Draft Program Models and Performance Measures

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Introduction

I. Background

In April of 2021 H3 contracted with EdeColigny Consulting LLC to draft intervention model descriptions, identify performance measures for those models, and recommend templates and language for inclusion in provider contracts. The original proposals and system analysis were submitted by Elaine de Coligny in October 2021. Elaine and H3 staff refined models to present to the community in February 2022.

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). Rapid Rehousing programs exit under 50% of participants to permanent housing (pg. 30), when the national average is around 80%. Some interviewees reported lots of time spent on case management, but not enough securing housing.

It became apparent that the CoC would benefit from aligning its efforts to improve system performance and updating the *Systemwide Written Standards for Providing Housing and Supportive Assistance* (the Written Standards) with this Performance Based Contracting (PBC) project. Individual provider performance and the CoC's performance are interdependent. Not all challenges faced by the CoC can be addressed by clearer Written Standards and more performance-based contracts, but nearly everyone felt the project could help with both performance and morale.

The seven intervention model descriptions, once vetted and adopted, are intended to be incorporated in the Written Standards as well as the provider contracts. This introduction includes a discussion of issues that emerged in the course of this work and the proposals for addressing them.

II. Intervention Model Descriptions

Each model description is standardized and outlined as follows:

a. Purpose of the Intervention both what it does on behalf of the participants and its role in the system
b. Eligible and prioritized population for the intervention
c. Required elements that define the Intervention
d. Best practices or optional activities
e. Minimal operating hours and other access issues, such as virtual or site-based versus mobile
f. Referral, enrollment and exit requirements
g. Continuum of Care capacity and anticipated turnover
h. HMIS participation
i. Staffing such as kinds of positions needed and/or responsibilities of staff
j. 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 need updating as well according to H3 staff.

Each description is about 2-2.5 pages in length. I recommend including them in their entirety in the Written Standards, that is where the community can understand the role and responsibilities of these interventions. Contracts are only seen by the vendor and the funders, which can lead to broader frustration with performance if expectations are not transparent.

III. Draft Service Plan template for provider contracts

The template is designed to use the language from the model descriptions and performance measures that will be adopted for the Written Standards. The template follows the outline of the Service Plan in the existing contracts but modifies the content of the first 4 items.

IV. How System Issues Are Addressed within Model Descriptions and Performance Measures

Several system level issues emerged during work on the project. They are discussed below in terms of how the model descriptions and performance measures are designed to address them.

1. Overlapping responsibilities between models: The *Purpose, Required and Optional Elements* of the model descriptions attempt to address this dynamic of duplication and gaps within and across models. Currently, there appears to be a more sporadic response to addressing gaps. As responsibilities are clarified it will be vital for the H3 and the CoC to resource programs in the models adequately to meet the requirements of the model. For example, this document recommends that year-round shelters have housing focused case managers to work on document readiness in support of reducing length of time homeless.

2. The perception of referrals to nowhere and the capacity of programs: Several interviewees expressed frustration regarding referrals and whether people got served. The system appears to be designed to encourage all eligible people to be referred to Rapid Exit and CARE Center Case Management. Yet the annual report shows a relatively small number of people served, 63 by Rapid Exit and 1,680 households used CARE Centers. The discussion of *Eligible and Prioritized Populations* as well as the *CoC Capacity and Anticipated Turnover* will help manage expectations of how many people/households can be served with the resources dedicated to an intervention. This approach requires the system to get clearer about who is prioritized for interventions when all eligible people can't be served. The capacity and turnover would need to be updated in the Written Standards **annually** using the HIC and the Annual Report data.

   The discussion of S*taffing* in the model descriptions also addresses capacity by identifying a point-in-time capacity as well as thinking about how many households an FTE can assist over the course of the year. The recommendations in the models are an educated guess feedback is welcome here.

3. Prioritization: The PSH and RRH models have the option to refer people at risk of losing their housing to prevention/diversion. Prior homelessness is the strongest indicator for future homelessness so people referred from these PH programs will be prioritized in the Prevention/diversion program.

   The models also affirm the prioritization of the longest time homeless and highest VI-SPDAT for RRH. The CoC uses case conferencing and dynamic prioritization to ensure that the most appropriate match is made between available units/programs and the highest priority individuals in terms of unit size and location, household preferences, and funder requirements. The efficacy of this approach should be formally evaluated.

4. Length of Time Homeless, document readiness, and timing of referrals to the Community Queue: The Calendar Year 2020 Annual Report notes that lengths of time homeless have increased by 42% since 2018. Anecdotes from interviews describe participants with housing vouchers or incomes taking six months to a year to locate units/landlords willing to rent to them. One possible explanation for this dynamic is that people are referred to the community queue and prioritized before they have a working relationship with staff or are document ready? When they come up for housing, it may be hard to locate them, and they may be weeks away from having the documents they need to move-in.

   We are recommending that the Community Queue be operated differently. It can be structured to flag household records when they are document ready for housing (I.e., picture ID, social security card, proof of income and disability and other documents as needed) and that units be filled from that list rather than exclusively the highest scoring. This can create a tension between housing the most vulnerable and housing the those who are high need and have the documents to move in. There are two strategies to mitigate that. The first is to have all the emergency services—shelters, CORE, and CARE Centers work to get all their clients document ready, starting at the first encounter whenever possible. The second is to identify the top 50 prioritized individuals in the queue and assign someone to locate and work with them to get the documents they need so they are ready when there is an opening. The model descriptions are written assuming these approaches.

   Model descriptions also expect shelters, CORE and CARE Centers to support RRH and PSH, with connecting to the households they are working with to facilitate enrollment and housing search persistence.

5. Frustration with data quality: "What gets measured, gets done." The model description and contract language include performance measures for data quality. The description articulates the role of the provider's HMIS administrator to go beyond program set up to include managing for data quality.

6. How to Benchmark Performance Measures: We have settled on the performance benchmarks to propose to the for your feedback. The benchmarks are consistent with expectations/performance in your or other CoCs. Where CCC 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, will be tracked in year one and then benchmarked for the next year.

Intervention Models

Intervention Model: Permanent Supportive Housing

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

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

III. **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. Can be scattered-site or project-based. Must include:

a) Rent subsidy such that the participant household pays no more than 30% of adjusted income for rent.

b) 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.

c) Each project must assist participant with locating and applying for housing.

IV. **Optional Elements or best practices:**

a) People get healthier in PSH and may not always need wrap around services. Helping participants who wish to "move-on" to less intensive permanent housing, such as Section 8 or an affordable housing development improves system flow by opening more PSH slots.

b) The system is designed to enroll households in PSH programs when they are "document ready" (I.e., picture ID, social security cards, proof of income and disability and other documents as needed), 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.

V. **Access and Operating Hours:** Housing must be available twenty-four hours per day, 365 days per year. Services must be available a minimum of regular business hours. 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.

VI. **Referrals to and from, Enrollment and Exit:**

a) 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.

b) 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 emergency response services.

c) 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.

d) 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.

VII. **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 program year July 1, 2022-June 30, 2023, the CoC anticipates 35 new units to become available.

VIII. **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. 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.

IX. **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.

X. Performance Standards:

a) Less than 5% of eligible CE referrals are declined
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 non-cash benefits, including health insurance, for which they would be eligible, have acquired those benefits by program exit/annual update or show a 10% improvement from prior year if rate is below 70%.
f) Program demonstrates equitable service delivery and results by enrolling, moving in, and retaining overrepresented racial groups at the same prevalence rates as they have in the homeless population
g) Staff, Leadership, and board membership of provider agency include people with lived experience and/or are reflective of the populations being served by race and gender mix.
h) Meet data quality standards as outlined in CoC HMIS Policy and Procedures' Data Quality and Monitoring Plan.

i) 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.

ii) Data entered within two days of service event including entry and exit.

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

Intervention Model: Rapid Rehousing

i. **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 may taper down over time, and 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 support.

ii. **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

iii. **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:

a. Medium-term rental assistance, meaning 6-24 months depending on the requirements of the funding source.

b. 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 strategy for reducing and eventually ceasing project assistance to the household.

c. Assisting households to secure any cash and non-cash benefits for which they are eligible and/or increase income.

d. 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.

e. Each project must assist participant with locating and applying for housing

f. Follow-up at 30-, 60-, 90- and 180-days post housing subsidy to confirm housing is stable and make additional referrals if needed.

IV. **Optional Elements or best practices:**

a. Staff positions dedicated to housing location, i.e., landlord facing, distinct from case managers, who are client facing.
b. The system is designed to enroll households in RRH programs when they are "document ready" (I.e., picture ID, social security card, proof of income and disability, and other documents as needed), 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.

V. **Access and Operating Hours:** Housing must be available twenty-four hours per day, 365 days per year. Services must be available a minimum of regular business hours. Evening and weekend

hours are encouraged if resources allow. Projects funded at 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.

VI. **Referrals to and from, Enrollment and Exit:**

a. Eligible households must be referred to the community queue. RRH openings are filled by drawing from the community queue in order of priority.

b. 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 emergency response services.

c. 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.

d. 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-participations is not a reason for terminating a participant. Persons exiting RRH are typically exiting the system of care.

VII. **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 program year July 1, 2022-June 30, 2023, the CoC anticipates 120 of new RRH slots to become available through Coordinated Entry.

VIII. **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.

IX. **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.

X. **Performance Standards:**

a. Less than 5% of eligible CE referrals are declined
b. 75% of program participants have moved into permanent housing and are receiving housing rental assistance. Or no more than 25% of participants 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 have exited program with permanent housing will continue to be permanently housed at the time of 180-day follow-up contact show a 10% improvement from if rate was below 70% in previous program year.
f. 80% of those who enroll in the program without non-cash benefits, including health insurance, for which they would be eligible, have acquired those benefits by program exit or show a 10% improvement from if rate was below 70% in previous program year.
g. 50% of those who enroll in the program without fixed incomes (SSI) have increased their income by program exit or show a 10% improvement from if rate was below 40% in previous program year.
h. Program demonstrates equitable service delivery and results by enrolling, moving in, and retaining overrepresented racial groups at the same prevalence rates as they have in the homeless population
i. Staff, Leadership, and board membership of provider agency include people with lived experience and/or are reflective of the populations being served by race and gender mix.
j. Meet data quality standards as outlined in CoC HMIS Policy and Procedures' Data Quality and Monitoring Plan.
    i. An error rate of no more than 5% for f null/missing and unknown/don't know/refused responses for all UDEs and program specific data elements excluding Domestic Violence and Social Security Number.
    ii. Data entered within two days of service event including entry and exit.

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

Intervention Model: Rapid Exit

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

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

III. **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 has no sobriety requirement, treatment compliance, criminal justice history exclusions or minimum income requirements for enrollment. Must include:

a) Housing Problem Solving with participants to make every effort to re-house the household quickly by reconnecting with family, friends and/or former landlords.
b) 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, other expenses that impact a person's ability to obtain or return to housing.

IV. **Optional Elements or best practices:**

a) The Housing Security Fund is a flexible source that does not limit payments to utility companies and formal landlords. It can include travel vouchers, food vouchers, repairs to residences, and a range of other cost that can be reasonably tied to ensure the participant obtains temporary or permanent housing.

V. **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.

VI. **Referral, Enrollment and Exit:**

a) Eligible households can be referred by CORE, CARE Centers, Emergency Shelters, or Prevention services that were unable to help the household avoid homelessness. 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.
b) Rapid Exit can make referrals to CARE Centers, CORE, or Emergency Shelters while assisting participant to exit homelessness.
c) 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 RRH or PSH. Once moved into housing they should be exited from emergency response services.
d) 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.

VII. **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 100, or 8-10 households/month, in program year July 1, 2022-June 30, 2023. The program can provide up to $3,000 of assistance on a first come first serve basis. Rapid Exit will notify referring agencies if monthly funds have been fully expended and will continue to provide Housing Problem Solving

VIII. **Required Staffing**:

a) *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. We estimate capacity will be 8-10 households per month.

IX. **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.

X. **Performance Standards:**

a) Less than 5% of eligible referrals are declined
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 show 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) Program demonstrates equitable service delivery and results by enrolling, moving in, and retaining overrepresented racial groups at the same prevalence rates as they have in the homeless population
g) Staff, Leadership, and board membership include people with lived experience and/or are reflective of the populations being served by race and gender mix.
h) Meet data quality standards as outlined in CoC HMIS Policy and Procedures' Data Quality and Monitoring Plan.
    i) An error rate of no more than 5% for f null/missing and unknown/don't know/refused responses for all UDEs and program specific data elements excluding Domestic Violence and Social Security Number.
    ii) Data entered within two days of service event including entry and exit.

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

Intervention Model: Year-Round Emergency Shelter/Interim Housing

I. **Purpose:** To provide safe interim housing for people experiencing literal homelessness while supporting their access to permanent housing opportunities by assisting them to secure benefits and income and obtain the documents needed to access housing (I.e., picture ID, social security card, proof of income and disability and other documents as needed).

II. **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 Standards of Service.

III. **Required Elements:** Emergency Shelter/Interim Housing programs operate year-round and are focused on helping participants exit to permanent housing. The model is Housing First and has no sobriety requirement, treatment compliance, criminal justice history exclusions or minimum income requirements for enrollment or continued stay. Must include:

a) A structure(s) that meets the ESG's minimum habitability standards for Emergency Shelters
b) Provides Housing Focused Case Management that helps participants to develop and pursue a housing plan; provides information and referrals; housing problem-solving; support with obtaining the documents necessary to acquire housing (I.e., picture ID, social security card, proof of income and disability and other documents as needed); connecting to public benefits and income; serves as a point of contact for Rapid Exit, RRH and PSH during enrollment and housing search.
c) Employ a trauma-informed care approach.
d) Provides a minimum of 2 meals per day. Three is a best practice.
e) 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.

IV. **Optional Elements or best practices:**

a) Reduces barriers further by accommodating partners, pets and possessions and eliminating curfews and other restrictions more appropriate for adolescents than adults.
b) Connect participants to health, behavioral health, and substance use services whenever possible.

V. **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.

VI. **Referral, Enrollment and Exit:**

a) 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 and work to reduce barriers to entry unless CORE does not have a referral the day the bed opens. Then beds can be filled with referrals from 211 or CARE Centers, Emergency Shelters, or Prevention services that were unable to help the household.

b) Shelters can make referrals to Rapid Exit or 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.

c) Participants enrolled in Emergency Shelters can be co-enrolled with Rapid Exit, RRH or 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.

d) 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.

VII. **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 2400 in program year July 1, 2022-June 30, 2023. This assumes each shelter bed is used by 4 of 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 youth than families with minor children. Turning shelter beds over more frequently because people exit to housing is the most efficient way to expand shelter capacity.

VIII. **Staffing**:

a) *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.

b) *Housing Focused Case Manager:* Conducts shelter intake, enrolls in CES (if not already completed by CORE or CARE), conducts triage tools as needed, the housing needs assessment (VI-SPDAT), makes referrals to Community Queue, housing problem solving, works with participant to develop a housing plan and remove barriers to housing such as acquiring documents (I.e., picture ID, social security card, proof of income and proof of disability and other documents as needed), connects to 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 25-30 participants.

IX. **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.

X. 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) 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. Includes temporary housing not funded by system of care and exits to RRH and PSH.

d) 40% of participants in Case Management that start without benefits are enrolled in one or more non-cash benefits or income sources by exit or show a 10% improvement if rate was below 25% in previous program year.

e) Year 1 will track % of people who enter program without housing docs and % who have them by exit to set performance benchmarks for 23-24 contracts.

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

g) Exits to unknown destinations are 20% or less or show a 10% improvement if exits are above 30%

h) Staff, Leadership, and board membership include people with lived experience and/or are reflective of the populations being served by race and gender mix.

i) Program demonstrates equitable service delivery and results by enrolling, moving in, and retaining overrepresented racial groups at the same prevalence rates as they have in the homeless population

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

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

   ii) Data entered within two days of service event including entry and exit.

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

Intervention Model: CARE Centers and CARE Center Case Management

I. **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.

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

III. **Required Elements:** CARE Centers are a low barrier, low demand resource center for unsheltered people. 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:

a) 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.

b) 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; support with obtaining the documents necessary to acquire housing (I.e., picture ID, social security card, proof of income and disability and other documents as needed); serves as a point of contact for Rapid Exit, RRH and PSH during enrollment and housing search.

c) Employ trauma-informed care practices.

IV. **Optional Elements or best practices:**

a) All drop-in participants, whether 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.

V. **Access and Operating Hours:** Services must be available a 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.

VI. **Referral, Enrollment and Exit:**

a) 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.

b) 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 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.

c) Participants enrolled in CARE Centers and 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 a CARE Centers may continue to be assisted by other CoC and ESG programs.

d) 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.

VII. **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 program year July 1, 2022-June 30, 2023. Up to **240** will be assisted by Housing Focused Case Management.

VIII. **Staffing**:

c) 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 CM, reviews attendance for referring active clients and schedules appointments with CM to begin housing focused case management.

d) *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 acquire documents for housing (I.e., picture ID, social security card, proof of income and disability and other documents as needed), 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 30 participants.

IX. **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.

X. **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 16%. 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 23-24 contracts.

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

d) Program demonstrates equitable service delivery and results by enrolling, moving in, and retaining overrepresented racial groups at the same prevalence rates as they have in the homeless population

e) Staff, Leadership, and board membership include people with lived experience and/or are reflective of the populations being served by race and gender mix.

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

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

   ii) Data entered within two days of service event including entry and exit.

   iii) 90% or greater of participants have been exited who have not had a service encounter within 120 days. A minimum of 3 attempts to contact before exiting.

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

Intervention Model: Outreach/CORE Teams

I. **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 to 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.

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

III. **Required Elements:** CORE Teams are a primary access and enrollment point for CES for unsheltered people. 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:

a) 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.

b) 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.

c) Continued work with persons who are in the Community Queue for Navigation, RRH or PSH, but cannot access a CARE Center or Emergency Shelter in the interim. CORE Teams help with document readiness (I, e., picture ID, social security card, proof of income and disability and other documents as needed), Housing Problem Solving, meeting survival needs and helping programs stay connected during housing search.

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

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

f) Provide transportation to and from appointments as needed for participants who are unsheltered and are unable to access other transportation services.

IV. **Optional Elements or best practices:**

a) All participants, whether 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.

V. **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.

VI. **Referral, Enrollment and Exit:**

a) 211 is the primary referral source and callers are transferred to the CORE hot 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).
b) 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. Staff should continue housing problem solving and document readiness (I.e., picture ID, social security card, proof of income and disability and other documents as needed) even after referrals are made. Centers can also make referrals to Emergency Shelters that are not filled through CORE referrals.
c) Participants working with CORE teams can be co-enrolled in CARE Centers (meaning they can use the drop-in centers), Rapid Exit, 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.

VII. **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.

VIII. **Staffing**:

a) *Lead Outreach Worker:* Plays a senior role on the team and works collaboratively to locate, engage, stabilize and house chronically homeless individuals and families. Provides guidance and expertise to a multidisciplinary team which serves to support and stabilize individuals moving from street to service.
b) *Outreach Workers: P*articipate on teams that 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.
c) *Dispatch staff:* Screen referral calls and assign teams to go and locate unsheltered people and help.
d) *Clinical Social Workers*: Provide comprehensive strengths-based, trauma informed, case management services to engage unsheltered and chronically homeless individuals and families in services. Social Workers hold an average caseload of 10-15 clients at any given time.
e) *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.
    i. *Program Manager:* Provide leadership, direction, and oversight of CORE operations to ensure the success of the program, which includes all administrative/management functions, reporting, supervising staff, contract monitoring and training.

IX. **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.

X. 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) 35% of participants in CORE that start without benefits are enrolled in one or more non-cash benefits or income sources by exit.

c) Year 1 will track % of people who enter program without housing docs and % who have them by exit to set performance benchmarks for 23-24 contracts.

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

e) Program demonstrates equitable service delivery and results by enrolling, moving in, and retaining overrepresented racial groups at the same prevalence rates as they have in the homeless population

f) Staff, Leadership, and board membership include people with lived experience and/or are reflective of the populations being served by race and gender mix.

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

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

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

   iii) 90% or greater of participants have been exited who have not had a service encounter within 120 days. Reasonable attempts to locate within final two weeks. Maybe an automated ping at 90 days.

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

Intervention Model: Homelessness Prevention/Diversion

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

II. **Eligible Population and Prioritization:** Eligible households meet HUD's definition of "at-risk of homelessness" in 24 CFR 576.2.

III. **Required Elements:** Those that meet the criteria for most at risk are supported with housing problem solving and, if needed, financial assistance to avoid time in emergency shelter or unsheltered homelessness.

a) 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.

b) 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 must be consulted with CE Manager.

IV. **Optional Elements or best practices:**

a) Secure commitment from landlord not to pursue eviction/canceling of the lease after payment.
b) Homeless prevention is provided based on need rather than proof of sustainability post assistance.

V. **Access and Operating Hours:** Services must be available a 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.

VI. **Referral to and from, Enrollment and Exit:**

a) Homelessness prevention may receive referrals from 211 or RRH or PSH programs. Referrals are made directly to the program, not through Coordinated Entry.
b) Participants enrolled in Homelessness Prevention/Diversion can be co-enrolled with PSH. Participants should not be co-enrolled in programs that require participants to be literally homeless, CORE, CARE, Emergency Shelter, Rapid Exit, and RRH.
c) 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.

VII. **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.

VIII. **Staffing**:

a) *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.

X. **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.

XI. Performance Standards:

a) Fewer than 20% of those assisted fall outside of the priority populations.
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) Program demonstrates equitable service delivery and results by enrolling, moving in, and retaining overrepresented racial groups at the same prevalence rates as they have in the homeless population
f) Staff, Leadership, and board membership include people with lived experience and/or are reflective of the populations being served by race and gender mix.
g) Meet data quality standards as outlined in CoC HMIS Policy and Procedures' Data Quality and Monitoring Plan.
    i) An error rate of no more than 5% for f null/missing and unknown/don't know/refused responses for all UDEs and program specific data elements excluding Domestic Violence and Social Security Number.
    ii) Data entered within two days of service event including entry and exit.

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

COMMUNITY CONVERSATION: HOMELESS PROGRAM MODELS

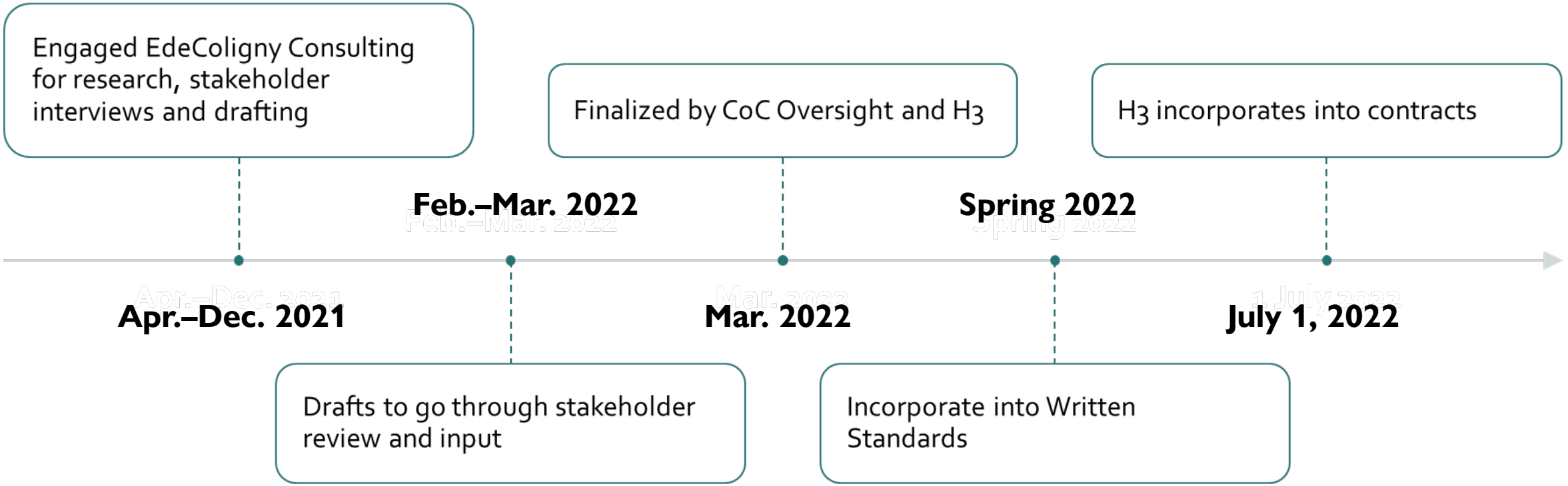
ELAINE DE COLIGNY

AGENDA

- Purpose
- Process
- Walk through proposed program models
- Parking Lot
- Training
- HMIS Configuration
- Discussion of proposed program models

PURPOSE

- To document and refine the program models used to operate the Contra Costa County CoC, enabling 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


Engaged EdeColigny Consulting for research, stakeholder interviews and drafting
Apr.–Dec. 2021
Drafts to go through stakeholder review and input
Feb.–Mar. 2022
Finalized by CoC Oversight and H3
Mar. 2022
Incorporate into Written Standards
Spring 2022
H3 incorporates into contracts
July 1, 2022

PROCESS

PROGRAM MODELS

- Permanent Supportive Housing
- Rapid Rehousing
- Rapid Exit
- Emergency Shelter
- CARE Centers
- Outreach
- Prevention/Diversion

STANDARDIZED STRUCTURE OF PROGRAM MODELS

A. Purpose

B. Eligible and prioritized population

C. Required elements

D. Best practices or optional activities

E. Minimal operating hours and other access issues

F. Referral, enrollment and exit requirements

G. Capacity and anticipated turnover

H. HMIS participation

I. Staffing

J. Performance Measures: two equity measures and one data quality measure

CHALLENGES ADDRESSED BY THE MODELS

Gaps and duplications in housing and services across different program models (Items A-D, I)

"Referrals to nowhere" (Items E-G, I)

Increasing lengths of time spent homeless (Changing the use of the community queue and responsibility for document readiness)

Unclear performance expectations (Item J)

Data Quality (Item H, J)

Racial Equity (Item J)

WALK THROUGH A MODEL

PERMANENT SUPPORTIVE HOUSING

PERMANENT SUPPORTIVE HOUSING

PARKING LOT

- Shelter Prioritization Tool
- Changing the Housing Needs Assessment (VI-SPDAT)
- Centralized Landlord Location
- Expanding Diversion/Prevention model to apply to all prevention programs broadly
- Prioritization Tool for Prevention
- Assessment for moving on from PSH to TCV or other housing
- Formal guidance on when RE and Diversion can override per household spending limits

TRAINING NEEDS

- 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)

TRAINING NEEDS- HMIS

- Triage Tool (REFRESH)
- Housing Needs Assessments (VI-SPDAT) (REFRESH)
- Follow ups after exit (NEW)
- Community Queue Referrals (NEW)
- Accepting & Denying Referrals (REFRESH)

SLIDE FOR CHRISTY

DISCUSSION & QUESTIONS

BREAKOUT ROOMS

PROGRAM MODELS WALK THROUGH

NEXT STEPS

- **February 1st to March 4th**: Community Input Period
  - Online posting and ability to submit comments
  - May include survey emailed to CoC members and service providers

- **End of March**: Consultant and H3 will integrate/respond to feedback and finalize draft for CoC Oversight review and approval.