see Performance Standards focused on evaluation by clients themselves, in addition to others evaluating their outcomes."

Response: See Chapter One, section Seven on how H3 will evaluate and solicit feedback from consumers.

Comment: "Getting people to the right programs very important and starting at the frontlines before referral will help assist more people."

Response: Agreed.

Comment: "Performance Standards recommendation: b) specifically identify which exit destinations to be included in the temporary category using the destinations list and categories from the HMIS data standards manual."

Response: Performance standards are unchanged as temporary versus permanent destinations are set by HUD. See permanent standards across models when destinations such as nursing facilities will not be counted against providers in their exits to non-permanent destinations.

Comment: "There should be some form of measurement to evaluate the feedback from clients."

Response: See Chapter One, section Seven on how H3 will evaluate and solicit feedback from consumers.

Community Queue

Survey

Do you have any other comments you would like to add about document readiness related to the Community Queue referral and matching process?

Comment: "Assistance gathering documents."

Response: Crisis response service providers such as CORE, CARE Centers and Emergency Shelters will be required to work on document gathering as soon as a consumer enrolls in their program.

Comment: "Documents should not stop anyone from receiving timely housing options."

Response: Agreed and document readiness is not required to access crisis response services. Some level of documentation is required for Rapid Rehousing and Permanent Supportive Housing projects depending on grant requirements. Consumers will be given time to gather documents and the emphasis is on crisis response service providers such as CORE, CARE Centers and Emergency Shelters to work on document readiness upon consumer enrollment into program so that when a housing opportunity presents itself, the consumer will be ready.

Comment: "Everyone should be working on this and it should be the entire system's responsibility. Warm hand off is important."

Response: Agreed, warm hands offs are essential in ensuring continuity of care and document readiness is not required to access crisis response services. Crisis response service providers such as CORE, CARE Centers and Emergency Shelters will be required to work on document gathering as soon as a consumer enrolls in their program.

Comment: “Lack of documents is a routine part of being unhoused. It should not be a barrier to entering an assistance program.”

Response: Agreed and document readiness is not required to access crisis response services. Crisis response service providers will be required to work on document gathering as soon as a consumer enrolls in their program. H3 is committed to working with housing providers to reduce documentation barriers whenever possible.

Comment: “SPIRIT Internships (from contra costa Community college and Office of Consumer Empowerment) can help with this process to give staff some support.”

Response: Appreciate this idea. Crisis response service providers can collaborate with SPIRIT interns whenever possible to support staff and consumers.

Comment: “Start the process ASAP and help people get their documents in order concurrently. Paperwork can be a huge challenge while homeless, and we need to focus on reducing the ways this can be a barrier to services.”

Response: Agreed and document readiness is not required to access crisis response services. Crisis response service providers will be required to work on document gathering as soon as a consumer enrolls in their program. H3 is committed to working with housing providers to reduce documentation barriers whenever possible.

Comment: “this is a very stressful time for the unhoused, and taking the time to ask for documents might be not well spent.”

Response: Understood and noted. Documents are not required for access to crisis response providers. Some level of documentation is required for Rapid Rehousing and Permanent Supportive Housing projects depending on grant requirements. Consumers will be given time to gather documents and the emphasis is on crisis response service providers such as CORE, CARE Centers and Emergency Shelters to work on document readiness upon consumer enrollment into program

Comment: “You don’t need much proof that someone is unhoused. Get them housed asap. The system should support households while enrolled in the programs to get their documents. The unhoused who have been homeless for short or long periods of time (years sometimes) have difficulty accessing documents that have been stolen, their identities stolen, and/or have mobility issues (physical or transportation difficulties) to getting their documents ready. It should not be PSH program staff can assist if they have capacity, it should be something staff.”

Response: Some level of documentation is required for Rapid Rehousing and Permanent Supportive Housing projects depending on grant requirements. It is not required for access to crisis services. Consumers will be given time to gather documents and the emphasis is on crisis response service providers such as CORE, CARE Centers and Emergency Shelters to work on document readiness upon consumer enrollment into program so that when a housing opportunity presents itself, the consumer will be ready.

Comment: “You should give the clients enough time to acquire all their documents.”

Response: Consumers will be given time to gather documents and the emphasis is on crisis response service providers to begin working on document readiness upon consumer enrollment in the program. Document readiness is not required to access crisis response services such as CORE, CARE Centers and Emergency Shelters.

Document Readiness

Community Meeting Questions and Comments

Question: "Do you need to have your Social Security to be doc ready?"

Response: Some housing providers will require social security cards depending on their funding source and grant requirements.

Survey

Do you have any other comments you would like to add about document readiness taking place within crisis response services?

Comment: "1 - provide bus passes and rides to the unhoused so they can gather their documents. Additional Comments adding them here because there is no section for additional comments. 1 - Include a program model that recommends all H3 programs advocate for stronger education and protection for the unhoused who are harassed by law enforcement and code enforcement not abiding by Martin v. Boise. 2 - If the County doesn't have adequate shelter, law enforcement should not sweep and work with H3 programs strongly to put people on a path towards permanent housing. 3 - If the County doesn't have adequate shelter, put an alert to all city/county/state agencies and organizations when shelter is not available, including law enforcement agencies, code enforcement units so they don't sweep unless they can confirm the person is being placed into some type of shelter. Sweeping is illegal under Martin vs Boise and we should educate all agencies and organizations about this. 4 - Define adequate shelter under Martin vs. Boise - Why is this important? It's not okay to force people into a shelter when there is a covid outbreak just so law enforcement could enforce a sweep. Concord PD tagged 25 people at a camp in Concord and gave 72-hour notices. During that time advocates called shelters and were told all shelters were full. The shelter in Concord on the day of the sweep opened up spots for Concord PD or the City of Concord, and they made people sign a waiver that they acknowledged there was an outbreak, to assist Concord PD in enforcing a sweep. There should be penalties from funders like H3 supporting those shelters when they behave badly."

Response: Agreed that transportation is essential in document gathering. The program models listed here are for current programs that are contracted and/or funded by the CoC. Future iterations of the program models may include additional programs. H3 is committed to continue advocating with local cities, public officials and law enforcement to end the practice of sweeping. Every effort is made by the CORE mobile outreach teams to ensure when a sweep occurs, every person has a safe place to relocate to, offering a shelter bed whenever possible. When a COVID outbreak has occurred at a shelter, intakes can continue. However, anyone new coming into that shelter has a right to know an outbreak has occurred so each consumer can make an informed decision on whether to enter shelter. The goal of the performance standards and required elements in the program models is to hold programs such as emergency shelters accountable.

Comment: "CORE has a lot of SPIRIT students who work for them already, but document readiness could be a specific niche for other internships."

Response: Outside the scope of this project. However, CORE and other crisis response services can collaborate with other services in the community to assist in document readiness whenever possible.

Comment: “Give out clipper cards or rides so that they can get their documents. If the county does not have adequate shelter, they should communicate with cities so that police will not do sweeps during this time. Define adequate shelter--for example, during a sweep in January in Concord, spots were opened up in the emergency shelter, but people had to sign a waiver saying they knew there was a COVID outbreak.”

Response: Noted and agreed providing ways to access transportation is essential in getting consumers document ready. Regarding encampment sweeping, H3 is committed to continue advocating with local cities, public officials, and law enforcement to end the practice of sweeping. Every effort is made by the CORE mobile outreach teams to ensure when a sweep occurs, every person has a safe place to relocate to, offering a shelter bed whenever possible. When a COVID outbreak has occurred at a shelter, intakes can continue. However, anyone new coming into that shelter has a right to know an outbreak has occurred so each consumer can make an informed decision on whether to enter shelter.

Comment: “I believe it a good idea.”

Response: Thank you and we agree.

Comment: “It doesn't seem appropriate to me. Document readiness is not something that can happen on an emergency basis; emergency services must not wait for it. I have a further comment on the very concept of emergencies in a homelessness context: They are often created by public agency staff in the first place, by sweeping people from self-shelter locations and confiscating or destroying their self-shelter equipment (tents or vehicles). This should never happen without first ensuring that ALL of those swept will be immediately placed in circumstances at least as safe as those from which they are being swept. Currently, it frequently does happen without ensuring any such thing. In other words, staff (esp law enforcement) are actively harming the safety and health of homeless people. To address emergencies, the first step should be to end this practice.”

Response: Document readiness is a challenge. Crisis Response service providers such as CORE, CARE Centers and Emergency Shelters will be required to assist consumers with document gathering immediately upon entry. Documents are NOT a requirement to enter shelter, as referenced in Chapter One, Section 6. H3 is committed to continue advocating with local cities, public officials, and law enforcement to end the practice of sweeping. Every effort is made by the CORE mobile outreach teams to ensure when a sweep occurs, every person has a safe place to relocate to, offering a shelter bed whenever possible.

Comment: “Just make sure the clients have enough time to obtain all documents needed, especially the ones who have been homeless a long time.”

Response: Agreed. Consumers will be given time to gather documents and the emphasis is on crisis response service providers to begin working on document readiness upon consumer enrollment in the program.

Comment: “There needs to be enough funding to provide people with the updated version such as a real ID versus a regular state id.”

Response: Thank you for your comment. CORE mobile outreach teams can provide an individual with a fee waiver to obtain their ID and assist with getting a REAL ID when possible.

Comment: “This should include transportation assistance since homeless people often don't have easy access to places where their documents are stored.”

Response: We agree transportation is an important part of document gathering. Whenever possible, crisis response services such as CORE, CARE Center and Emergency Shelters are strongly encouraged to provide transportation when participants are gathering documents.

Comment: "This will be a more productive way to reach more folks."

Response. Thank you for your comment. Agreed.

General Questions and Comments

Comment: "Overhaul everything. Has not been working."

Response: Thank you for your comment. The program models will provide more direction and accountability for contracted providers with the goal of improvement. After year one of implementation, the community will have the opportunity to evaluate the effectiveness of the program models and performance standards.

Question: "where do folks go to answer all of their other questions. (Not necessarily related to housing)"

Response**:** The 211 database has a full list of housing and non-housing related resources. See here: https://cccc.myresourcedirectory.com/.

Comment: "Better help with Social Security accessibility. They work against our clients and our program requirements. Someone needs to tell a congressman about this and make sure our homeless citizens can access the service. especially when it is necessary for housing."

Response: Outside of the scope of this project. Crisis response service providers such as CORE, CARE Centers and Emergency Shelters will continue to partner with local social security to assist in providing social security cards and statements.

Question: "With SSVF self-referrals, many participants and not entering CES and they are often missing out on housing opportunities that go through CE."

Response: Participants who access a program outside of the coordinated entry system (CES) can access housing opportunities by completing a VI-SPDAT through a CORE team, CARE Center or Emergency Shelter and being referred to the Community Queue.

Comment: "the feedback process was very limited...60 minutes for presenting the model along with other models, and 60 minutes for questions about this and the RRH model. Not nearly enough time for a meaningful discussion. Also, we have questions about how standards will be measured and reported."

Response: Thank you for your comment and we hear your frustration. See Chapter Two on the community feedback process. The Homeless Management and Information System (HMIS) will have the ability to generate reports. The Research, Evaluation and Data (RED) team will lead developing reports and dashboards to reflect the performance standards.

Comment: "I wish this were a discussion instead of a 500-word limit in a 93-question survey. Lots of questions about what data this was based on, if providers can see and learn from the data you saw, and how certain standards will be measured and reported. Will HMIS generate reports based on the standards?"

Response: Thank you for your comment and we hear your frustration. See Chapter Two on the community feedback process. The Homeless Management and Information System (HMIS) will have the ability to generate reports. The Research, Evaluation and Data (RED) team will lead developing reports and dashboards to reflect the performance standards.

Comment: "Don't operate out of scarcity, build safe places where unhoused people can camp and live/park their cars with sanitation while they wait to get into an emergency shelter, and advocate for more funding for housing."

Response: H3 recognizes the need in our community for more shelter and housing resources. H3 is committed to working with local cities and stakeholders to provide safe and affordable housing and continuing to partner with other county departments such as Housing Authority, the Department of Conservation and Development (DCD) and other city developers in creating more safe and affordable housing in our community.

Comment: "The models seem to change every few years. It is always confusing for everyone involved all the new names of programs, and the process to access the services."

Response: H3 agrees and understands the models have changed over time and recognizes that confusion that can cause for everyone. H3 is committed to transparency and continued training and support to our community, providers, and the people we serve on programming and how to access our homeless system of care.

Comment: "More funding for both shelter expansion and housing. Establishment of lower-cost (to the County) places where unhoused people can legally stay in self-provided shelter (tents, vehicles, etc) when shelter space is not available to them."

Response: H3 recognizes the need in our community for more shelter. H3 committed to working with local cities and stakeholders to create, advocate for and provide safe housing whenever possible.

Comment: "More interim solutions e.g., legal parking and camping places while we build more housing and shelter."

Response: H3 recognizes the need in our community for more shelter. H3 committed to working with local cities and stakeholders to create, advocate for and provide safe housing whenever possible.

Comment: "Think all programs need to be overhauled all together & everything in them."

Response: Thank you for your comment. These program models will be implemented in the 2022-2023 contracts. After a year of implementing these new models, the CoC and providers will have the opportunity to evaluate the effectiveness of the models.

Comment: "Housing options. More low-income housing. Need more desired options."

Response: See Chapter One, Section 6. H3 is committed to making housing affordable and providing support services to those once in housing by creating additional Permanent Supportive Housing projects when funding is available.

Comment: "Housing people can afford and be supported."

Response: See Chapter One, Section 6. H3 is committed to making housing affordable and providing support services to those once in housing by creating additional Permanent Supportive Housing (PSH) projects when funding is available.

Comment: "I feel that there are good intentions, programs and funding, however living in East CoCoCo. To access the needs for individuals in needs to difficult to access and very time consuming for individuals seeking immediate needs."

Response: H3 recognizes the lack of programming in East County and wants to highlight an interim housing program in East County, Delta Landing, that provides shelter and services to people experiencing homelessness. H3 is committed to working with cities in East County in applying for funding when available to support additional services and housing in East County.

Comment: "The format used seemed to be created for use with an oral presentation. The information in the slides was inadequate to evaluate."

Response: Thank you for your comment and noted. The community feedback process is referenced in Chapter Two.

Comment: "Need more community feedback overall."

Response: Thank you for your comment and noted. The community feedback process is referenced in Chapter Two.

Comment: "I feel like currently the programs listed aren't capturing all that could benefit the outreach for these populations aren't easy to locate."

Response: CORE mobile outreach teams will continue to partner with local cities, community members and people with lived experience to outreach people who may be difficult to locate. Community members are encouraged to reach out to CORE by calling 211 and pressing 3 to speak with CORE dispatch when a member of our community needs outreach.

Question: "Is it possible for providers to get a view of the whole system? The Contra Costa Homeless Service System Map is helpful, and, it would be great to get a more detailed view of which organizations have how many slots for each housing type."

Response: "Outside of the scope of this project. H3 will look into this idea."

Question: "When are performance measure expectations expected to be reality?"

Response: Performance measures will be part of the 2022-2023 contracts, starting July 1st, 2022.

Question: "How will HUD timeline expectations align with bay area housing market?"

Response: "Outside of the scope of this project."

Question: "Page 3, IV.3: *"The models also affirm the prioritization of the longest time homeless and highest VI-SPDAT for RRH."* Is it possible to share the data you saw that led to the decision to do away with VI ranges for various program models? We ask not to challenge, but to learn."

Response: The decision to prioritize Rapid Rehousing like Permanent Supportive Housing (highest VI-SPDAT score and highest length of time homeless) was made and piloted in 2019 with a technical assistance provider, Technical Assistance Collaborative (TAC) and maintained throughout the pandemic. Materials from those meetings can be provided by H3. National studies commissioned by the Veteran's Administration and HUD have

demonstrated that this approach is viable for achieving housing stability for high needs populations and does not lead to greater returns to homelessness.

Question: "The Housing First model allows space for a client to fail in a program and take those lessons and be rehoused in a different model… Will the CoC explicitly state that this element is in practice? For example, if a client in an RRH model fails, instead of exiting them to homelessness, can they be put in the "front of the line for" PSH, even if they don't have the highest VI score and length of time homeless?"

Response: Currently households who enter a Rapid Rehousing project chronically homeless and with a disability are eligible for Permanent Supportive Housing. The program models do not change that, nor will those households move to the top of the community queue. The community queue will continue to be ordered by VI-SPDAT score and length of time homeless.

Question: "The Program description does not mention referrals to Housing Navigation (Hope Solution). Will this still be the case?"

Response: The Housing Navigation program model will not be a part of these program models. However, referrals to CORE, CARE Centers and 211 will continue.

Comment: "Much of what you propose assumes the people you want to help, want your help. I have heard anecdotally from those servicing chronic homelessness there is a sizeable percentage that prefer life on the street. Drug abuse, alcoholism, mental disease, affect a large proportion. They need to be moved to community housing in areas where they do not disturb residents or business neighbors. With their cooperation or without. Whether that space is city, county or state, the time has come to respect neighbors and communities, move the chronic homeless off the streets, parks, and roadways. Their lifestyle choice and chaos are not appreciated by anyone. Asking public services employees to intervene is dangerous work. It is beyond the time to ensure their safety by placing chronic mentally ill, drug addicted homeless to sanctioned camps or housing when possible."

Response: There are many factors that contribute to homelessness and chronic homelessness. H3 will continue to operate mobile outreach teams to bring people into shelter. H3 will continue to partner with local cities, public officials, and law enforcement to ensure health and safety within our community.

Appendix B: Glossary of Terms