MORE.
BETTER.
DIFFERENT.

A Strategic Plan to Address Homelessness in Sacramento

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SACRAMENTO
STEPS FORWARD

Ending Homelessness. Starting Fresh.

HomeBase
Advancing Solutions to Homelessness

Contents

Executive Summary and Timeline

Our Vision

We envision a system of care in which people at risk of homelessness receive necessary support to stay housed, people who become homeless are permanently housed with appropriate services, and long-term homelessness is a thing of the past.

Our Goal

Our goal is to align our system of affordable and accessible housing and services to maximize the number of individuals achieving housing stability.

In Sacramento County, federal and state policy, local gaps and disparities, resource limitations, and the needs of diverse people all intersect to create the homeless system of care. Aligning our system of care to address homelessness effectively within those realities requires careful evaluation of existing housing and services, the needs and demographics of our homeless neighbors, and a systems-oriented approach to targeting our resources and measuring successes.

The Sacramento homeless system of care is robust, and we have made great progress in creating effective programs and coordinating our efforts to end homelessness. However, we need to know more about the gaps in our system, and we must increase the efficiency and effectiveness of our work to end homelessness in our community.

A Continuum of Care or CoC is a group of stakeholders responsible for coordinating homeless services n a particular geographic area. Our CoC covers all of Sacramento County and encompasses the cities of Citrus Heights, Elk Grove, Folsom, Galt, Isleton, Rancho Cordova, and Sacramento, as well as the unincorporated areas of the county. Unless specifically noted, "Sacramento" in this plan refers to the entire geographic area encompassed by the CoC.

The Opportunities for System Improvement

Through the meetings, conversations, and other input gathered during the creation of this plan, there were thirteen opportunities for improving the system of care that arose again and again. Those key opportunities became the thirteen sections of this plan.

This plan classifies those opportunities into three categories, each based on the approach necessary to improve our system of care. In some cases, we have not targeted enough resources or attention to meet our community's needs; in other cases, we need to increase efficiencies; and finally, in yet other cases, we need to completely change our approach. These differences provided our More, Better, Different framework.

When we respond on-the-ground to these thirteen opportunities, however, we will categorize them differently.

This community needs **more of specific resources**:

- Permanent Supportive Housing, particularly for the most vulnerable and specific populations

- Affordable Housing, both for those who do not need service-enriched housing and those who are ready to move on from supportive housing
- Crisis Responses, including rapid rehousing
- Behavioral Health Services
- Employment Services

This community needs **increased system-level responses**:

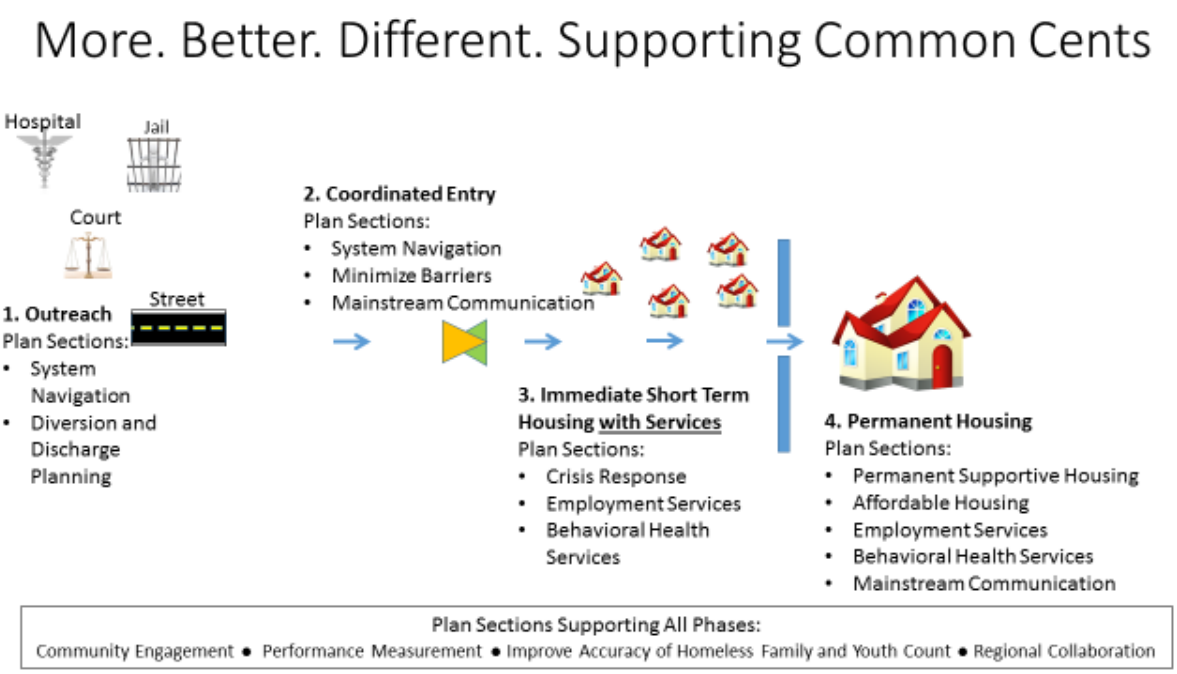
- System Navigation
- Performance Measurement
- Crisis Responses
- Minimized Barriers to Housing
- Diversion and Discharge Planning
- Improved Accuracy of Homeless Family and Youth Count

Finally, this community needs **increased collaboration and partnership**:

- Community Engagement
- Diversion and Discharge Planning
- Mainstream Communication
- Crisis Response
- Regional Collaboration

Focus on Common Cents

Parallel to this planning process, this community is beginning to implement Common Cents, Sacramento's coordinated entry and housing placement pilot system focused on chronically homeless persons and veterans designed to help individuals living on the street or exiting corrections or health care institutions to navigate the system of care and access the short term housing, long term housing, and services needed to end their homelessness. This plan is linked to the strategies and stages of Common Cents.



Responding to Individual Needs

This plan emphasizes that one size does not fit all, and this community is committed to using data and best practices to meet the needs of different people using resources in the most effective way. See Appendix C for an example of this plan broken out by population.

Moving Forward

This plan begins where our community is, and moves us forward to where we want to be. We are committed to using our resources as efficiently and effectively as we can, and to do that, we need to ensure our decisions are supported by data, information, and the reality on the ground. Where we do not have that information yet, this plan calls for getting that information before we make changes. We have frontloaded the data gathering and analysis required in the timeline below. *A compilation of those data-related strategies may be found in Appendix B at page 95.*

Plan Summary

Overall Indicators of Success

End veteran homelessness by 2016

End chronic homelessness by 2017

End family and youth homelessness by 2020

Overall reduction in homelessness by 10% biennially

These indicators of success align with those in *Opening Doors* and reflect community priorities.

More

Things we're doing well already; we just need more!

This section highlights selected strategies from each section of the plan. Additional background detail, best practices, strategies, specific action steps, timelines, and responsible parties may be found in the plan body.

Permanent Supportive Housing

INDICATOR OF SUCCESS

By 2017, chronic homeless population is zero; functional zero maintained each year.

Permanent supportive housing (PSH) is an essential support for people with high needs and many barriers to housing. Though the Sacramento Continuum of Care has a strong and growing stock of PSH, there is not enough to meet existing need. Key strategies include:

- Increasing targeting of existing PSH to the most vulnerable people
- Increasing the supply of PSH targeting specific populations

Affordable Housing

INDICATOR OF SUCCESS

By 2025, less than 5% of people who have been homeless and been housed become homeless again.

In order to reduce the number of people who become homeless and to provide housing for those leaving homelessness, Sacramento needs more housing affordable to people with extremely low incomes. Key strategies include:

- Partnering with the Sacramento Housing and Redevelopment Agency (SHRA) to maximize homeless households' access to affordable housing
- Increasing our affordable housing stock

Behavioral Health Services

INDICATOR OF SUCCESS

By 2020, homeless people in need of serious behavioral health intervention consistently access services within 10 days.

People who are homeless frequently require behavioral health services to regain and maintain long-term stability; additionally, behavioral health intervention at appropriate times can prevent homelessness for some people. In Sacramento, though our behavioral health services are high-quality, people who are homeless do not have sufficient access. Key strategies include:

- Supporting local expenditure of MHSA funds for targeting people who are homeless
- Increasing intake and assessment capacity to reduce system backlogs
- Increasing available substance abuse services

Diversion and Discharge Planning

INDICATOR OF SUCCESS

By 2025, reduce by 50% the number of people presenting to Common Cents who come directly from another system of care or whose homelessness could have been avoided through diversion.

To end homelessness, we need to reduce the number of people who become homeless. By working with other systems of care like corrections or health care to avoid discharge into homelessness and diverting people from the homeless system of care by helping them identify housing alternatives, we can improve outcomes for people at risk of homelessness and open shelter beds to those who have no alternatives. Sacramento's existing discharge protocols are strong, but more coordination and implementation of diversion protocols are necessary. Key strategies include:

- Build efforts to connect people to resources before discharge from corrections and healthcare institutions

- Develop community-wide diversion system to identify housing alternatives for households seeking shelter.

Better

Key elements of our successful system, but room for improvement

System Navigation

INDICATOR OF SUCCESS

By 2025, reduce average length of homelessness by 50% from 2018

A homeless system of care with the best possible housing and services available is useless if the people who need those resources are unaware of them or are unable or unwilling to access them. Coordinated entry, outreach and system navigation locate and connect homeless persons who might otherwise be underserved to the assistance they need. Sacramento has made great strides in improving system navigation, but additional coordination is needed. Key strategies include:

- Implement Common Cents coordinated entry system
- Ensure all outreach workers are competent to work with all populations, including youth, veterans and persons with mental illness

Employment and Education Services

INDICATORS OF SUCCESS

By 2025, 75% of non-disabled homeless youth access education services or are employed and 50% of homeless people are accessing education services or are employed.

Rental subsidies and mainstream income supports may be insufficient for long-term housing stability; access to adequate employment can be key to successful housing outcomes. Sacramento has some successful employment programs, but it remains difficult for many homeless people to obtain employment. Key strategies include:

- Explore establishment of Integrated Employment model employment programs, providing rapid access to jobs instead of extensive reemployment readiness services.
- Strengthen existing and develop new partnerships with employers
- Establish coordinated employment location system

Minimize Barriers

INDICATOR OF SUCCESS

By 2025, 100% of people who enter Common Cents can be placed in housing that meets their needs within 90 days.

People who are homeless, particularly those with felony records, multiple evictions, behavioral health challenges, and histories of long-term or chronic homelessness, face many barriers to accessing housing, including difficulties affording market rate rental units and meeting the screening criteria set by property owners, managers, landlords and homeless housing providers. Additionally, many people who are homeless keep pets for companionship; policies adopted by many landlords and homeless housing providers prohibit pets for reasons of safety and potential property damage.

Key strategies include:

- Increase Housing First implementation in all CoC-funded permanent supportive housing
- Reduce barriers to housing for people with high needs, particularly those with criminal justice histories
- Improve pet-friendly housing options for homeless people with pets

Community Engagement

INDICATOR OF SUCCESS

By 2025, increase level of community-based donations (i.e. private, business, faith-based donations) to homeless programs (Winter Shelter, One Day to End Homelessness, and/or other programs as determined by SSF) by 50%.

Community members frequently worry that allowing people to live in public places or siting homeless housing projects in their neighborhoods may present a public safety risk, decrease property values, or become a nuisance to a neighborhood's other residents. In many areas of the Sacramento Continuum of Care, communities are poorly informed about the realities of homelessness and are reluctant to accept the development of new housing projects. A key strategy is:

- Develop public engagement program sensitive to the needs of different neighborhoods

Different

Dramatic shift in thinking needed

Performance Measurement

INDICATORS OF SUCCESS

By 2020, all local homeless funders adopt CoC-established performance measures as funding criteria.
By 2025, increase CoC-level performance on all measures.
By 2025, 100% of CoC funding decisions are data-driven.

CoCs should systematically use information about how well individual projects and the system as a whole are meeting identified needs to adjust efforts and improve results. Successful performance measurement allows a CoC to minimize duplication of services, understand whether existing efforts are meeting needs, communicate successes to increase community support, and ensure that limited resources are working effectively to reduce and eventually end homelessness. Sacramento currently has a robust performance measurement protocol in place for CoC-funded providers, but collaboration with providers for improvement and system-wide performance measurement are limited. Key strategies include:

- Establish year-round collaborative performance review for CoC-funded projects
- Provide monitoring, technical assistance and other supports to all CoC-funded projects to comply with HUD requirements and align with CoC needs
- Implement system-wide performance measurement for CoC policymaking
- Work with other local funders (including DHA and SHRA) to use CoC performance metrics as funding criteria

Improve Accuracy of Homeless Family and Youth Count

INDICATOR OF SUCCESS

By 2020, using improved data and best practices for counting each population, end family and youth homelessness.

In order to determine what housing and services are necessary to serve our homeless population, first we must understand the extent and attributes of that need. Family and youth homelessness frequently looks very different from single adult homelessness; the different characteristics of family and youth homelessness mean that traditional counting practices often fail to accurately capture the scale of need for these populations. Though progress is underway to improve our understanding of these populations in our community, Sacramento's 2013 Point-in-Time Count (the primary data source on the status of

homelessness referenced in this plan) of families and youth is widely acknowledged to be an undercount. Key strategies include:

- Amend Point-in-Time Count methodology to include best practices for counting youth
- Collect data on persons who are homeless under other Federal definitions

Mainstream Communication

INDICATORS OF SUCCESS

By 2020, 100% of eligible people who are homeless are enrolled in MediCal and have a medical home.
By 2025, beginning with 2018 data, first-time homelessness is reduced by 10% year over year.

Mainstream services are often the first line of defense for people with unstable housing. Collaboration with these entities is key to supporting housing stability and reducing economic vulnerability. In Sacramento, though there are promising steps toward communication with some mainstream programs, mainstream services are largely isolated from the homeless system of care and can be difficult to engage. Key strategies include:

- Increase capacity within mainstream service providers to provide prevention services before households become homeless.
- Leverage Affordable Care Act implementation to increase healthcare service available to people who are homeless.

Crisis Response

INDICATOR OF SUCCESS

By 2025, beginning with 2018 data, percentage of people accessing diversion, prevention or rapid rehousing instead of shelter or no services increases year over year.

Intervening quickly to prevent homelessness or end a homeless episode as quickly as possible is key to reducing overall homelessness in a community. Early intervention strategies identifying households in crisis and providing short-term assistance (either prevention or rapid rehousing) to improve stability can be very effective. In Sacramento, prevention resources are limited, while our rapid rehousing stock has grown quickly and may not be appropriately targeted. Traditional crisis response models such as emergency shelter and transitional housing may not be the most effective use of resources. Key strategies include:

- Determine whether current mix of existing emergency shelter, transitional housing and rapid rehousing meet community needs.
- Access homeless prevention resources
- Develop partnerships with mainstream partners, including Legal Services of Northern California, the Sacramento Rental Housing Association, and McGeorge School of Law to provide diversion services and eviction defense

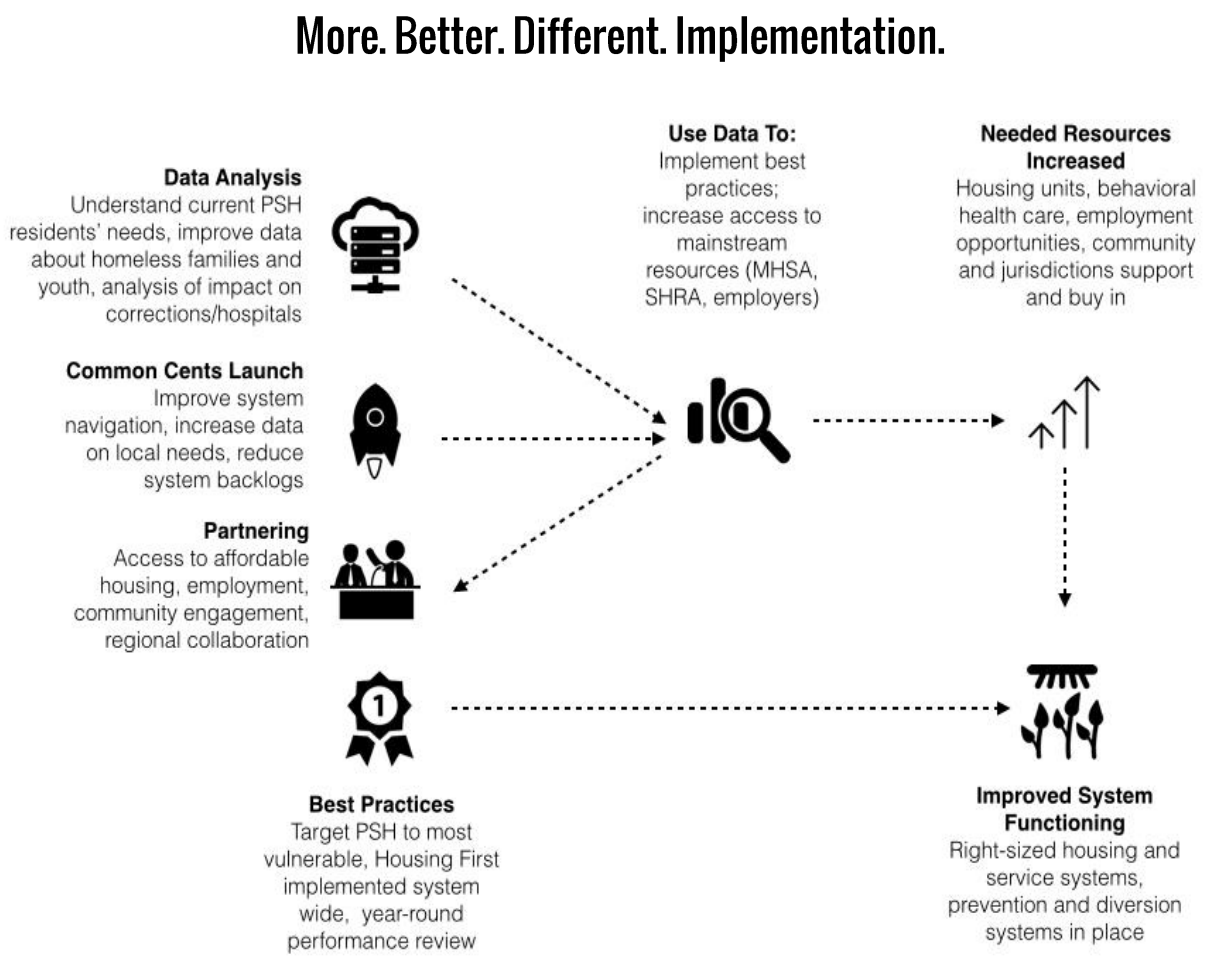
Regional Collaboration

INDICATOR OF SUCCESS

By 2025, reduce homelessness across the region by at least 25%.

Though not required by federal initiatives, because homelessness is a borderless issue and populations are fluid between communities, coordination across jurisdictional borders is the next appropriate step. In Sacramento, though informal engagement occurs among the Continuum of Care, the County, and the cities, there is no existing forum for formal engagement with the Continuum's local governmental bodies. Additionally, formal collaboration with neighboring Continuums of Care is limited. Key strategies include:

- Create forum for coordination between jurisdictions in the Sacramento CoC
- Create forum for regional inter-CoC collaboration
- Re-open discussions regarding possible mergers with neighboring CoCs



Timeline

Timelines indicate completion dates; for most items, work will begin much sooner

Phase One: *first steps and work underway* 2015-2016

Data Analysis

- Completion of initial data collection and analysis to right-size our system of care (See Appendix B)
- Year-round collaborative performance review for CoC-funded projects established (PM, Strategy 1)

Common Cents Launch

- Coordinated entry system implemented (SN, Strategy 1)
- System navigation improved, including culturally competent and geographically diverse outreach workers (SN, Strategy 2-3)

Partnering

- Partnership established with the Sacramento Housing and Redevelopment Agency (SHRA) to maximize homeless households' access to affordable housing (AH, Strategy 2)
- Existing partnerships with employers strengthened and new partnerships developed (EES, Strategy 3)
- Public engagement program sensitive to the needs of different neighborhoods developed (CE, Strategy 1)
- Landlord outreach plan to reduce reluctance to house high-needs persons developed (MB, Strategy 2)

Best Practices Implementing

- Targeting of existing PSH to the most vulnerable people increased (PSH, Strategy 2)
- Education and training opportunities improved for all populations (EES, Strategy 4)
- Implementation of Housing First in all CoC-funded permanent supportive housing (MB, Strategy 1)
- Education provided to people who are homeless about health care resources; education provide to heath care providers regarding cultural competency (DDP, Strategy 2)
- System-wide performance measurement for CoC policymaking implemented (PM, Strategy 3)

End of Phase 1: Review and Update Indicators of Success

CHRONIC AND VETERAN HOMELESSNESS ENDED

Phase Two: *next steps* 2017-2020

Use Information for Promoting New Resources

- Partnership with the Sacramento Housing and Redevelopment Agency (SHRA) continued to maximize homeless households' access to affordable housing (AH, Strategy 2)
- Mental health intake and assessment capacity increased to reduce system backlogs (BHS, Strategies 2-5, 7-8)
- Diversion resources expanded for transition aged youth (DDP, Strategy 5)
- Barriers to housing for people with high needs reduced, particularly those with criminal justice

histories (MB, Strategy 2)
- New permanent supportive housing units created, some targeting specific populations (PSH, Strategy 3)

Further Partnering
- Public engagement program sensitive to the needs of different neighborhoods continues to develop (CE, Strategy 1)
- Resources for former and emancipated foster youth increased through partnerships (DDP, Strategy 3)
- Prevention services and health care services increased through partnerships with mainstream service providers (MC, Strategy 1-2)
- Collaborations among jurisdictions within the Sacramento CoC formed (RC, Strategy 1)

Further Best Practices
- PIT count methodology amended to include best practices for counting youth (FYC Strategy 1)
- Program rules in housing/shelter programs amended, as needed (MB, Strategy 3-4)
- Access to existing employment programs increased, including through logistical support, and education and training improved for all populations, particularly youth (EES, Strategy 1- 2, 4-5, 7)
- Monitoring, technical assistance and other supports provided to all CoC-funded projects to comply with HUD requirements and align with CoC needs (PM, Strategy 2)

End of Phase 2: Review and Update Indicators of Success

FAMILY AND YOUTH HOMELESSNESS ENDED

Phase Three: *long-term work 2020-2025*

Increase Needed Resources
- Affordable housing stock for extremely low income households increased and maintained (AH, Strategy 3)
- Rapid rehousing and prevention resources developed for priority groups (CR, Strategy 2-4)
- Available substance abuse services increased (BHS, Strategy 6)

Improve System Functioning
- Referral system established to connect people with employment location services appropriate for their skills and interests (EES, Strategy 6)
- CoC-wide diversion system developed to identify housing alternatives for households seeking shelter (DDP, Strategy 4)

Further Partnering
- Partnerships with mainstream partners developed to provide diversion services and eviction defense (CR, Strategy 6)
- Performance metrics implemented as funding criteria by other funders (PM, Strategy 3)
- Inter-CoC regional collaboration established (RC, Strategy 2-3)

End of Phase 3: Review Indicators of Success

HOMELESSNESS FOR ALL POPULATIONS ENDED

Introduction

For more than a decade, the Sacramento homeless system of care has worked diligently to meet the needs of people experiencing homelessness. Our system of care operates many successful housing projects, provides behavioral health, employment, and countless other services to a wide range of people, and assists thousands of people each year to access and maintain permanent housing.

However, despite years of hard work and much success, homelessness is still an unacceptable reality in Sacramento. In January 2013, we counted 2,538 homeless adults, youth and children; 31% of people experiencing homelessness in Sacramento were sleeping on the streets, in cars, in campgrounds, by the river, and in other unsheltered locations.

Much of what we do is done well and should be expanded. Some of what we do has a good foundation, but needs adjustment. And some things will require a fundamental shift in the way we view homelessness and our system of care. This strategic action plan identifies each of these things, and based on data gathered about the Sacramento Continuum of Care presents specific desired outcomes, strategies for success, and responsible parties.

Let's shift our consciousness, and end homelessness for all Sacramentans.

Our Vision

Homelessness is not a permanent characteristic of a person, like eye color or veteran status or national origin. It is a description of a person's current housing status, and is, therefore, changeable. It follows, then, that the status of homelessness in a community is also always in flux; as homelessness is ended for one household, another household may become homeless. "Ending homelessness" does not mean that no one in our community will be homeless again. It means that fewer people become homeless, and those who do return to permanent housing quickly.

We envision a system of care in which people at risk of homelessness receive necessary support to stay housed, people who become homeless are permanently housed with appropriate services, and long-term homelessness is a thing of the past.

Our Goal

Resources for homeless housing and services are limited. To end homelessness, it is essential that we target our resources carefully to meet our needs. An effective system of care identifies exactly what housing and services are needed and invests in programs that demonstrate an effective response to those needs.

Our goal is to align our system of affordable and accessible housing and services to maximize the number of individuals achieving housing stability.

Background

Federal Initiatives

Because our work stands at the intersection of national policy and local needs, to plan effectively we must understand the wider context. This section summarizes this plan's driving forces.

Continuum of Care

In 1995, in order to coordinate historically scattered efforts to address homelessness, the US Department of Housing and Urban Development (HUD) began to require community coordination in order to access the McKinney-Vento Homeless Assistance Act grants, a major source of federal funding for homeless housing and services.

A *Continuum of Care (CoC)* is the group of stakeholders (including representatives from nonprofit homeless housing and service providers, local government, education, law enforcement, healthcare, victim services providers, businesses, and others) responsible for coordinating homeless services and homelessness prevention activities in a particular geographic area.

The Sacramento CoC covers all of Sacramento County and encompasses the cities of Citrus Heights, Elk Grove, Folsom, Galt, Isleton, Rancho Cordova, and Sacramento, as well as the unincorporated areas of the county. Unless specifically noted, "Sacramento" in this plan refers to the entire geographic area encompassed by the CoC. The CoC Advisory Board acts as the lead decision-making body of the CoC, and Sacramento Steps Forward carries out the CoC's day-to-day business per the CoC Advisory Board's guidance.

HEARTH and Continuum of Care Regulations

In 2009 and 2012 respectively, the Federal Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act and the Continuum of Care Regulations introduced many significant changes to the way CoCs respond to homelessness. HEARTH required formalization of Continuum of Care structure, emphasized the importance of prevention, rapid rehousing, and ending chronic homelessness, and shined a renewed spotlight on CoC performance and outcomes. The Continuum of Care Interim Regulations, which implement the HEARTH Act, continued this directional shift, causing major systems-level realignment for most CoCs. Among other things, the CoC regulations require CoCs to:

- Have a board to act on behalf of the Continuum, as well as governance documents outlining the CoC's structure and decision-making responsibilities
- Establish and maintain a centralized or coordinated assessment system
- Set performance targets and evaluate outcomes
- Engage in community planning

Opening Doors: The Federal Strategic Plan to Prevent and End Homelessness

In 2010, the US Interagency Council on Homelessness released *Opening Doors*, a plan designed to address homelessness through partnerships between federal agencies, including the Department of Housing and Urban Development, the Department of Veterans Affairs, Health and Human Services, and the Department of Labor. *Opening Doors* and its annual updates set ambitious goals for our work to end homelessness, including:

- End veteran homelessness by the end of 2015
- End chronic homelessness by 2017
- End family and youth homelessness by 2020

Since its release, *Opening Doors* has influenced the allocation of HUD and other federal spending, driven HUD policy, spawned planning initiatives, including Zero: 2016 (an initiative providing targeted technical assistance to help CoCs meet the *Opening Doors* goals to end chronic and veteran homelessness), and given direction to CoC planning efforts.

Our Data

Because of the fluid nature of homelessness, data about people experiencing homelessness is never perfect. Sacramento's data is based on years of refining point-in-time count methodology and HMIS participation. Despite this experience, known data gaps include an accurate picture of family and youth homelessness, the needs of people experiencing homelessness in outlying areas of the County, and the experience of people who do not speak English.

Data sources used to inform this plan include:

- 2013 Unsheltered/Sheltered Point-in-Time Count
- 2014 Housing Inventory Count
- Stakeholder Interviews
- Consumer Interviews
- Provider Information
- Electronic Surveys
- Strategic Action Planning Summit

Who Is Homeless in Sacramento?

The Definition of Homelessness

Before we can accurately discuss who is homeless, it is first important to clarify that there are a number of different definitions of homelessness used by various federal funding sources. Here is a simplified summary of the major definitions [see Appendix E for full definitions]:

Department of Housing and Urban Development (HUD): "Literally homeless" refers to persons who are sleeping in places not meant for human habitation, or who are sleeping in an emergency shelter. This includes people who are sleeping on streets, in cars, campgrounds, parks, bus stations, and abandoned buildings and people who are using motel vouchers. It also includes people who have been institutionalized (e.g. staying in a hospital or jail) for a short time and were sleeping in a place not meant for human habitation before their institutionalization. **Importantly, this does not include people who are doubled-up, couch surfing, paying for a motel room, or otherwise poorly housed.**
Department of Education: "Homeless" means "individuals who lack a fixed, regular, and adequate nighttime residence." Broader than HUD's definition, this includes all persons who HUD defines as "literally homeless," as well as children and youth who are doubled up due to loss of housing, living in motels and hotels, and those who are awaiting foster care placement.

Department of Health and Human Services: Runaway and Homeless Youth Act:
Broadest of all, the Runaway and Homeless Youth Act defines a homeless youth as a youth under age 21 "for whom it is not possible to live in a safe environment with a relative, and who has no other safe alternative living arrangement." This means that any youth, including those considered homeless under the definitions used by the Department of Education or HUD, is considered homeless if she or he cannot live with relatives and has no other safe place to go.

Unless otherwise noted, in this plan "homeless" refers to the definition of homelessness used by HUD. We use this definition not to minimize the needs of households who are doubled up, poorly housed, or at serious risk of homelessness, but to target limited homeless-specific resources to those who have the highest need. Most homeless-specific housing and services funding comes through HUD, while other systems of care may be most appropriate for serving these other populations.

THE SACRAMENTO HOMELESS POPULATION AT A POINT IN TIME: A STREET AND SHELTER COUNT IN JANUARY 2013

Total Homeless Persons: 2538	
Individuals: 1,729 (68%)	
Unsheltered: 777	Sheltered: 952
Families: 249 households (801 persons) (31.6%) ***See* What We Know About Child and Youth Homelessness, *below***	
Unsheltered: 1 household (5 persons, 4 children)	Sheltered: 248 households (796 persons, 489 children)
Unaccompanied Children: 8 (<1%) ***See* What We Know About Child and Youth Homelessness, *below***	
Unsheltered: 4	Sheltered: 4

SUB-POPULATIONS (may duplicate)	
Chronically Homeless: 440 (17.3%)	
Unsheltered: 285	Sheltered: 155 (including 5 in a family with children)
Veterans: 302 (11.9%)	
Unsheltered: 136	Sheltered: 166
Severely Mentally Ill: 677 (26.7%)	
Unsheltered: 326	Sheltered: 351
Chronic Substance Abuse: 993 (39.1%)	
Unsheltered: 470	Sheltered: 523
HIV/AIDS: 39 (1.5%)	
Unsheltered: 24	Sheltered: 15
Victims of Domestic Violence: 504 (19.9%)	
Unsheltered: 284	Sheltered: 220
Transition Aged Youth: 139 (5.5%) *May be as many as 400* ***See* What We Know About Child and Youth Homelessness, *below***	
Unsheltered: 54	Sheltered: 85

What We Know About Child and Youth Homelessness

We know from community feedback that the numbers of homeless families and youth counted in the 2013 Point-in-Time (PIT) Count are likely a significant undercount. In the absence of updated PIT Count numbers, local service data can help us make an educated guess about the number of homeless children and youth.

Children and Youth in School
The California Department of Education 2013-2014 Snapshot Report for homeless students reports the number of students that California public schools have identified as homeless and who are then tracked through CALPADS, a data system used to maintain individual-level data including student demographics, course data, discipline, and other data for state and federal reporting. This report includes both accompanied (i.e., children living with their parents) and unaccompanied students.

It is essential to understand the difference between the numbers reported from CALPADS and the data collected through the PIT Count: CALPADS numbers are longitudinal, reflecting the number of students who are homeless over the course of a school year; PIT Count numbers tell us how many households were homeless on a single night. Because housing status is fluid, the PIT Count does not capture everyone who is homeless over time. **Though the Department of Education uses a broader definition of homelessness, to align with the HUD definition of homelessness for the purpose of this report we have excluded students doubled-up or living in hotels/motels**. CALPADS reports that:

- 835 students were sleeping in emergency shelters or transitional housing projects during the 2013-2014 school year
- 237 students were unsheltered during the 2013-2014 school year
- **Total: 1072** homeless students (per HUD definition) **over the course of the 2013-2014 school year for Sacramento County**

Youth
Our currently available data tells us the following:

- Wind Youth Services outreach workers make an average of 45 unduplicated contacts with youth sleeping on the streets each month.
- Wind Youth Services' Drop-In Center sees over 400 unduplicated youth annually; homeless status for these youth is not verified.
- Between October 2013 and September 2014, Waking the Village turned away for lack of space 100 pregnant and parenting youth between 18-21 who meet the Runaway and Homeless Youth Act definition of homelessness.

This provider data is not de-duplicated, which means that youth served by more than one project may be reported multiple times. Additionally, for some services, homeless status is not verified; when homeless status *is* verified, because different projects report to different funders, they often use different definitions of homelessness (see page 19, above).

Because of these limitations, we do not currently have the ability to accurately estimate the number of children and transition age youth (TAY) experiencing homelessness.

However, the CoC is actively working to improve current data on youth homelessness. The 2015 PIT Count implemented several best practices for enumerating youth, Wind Youth Services has begun entering data into the Homeless Management Information System (HMIS; a homelessness data system mandated by HUD), and the CoC is establishing new youth-focused outreach workers.

Serving Different Populations

Many of the best practice housing and service models discussed in this plan are appropriate and effective for a variety of populations. However, it is essential to remember that two projects using the same model but serving different populations may look very different in implementation. For example, rapid rehousing (short-term rental subsidies in permanent housing coupled with services) has been shown to be effective with both families with children and transition age youth; however, many families stabilize and are able to be self-sufficient with as little as three to six months of assistance, while youth typically require a much longer period of assistance and more intensive services. When this plan recommends establishment of a particular model of housing or service delivery, it assumes implementation in accordance with best practice for that project's target population.

Strategic Action Plan

Overall Indicators of Success

These indicators of success align with those established in *Opening Doors* and reflect community priorities.

End veteran homelessness by 2016

End chronic homelessness by 2017

End family and youth homelessness by 2020

Overall reduction in homelessness by 10% biennially

More

Things we're doing well already; we just need more!

Permanent Supportive Housing

Some people who are homeless have multiple barriers to successful independent living and require long-term housing support and associated services. Permanent supportive housing (PSH) provides homeless people with disabilities with permanent housing and attached supportive services that are flexible to meet changing client needs. PSH is appropriate for households who, without that level of ongoing assistance, would remain on or return to the streets. (It is important to note that while "permanent housing" must allow residents to remain indefinitely, many people can and do eventually achieve stability and exit to independent housing. For further discussion, see *Affordable Housing*, page 29.)

Permanent supportive housing generally takes the form of one of three models: scattered-site rental units for which a project pays a rental subsidy and offers services to residents; a single site operated by a project encompassing many units and on-site services; or a set-aside of subsidized units at a housing property with attached services.

Because PSH is an important resource for high-need homeless people and because resources for PSH are limited, HUD asks that CoCs prioritize PSH for persons who have been homeless the longest and have the highest need. *Opening Doors*, the federal strategic plan to end homelessness, has set a goal of ending chronic homelessness (sustained and/or repeated homelessness among people with disabilities; see definition in Appendix E) by 2017. HUD notes that currently, only 40% of PSH nationwide is dedicated to chronically homeless households, and has implemented funding incentives to promote the dedication of PSH to the chronically homeless. CoC-funded PSH projects are now asked to *prioritize* chronically homeless persons for units that become vacant through turnover.[1]

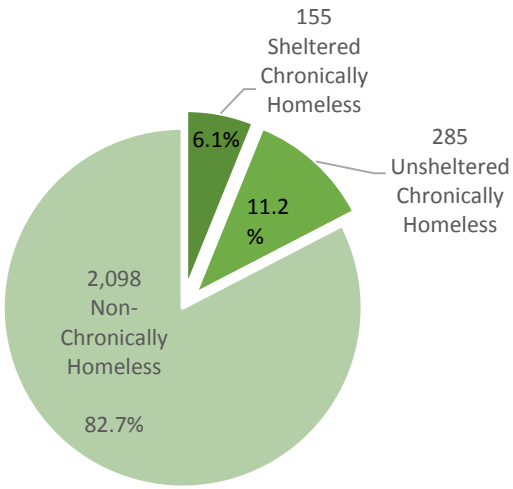
Though providing permanent housing with attached services sounds expensive, because many of the persons appropriate for PSH are high users of other public systems, PSH can actually save communities money.

- In New York City, each unit of permanent supportive housing reduced public costs in healthcare, shelter, criminal justice, and mental health services by $16,282 per year, nearly equal to the cost of the permanent supportive housing unit and services.[2]
- In a King County, Washington study of 95 chronically homeless individuals who had incurred the highest total costs for use of alcohol-related hospital emergency services, pre-housing costs for each individual were an average of $4,066 per month. After six months in housing, monthly costs decreased to $1,492, and after 12 months in housing, to $958. After accounting for housing program costs, permanent supportive housing saved an average of $2,449 per month.[3]

Additionally, some communities are able to leverage existing stable permanent supportive housing projects to increase affordable housing stock; in some cases, a long-term funding commitment for new project-based permanent supportive housing can serve as the foundation for a new affordable housing development. CoCs may wish to consider incentivizing new permanent supportive housing projects structured to help develop additional affordable housing.

Current System

As of the 2013 Point-in-Time count, 17% of Sacramento's homeless population was chronically homeless. 285 chronically homeless persons were unsheltered and 155 were staying in emergency shelter (including a family with children). As of January 2014, the Sacramento CoC offered 1,500



[1] "Prioritization" does not mean that projects must only serve chronically homeless persons in newly vacant beds. Prioritizing chronically homeless persons means that if a chronically homeless person and a non-chronically homeless person are both seeking housing and meet other project eligibility requirements, the bed will go to the chronically homeless person.

[2] Culhane, Denis, "Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing," 2002

[3] Larimer, ME, et al, "Health care and public service use and costs before and after provision of housing for chronically homeless persons with severe alcohol problems," 2009

PSH units for individuals and 388 units for families with children; PSH units are generally operating at 100% capacity, and there is limited turnover. Local stakeholders have identified units targeting women and transition aged youth as a potential housing gap.

In November 2014, Sacramento County was selected to receive technical assistance to end chronic homelessness by 2017 and veteran homelessness by 2016 (goals set in *Opening Doors*) through the Zero: 2016 initiative. Beginning in January 2015, Zero: 2016 assists the Sacramento Continuum of Care to evaluate the number of veterans and chronically homeless persons in need of housing as compared with available units to determine how many people must be housed each month to meet these goals, implement a common assessment tool (Sacramento has chosen the VI-SPDAT), use assessment data to sort households by appropriate intervention, and bring together local leaders (including CoC leadership, PHA directors, Veterans Administration Medical Center leadership, and others).

Sacramento's "takedown targets" as calculated through Zero: 2016 are:

- Veterans: house 38 veterans per month to end veteran homelessness by the end of 2015. In January 2015, the CoC housed 41 veterans.
- Chronically homeless: house 20 chronically homeless persons per month to end chronic homelessness by the end of 2016. *(This number may change pending additional information from the 2015 PIT count.)* In January 2015, the CoC housed 34 chronically homeless persons

Permanent Supportive Housing

OUTCOME: All Persons in Need of Permanent Supportive Housing Are Appropriately Housed

INDICATOR OF SUCCESS: By 2017 chronic homeless population is zero; functional zero maintained each year.

CURRENT RESOURCES INCLUDE

- 1,500 total PSH beds for individuals
- 388 PSH units (1,236 beds) for families
- 1 PSH project for former foster youth, with a total of 26 PSH beds
- Average PSH utilization: 100%
- *To come online in 2015:*
  - 30 PSH units for chronically homeless individuals with chronic substance abuse and severe mental illness
  - 40 units for chronically homeless adult individuals
  - 40 units for senior individuals
  - 27 chronically homeless TAY units (not limited to former foster youth), including 15 units for TAY families with children and 12 single TAY units

GAP

- Complete understanding of available PSH admission requirements and other policies
- Assessment of exact need for additional units
- Adequate targeting of existing PSH to chronically homeless persons
- Adequate PSH to house all chronically homeless persons
- Adequate PSH to house all appropriate populations

STRATEGY

1. Determine number and type of additional permanent supportive housing units necessary, including number of units needed for subpopulations

ACTIONS

1A. Evaluate information collected during the Point-in-Time and Housing Inventory Counts in conjunction with Common Cents data and Zero: 2016 analysis to determine housing stock required to end veteran and chronic homelessness IN 2015.

Responsible Party: SSF

1B. Collect data regarding the number and target population of existing PSH beds to assist in identifying underserved populations ANNUALLY.

Responsible Party: SSF

1C. Assess, based on data from the Point-in-Time count, HMIS, coordinated intake, outreach worker records, institutions (such as hospitals and school districts) and housing and service providers, the needs of people experiencing homelessness in Sacramento and the appropriate interventions ANNUALLY.

Responsible Party: SSF, Performance Review Committee

1D. Recommend for realignment (e.g. voluntary transition to more appropriate project type, reallocation to a new project, etc.) beds and services not aligned with identified needs per evaluation ANNUALLY.

Responsible Party: Performance Review Committee

STRATEGY

2. Increase number of CoC-funded PSH beds prioritizing chronically homeless persons

ACTIONS

2A. Review number and target population of existing Continuum of Care PSH beds prioritizing (see definition of "prioritizing" on page 25) chronically homeless persons through turnover IN 2015.

Responsible Party: SSF

2B. Identify beds that should be prioritized to chronically homeless persons and are not IN 2015.

Responsible Party: SSF

2C. Determine turnover rate of prioritized beds IN 2015.

Responsible Party: SSF

2D. Conduct outreach to projects reluctant or unable to prioritize chronically homeless persons to determine and overcome barriers to prioritization, including, for example, restrictions from other funding sources, need for staff training on serving people who are chronically homeless, or project design

barriers IN 2016.

Responsible Party: SSF

2E. Develop curriculum to provide education on serving chronically homeless persons to PSH projects newly prioritizing that population IN 2016.

Responsible Party: SSF in partnership with housing providers

STRATEGY

3. Create new permanent supportive housing units; some units should target specific populations

ACTIONS

3A. In accordance with HUD priority, review existing Continuum of Care transitional housing stock to determine number appropriate for reallocation to PSH based on population served, outcomes, capacity, and other criteria determined by CoC ANNUALLY.

Responsible Party: Performance Review Committee

3B. Conduct year-round review of available funding streams to support PSH, including for special populations such as veterans and youth and possible new Continuum of Care funding, ANNUALLY.

Responsible Party: Advisory Board, Housing Committee

3C. Maintain a PSH housing pipeline to develop needed units, including for target populations; reevaluate annually IN PHASE 2.

Responsible Party: SSF, Housing Committee

3D. Provide support and technical assistance to youth housing and services providers to increase organization capacity to expand youth-specific housing stock ANNUALLY.

Responsible Party: SSF

STRATEGY

4. Create pipeline to transition youth aging out of youth-specific PSH into appropriate adult housing

ACTIONS

4A. Create standard evaluation for youth approaching maximum age for youth-specific PSH to determine best adult placement as available (e.g. affordable housing, adult PSH) IN 2016.

Responsible Party: Homeless Youth Task Force, SSF

4B. Design procedure to place youth on appropriate wait lists at appropriate times and ensure youth retain housing during transition period. Ensure youth are properly connected to services at all times during transition IN PHASE 2.

Responsible Party: Homeless Youth Task Force, SSF

Affordable Housing

Ending homelessness requires housing. While some of the individuals and families experiencing homelessness in Sacramento County need support services to maintain housing, most households just need access to housing they can afford. In addition, some of the formerly homeless people in our community no longer need service-intensive supportive housing, and increasing their access to affordable housing would support their independence while increasing the supply of permanent supportive housing available for those with higher needs.

While some people who experience homelessness will find and access housing on their own, others cannot because they cannot afford housing that is available. Rapid rehousing programs (see page 82) help homeless households access housing and often provide a transitional subsidy, but in order to maintain housing going forward, many households need continuing access to affordable housing.

On June 10, 2013, HUD's Office of Public and Indian Housing released a Notice[4] suggesting strategies that public housing agencies can use to increase housing opportunities for homeless households through the Public Housing and Housing Choice Voucher programs. Some of the methods that the Notice encouraged include:

- Overcoming barriers created by public housing wait lists, including improving outreach to homeless populations, changing processes for contacting applicants, or creating more flexible intake procedures
- Creating a preference in admissions policies for homeless households or households transitioning from permanent supportive housing
- Reducing barriers to admission by reviewing discretionary admission policies
- Reviewing termination and eviction policies to avoid creating homelessness
- Increasing access to housing stability services
- Increasing use of project based vouchers to develop housing for people experiencing homelessness.

At the same time, HUD encouraged CoCs, through its Notice of July 28, 2014, to ensure that permanent supportive housing beds are serving the most vulnerable chronically homeless people.[5] As discussed above, permanent supportive housing is a key resource for responding to chronic homelessness, but not all homeless people require the services associated with the housing. Providing access to affordable housing for people who can maintain housing independently is more cost-effective and allows the system to better serve all homeless people.

Some communities have begun to create "Moving On" or "Moving Up" initiatives to support residents of permanent supportive housing who have stabilized and are ready and willing to move to more independent housing. These initiatives are voluntary and often provide transition services, including

[4] U.S. Department of Housing and Urban Development, Office of Public and Indian Housing (June 10, 2013). *Guidance on Housing Individuals and Families Experiencing Homelessness through the Public Housing and Housing Choice Voucher Programs* (Notice PIH 2013-15 (HA)), available at http://portal.hud.gov/hudportal/documents/huddoc?id=pih2013-15.pdf.

[5] U.S. Department of Housing and Urban Development Office of Community Planning and Development (July 28, 2014). Notice on Prioritizing Persons in Permanent Supportive Housing and Recordkeeping Requirements for Documented Chronic Homeless Status (No. CPD-14-012), https://www.hudexchange.info/resources/documents/Notice-CPD-14-012-Prioritizing-Persons-Experiencing-Chronic-Homelessness-in-PSH-and-Recordkeeping-Requirements.pdf Recordkeeping-Requirements.pdf .12cpdn.pdf.

moving assistance, subsidized housing (e.g. Housing Choice Vouchers), and assistance with accessing community-based services. Initiatives vary widely in how potential clients are identified.[6]

- New York. Beginning in 2004, this initiative supported 100 formerly homeless tenants in exiting permanent supportive housing. The participants had an average of 766 days of homelessness prior to receiving supportive housing, but were identified as stable tenants when assessed for the Moving Out program. Participants received apartment locater services, grants for moving costs, Section 8 vouchers, and were enrolled in mental health clinics. A 2006 survey found that as many as 40% of PSH tenants were capable of moving on. As the program continued, there was high demand from permanent supportive housing tenants, a lower acceptance rate due to tenant characteristics, and a moving on rate of 19%. Barriers included lack of housing placement resources and lack of accessible, attractive housing options.
- Los Angeles. In 2011, a new preference in Section 8 Administrative Plan was created to provide Housing Choice Vouchers for individuals ready to move on from Shelter Plus Care. Service providers support housing search, community linkage, and supportive services. Participants have needed a variety of supports to succeed, but 300 people have moved to more independent housing.
- Chicago. Beginning May 2012, providers used an assessment tool to identify candidate PSH tenants who had achieved self-sufficiency and housing stability. Chicago Housing Authority (CHA) provided 50 individuals with Housing Choice Vouchers during its 2012-2014 pilot. PSH providers assisted with paperwork, linked participants to community-based services, and conducted follow up calls. While not all identified tenants moved on due to difficulty with affording or finding other housing, 23 were housed, with others in process.
- *Note: Housing Choice Voucher waitlists are frequently many years long. Many communities implementing "Moving On" or "Moving Up" programs have established separate waiting lists for these programs.*

Current System

The Sacramento Housing Authority (SHRA) administers 11,956 Housing Choice Vouchers (HCV) (648 of which are project based units) and 3,300 public housing units. SHRA manages numerous wait lists for public housing and HCV with approximately 22,291 families currently placed on these lists.

There are separate waiting lists for the tenant based and various project based voucher sites. SHRA selects families to occupy project based voucher units from a wait list that is maintained by the Housing Authority. While the preferences vary per site, all project-based units receive a homeless preference or rent burden preference. That means the families must be either homeless or rent burdened to receive a preference (or priority) for the project-based housing.

In addition, SHRA administers Shelter Plus Care (S+C) certificates and Veterans Affairs Supportive Housing (HUD-VASH) vouchers for veterans, which are Permanent Supportive Housing beds provided to disabled

[6] The following examples are taken from Corporation for Supportive Housing (CSH) (Sept. 8, 2014). Moving On from Supportive Housing (presentation) available at http://www.csh.org/2014/09/moving-on-from-supportive-housing/ and U.S. Department of Housing and Urban Development (Nov. 15, 2013). Move-Up: A Strategy for PHAs and CoCs (presentation) is available at https://www.hudexchange.info/course-content/implementing-a-move-up-strategy-webinar/Move-up Strategies Webinar_Final_v2 11 15 131.pdf.

homeless households and homeless veterans. Referrals for the S+C program are received from local service providers. 638 S+C certificates house homeless, disabled families in Sacramento County at the Shasta Hotel and Boulevard Court.

The HUD-VASH program receives referrals directly from the Veterans Administration. 355 VASH vouchers house homeless, disabled veterans in Sacramento County. SHRA was recently asked to apply for an additional 44 vouchers; in addition to our additional stock of HUD-VASH vouchers, if approved these vouchers will bring the total number of HUD-VASH vouchers in Sacramento to 399. SHRA was awarded the 2014 VASH Program of the Year Award by HUD for successfully utilizing over 90% of the vouchers to serve disabled, homeless veterans.

SHRA has project-based some of its Housing Choice Vouchers for the homeless population:

Dedicated for people who are homeless:

- 56 units for homeless families at Saybrook
- 40 units for homeless families at Serna Village
- 37 units for homeless families at 7th and H

Project-based waitlist with preference for homeless or rent burdened persons:

- 284 units for homeless or rent burdened families at Phoenix Park
- 231 units for the homeless or rent burdened elderly families at Washington, Sutterview and Sierra Vista developments

Altogether, between project-based vouchers dedicated to homeless households, project-based vouchers preferenced for homeless or rent burdened households, S+C vouchers and HUD-VASH vouchers, approximately 1,641 families are served directly from the homeless population or selected from a project based waitlist that has a homeless preference. Because many of these units are occupied by households who might not otherwise be able to afford housing, these units play an important role in homeless prevention in our community.

Since 2012, 63% of the families served in either the tenant based HCV program, project-based vouchers or specialty programs such as VASH and SPC, were pulled from a waitlist that provided a homeless preference or were directly referred by a local homeless service provider or the Veterans Administration (in the case of HUD-VASH vouchers).

The President's 2016 proposed HUD budget recommends the allocation of $177.5 million nationwide to be targeted in Special Purpose Vouchers to be awarded to Housing Authorities for populations including homeless families and veterans (regardless of discharge status). While this is not the final 2016 budget, there are additional funding opportunities targeted to homeless and veteran families.

Sacramento currently has a number of policies in place to create new and to preserve existing affordable housing:

- Sacramento City ordinances require that 712 residential hotel or comparable units be maintained within the City of Sacramento. SHRA is required to provide an annual report on the number of residential hotel units withdrawn, the number of new units expected based on approved replacement housing plans, and the number of units constructed in anticipation of conversions or withdrawals.

- As the housing finance agency for the City and County of Sacramento, SHRA uses funding from the federal Home Investment Partnership (HOME) and Community Development Block Grant (CDBG) Programs, which are received by the City of Sacramento and County of Sacramento as entitlement jurisdictions, to provide gap financing assistance of rehabilitation/preservation and new production of affordable housing.
- Sacramento County Board of Supervisors adopted an Affordable Housing Ordinance in December 2004 to implement an affordable housing program. Updated in 2014, housing developers must pay a $2.50 in-lieu fee per square foot of market-rate units built in new developments. The fee is deposited into a Housing Fund to subsidize new workforce affordable housing. The $2.50 in-lieu fee replaces a former mandate that 15% of units in new developments be affordable.
- City of Sacramento has a Mixed-Income Housing Ordinance, which established an inclusionary housing program in 2000 requiring 15% of all housing built in the new growth areas of the City to be affordable to low (80% of Area Median Income (AMI)) and very low-income (50% AMI) households.
- City of Sacramento's Housing Trust Fund requires commercial development to pay a per-square-foot fee to address the resulting need for new affordable workforce housing in the community due to the creation of low-wage jobs. The fee is expected to generate approximately $650,000 annually between 2013 and 2021.[7]

Much of the affordable housing required to be developed in Sacramento will be inaccessible to the homeless population. The City of Sacramento and Sacramento County's Housing Trust funds provide for the development of housing for those likely to be in the workforce; many people who are homeless are unable to work and therefore unable to access these units. Much of Sacramento's affordable housing targets households at 50%-60% of AMI; however, most homeless households have substantially lower incomes. For example, the Homeless Prevention and Rapid Rehousing Program (HPRP), a short-term HUD program designed to return homeless households to permanent housing quickly, required that recipients of rapid rehousing assistance be at or below 50% AMI. In Sacramento, local policy required that HPRP rapid rehousing recipients be at or below 30% AMI, a limit that reflects the actual income of persons in need of this kind of assistance. Most affordable housing units in Sacramento are unaffordable for the homeless population.

Affordable Housing

OUTCOME: All Formerly Homeless Households Capable of Maintaining Independent Housing Have Access to Housing Affordable for Their Income

INDICATOR OF SUCCESS: By 2025, less than 5% of people who have been homeless and been housed become homeless again.

[7] City of Sacramento 2013-2021 Housing Element, adopted December 17, 2013, available at: http://portal.cityofsacramento.org/Community-Development/Planning/Long-Range/Housing-Programs/Housing Element

CURRENT RESOURCES INCLUDE	GAP
• 11,956 Housing Choice Vouchers are administered with a 99% utilization rate • For all populations in 2014, 3,300 public housing units • 22,291 families are on the HCV and public housing wait lists • Preferences in the SHRA wait list for homeless, rent-burdened and disabled households • 648 project-based Housing Choice Vouchers for homeless or rent-burdened households • 993 Shelter Plus Care and VASH vouchers for homeless households • 38% of the units regulated by SHRA are restricted to individuals and family earning less than 50% AMI • 3% of the units regulated by SHRA are restricted to 30% AMI or less	• Assessment of precise affordable housing need for people who are homeless • Sufficient affordable units targeting households with 0-30% AMI • Adequate funding to support need for affordable housing

STRATEGY

1. Assess the need for affordable housing for people who are homeless or residents of permanent supportive housing in Sacramento County.

ACTIONS

1A. Create assessment tool for current PSH residents to determine interest in and ability to exit to more independent housing IN 2015.

Responsible Party: Housing Committee, SSF

1B. Survey all current PSH residents to determine who could succeed in and benefit from affordable housing IN 2015.

Responsible Party: Current PSH providers

1C. Evaluate information collected during survey, Point-in-Time and coordinated entry data to determine necessary affordable housing stock to serve people who are currently homeless or able to transition from PSH IN 2016.

Responsible Party: SSF

1D. Collect information from SHRA regarding existing affordable housing stock targeting Extremely Low Income (30% AMI or below) households, including unit size, target population and income

targets IN 2015.

Responsible Party: SSF | *Responsible Government Entity:* SHRA
1E. Issue recommendation for creation of new affordable housing units accessible for homeless people and PSH residents BIENNIALLY.

Responsible Party: SSF, Housing Committee | *Responsible Government Entity:* SHRA

STRATEGY

2. Convene community conversation to build on existing affordable housing resources for people who are homeless.

ACTIONS

2A. Establish task force of leadership from SHRA and SSF and other pertinent agencies to discuss application of best practices for making affordable housing accessible to homeless people IN 2015.

Responsible Party: SSF
Responsible Government Entity: SHRA

2B. Implement recommendations agreed upon by Task Force described in Strategy 2A, "Convene community conversation to build on existing affordable housing resources for people who are homeless," above, IN PHASE 2.

Responsible Party: SSF in partnership with SHRA
Responsible Government Entity: SHRA

Best practices to consider include: increase preferences for homeless persons and PSH residents, reviewing discretionary admissions policies, reviewing eviction policies, creating access to stabilization services for residents, streamlining access to affordable housing through outreach to homeless households, ensuring that homeless applicants are connected to a service provider and are contacted using the easiest method for them, and streamlining intake barriers.

STRATEGY

3. Support efforts to maintain and increase affordable housing for extremely low-income households in Sacramento.

ACTIONS

3A. Inventory existing Single Room Occupancy (SRO) units not monitored by SHRA, including location and management of units IN 2015.

Responsible Party: Housing Committee

3B. Develop plan to monitor status of existing SRO units not currently monitored by SHRA and reported on annually and ensure preservation over time IN 2015.

Responsible Party: Housing Committee

3C. Develop and implement advocacy plan to increase number of affordable units targeting Extremely Low Income (30% AMI or below) households IN PHASE 2.

Responsible Party: Housing Committee, CoC Advisory Board, SSF
Responsible Government Entity: SHRA

3D. Develop and implement advocacy plan to facilitate an increase in City and County support for affordable units IN PHASE 3

Responsible Party: Housing Committee, CoC Advisory Board, SSF
Responsible Government Entities: County of Sacramento, Cities within County geography

3E. Develop and implement advocacy plan to increase targets of affordable housing developed with cap and trade and tax credit financing to households with extremely low incomes, especially homeless people IN PHASE 3.

Responsible Party: Housing Committee, CoC Advisory Board, SSF
Responsible Government Entity: SHRA

Behavioral Health Services

People who experience homelessness often have needs beyond housing assistance, and may interact with many different systems of care. Mental health and substance abuse services are both common needs among people who are homeless; per the 2014 Annual Homeless Assessment Report (AHAR) provided by HUD to Congress, 20.5% of homeless people nationwide are severely mentally ill, while 20.2% struggle with chronic substance abuse. The percentages reported in California are even higher: 28.3% of people who are homeless are severely mentally ill, and 25.5% chronically abuse substances.[8] The likelihood that a homeless person will become chronically homeless increases when that person has substance abuse or mental health problems, as many people with these treatment needs lack social supports and may have a wide variety of other needs. Recovery frequently requires not only housing assistance, but also mental health, substance abuse, medical, occupational, and social services.[9]

The Substance Abuse and Mental Health Services Administration identifies five stages of behavioral health rehabilitation for people who are homeless, and notes that the amount of time an individual may spend in any stage depends on variables such as housing availability, severity and chronicity of behavioral health issues, and the availability of social supports. Additionally, clients may relapse and require outreach and reengagement several times. The identified stages are:

- Outreach and engagement
- Transition to intensive care
- Intensive care
- Transition to ongoing rehabilitation
- Ongoing rehabilitation[10]

Among other behavioral health treatment best practices, case management is often essential to ensure that a homeless person's diverse needs are met and to prevent that person from falling through the cracks of the system of care. Case management should begin immediately upon entry into the service system to ensure that all needs are identified and multiple referrals are appropriately navigated, and should continue throughout the first four stages of rehabilitation.[11]

Current System

Behavioral health services in the Sacramento CoC range from intensive services for people with high needs (persons with Serious and Persistent Mental Illness, or SPMI) to a lighter touch for people with mild to moderate mental health service needs. Depending on assessed needs, people seeking assistance may be served by one of six Full Service Partnership (FSP) programs funded by Sacramento County Department of Behavioral Health Services (DBHS) for people with SPMI, one of five community-based Federally Qualified Health Centers, or by one of four Mental Health Regional Support Teams. Though hard data is currently unavailable, providers report that people with high service needs not determined to have SPMI fall into an existing service gap.

[8] U.S. Department of Housing and Urban Development, "2014 Homeless Populations and Subpopulations Report"
[9] Substance Abuse and Mental Health Services Administration, "Behavioral Health Services for People Who Are Homeless," 2013, p. 17
[10] Id. at p. 29
[11] Id. at p. 37

The front door for behavioral health services for people experiencing homelessness in Sacramento is the Guest House, a community-based organization that provides screening, assessment and referral services as well as medication and rehabilitation. Homeless persons seeking behavioral health services attend an orientation at 8 a.m. three days per week, at which Guest House staff triage consumers by acuity of symptoms. Consumers who are currently linked to Mental Health Services are directed to these programs to continue to address their mental health needs. Because of system capacity issues, once assessed it may be months before a person with SPMI not already connected to services receives a service appointment at an FSP (though they may receive Guest House services in the meantime). Additionally, local TAY service providers indicate that this system is not accessible for youth. Although there is now a TAY-specific orientation once per month, the limited time available for culturally competent intervention prevents many youth from seeking services.

Though DHBS provides some case management-type support to persons served by FSPs to connect them with services outside the behavioral health care system such as unemployment benefits or housing, there is little system navigation support available to people who are homeless. Providers report that homeless people seeking behavioral health services may struggle to provide eligibility documentation and navigate a complex referral system with limited assistance.

Currently, DHBS is expanding many areas of service to reduce system backlog. Over the next 12 months (by March 2016) DBHS is expanding the existing FSPs, adding a TAY-specific FSP, and expanding the Mental Health Regional Support Teams. Additionally, DHBS is funding 22 new mental health navigators, to be stationed in medical facilities, jails, and other locations, to provide outreach and system navigation assistance to people who are homeless.

Providers report that access to substance abuse treatment services is major gap in Sacramento's system of care. Much available funding for behavioral health treatment services requires that a person's primary diagnosis be mental health-related; if a person's primary treatment need is substance abuse related, funding for services is limited. However, DBHS is adding a mental health counselor qualified to assess people with primary substance abuse diagnoses at Guest House.

Finally, one further barrier faced by behavioral health service providers in Sacramento is staffing shortages and turnover. Providers report a shortage of qualified psychiatrists; because private hospitals are able to reimburse for services at a higher rate than Full Service Partnerships, few psychiatrists are available to work with the homeless population. Additionally, staff burnout causes significant turnover, which results in a lack of service continuity and additional administrative and training burdens on providers.

Behavioral Health Services	
OUTCOME: All Persons in Need of Behavioral Health Services Have Access in a Timely Manner **INDICATOR OF SUCCESS:** By 2020, homeless people in need of serious behavioral health intervention consistently access services within 10 days.	
CURRENT RESOURCES INCLUDE	**GAP**
• Guest House intake sessions on specified	• Adequate Guest House intake workers to

weekdays for homeless persons seeking mental health services • 6 Full Service Partnership programs providing mental health services to people with SPMI • Sacramento Multiple Advocate Resource Team, operated by Guest House, for SSI/SSDI Advocacy for people who are homeless • *To come online in 2015: 22 mental health outreach workers funded by MHSA and managed by TLCS*	quickly evaluate and refer persons seeking services • Adequate psychiatrist hours to meet treatment demand • Access and referral system that is responsive to the needs of all populations, particularly TAY • Sufficient substance abuse treatment funding to meet needs • Adequate case management services to support homeless clients through rehabilitation and assist with system navigation

STRATEGY

1. Support implementation of expanded FSPs and Mental Health Regional Support Teams, new system navigators, and crisis residential programming underway through DBHS

ACTIONS

1A. Designate CoC representative to attend MHSA Steering Committee meetings IN 2015

Responsible Party: Health Committee

1B. Designate DBHS representative to participate in Health Committee meetings IN 2015

Responsible Party: DBHS

STRATEGY

2. Evaluate behavioral health needs of people experiencing homelessness

ACTIONS

2A. In partnership with the Sacramento Police Department's Homeless Impact Team, conduct evaluation of behavioral and other health needs of unsheltered homeless people encountered by Impact Team IN 2016.

Responsible Party: SSF, Homeless Impact Team | *Responsible Government Entity*: DBHS

2B. Review aggregate data from Common Cents, Point-in-Time count, HMIS, outreach worker data (including Impact Team evaluation) and other system entries to determine behavioral health needs (both mental health and substance abuse) of people experiencing homelessness. Include assessment for subpopulations (veterans, youth, chronically homeless persons, seniors) IN 2016.

Responsible Party: SSF

2C. Review evaluation data in partnership with DBHS, Guest House and Health Committee to determine appropriate system size and qualities (e.g. number of intake workers, psychiatrist hours, interventions for populations without SPMI diagnoses, cultural competency needs, etc.) to meet needs of people experiencing homelessness IN 2016.

Responsible Party: SSF, Guest House and Health Committee | *Responsible Government Entity*: DBHS

STRATEGY

3. Access new MHSA funding opportunities to provide services to people who are homeless

ACTIONS

3A. Designate CoC representative to remain abreast of possible funding availability IN 2015.

Responsible Party: Health Committee

3B. Develop proposals for mental health services projects to serve people who are homeless to meet needs identified through assessment in *Strategy 2: Evaluate behavioral health needs of people experiencing homelessness* IN PHASE 2.

Responsible Party: Health Committee, CoC Advisory Board

3C. When funds become available, determine highest priority proposals for submission. Submit proposals to MHSA Steering Committee IN PHASE 2.

Responsible Party: Health Committee, CoC Advisory Board

STRATEGY

4. Increase Guest House intake workers to reduce system delays

ACTIONS

4A. Determine reasonable turnaround time from intake to services to avoid losing connection with service seekers IN 2015.

Responsible Party: Health Committee

4B. Determine how many additional intake workers are necessary to reduce current turnaround time IN 2016.

Responsible Party: Guest House, Health Committee

4C. Identify and access potential funding sources to support additional intake workers, including possibly MHSA, IN 2016.

Responsible Party: SSF

STRATEGY

5. Secure additional psychiatrist hours for services through full service partnerships.

ACTIONS

5A. Identify potential funding sources to support additional psychiatrist hours, including possibly MHSA IN PHASE 2.

Responsible Party: SSF

5B. Investigate partnership with UC Davis psychiatry residents to provide services at lower costs IN PHASE 3.

Responsible Party: Health Committee

STRATEGY

6. Ensure all behavioral health services front doors are accessible to and culturally competent for all populations

ACTIONS

6A. Investigate behavioral health intake and assessment best practice models for each subpopulation (veterans, youth, chronically homeless persons, seniors) IN PHASE 2.

Responsible Party: Health Committee

6B. Develop plan to address gaps identified in analysis IN PHASE 2.

Responsible Party: Health Committee, SSF | *Responsible Government Entity:* DBHS

STRATEGY

7. Seek additional funding for expanded substance abuse treatment.

ACTIONS

7A. Evaluate size of current substance abuse treatment system IN 2015.

Responsible Party: Health Committee | *Responsible Government Entity:* DBHS

7B. Draft analysis of unmet substance abuse needs, including potential practices to fill identified gaps IN 2016.

Responsible Party: Health Committee, SSF

7C. Identify potential funding sources to fill identified gap IN 2016.

Responsible Party: Health Committee, SSF

7D. Develop plan to access funds and implement recommended practices IN 2016.

Responsible Party: Health Committee, SSF | *Responsible Government Entity:* DBHS

Diversion and Discharge Planning

To end homelessness, neighboring systems of care, like corrections and health care, must support people's needs to help them avoid becoming homeless. To do this, the homeless system of care, partnering with other such systems, can develop connections and resources to ensure people access and maintain housing. This is especially true for institutions, as people exiting them are often especially vulnerable to becoming homeless. In Sacramento, we believe no person should exit public institutions into homelessness.

Diversion programs prevent homelessness by assisting people seeking shelter to identify housing alternatives; by preventing entry into the homeless system of care by linking people with other immediate housing and, in some cases, necessary support services, diversion opens shelter beds to those who have no alternatives and can reduce shelter waitlists.

Current System

Currently, there is little coordinated diversion programming available in Sacramento. While programs may seek to identify alternative housing on an individual basis, no CoC policies or guidance regarding diversion exist.

Sacramento has systems to support discharge planning, but resources need to increase to the scale necessary to ensure people do not become homeless upon exiting various systems of care.

Corrections

In Sacramento, people who are homeless when they enter custody are assigned to a CoC Re-Entry Specialist or a waiting list. Specialists meet participants during their first week in custody to create a reentry plan and identify re-entry needs, such as housing, employment, education, sobriety, family reintegration, child care, transportation, medical, dental and legal needs. Federal Second Chance Act funding provides in-reach, evaluation, mental health, and substance abuse services for female County jail inmates--and for their family members--upon their release. Women receive re-unification assistance for up to 2 years to prevent discharge into homelessness.

Most discharged individuals exit to market-rate rental or shared housing or return to their families. In 2013, the Sheriff's Department acquired 45 beds for participating offenders released from the Rio Consumnes Correctional Center and an additional 20 beds for offenders on probation.

A CoC Re-Entry Council is charged with creating and implementing improved discharge planning and processes. The Council is composed of representatives from a wide array of government, community-based, and faith-based organizations from law enforcement, probation, the district attorney's and public defender's offices, substance-abuse and mental health care assistance, employment assistance, ex-offender networks and the business community. The Re-entry Council has partnered with The Effort, Calvary Christian Center, Strategies for Change, ManAlive, and Change Counseling Services to provide reentry services to offenders while they are incarcerated and while in the community.

Health Care Facilities

In Sacramento, a collaborative of hospitals, community based organizations and county government work together under the Interim Care Program (ICP), a respite care shelter for homeless individuals being discharged from hospitals. Nursing and social services are provided to support clients in their

recuperation and accessing permanent supportive housing. They are linked to mental health services, substance abuse and recovery services, housing workshops and mainstream benefit access assistance, as needed. Homeless patients are referred to the ICP Nurse from area hospitals upon discharge.

Kaiser Permanente, Mercy, Sutter Medical Center, Sacramento, UC Davis Medical Center, and the County of Sacramento provide on-going funding for the Interim Care Program (ICP) and nine area hospitals participate in referrals. The Salvation Army provides food, monitoring, and 28 beds (increased from 18 beds in 2010) in a designated wing of the shelter where clients have three meals a day and a safe, clean place to recover from their hospitalizations.

Hospitals have also implemented a frequent users initiative called Triage, Transport, Treat (T3) for homeless emergency room (ER) patients. Non-urgent patients in the ER are triaged, transported to a primary care clinic and provided primary medical and behavioral health treatment, providing the supportive services in permanent housing to assist in successful discharge from institutions and into housing. Sutter Medical Center contracts with WellSpace Health, a health, mental health and addictions provider, and Kaiser South to implement the T3 program. Sacramento Self-Help Housing assists the T3 program by providing housing on a short-term basis while T3 patients wait to move into permanent housing. Additionally, Dignity Health and Lutheran Social Services operate five interim beds for emergency room frequent users while awaiting permanent housing placement. The CoC is currently working to bring these beds into the Common Cents coordinated entry pilot program.

Youth and Transition Aged Youth

An early adopter of the federal Fostering Connections to Success Act, California implemented multiple legislative acts so youth may remain connected to the foster system to age 21. In 2004, the Sacramento Board of Supervisors created a homelessness prevention discharge planning policy Independent Living Program (ILP), functioning through an agreement between County Health & Human Services and Sacramento CoC (run by County Child Protective Services Division). Children's Receiving Home also provides ILP services, collaborating with Pride Industries to provide free apartment rent to foster youth for up to six months once ILP is completed. The We Help Youth (WHY) Sacramento collaborative network of 20 youth service providers acts as a safety net and referral mechanism to ensure referral of all eligible youth to ILP. Members include the Sacramento County Office of Education, Sutter Teen Program and Crossroads Diversified. Volunteers of America's Adolfo Former Foster Youth Transitional Housing Program serves youth aged 18-23, providing housing for up to two years. Youth also receive living-skills training, housing, employment and educational services, mentoring, and counseling. Lutheran Social Services' Adolfo PSH provides 24 beds for emancipated foster youth who are homeless and have a disability. LSS also operates transitional housing programs Connections (12 beds) and Transitional Housing Program for Youth (16 beds), both for homeless youth but not limited to former foster youth. LSS's AB12 program provides housing for youth who remain in foster care between ages 18 and 21. Volunteers of America's Adolfo Transitional Housing Program provides 68 beds to former foster youth through the ILP program. Finally, Wind Youth Services provides a mental-health focused drop-in center for youth.

In 2013, the National Association for the Education of Homeless Children and Youth launched a Homeless Youth Task Force in Sacramento, which meets monthly with providers and youth. The CoC Advisory Board includes representation from the County Office of Education and the California Coalition for Youth to sharpen focus on these youth; the CoC also created a small committee of providers representing housing,

health services and education to focus on youth needs not easily addressed in larger committee meetings.

Most youth discharge to rental or shared housing, or return to their families. The Children's Receiving Home, Lutheran Social Services, Volunteers of America and County Health & Human Services staff work with youth through social workers and workshops to ensure best housing placement options and provide "safety nets."

Diversion and Discharge Planning

OUTCOME: People receive necessary assistance to avoid entering the homeless services system; people exiting corrections, healthcare and foster care systems are not discharged to the street.

INDICATOR OF SUCCESS: By 2025, reduce by 50% the number of people presenting to Common Cents who come directly from a system of care or whose homelessness could have been avoided through diversion.

CURRENT RESOURCES INCLUDE

- Corrections:
  - Re-entry specialists to work with incarcerated persons
  - Re-entry council to develop re-entry policy
- Healthcare:
  - Interim Care Program respite shelter
  - Triage, Transport, Treat program for homeless emergency room patients
- Foster Care:
  - We Help Youth collaborative/referral network
  - Homeless Youth Task Force
  - Independent Living Skills program
  - VOA's Former Foster Youth Transitional Housing Program and LSS's Adolfo Permanent Housing projects

GAP

- Additional services for healthcare and corrections discharge
- Universal transition aged youth access to available services
- Coordinated diversion from the homeless system of care

STRATEGY

1. Build efforts to connect people to resources before discharge from corrections and health care institutions

ACTIONS

1A. Through contract with Sacramento County, station navigators managed by TLCS in local jails and hospitals to identify homeless individuals at intake, provide pre-release services, and connect people

to housing, community-based services, and benefits resources prior to discharge IN 2015.

Responsible Party: SSF, Re-entry Council, Hospital Council

1B. Through Common Cents street outreach, identify individuals with medical needs and connect them with appropriate housing and services IN 2016.

Responsible Party: SSF, Hospital systems

1C. Provide cross-training to partners in the corrections and health care systems about available services, housing access, and benefits/employment support IN PHASE 2.

Responsible Party: Re-entry Council, Hospital Council

1D. Undertake cost study quantifying the impact of homelessness on the healthcare and criminal justice systems and measuring the results of local interventions in IN 2016.

Responsible Party: SSF

1E. Using cost study results and mainstream resources, such as the Affordable Care Act, augment existing housing resources (e.g. T-3, Interim Care Program) for people re-entering from the corrections and health care systems such that no one becomes homeless upon exiting such institutions IN PHASE 3.

Responsible Party: Re-entry Council, Hospital Council

STRATEGY

2. Provide education to people who are homeless about using healthcare services. Provide cultural competency assistance to healthcare providers serving people who are homeless.

ACTIONS

2A. Develop educational tools to assist people who are homeless about what to expect in healthcare facilities and how to access care IN 2016.

Responsible Party: Health Committee, SSF

2B. Conduct outreach to inform homeless service providers of available educational tools IN 2016.

Responsible Party: Health Committee, SSF

2C. Develop training to support healthcare providers serving people who are homeless IN 2016

Responsible Party: Health Committee, SSF

2D. Conduct outreach to healthcare providers to improve support to serve people who are homeless IN 2016.

Responsible Party: Health Committee, SSF

STRATEGY

3. With partners in the foster care and educational systems, build on available resources to ensure all former and emancipated foster youth can access the resources available to them.

ACTIONS

3A. Partner with former and emancipated foster youth to determine barriers accessing resources IN 2015.

Responsible Party: Homeless Youth Task Force

3B. Develop plan to minimize those barriers and divert former and emancipated foster youth from homelessness IN 2016.

Responsible Party: Homeless Youth Task Force

STRATEGY

4. Develop CoC-wide diversion system to identify alternatives for households seeking shelter

ACTIONS

4A. Evaluate Common Cents data to determine characteristics of households potentially appropriate for diversion IN PHASE 2.

Responsible Party: SSF

4B. Develop policies for shelter diversion for appropriate households IN PHASE 3.

Responsible Party: SSF, Housing Committee

4C. Identify resources to support stabilization services for diverted households IN PHASE 3.

Responsible Party: SSF, Housing Committee

STRATEGY

5. Expand diversion resources for transition aged youth that are not foster care graduates

ACTIONS

5A. Identify best partners for early homeless intervention for non-foster youth, including juvenile detention systems and school districts, IN PHASE 2.

Responsible Party: Homeless Youth Task Force

5B. Link TAY-focused outreach workers to juvenile detention systems, school districts and other identified partners to link transition aged youth with service providers and targeted housing IN PHASE 2.

Responsible Party: SSF, identified partners

5C. Create family reunification vouchers for transition-aged youth IN PHASE 3.

Responsible Party: SSF | *Responsible Government Entity:* SHRA

Better

Key elements of our successful system, but room for improvement

System Navigation

A homeless system of care with the best possible housing and services available is useless if the people who need those resources are unaware of them or are unable or unwilling to access them. People who are homeless for the first time frequently are unfamiliar with the system of care and may not know where to go for assistance; others may have had negative experiences with services in the past that make it difficult to access help in the present. Coordinated entry, outreach and system navigation locate and connect homeless persons who might otherwise be underserved to the assistance they need.

The CoC Program Interim Rule requires Continuums to establish and operate a coordinated entry system. A coordinated entry system is intended to end the often fragmented and luck-of-the-draw manner of entering many homeless systems of care, and therefore to minimize the system navigation burden on people who are homeless. Coordinated entry may be through a single point of access, multi-site access, a "no wrong door" approach, or though services like 2-1-1, and involves client assessment using a common assessment tool.

To be designated a High Performing Community under the HEARTH Act (meaning a community that is effectively implementing systems to end homelessness, a designation that brings with it funding flexibility), a Continuum must, among other requirements, demonstrate that it has "actively encouraged homeless individuals and families to participate in homeless assistance services available in that geographic area."[12] HUD has further defined this provision to mean that a Continuum has implemented a "comprehensive outreach plan, including specific steps for identifying homeless persons and referring them to appropriate housing and services in that geographic area."[13]

Current System

System navigation is cited by local stakeholders and people experiencing homelessness alike as a major need in Sacramento. Homeless respondents and local service providers indicated that many people, particularly those new to homelessness, do not know how to access assistance.

Funded by the City of Sacramento, Sacramento Steps Forward, and match partners (including healthcare providers Sutter Health, Dignity, and Kaiser as well as the California Endowment and Wells Fargo), Sacramento Steps Forward is implementing a coordinated entry and housing placement pilot system focused on chronically homeless persons and veterans in the City of Sacramento, called Common Cents. The project will target homeless persons living in geographic areas identified as having the highest homeless mortality rate and will streamline placement of these households into permanent housing. Common Cents will use the Integrated Outreach Team (described below) to identify target population members, determine eligibility, and offer placement in interim housing. Common Cents uses a standardized assessment tool (the VI-SPDAT), which identifies the level of vulnerability and appropriate housing intervention for each person assessed.

Ultimately, Sacramento's coordinated entry system will include all housing types (including emergency shelter, transitional housing and rapid rehousing) and populations (including households with children,

[12] USC 11384 (d)(3)(a)
[13] 24 CFR §578.65(i)

non-veterans, and non-chronically homeless persons). Common Cents will allow Sacramento to address potential roadblocks and make necessary changes on a small scale for a high-needs population before expansion.

The Downtown Sacramento Partnership's three outreach workers were frequently cited by community members as one of the most effective elements of the homeless system of care, though many people felt that more outreach workers with a wider geographic scope were necessary to fully reach all people experiencing homelessness in Sacramento. Additionally, Wind Youth Services' two TAY-specific outreach workers were acknowledged as very helpful for their target population, though insufficient to meet existing need. Additionally, Dignity Health funded two outreach workers for persons with mental health needs, provided by TLCS and Loaves and Fishes' Genesis program. Additional outreach workers are provided by Guest House homeless clinic (one worker) and HOPE, Inc. (two workers).

The gap in available outreach services is already beginning to be addressed. With funding from the City of Sacramento, the County of Sacramento, Sacramento Steps Forward, and The River District Business Association, the original Downtown Sacramento Partnership and Wind outreach workers have been supplemented by one new TAY outreach worker, one veterans-focused outreach worker, two general population outreach workers (one specifically targeting the River District), and two part-time outreach workers centered on the rotating Winter Sanctuary shelter locations. Two additional outreach workers (one focused on TAY and the other on veterans) are scheduled to come online during 2015. Finally, TLCS will be bringing 22 new mental health outreach workers (funded by state MHSA through a Sacramento County RFP) online in 2015 to provide outreach and intake services to homeless persons.

The outreach workers funded by the City of Sacramento work closely with the Sacramento Police Department's Homeless Impact Team. The Homeless Impact Team is dedicated to proactively working with homeless persons, linking them with services and support and acting as a liaison to outreach workers. The Homeless Impact Team consists of a Lieutenant, a Sergeant and three officers, as well as a County mental health staff person dedicated to assisting persons having mental health crises). Similarly, the outreach workers funded through the County of Sacramento will work closely with the Sacramento County Sheriff's Department.

To coordinate these efforts, Sacramento Steps Forward has established a Director of Homeless Outreach, who will ultimately oversee and coordinate the efforts of all non-mental health-specific homeless outreach workers in Sacramento. Currently, the Director of Homeless Outreach meets with the various outreach entities in a variety of regular forums to ensure that outreach workers are fully responsive to community need. Though not under the Sacramento Steps Forward umbrella, the TLCS mental health outreach workers communicate closely with the Director of Homeless Outreach; ultimately, outreach workers will connect all persons with mental health needs encountered on the streets with TLCS's team. SSF hosts a monthly Integrated Outreach Team meeting that includes all outreach workers in Sacramento, for the purposes of sharing information about resources and conducting standardized trainings.

System Navigation

OUTCOME: Outreach Workers Connect All Unsheltered Persons to Resources

INDICATOR OF SUCCESS: By 2025, reduce average length of homelessness by 50% from 2018

CURRENT RESOURCES INCLUDE

- Outreach workers managed by Sacramento Steps Forward:
  - 3 outreach workers through Downtown Sacramento Partnership
  - 2 outreach workers (1 focused on veterans) funded by the City of Sacramento
  - 1 outreach worker funded by the River District Business Association
  - 2 part-time Winter Sanctuary outreach workers funded by SSF
  - *To come online in 2015: 1 veterans-focused outreach worker funded through the County of Sacramento*
- Outreach workers managed by Wind Youth Services:
  - 4 youth-focused outreach workers
  - *To come online in 2015: 1 youth-focused outreach worker funded through the County of Sacramento*
- Outreach workers managed by TLCS:
  - 1 mental health outreach worker funded by Dignity Health
  - *To come online in 2015: 22 mental health outreach workers and funded by MHSA*
- Outreach workers managed by Genesis:
  - 1 mental health outreach worker funded by Dignity Health
- 1 outreach worker managed by Guest House
- 1 outreach worker managed by HOPE, Inc.
- Common Cents coordinated entry pilot for chronically homeless persons and veterans
- City of Sacramento Police Department Homeless Impact Team

GAP

- Coordination of existing navigators
  - Navigators trained in cultural competence for all populations including chronically homeless, youth, veterans, and people with mental health needs
    - Coordinated entry for all populations

STRATEGY

1. Implement coordinated entry system for all populations

ACTIONS

1A. Establish coordinated referral system in HMIS to allow coordinated entry referrals into permanent housing IN 2015.

Responsible Party: SSF

1B. Provide VI-SPDAT training (including VI-SPDAT, Family VI-SPDAT, and TAY assessment tool) to emergency shelter staff to begin broadening coordinated entry implementation IN 2015.

Responsible Party: SSF

1C. Cross-train all staff administering VI-SPDAT to administer Family VI-SPDAT and, when available, TAY assessment tool IN 2016.

Responsible Party: SSF

1D. Develop common entry and service standards for permanent supportive housing, transitional housing rapid rehousing IN 2016.

Responsible Party: Rapid Rehousing and Emergency Shelter Committee, SSF

1E. Develop plan to implement CoC-wide coordinated entry after expiration of Common Cents pilot IN 2016.

Responsible Party: SSF

STRATEGY

2. Ensure all outreach workers are competent to work with all populations, including youth, veterans and persons with mental illness

ACTIONS

2A. Develop trainings for working with key populations, including chronically homeless persons, youth, veterans and persons with mental illness, IN 2015.

Responsible Party: SSF (through consultation with providers for each population)

2B. Provide minimum quarterly training to all outreach workers IN 2015.

Responsible Party: SSF (through consultation with providers for each population)

STRATEGY

3. Ensure outreach workers are placed to reach all geographic areas of Sacramento

ACTIONS

3A. Conduct evaluation of outreach worker territory as compared to locations of unsheltered persons counted during Point-in-Time count, by outreach workers, and through police department service calls BIENNIALLY.

Responsible Party: SSF

3B. Assign outreach workers to identified areas of high-density unsheltered homelessness BIENIALLY.

Responsible Party: SSF

Per the 2013 Point-in-Time count, these areas include South Sacramento, Arden-Arcade, the Auburn Boulevard corridor, and Tahoe Park, in addition to the downtown area and the River District. Outreach workers have also identified Central Sacramento near Capital City Freeway as an area of need.

Employment and Education Services

In our current economic climate and rental market, rental subsidies and mainstream income supports may be insufficient for long-term housing stability; access to adequate employment can be key to successful housing outcomes. Less tangibly, employment can also provide dignity and self-respect and supports recovery for those with mental health and substance use disorders. In recognition of these realities, *Opening Doors* includes among its objectives, "Increase meaningful and sustainable employment for people experiencing or most at risk of homelessness," and Continuums of Care are expected to report to HUD that, at a minimum, 20% of participants in CoC-funded projects receive employment income.

Despite popular stereotypes, studies show that people who are homeless frequently want to work;[14] with proper support, even those with long histories of homelessness and multiple disabilities can successfully work.[15] However, effective employment programs for people who are homeless must include comprehensive services.

In Sacramento, a 2010 survey of 185 homeless men and women conducted by the Homeless Employment and Income Committee[16] indicated that while 88% of respondents were not currently employed and 47% had been unemployed for at least two years, 88% wanted to work either full- or part-time. However, 48% indicated that a disability or medical issue was a barrier to work, and 38% reported a need for disability accommodation in order to work. Homelessness itself was a major barrier for 32% of respondents, and 19% felt that appearance and lack of access to appropriate clothing made it more difficult to find work.

Employment programs that successfully serve homeless people have a few core characteristics in common:

- Strong links with homeless-specific agencies
- Thorough assessment and ongoing case management
- Job search assistance provided with little delay, to help people access employment as quickly as possible
- Basic skills assistance/training
- Follow-up and support provided after employment is secured
- Staff trained on common needs of and misconceptions about people who are homeless, as well as best practices for serving this population.[17]

Integrated Employment models seek to place people in community-based employment settings as quickly as possible, without requiring extensive employment training and other services prior to employment. Integrated Employment programs are flexible and customizable to participant needs and strengths, and may consist of paid internship programs, on-the-job training, subsidized employment and other supports to help people succeed in permanent employment. Studies have found that programs using this model increase positive employment outcomes, especially among people with disabilities, more effectively than

[14] Marrone, J., "Creating hope through employment for people who are homeless or in transitional housing," *American Journal of Psychiatric Rehabilitation*, (2005).

[15] See, e.g., Burt, M., Aron, L. Y., & Lee, E., "Homelessness: Programs and the people they serve," The Urban Institute. (1999); Rog, D. J., & Holupka, C. S., "Reconnecting homeless individuals and families to the community," *The 1998 Symposium on Homelessness Research* (Fosburg, L. & Dennis, D., eds., 1998); Theodore, N., *Homeless who can't make enough to get ahead* (Chicago Coalition for the Homeless, 2000).

[16] 2010 Homeless Employment Report

[17] Department of Labor, *Employment and Training for America's Homeless: Best Practices Guide*, 1997

those requiring extensive pre-employment services, [18] and that programs serving clients with mental illness achieve the best outcomes when they focus as much on employment services as on housing and treatment. [19]

Education is also key to increasing income and self-sufficiency. Education and training open doors to careers beyond minimum wage labor. Youth providers note that education programs for youth are particularly important, as homelessness often interrupts education for youth and young people typically do not have work experience to take the place of education.

Current System

Most employment services currently available to people who are homeless in Sacramento are mainstream resources not specifically designed to meet the needs of this population. Available income and employment services are not clearly mapped, and many people in need may not know how to access services. The *2010 Homeless Employment Report* reported that 27% of respondents had found that mainstream services agencies were not aware of services available to homeless people, and 35% cited issues such as long waiting lists, red tape, and lack of agency follow-up as employment barriers.

Employment services that *are* targeted to homeless people are commonly available through enrollment in a housing project. Some projects have strong employment outcomes; many other projects, particularly permanent supportive housing projects, have much lower outcomes. (It should be noted that lower employment outcomes are expected in most permanent supportive housing projects, which serve people with long-term disabilities who are accordingly more likely to access disability income benefits rather than employment.) Sacramento's Continuum of Care-funded projects in 2014 reported that CoC-wide, 22% of project participant households receive income from employment, slightly higher than HUD's expected minimum of 20%. Homeless people and service providers report that access to employments services is a major barrier to long-term financial stability.

Additionally, homeless people and service providers both cite criminal records as a major barrier to employment; employers are reluctant to offer positions to persons with felony records. Other employment barriers include lack of logistical supports such as transportation and childcare.

Though outcome data is not currently available, community members reported that Wheels to Work, a mobile employment counseling program providing employment services, transportation, and internet access to homeless and low-income residents is helpful, providing much-needed flexible support to people who are homeless.

To date, Sacramento has hosted four Employment Connect events, engaging over 100 businesses and corporations and resulting in more than 200 job placements for people who are homeless.

[18] *See* Cook, J. et al., "Vocational outcomes among formerly homeless persons with severe mental illness in the ACCESS program," *American Psychiatric Association*, Vol. 52(8) (2001).
[19] *See id*.

Employment Services

OUTCOME: All Persons Capable of Employment Are Connected to Appropriate Employment

INDICATORS OF SUCCESS: By 2025, 75% of non-disabled homeless youth access education services or are employed and 50% of homeless people are accessing education services or are employed.

CURRENT RESOURCES INCLUDE

- Wheels to Work
- Women's Empowerment
- Men's Empowerment
- Sacramento Employment and Training Agency (SETA)
- DHA Veterans Services
- One Stop Career Centers
- CalWORKS Welfare to Work services, including Life Success, Job Club, Vocational Assessment, Job Link, and Community Work Experience Program
- DHA-funded subsidized employment provided by Volunteers of America, Lao Family Community Development, Crossroads, and SETA
- Homeless Veterans Rehabilitation Program service provided by VOA and Sacramento Veterans Resource Center
- Employment Connect

GAP

- Adequate employment and training services
- Employment opportunities for people with criminal records

STRATEGY

1. Increase awareness of and access to existing employment programs

ACTIONS

1A. Compile resource list of existing employment programs, including eligibility criteria and program capacity IN 2015. Coordinate sharing of information through Common Cents.

Responsible Party: Homeless Employment and Income Committee

1B. Develop communications strategy to disseminate information about existing services IN 2015.

Responsible Party: Homeless Employment and Income Committee

STRATEGY

2. Explore establishment of Integrated Employment model employment programs, providing rapid access to jobs instead of extensive re-employment readiness services.

ACTIONS

2A. Assess prevalence of programmatic barriers such as "job readiness" in existing employment services IN 2016.

Responsible Party: Homeless Employment and Income Committee

2B. Assess barriers to employment for homeless persons and identify job skills at assessment/program entry IN 2016.

Responsible Party: Integrated Outreach Team, SSF

2C. Identify potential community partners to provide job placement and ongoing support services for Integrated Employment pilot project IN 2016.

Responsible Party: Homeless Employment and Income Committee

2D. Begin Integrated Employment education and outreach IN PHASE 2.

Responsible Party: Homeless Employment and Income Committee

2E. Identify employers willing to provide on-the-job training as part of an Integrated Employment pilot project IN PHASE 2.

Responsible Party: Homeless Employment and Income Committee

STRATEGY

3. Strengthen existing and develop new partnerships with employers

ACTIONS

3A. Identify Employment Liaison to communicate with employers and business associations IN 2015.

Responsible Party: Homeless Employment and Income Committee, SSF

3B. Strengthen partnerships with SETA to collaborate on employer outreach and relationship building IN 2015.

Responsible Party: SSF, Homeless Employment and Income Committee
Responsible Government Entity: SETA

3C. Develop employer education plan to reduce stigmas surrounding homelessness, criminal records, mental illness, and other common employment barriers IN PHASE 2.

Responsible Party: Homeless Employment and Income Committee

3D. In coordination with the Sacramento County Department of Human Assistance, establish Homeless Employment Pipeline to foster partnerships between employers, employment training

providers, workforce development providers, and homeless service providers IN 2016.

Responsible Party: Homeless Employment and Income Committee, SSF
Responsible Governmental Entity: DHA

3E. Host two Employment Connect events annually IN 2015.

Responsible Party: Homeless Employment and Income Committee, SSF

3F. Conduct outreach to employers; prioritize businesses that attend Employment Connect, employers in high-growth employment sectors IN 2016.

Responsible Party: Homeless Employment and Income Committee
Responsible Governmental Entity: DHA

3G. Identify subsidized training and employment resources and ensure that these resources are connected with employers IN PHASE 2.

Responsible Party: Homeless Employment and Income Committee

STRATEGY

4. Improve education and training opportunities for all homeless populations, particularly youth

ACTIONS

4A. Identify existing relationships between the CoC and the Sacramento County Office of Education (SCOE), community colleges and vocational training schools IN 2015.

Responsible Party: SSF, Homeless Employment and Income Committee

4B. Identify opportunities to build and expand partnerships with SCOE, community colleges and vocational training schools IN 2016.

Responsible Party: SSF, Homeless Employment and Income Committee
Responsible Governmental Entity: SCOE

STRATEGY

5. Increase logistical supports to employment, such as childcare and transportation

ACTIONS

5A. Identify existing childcare and transportation resources available to people who are homeless or extremely low income IN 2016. Coordinate sharing of information through Common Cents.

Responsible Party: SSF, Homeless Employment and Income Committee

5B. Using data collected through coordinated entry, HMIS and service providers, identify extent of childcare and transportation barriers to employment IN PHASE 2.

Responsible Party: SSF, Homeless Employment and Income Committee

5C. Identify resources to support expansion of childcare and transportation programs for people

who are homeless IN PHASE 2.

Responsible Party: SSF, Homeless Employment and Income Committee

STRATEGY

6. Establish coordinated employment location system

ACTIONS

6A. Identify projects demonstrating success at employment location and identify gaps in employment location services IN PHASE 2.

Responsible Party: SSF, Homeless Employment and Income Committee

6B. Explore funding to support homeless employment locators at key service providers IN PHASE 2.

Responsible Party: Homeless Employment and Income Committee, SSF

6C. Establish system to coordinate employment locators CoC-wide IN PHASE 3.

Responsible Party: Homeless Employment and Income Committee, SSF

Possibilities include creating a common contact for employers through the Homeless Employment and Income Committee, establishing a coordinator through Sacramento Steps Forward, and engaging the Sacramento Employment and Training Agency to provide coordination

6D. Create survey to supplement the VI-SPDAT for the coordinated entry system to assess employment skills and interest at entry into homeless system of care IN PHASE 2

Responsible Party: Homeless Employment and Income Committee, SSF

6E. Establish referral system to connect people with employment location services appropriate for their skills and interests IN PHASE 3.

Responsible Party: Homeless Employment and Income Committee, SSF

STRATEGY

7. Expand access to Wheels to Work

ACTIONS

7A. Conduct survey of homeless housing projects and Wheels to Work participating agencies to determine employment/income needs of residents and Wheels to Work utilization IN 2016.

Responsible Party: SSF, Homeless Employment and Income Committee

7B. Evaluate Wheels to Work program outcomes, including participants connected to employment or training resources as a result of Wheels to Work assistance, IN 2016.

Responsible Party: SSF

7C. Identify projects, geographic locations, and populations underutilizing Wheels to Work IN 2016.

Responsible Party: Homeless Employment and Income Committee

7D. Realign marketing and outreach to expand access among identified locations and populations underutilizing Wheels to Work IN PHASE 2.

Responsible Party: Homeless Employment and Income Committee

7E. Identify resources to expand Wheels to Work services to reach more persons if determined through survey process that current services are insufficient to meet need IN PHASE 2.

Responsible Party: Homeless Employment and Income Committee

Minimize Barriers

People who are homeless face many barriers to accessing housing. In particular, the hardest-to-house populations, such as persons with felony records, multiple evictions, behavioral health challenges, and long-term or chronic homelessness have historically faced difficulties affording market rate rental units and meeting the screening criteria set by property owners, managers, and landlords.

Strategies such as providing financial incentives to landlords can help mitigate the real and perceived risks associated with renting to homeless households, such as non-payment of rent, property damage, or the burden of having to deal with other potential problems caused by tenants. Financial incentives include leasing bonuses to landlords for each unit rented to homeless persons; "risk mitigation pools," which create a reserve fund that can be accessed by landlords to reimburse payments for damage and inconveniences that are not covered by a security deposit; and increased security deposits to reduce landlord concerns about potential damages.

- King County, WA provides funding for and holds management and oversight of a risk mitigation pool. Staff oversee the process of approving and submitting claims to the County for damages. Examples of typical costs include: carpet, vinyl floor, wall damage, cleaning, garbage hauling, and legal costs.[20]

Financial incentives for landlords are often paired with nonfinancial incentives that create a supportive environment for the tenant and landlord alike.[21] Nonfinancial incentives include tenant certification and recommendation programs that provide hard-to-house clients with education on topics such as budgeting, tenant rights, repairing credit, and other tools to be a responsible tenant; landlord access to support hotlines, character letters from case managers and/or respected third parties such as religious leaders, employers, or even parole officers; property maintenance for client-occupied units provided by rental assistance program or associated agencies, and clear communication with landlords about case management and other supports available to persons in scattered site housing.

Many people who are homeless have physical or other disabilities that may make it difficult to locate accessible housing. In Sacramento, 29.2% of households have a member with a disability, notably higher than the statewide average of 25.6%. Our CoC is committed to housing access for all persons regardless of disabilities and working to ensure that our projects comply with the Americans with Disabilities Act.

Additionally, many people who are homeless keep pets for companionship; policies adopted by many landlords and homeless housing providers prohibit pets for reasons of safety and potential property damage. Landlord who do allow pets often charge expensive pet deposits to secure against possible damage; funding for pet deposits is typically very limited.

- In Chico, CA, Chico Homeless Animal Outreach provides free veterinary care to pets of people who are homeless. To enable people who are homeless to seek shelter and services, Chico Homeless Animal Outreach will arrange to temporarily foster pets so that their owners do not have to give them up.

Within the homeless system of care itself, some homeless housing projects use a "housing readiness" approach to client service, which requires clients to meet prescribed standards (such as sobriety,

[20] www.kingcounty.gov/*.../DCHS/*Levy/*ProcurementPlans/*VHS_Levy_*2_3.ashx*

[21] http://partnering-for-change.org/wp-content/uploads/2011/07/Brief_RehsingStrategiesFINAL.pdf.

employment, or willingness to engage in services) prior to project admission. However, studies have shown that most households are much more successful in attaining and maintaining sobriety, employment and other indicators of wellness and stability when housing placement comes before service engagement.

"Housing First" is a homeless housing project approach recognized nationally for its success in housing and supporting people who are homeless. Projects operating using a Housing First model assist people to regain housing without preconditions such as sobriety, income, or acceptance of services. Housing First recognizes that people with health, behavioral health and other needs stabilize much more quickly and more effectively in housing, and that services are more successful after stabilization. In fact, lack of housing stability itself may cause many problems, such as engagement with the criminal justice or child welfare systems. Housing First projects offer permanent housing in conjunction with services to address needs and increase potential for independence. Studies have shown the Housing First approach to be successful with a variety of populations, including persons with serious disabilities, people with long criminal justice histories, chronically homeless persons, and families with children; it is particularly helpful for households who have been refused other housing and are least likely to seek housing on their own.

- A HUD-sponsored study of three Housing First programs serving people who are chronically homeless and have a mental illness or a co-occurring disorder found that 84% of clients were still housed after 12 months[22].

Opening Doors, the federal strategic plan to end homelessness, includes Housing First as a key strategy to end homelessness. With the adoption of *Opening Doors*, HUD and its federal partners began strongly encouraging homeless housing projects to adopt the Housing First model.

While the question of Housing First adoption is more of a spectrum than a black-and-white "Housing First" or "Not Housing First," as a general rule projects that answer "yes" to any of the following questions are not using a Housing First approach:

- Are applicants required to have income prior to admission?
- Are applicants required to be "clean and sober" or "treatment compliant" prior to admission?
- Are tenants able to be evicted for not following through on their services and/or treatment plan?[23]

Current System

Though many of Sacramento's permanent supportive housing projects self-report using a Housing First approach, more in-depth analysis is needed to determine the extent of Housing First implementation in Sacramento's system of care.

One major identified barrier to entry into the homeless housing and services system, particularly to emergency shelter, is active alcohol use; while some emergency shelter beds do not require sobriety, none allow alcohol use onsite, which anecdotal reports indicate can prevent some people, primarily chronically homeless persons with long histories of alcoholism, from engaging in services.

[22] Locke, G, Khadduri, J and O'Hara, A. *Housing Models.* Discussion Draft for the 2007 National Symposium on Homelessness Research. p. 14.

[23] US Interagency Council on Homelessness, "The Housing First Checklist: A Practical Tool for Assessing Housing First in Practice," 2013, p. 2

Currently, the Serial Inebriates Program (SIP) provides 80 beds for homeless people who are publically intoxicated; the beds are accessed through the Sacramento Police Department as an alternative to jail, and once admitted to SIP a person is held for 72 hours. Program records indicate that many of these beds are used repeatedly by the same persons, sometimes for years at a time. However, because the SIP is not categorized as emergency shelter for homeless people, people accessing these beds do not meet HUDs definition of chronic homelessness, which limits their access to permanent supportive housing.

Both providers and people who are homeless report that it is especially difficult for people with criminal justice histories (particularly those with felony records) to access housing, both in homeless-specific housing projects and in community-based market housing.

Finally, the system itself is sometimes a barrier to housing people quickly; some beds in Sacramento may remain empty longer than necessary with people waiting to fill them because of administrative barriers like limited access to security deposit funds and lack of timely Housing Quality Inspections.

Minimize Barriers

OUTCOME: People Experiencing Homelessness Can Access Housing and Resources No Matter Their Needs

INDICATOR OF SUCCESS: By 2025, 100% of people who enter Common Cents can be placed in housing that meets their needs within 90 days.

CURRENT RESOURCES INCLUDE

- 80-bed Serial Inebriates Program for publically intoxicated homeless persons; accessed through Sacramento Police Department
- Some implementation of Housing First in CoC-funded permanent supportive housing
- Difficulty for homeless persons with felony records to access housing, both homeless-specific and market rate
- Mercer Veterinary Clinic serving the pets of people who are homeless

GAP

- Complete data regarding Housing First adoption in permanent supportive housing units
- Access to housing for persons with felony records
- Limited housing options for homeless people with pets
- Emergency shelter (outside the criminal justice system) for people using alcohol and other drugs

STRATEGY

1. Increase Housing First implementation in all CoC-funded permanent supportive housing

ACTIONS

1A. Collect data on admissions criteria and policies on program termination for CoC-funded PSH IN 2015.

Responsible Party: Housing Committee, SSF

1B. Identify how many PSH beds are authentically using Housing First model IN 2015.

Responsible Party: Housing Committee, SSF

1C. Among projects not implementing Housing First, determine barriers, including restrictions of other funding sources, programmatic philosophy, and neighborhood concerns IN 2016.

Responsible Party: Housing Committee, SSF

1D. Develop technical assistance support and training curriculum to build capacity among PSH projects to adopt Housing First IN 2016.

Responsible Party: Housing Committee, SSF

1E. Require CoC-funded permanent housing projects to adopt a Housing First philosophy (where possible; some programs, for example, may be limited by other funding streams) IN PHASE 2.

Responsible Party: CoC Advisory Board

1F. Evaluate the extent of Housing First implementation in CoC-funded PSH ANNUALLY.

Responsible Party: SSF

STRATEGY

2. Reduce barriers to housing for people with high needs, particularly those with criminal justice histories

ACTIONS

2A. Identify connections at local landlord associations IN 2015.

Responsible Party: CoC Advisory Board

2B. Cultivate relationships between CoC and local landlord associations IN 2015.

Responsible Party: Housing Committee, SSF

2C. Develop educational tools to reduce myths about housing high-needs persons IN 2016.

Responsible Party: Housing Committee

2D. Develop landlord outreach plan to reduce reluctance to housing high-needs persons IN 2016.

Responsible Party: Housing Committee

2E. Develop training for local service providers and housing locators on best practices for reducing landlord reluctance to rent to people with high needs, including tenant education and certification programs, character recommendation letters, on-site and off-site case management, IN 2016.

Responsible Party: SSF in partnership with Housing Committee

STRATEGY

3. Ensure CoC-funded and affordable units are accessible to persons with disabilities

ACTIONS

3A. Ensure all CoC-funded units are ADA-compliant IN 2016.

Responsible Party: Housing Committee, SSF

3B. Work with SHRA to determine accessibility and ADA compliance of affordable units IN PHASE 2.

Responsible Party: SSF

STRATEGY

4. Consider transitioning some existing sober emergency shelter beds to accommodate active users of alcohol and other drugs

ACTIONS

4A. Identify existing substance use policies of existing emergency shelters IN 2015.

Responsible Party: Emergency Shelter and Rapid Rehousing Committee

4B. Identify existing shelter beds whose funding sources do not prohibit use of alcohol/drugs IN 2015.

Responsible Party: Emergency Shelter and Rapid Rehousing Committee

4C. Develop strategy and outreach to existing shelters to consider transitioning substance use policies IN 2015.

Responsible Party: Emergency Shelter and Rapid Rehousing Committee

4D. Develop training curriculum to build capacity of existing shelters to safely accommodate active alcohol users IN PHASE 2.

Responsible Party: Emergency Shelter and Rapid Rehousing Committee, SSF

STRATEGY

5. Improve pet-friendly housing options for homeless people with pets

ACTIONS

5A. Identify existing homeless housing and shelter providers serving people with pets IN 2015.

Responsible Party: Housing Committee

5B. Determine for how many homeless people pet ownership is a barrier to housing; consider including pet ownership in supplement to VI-SPDAT assessment in Common Cents IN 2015.

Responsible Party: SSF, Integrated Outreach Team

5C. Explore creation of a "foster care" program to temporarily care for pets of people who are currently in emergency shelter, until pets can be reunited with owners IN 2015.

Responsible Party: Housing Committee

5C. Establish fund to provide pet deposits for people who are homeless with pets IN PHASE 2.

Responsible Party: SSF, Housing Committee

Community Engagement

People who are homeless often have no option but to sleep on sidewalks, in parks, in cars parked on streets or in parking lots, or in other public places. Other community members frequently worry that people living in public places may present a public safety risk, decrease property values, or become a nuisance to the neighborhoods' other residents.

Many CoCs also struggle with neighborhood resistance to location of nearby homeless housing and services projects. Some communities fear that these projects may reduce their housing values, damage neighborhood quality of life, or be a safety concern. On the contrary, however, studies have shown that single-family home values near to affordable housing projects are not adversely affected,[24] and introduction of affordable housing also does not appear to increase crime rates and may in fact reduce crime in neighborhoods in which it replaces run-down buildings.[25]

While the ideal solution to this problem is ending homelessness altogether (through strategies addressed elsewhere in this Plan), there are actions CoCs can take to minimize community resentment of homelessness in the present. In a 2012 report, the US Interagency Council on Homelessness in partnership with the Department of Justice and the Department of Housing and Urban Development identified community engagement strategies to help increase community support of Continuum of Care activities, including:

- Engage stakeholders from a wide variety of affiliations, including local elected officials and policymakers, consumers, businesses, law enforcement, and community members to engage in communitywide planning processes to address homelessness.
- Increase opportunities for community collaboration on homelessness through donation drives, volunteer opportunities, and education. [26]

Other strategies for engaging community members around homelessness in a positive manner include:

- Listening respectfully to community concerns
- Implementing strategies to mitigate fears and providing well-researched education when fears are based on misconceptions
- Fully communicating the supportive services aspects of the project to community members to convey that high-needs residents will have support and that neighbors will have someone to reach in case of problems
- Ensuring that new developments are designed attractively and built with high-quality materials and that existing properties are well-maintained.[27]

Engagement with community members does not need to begin with concerns about a specific housing project. Proactively cultivating relationships with local elected officials, the faith community, and other neighborhood leaders can minimize resistance later on.

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[24] Paul M. Cummings and John D. Landis, *Relationships between Affordable Housing Developments and Neighboring Property Values*, (Univ. of California at Berkeley, Sept. 1993)

[25] Urban Institute, The Impacts of Supportive Housing on Neighborhoods and Neighbors (April 2000)

[26] US Interagency Council on Homelessness, "Seeking out Solutions: Alternatives to the Criminalization of Homelessness," 2012, p. 3

[27] Corporation for Supportive Housing, "Thinking Beyond NIMBY," March 2006

- In San Diego, the Downtown San Diego Partnership implemented a unique approach to conducting community engagement and homeless outreach together. With support of local elected officials in a selected neighborhood, the Partnership began by working with law enforcement to address non-indigent crime, such as drug trafficking. Next, neighbors (particularly those who had expressed concerns about homelessness) were invited to participate in a "registry week" to count homeless residents and conduct intakes and assessments. A week later, the team returned with on-site services, and worked to connect individuals with nearby housing and services. Finally, the Partnership worked with community groups such as Rotary clubs to beautify former homeless encampments. This approach allowed the community to house many people and connect them to services, educate members of the public, and increase community ownership in neighborhood welfare during and after the event.

Current System

Stakeholders report that in many areas of the Continuum, communities are poorly informed about the realities of homelessness and are reluctant to accept the development of new housing projects.

The CoC has made significant progress on community engagement in a number of forums during the last several years. During the 2014-2015 Winter Sanctuary fundraising drive, Rev. Rick Cole of the Capital Christian Center drew much local attention to the realities of homelessness and raised more than $100,000 for the rotating winter shelter program by living as a homeless man for two weeks. Additionally, Sacramento Steps Forward's Executive Director has been invited to speak in community forums about homelessness.

Community Engagement

OUTCOME: Neighborhoods and municipalities are accepting of homeless projects; projects are engaged with and responsive to community concerns.

INDICATOR OF SUCCESS: By 2025, increase level of community-based donations (i.e. private, business, faith-based donations) to homeless programs (Winter Shelter, One Day to End Homelessness, other programs as determined by SSF) by 50%.

CURRENT RESOURCES INCLUDE	GAP
• Neighborhood reluctance about siting of homeless projects • Increasing community engagement on homeless issues	• Broad community support of and engagement in homeless issues

STRATEGY

1. Develop public engagement program sensitive to the needs of different neighborhoods

ACTIONS

1A. Identify areas with particularly strong concerns about homelessness and identify key community leaders in those areas **IN 2015.**

Responsible Party: SSF

1B. Begin targeted outreach to identified community leaders to learn about neighborhood concerns **IN 2015.**

Responsible Party: SSF

1C. Determine neighborhood appropriate for an outreach and community engagement event such as that implemented in San Diego **IN 2015.**

Responsible Party: SSF

1D. Conduct regular neighborhood engagement events in identified areas of concern **IN 2015.**

Responsible Party: SSF

Different

Dramatic shift in thinking needed

Performance Measurement

Performance measurement is a systematic process for gathering information to determine how well individual projects and a system as a whole are meeting identified needs; CoCs should use that information to adjust efforts to improve results. Successful performance measurement allows a CoC to minimize duplication of services, understand whether existing efforts are meeting needs, communicate successes to increase community support, and ensure that limited resources are working effectively to reduce and eventually end homelessness.

Effective performance measurement, both at a project and at a system level, relies on evaluation of *outcomes* rather than *outputs.* Outcomes are what is changed or gained as a result of a system's or project's work; examples of outcomes include housing destination, change in income, and returns to homelessness. Outputs are what a system or project does, such as how many people receive services, or how much a project spends per person served.

For many years, HUD has required that CoC-funded projects report their success in assisting clients to exit to permanent housing, retain stable housing, and access employment. In many CoCs, this measurement was conducted through an annual competitive review process through which projects were ranked based on scores calculated on these metrics and other criteria. HUD then required these project rankings be reported as part of a CoC's annual application for Continuum of Care funds.

Though the performance of individual projects remains important to determining the use of CoC dollars and identifying projects that may need assistance (and HUD still requires an annual evaluation and ranking of CoC-funded projects), with the passage of HEARTH in 2009, emphasis shifted away from only project-level evaluation toward system-wide performance measurement. HEARTH[28] and HUD[29] identify the following system-wide indicators of CoC success:

- Length of time homeless
- Recidivism (subsequent return to homelessness)
- Access/coverage (thoroughness in reaching persons who are homeless)
- Overall reduction in number of persons who experience homelessness
- Job and income growth for persons who are homeless
- Reduction in first time homeless
- Successful placement from street outreach
- Successful housing placement or retention in a permanent housing destination

HUD anticipates that CoCs will report progress on these performance measures using data from the sheltered and unsheltered Point-in-Time counts and unduplicated HMIS data (including both CoC- and non-CoC-funded projects participating in HMIS). HUD will set national targets for each performance measure, and continuums will also be expected to set appropriate local targets accounting for the homeless population and other circumstances particular to the community.

[28] HEARTH Sec. 247(B)(1)(a)

[29] US Department of Housing and Urban Development, "System Performance Measures," July 2014 p. 3

HUD has assured CoCs that they will not be expected to implement these performance measures in the absence of HMIS programming specifications from HUD. Though these specifications were expected in Fall 2014, CoCs are still waiting for additional guidance.

Because HUD is increasingly focused on community coordination and the performance of the CoC as a whole, some CoCs are moving away from a competition-centric project review model.

- The San Diego Regional Continuum of Care Council has a standing body, the Rating and Review Committee, which designs scoring tools (measuring exits to permanent housing, housing stability, bed utilization, fiscal accountability, CoC participation, and leverage), reviews applications, and recommends a ranked list of projects for CoC approval. Project review and a preliminary ranking occur well in advance of the national Continuum of Care Program competition. During this preliminary ranking, projects are assigned a rating of high, medium, low and failing. Projects with a rating of "high" are automatically awarded funds in the next competition, while projects with a rating of "failing" are reallocated and those funds opened for applications from the community. Projects with a score of "medium" and "low" may receive calculated funding reductions or eliminations; these projects are informed of the reasons for their rating and are asked to submit a plan for improvement. When the CoC Program competition begins, the Rating and Review Committee reviews improvement plans, any evidence of improved performance, and guidance from HUD released in the NOFA to determine whether a change of rating is warranted. A ranked list is generated from the assigned ratings. This model allows the CoC to collaborate with low-performing projects to improve, and the year-round performance review model permits the CoC to address performance issues before system-wide performance is reported to HUD.
- In Santa Clara County, CA, CoC leadership and technical assistance providers conduct Technical Assistance Reviews with each CoC-funded project to discuss performance and other key issues. Each project receives a report summarizing activities needed for improvement. During the CoC Program competition Review and Rank, each project is scored based on its response to the technical assistance report.

Current System

Project-Level Performance Measurement

For many years, Sacramento has designed its review and rank process annually, taking into consideration necessary changes from previous years, new guidance from HUD, and community priorities. The HUD Committee of the CoC Advisory Board undertakes this task, and works to create a process and scoring tool that are neutral to all funded providers, will provide needed feedback to projects on areas for improvement, and will result in a ranked list for HUD reflective of CoC priorities. However, CoC members report significant concern that in recent years, all members of the HUD Committee are also CoC-funded providers. Though providers offer an essential perspective in the design of both scoring tools and process, such a conflict of interest may result in a scoring process (or the appearance of a process) more likely to preserve the funding of existing providers than to align CoC dollars with community's needs and priorities. Though the CoC Advisory Board can and does make adjustments to the tools as recommended by the HUD Committee, the Board gives substantial deference to the HUD Committee's recommendations.

Scoring criteria include performance and outcomes (including exits to permanent housing, access to income and employment, and housing retention), budget and cost effectiveness, administrative capacity (including HUD or financial audit findings), alignment with HUD policy, and participation in CoC activities. A Review Panel, composed of non-conflicted community volunteers, reviews and scores applications. Projects scoring below a predetermined threshold may have funds fully or partially reallocated to a new project application. The Review Panel recommends funding or full or partial reallocation for each project, as well as a ranked list, to the CoC Advisory Board. The CoC Advisory Board approves the final ranked list, which is then submitted to HUD. Because the application and review process is dependent on the variable timing of the CoC Program competition, project application preparation and submission, review, scoring and appeals may happen in as few as four weeks.

Providers and Advisory Board members report that, as HUD's expectations of intentional priority setting have increased while available funds have decreased, the existing review process no longer allows for sufficient time, flexibility and expertise to align CoC funds with CoC needs. Preparation of extensive application materials on a short timeframe is burdensome for providers, and it is difficult to recruit qualified Review Panelists who are able to participate in intensive application reviews with little turnaround time. Respondents would like to implement a review system that works with providers on a more flexible timeframe to reach a result suitable for the whole continuum.

Currently, Sacramento Steps Forward, the Continuum's Collaborative Applicant, provides monitoring and technical assistance to identify and address performance issues for its subrecipients (approximately 65% of the CoC-funded projects in the Continuum). Projects that are not SSF subrecipients self-report many of their outcomes for the review and rank process; limited oversight is available to ensure that outcomes are correctly reported. Additionally, if performance issues are identified, there are limited or no resources available to non-SSF subrecipients to improve.

System-Level Performance Measurement

The Continuum reports system-level performance on these HUD-required metrics (which may change year to year) as part of the annual Continuum of Care application:

- Progress toward ending chronic homelessness (including the number of beds dedicated to and prioritized for chronically homeless persons)
- Increasing housing stability
- Increasing project participant income
- Increasing project participant access to mainstream benefits
- Using rapid rehousing as a method to end family homelessness

Ultimately, the Continuum of Care plans to work with other funders of homeless housing and services (including the Department of Human Assistance and the Sacramento Housing and Redevelopment Agency) to use these performance metrics as criteria for funding projects beyond the Continuum of Care Program.

As the Collaborative Applicant, in 2015 Sacramento Steps Forward is hiring Research Consultant to, in part, assist with the implementation of system-wide performance measures and regular performance reporting to the CoC Advisory Board.

Performance Measurement

OUTCOME: The CoC reviews the performance of all projects and provides assistance to low-performing projects as necessary. System-level performance is measured regularly and guides Continuum policymaking.

INDICATORS OF SUCCESS: By 2020, all homeless funders adopt CoC-established performance measures as funding criteria. By 2025 increase CoC-level performance on all measures. By 2025 100% of all CoC funding decisions are data-driven.

CURRENT RESOURCES INCLUDE

- Annual CoC-competition based review and ranking of CoC-funded projects; low-scoring projects may be fully or partially reallocated
- Limited system-level performance reported to HUD in annual CoC Application

GAP

- Year-round measurement of project performance
- CoC collaboration with low-performing projects to improve performance
- Full implementation of CoC performance measures; regular use of performance measures for CoC policymaking

STRATEGY

1. Establish year-round collaborative performance review for CoC-funded projects

ACTIONS

1A. Identify weaknesses of existing review and rank model using feedback from providers, review panel members, HUD Committee and CoC Advisory Board **IN 2015.**

Responsible Party: SSF, Performance Review Committee

1B. Review alternative performance review models from other CoCs, including that used in San Diego **IN 2015.**

Responsible Party: SSF, Performance Review Committee

1C. Determine ideal composition of Performance Review Committee, including local stakeholders familiar with grant-making processes, those familiar with homelessness and housing, and (possibly) limited rotating seats for at-large community representatives **IN 2015.** For process and scoring tool design, should include limited representation from CoC-funded agencies to provide context on the impact of proposed process and scoring tools on CoC projects.

Responsible Party: SSF, CoC Advisory Board

1D. Identify CoC members to invite for participation in Performance Review Committee and conduct

outreach IN 2015.

Responsible Party: SSF, CoC Advisory Board

1E. Design project performance review model and scoring tools based on alternative models and existing system in Sacramento IN 2015.

Responsible Party: SSF, Performance Review Committee

1F. During development of new performance review model, design abbreviated Review and Rank process for use in 2015 CoC competition IN 2015.

Responsible Party: SSF, HUD Committee

1G. Conduct new collaborative review process ANNUALLY.

Responsible Party: Performance Review Committee

1H. Collect feedback regarding the strengths and weaknesses of review process to improve future review ANNUALLY.

Responsible Party: HUD Committee

STRATEGY

2. Provide monitoring, technical assistance and other supports to all CoC-funded projects to comply with HUD requirements and align with CoC needs

ACTIONS

2A. Identify and apply for funding to provide CoC-wide monitoring of outcomes and compliance with HUD requirements, as well as technical assistance to help providers align with requirements, IN 2016.

Responsible Party: SSF

2B. Develop plan for monitoring of and technical assistance to non-SSF subrecipients, including identifying frequency and manner of monitoring as well as what areas to monitor and what technical assistance will be available, IN 2016.

Responsible Party: SSF

2C. Adopt CoC policy requiring participation in monitoring and acceptance of necessary technical assistance as a condition of receipt of CoC funds IN 2016.

Responsible Party: CoC Advisory Board

2D. Conduct outreach to CoC members to inform monitoring and technical assistance plan IN 2016.

Responsible Party: SSF

2E. Begin monitoring all CoC-funded projects IN 2016.

Responsible Party: SSF

2F. Incorporate monitoring findings and technical assistance plan into annual performance review process IN PHASE 2.

Responsible Party: SSF, Performance Review Committee

STRATEGY

3. Implement system-wide performance measurement for CoC policymaking

ACTIONS

3A. On release of performance measure HMIS programming specifications from HUD, work with Clarity (HMIS software provider) to design HMIS reports IN 2016.

Responsible Party: SSF

3B. Design quarterly performance report for delivery to CoC Advisory Board IN 2015.

Responsible Party: SSF

3C. Run HMIS performance reports to identify areas for improvement QUARTERLY.

Responsible Party: SSF

3D. Use system-wide performance reports to create CoC funding priorities and initiatives ANNUALLY.

Responsible Party: CoC Advisory Board, SSF

3E. Educate non-CoC projects regarding the importance of performance measurement IN 2016.

Responsible Party: SSF

3F. Provide HMIS performance reports to all providers, both CoC-funded and non-CoC-funded, QUARTERLY.

Responsible Party: SSF

3G. Develop plan to encourage performance improvement among non-CoC-funded projects IN PHASE 3.

Responsible Party: SSF, Performance Review Committee

3F. Work with other local funders (including DHA and SHRA) to use performance metrics as funding criteria IN PHASE 3.

Responsible Party: SSF | *Responsible Government Entity:* DHA, SHRA, other funders

Improve Accuracy of Homeless Family and Youth Count

In order to determine what housing and services are necessary to serve our homeless population, first we must understand the extent and attributes of that need. To that end, HUD requires each Continuum of Care to conduct a biennial census of sheltered and unsheltered people experiencing homelessness, known as the "Point-in-Time" (PIT) Count. The PIT Count is conducted on a single day/night during the last week of January, and is therefore not meant to represent the overall number of individuals who experience homelessness over the course of a year.

HUD requires each community to report not just the total number of homeless persons counted, but also information about specific household types and subpopulations. Among other reporting requirements, CoCs must report the number of single adult households, the number of households with children, and for the first time in 2013, the number of both unaccompanied minors and transition age youth (TAY).

Family and youth homelessness frequently looks very different from single adult homelessness; both populations are more likely to "double-up," rendering them not literally homeless per HUD's definition. Though the HUD definition is intended to prioritize funds for those populations with the most extreme need, counting only this population results in communities missing segments of the population who, while not "literally homeless," may have high needs and a high likelihood for entering literal homelessness in the future.

The different characteristics of family and youth homelessness also mean that traditional counting practices often fail to accurately capture the scale of need for these populations. Partnering with local school districts, which are required to identify and track homeless students, can help more accurately capture the number of homeless families with children and unaccompanied homeless youth. However, it is important to remember that schools use the federal McKinney-Vento Homeless Education Assistance Improvements Act definition of homelessness, which includes a broader population than the HUD definition. (See page 19 in Introduction for more detail.) This data can be disaggregated by residency type which includes children who are reported as unsheltered, staying in emergency shelters or motels, and students who are doubled up, but because schools identify homeless students throughout the school year, it is difficult to compare this data with the Point-in-Time count data collected for HUD.

Additionally, educational records are protected under the Family Educational Rights and Privacy Act of 1974 (FERPA). Many school districts are hesitant to share data for fear of FERPA violations; however, FERPA permits school districts to share for research and evaluation purposes statistical data that contains no mention of personally identifiable information about specific students. Under FERPA, schools may share the number of students experiencing homelessness at the time of the PIT count, including grade level, primary nighttime residence, race and gender, as long as the data contains no personally identifiable information. For Point-in-Time count purposes, schools may use personally identifiable information to de-duplicate their own count of homeless students, but may not disclose personally identifiable information to the CoC for de-duplication.

Some schools collaborate even more closely with Continuums of Care, by entering data on homeless students directly into HMIS. West Contra Costa Unified School District, in Contra Costa County, CA, completes an HMIS intake form for each homeless student at identification and/or enrollment.

Many best practices for counting homeless youth have been identified in recent years, as awareness about this population rises and HUD has begun to require specific data collection. The California Homeless Youth Project recommends the following strategies:

- Collaborate with federally-funded Runaway and Homeless Youth (RHY) programs to identify where unaccompanied youth might be located.
- Engage homeless and formerly homeless youth to inform the survey instrument development.
- Survey locations during multiple times throughout the day of the count.
- Practice culturally sensitive data collection methods that clearly inform youth about the goals of the count, give advance notice of sensitive survey questions, and stress voluntary participation.
- Understand that youth often do not associate with the term "homeless."
- Use incentives to engage youth in the count, including stipends for youth assisting with planning and enumeration, as well as in-kind gifts for youth participating in the survey.[30]

Additionally, We Count, California! developed a youth-specific survey[31] for use during the 2015 PIT Count. The survey is intended to capture not only the data HUD requires, but also information more specific to the youth experience of homelessness.

Current System

In 2013, the Sacramento Point-in-Time count, like that of many CoCs, did not make special efforts to identify homeless youth. Local youth and family service providers note that their experience of full family and youth shelters, many turnaways for lack of beds, and numerous unsheltered outreach encounters with families and (particularly) youth do not align with the low numbers reported in the 2013 PIT. To improve the accuracy of the count and capture the extent of homelessness among all populations, the Sacramento CoC began implementing some of these best practices in the 2015 PIT. The CoC collaborated with Wind Youth Services, a primary provider of services and shelter to unaccompanied minors and transition age youth, to train count volunteers and confidentially count at locations where outreach workers regularly encounter youth. Sacramento provided stipends to youth volunteers and incentives to youth survey respondents.

Improve Accuracy Of Homeless Family And Youth Count

OUTCOME: Accurate Count of Homeless Families and Youth in Sacramento

INDICATORS OF SUCCESS: By 2020, using improved data and best practices for counting each population, end

[30] California Homeless Youth Project, *Hidden in Plain Sight*, p. 7-8
[31] Available at https://drive.google.com/file/d/0ByU_wEyialhURVdRdlNGWkk4b0k/view

family and youth homelessness.	

CURRENT RESOURCES INCLUDE
• Point in Time (PIT) Count:
  ○ Uses HUD's definition of homelessness
  ○ Limited coordination with McKinney-Vento Education Liaisons
  ○ Stipends available to homeless/formerly homeless youth to participate in Count
  ○ Some youth participation in counting
	GAP
	• Year-round enumeration of homeless families and youth
	• Inclusion of students identified as homeless by school districts in PIT

STRATEGY

1. Amend PIT count methodology to include best practices for counting youth

ACTIONS

1A. Based on best practices, develop protocol for inclusion of homeless or formerly homeless youth in PIT count planning IN 2015.

Responsible Party: Homeless Youth Task Force

1B. Implement best practices for counting youth in 2017 PIT Count IN PHASE 2.

Responsible Party: SSF

1C. Develop protocol for verification and de-duplication of students identified as homeless by school districts IN 2016.

Responsible Party: SSF

1D. Verify homeless status of students identified as homeless by school districts on day of PIT Count IN PHASE 2.

Responsible Party: Homeless family/youth service providers, Homeless Youth Task Force, McKinney Liaisons
Responsible Government Entities: School districts

STRATEGY

2. Collect data on persons who are homeless under other Federal definitions

ACTIONS

2A. Establish working group to determine best way to collect data about people who are homeless under other federal definitions IN PHASE 3.

Responsible Party: SSF

2B. Review best practices of other communities collecting data on populations who are homeless under other definitions **IN PHASE 3.**

Responsible Party: Homeless Definition Working Group

2C. Adopt local data collection standard **IN PHASE 3.**

Responsible Party: CoC Advisory Board

2D. Develop PIT Count tool reflecting data collection standard **IN PHASE 3.**

Responsible Party: SSF

2E. Develop protocol to distinguish persons homeless under HUD's definition from those meeting broader local data collection standard **IN PHASE 3.**

Responsible Party: SSF

STRATEGY

3. Maintain year-round data on number of unsheltered youth and families

ACTIONS

3A. Develop training on differences in the definitions of homelessness used by the Department of Education and HUD **IN 2016.**

Responsible Party: Homeless Youth Task Force, SSF

3B. Provide training on homeless definitions to McKinney-Vento Act Liaisons, youth/family providers, outreach workers **IN 2016.**

Responsible Party: SSF

3C. Review quality of existing HMIS data pertaining to youth and determine improvement strategy, particularly for homeless youth under 18 **IN 2016.**

Responsible Party: Homeless Youth Task Force, SSF

3D. Develop protocol for regular de-duplicated counting and reporting of unsheltered families and youth encountered by outreach workers **IN 2016.**

Responsible Party: SSF

3E. Establish working group of CoC and school district personnel to explore how to integrate school district data with HMIS **IN PHASE 3.**

Responsible Party: Homeless Youth Task Force, SSF | *Responsible Government Entities:* School Districts

Mainstream Collaboration

Mainstream services providers are key partners in the fight to end homelessness. Such services include services that are available to all persons regardless of housing status, including low-income programs such as food support, healthcare, law enforcement, education systems, faith-based services, or Child Protective Services, to name just a few. They are often the first line of defense for people with unstable housing and have access to a much wider array of funding streams for services than do most homeless-specific providers. *Opening Doors* cites mainstream collaboration as a key strategy to supporting housing stability and reducing economic vulnerability.

The implementation of the Affordable Care Act, which expands Medicaid (locally, Medi-Cal) eligibility to include most people who are homeless, provides a rich opportunity to coordinate with mainstream services. With access to preventative, acute, and chronic care as well as to mental health and substance abuse services, more people will be able to achieve housing stability and ongoing wellness. With more of their clients receiving Medicaid, PSH, and other homeless programs may be able to claim Medicaid reimbursements for services they provide, thus offering access to a new source of badly needed funding. The possibility of greater integration between the homeless and healthcare systems also raises potential opportunities for data sharing regarding client eligibility, service utilization and costs, and outcomes achieved. This information has the potential to inform and improve existing practices. Service delivery will also likely evolve due to a stronger focus on outcomes rather than volume.

Current System

In Sacramento, though there are promising steps toward communication with some mainstream programs, mainstream services are largely isolated from the homeless system of care and can be difficult to engage. The Director of the Sacramento County Department of Human Assistance (which administers CalWORKS and other low-income supports) sits on the CoC Advisory Board, as does a representative of the Sacramento Police Department, a McKinney-Vento Act Homeless Education Liaison, affordable housing providers, and a County public health officer.

As noted above in System Navigation, the Sacramento Police Department has a three-member Homeless Impact Team (Impact Team), a group of officers trained in homeless-related issues who respond to service calls involving people who are homeless. The Impact Team collaborates with the Continuum of Care to connect people who are homeless to housing and appropriate service interventions, rather than the criminal justice system. Additionally, the new TLCS mental health outreach workers will provide key links between people who are homeless and the mainstream system of care.

Sacramento Steps Forward has begun partnering with many local entities that CoCs often overlook as sources of potential partnerships. For example, the Office of Emergency Services (OES) provides emergency shelter during cold and hot weather events; OES and SSF will coordinate with the faith community to open sanctuaries to protect people from weather and communicate information to people who are homeless. Sacramento Steps Forward is also working with Sacramento County Code Enforcement to educate Code Enforcement officers investigating vacant properties about where to refer homeless people who are camping. Code Enforcement officers will also notify Sacramento Steps Forward of areas in which camping in vacant buildings is a particular concern, and SSF will

direct outreach to those places. Sacramento Steps Forward has begun to coordinate with various conservation groups interested in preserving the health and safety of Sacramento's river and creek system, which many unsheltered persons use for camping.

Finally, the Sacramento CoC's partnership with the faith community is strong; for five years, more than 25 congregations have provided winter shelter on a rotating basis from late November through March. The Winter Sanctuary program provides dinner, breakfast and activities, in addition to shelter, free of charge to homeless persons.

Despite the above promising steps, homeless providers identify lack of coordination with Child Protective Services (CPS), the Department of Behavioral Health Services (DBHS), and the Department of Human Assistance (DHA) as major barriers to effective service delivery. Providers report that despite participation in CoC work from high levels of departmental leadership, services offered by DBHS and DHA remain siloed and difficult for homeless clients to access. CPS/Child Welfare System is another major barrier; due in part to limited funding and limited staff, providers report extreme reluctance from CPS/Child Welfare System to coordinate with the homeless system of care.

Mainstream Collaboration

OUTCOME: Mainstream Providers Coordinate with Homeless System of Care

INDICATORS OF SUCCESS: By 2020, 100% of eligible people who are homeless are enrolled in MediCal and have a medical home. By 2025, beginning with 2018 data, first-time homelessness is reduced by 10% year over year.

CURRENT RESOURCES INCLUDE

- Total of 28 McKinney-Vento Act education liaisons in schools
- 1 McKinney-Vento Act education liaison on CoC Advisory Board
- Sacramento Police Department Lieutenant on CoC Advisory Board
- Homeless Impact Team at Sacramento Police Department
- Rotating faith-based winter shelter encompassing 25+ congregations

GAP

- Coordination with Child Protection Services (CPS)/Child Welfare System, Adult Protective Services (APS) Department of Behavioral Health Services (DBHS) and the Department of Human Assistance (DHA)

STRATEGY

1. Increase capacity within mainstream service providers to provide prevention services before households become homeless.

ACTIONS

1A. Identify existing relationships between homeless service providers and CPS/Child Welfare System, school districts, APS, DBHS, and DHA staff to leverage **IN 2015.**

Responsible Party: SSF

1B. Establish working group to cultivate relationships with CPS/Child Welfare System, school districts, APS, DBHS, and DHA **IN 2016.**

Responsible Party: SSF | *Responsible Government Entities:* DHA, DHBS, APS, CPS/Child Welfare System, school districts

1C. Develop strategies for long-term coordination with CPS/Child Welfare System, school districts, APS, DBHS, and DHA **IN PHASE 2.**

Responsible Party: Mainstream Coordination Working Group, SSF

1D. Provide training to mainstream organization staff on best practices for homelessness prevention and serving families and youth who are homeless or at-risk **IN PHASE 2.**

Responsible Party: Mainstream Coordination Working Group, SSF
Responsible Government Entities: DHA, DHBS, APS, CPS/Child Welfare System

STRATEGY

2. Leverage Affordable Care Act implementation to increase healthcare service available to people who are homeless.

ACTIONS

2A. Submit public comment on proposed 1115 Medicaid waiver to advocate for use of Medi-Cal funds to pay for supportive services to the State of California **IN 2015.**

Responsible Party: SSF

2B. Evaluate potential to build partnerships between housing providers and providers eligible to bill for Medi-Cal **IN 2015.**

Responsible Party: SSF

2C. Support providers interested in becoming eligible to bill for Medi-Cal services **IN 2015.**

Responsible Party: SSF

Crisis Response

Intervening quickly to prevent homelessness or end a homeless episode as quickly as possible is key to reducing overall homelessness in a community. Homelessness is a traumatic experience that disrupts every aspect of a household, and may have long-term consequences to physical and mental health, education and employment opportunities, and the ability to maintain stable housing long term. These impacts are particularly apparent among children, and childhood housing instability and homelessness is an indicator of future homelessness.[32] Homeless children are at high risk of becoming homeless themselves as adults and perpetuating the cycle of housing loss and instability.

Early intervention strategies identifying households in crisis and providing short-term assistance to improve stability have been effective in many communities.

Homeless Prevention

Prevention assistance is appropriate for individuals and families who are currently housed but are at imminent risk of becoming homeless; e.g. persons renting a unit and facing eviction for nonpayment of rent and/or utilities, living in housing that has been condemned or declared uninhabitable, are temporarily or unstably doubled-up with friends/family or couch-surfing, or staying in a hotel/motel (for which they are paying).

Analysis of data from the federally funded Homeless Prevention and Rapid Re-Housing Program (HPRP), a time-limited program that funneled $1.5 billion in prevention and rapid rehousing funding to communities over three years, identified several strategies used by the most successful community-based prevention programs:

- Utilization of partnerships with providers, agencies, community leaders, and other mainstream entities that interact with people who may be at risk of homelessness
- Targeting people who are most likely to become homeless based on local HMIS or other data, or risk factors used by similar communities
- Performance improvement through constant review of shelter admission data to analyze who received prevention assistance but still became homeless and who was not provided assistance and became homeless
- Providing "just enough" resources to directly resolve a particular household's specific and immediate barriers to getting or keeping housing, and to prevent its near-term recurrence

When effectively targeted, homeless prevention interventions can cost one-sixth the average cost of a stay in a shelter, according to a U.S. Department of Health and Human Services study of homeless prevention programs.[33] However, it should be noted that during HPRP implementation, many communities found it difficult to effectively identify those persons who are most likely to become homeless, and to determine the minimum resources necessary to resolve barriers.

[32] Burt, Martha R. "Demographics and Geography: Estimating Needs" for the 1998 National Symposium on Homelessness Research.

[33] U.S. Department of Health and Human Services Office of the Inspector General (1990). Homeless Prevention Programs. [OIG: 07-90-00100]. Washington, DC: Author. http://www.oig.hhs.gov/oei/reports/oei-07-90-00100.pdf.

- In western Massachusetts, mediation with landlords through housing court preserved housing for up to 85% of single adults with serious mental illness facing eviction. Compared to the housing outcomes of similar people who were waitlisted but did not receive services, the Western Massachusetts Tenancy Preservation Project reduced the number who became homeless by at least one-third.[34]
- In New York City, the Homebase Community Prevention Program provides intensive case management and limited financial assistance to families that are at risk of homelessness but not currently residing in the shelter system. A study of 295 families with children from 2010 to 2013 demonstrated that the assistance provided by Homebase reduced the time participants spent in emergency shelter from an average of 32.2 nights over two years to 9.6 nights. The study calculated that the prevention program saved taxpayers an average of $2,235 per participant in shelter costs.[35]

Currently, there are limited funding sources for homeless-specific prevention assistance. The Emergency Solutions Grant program may provide prevention resources to households living in situations as described above who are can be given to individuals and families that fall in this category, have income below 30% AMI, and lack resources and support networks that would prevent them from moving into an emergency shelter. Currently in Sacramento, ESG resources provide rapid rehousing services with a preference to families with children. The Supportive Services for Veteran Families program also allows use of funds for prevention services; currently in Sacramento, this funding provides rapid rehousing.

However, "homeless prevention" includes all efforts to prevent homelessness, including connecting people at risk of homelessness with mainstream resources and traditional community supports, such as family and faith groups.

Rapid Rehousing

The HEARTH Act promotes "short-term flexible subsidies to overcome barriers to rehousing, support services concentrating on improving incomes to pay rent, coupled with performance measures emphasizing rapid and permanent rehousing," (i.e., rapid rehousing) as a housing model effective at reducing homelessness. As such, Congress encouraged HUD to provide incentives to communities who successfully implement rapid rehousing projects. Per HEARTH, the Continuum of Care Program now provides funding for rapid rehousing projects; thus far CoC funding for rapid rehousing has been limited to homeless families with children.

In addition to its success addressing homelessness for low-barrier families, rapid rehousing has been shown to be an effective housing model for a much wider segment of the homeless population. According to the National Alliance to End Homelessness, approximately 10% of single adults in the United States are chronically homeless, and an additional 9% are episodically homeless (repeat shelter users who are not chronically homeless). These numbers suggest that as many as 81% of single homeless adults are "transitionally homeless;" for these people, homelessness is likely to be

[34] Burt, M, Pearson, C and Montgomery, AE. Community-Wide Strategies for Preventing Homelessness: Recent Evidence, J Primary Prevent (2007) 28:213–228, p.219

[35] Abt Associates, "Evaluation of the Homebase Community Prevention Program," June 2013, p. 13-14.

short-term and many will stabilize with short-term assistance such as rapid rehousing (or transitional housing, for special populations such as survivors of domestic violence).

- A 2014 US Department of Veterans Affairs study of all veterans exiting the Supportive Services for Veteran Families (SSVF) program between October 1, 2011 and September 30, 2012 found that approximately 84% of single veterans and 90% of veterans in families did not experience subsequent episodes of homelessness in the year after receiving rapid rehousing assistance. The study found that there was no significant relationship between income level at program entry and the likelihood of experiencing subsequent homeless episodes, indicating that households of all income levels may be successfully served with rapid rehousing assistance. (The study notes, however, that the low rates of re-entry into homelessness may be in part attributed to the substantial number of veterans transitioning from SSVF to HUD-VASH, a permanent supportive housing program for veterans.)[36]
- In Portland, Oregon, the Transitions to Housing Program provided short-term emergency rental assistance to over 1,300 individuals and families who were newly housed after homelessness or at-risk of becoming homeless. Twelve-month estimates in 2006 showed that 71 percent of households retained permanent housing free of rent assistance and households, on average, increased their monthly income by almost 35 percent.[37]
- In Connecticut, three years after receiving rapid rehousing assistance, 82% of singles and 95% of families remained stably housed.[38]
- Though successful implementation of rapid rehousing for youth generally requires longer-term financial assistance and case management support than that necessary for other populations, rapid rehousing remains a viable intervention for non-chronically homeless youth that is less expensive than transitional housing.[39]

Rapid rehousing funds are available nationally through HUD's CoC and ESG programs, as well as the VA's Supportive Services for Veterans Families program. In California, the CalWORKS Housing Support Program in 2014 provided $20 million to support families receiving CalWORKS who are homeless or at risk of homelessness, including through rapid rehousing.

Transitional Housing

Historically, the only housing alternative for households that did not require the extensive supports provided by permanent supportive housing was long-term (12-24 months) congregate transitional housing; however, in recent years evidence has shown that many populations traditionally served through transitional housing projects are served more effectively and more efficiently through other housing models, particularly rapid rehousing. Though transitional housing remains an eligible

[36] Byrne, Thomas. "Housing Outcomes of Veterans Following Exit from the Supportive Services for Veteran Families (SSVF) Program," February 2014, p. 3.
[37] National Alliance to End Homelessness, "A New Vision: What is in Community Plans to End Homelessness?", November 2006, p. 27.
[38] Connecticut Coalition to End Homelessness, "Three Years Later, Did Rapid Re-Housing Work in Connecticut?" October 2013
[39] National Alliance to End Homelessness, "An Emerging Framework for Ending Unaccompanied Youth Homelessness," p. 3-4.

project type under the Continuum of Care Program, HUD requires that communities use resources strategically, considering research, project design, and outcomes when determining the role of transitional housing in the Continuum. HUD has specifically indicated that survivors of domestic violence, youth and persons with substance abuse treatment needs can be effectively served in transitional housing projects.

- In Alameda County, California, 192 families were rapidly rehoused at an average cost of $2,587 per household, compared with $25,000 average cost for a successful exit from transitional housing. Only 3% of the families rapidly rehoused returned to shelter within 12 months.[40]

Current System

As of the 2014 Housing Inventory Count (HIC), Sacramento had 22 shelter programs; 311 of our shelter beds are for individuals, 300 (74 units) are for families and 6 are for unaccompanied children. In late 2014, Sacramento County funded a new 9-bed TAY emergency shelter. Our 19 transitional housing programs average 100% utilization; 525 of these beds are for individuals, 411 (148 units) are for families, and 189 are for youth.

Though the 2014 HIC reports an average emergency shelter utilization rate of 86%, local providers report that that number (from a single point in time) is an anomaly. For example, in February 2015 Next Move's family emergency shelter turned away 96 households with children and was able to admit only 30 families.

Exits to permanent housing from our emergency shelters and transitional housing are low: 33% of persons exiting emergency shelter and 74% of persons leaving transitional housing projects go to permanent housing.

Community members and consumers have told us that homelessness prevention services are one of the biggest gaps in the community.

Since the publication of the 2014 HIC, Sacramento has established a significant stock of rapid rehousing for families. The Sacramento County Department of Human Assistance (DHA) can rapidly rehouse 400 families between December 2014 and June 2015; DHA expects that funding to continue. Additionally, DHA can serve an additional 50-60 Welfare to Work eligible families per year. Volunteers of America can rapidly rehouse 180 homeless families per year, and plans to transition some or all of those units to serving homeless individuals during 2015. Finally, Sacramento received funding for 81 units of rapid rehousing for families through the 2014 Continuum of Care competition. Currently, there are as many as 640 units of rapid rehousing for families available annually in Sacramento; by the end of 2015, Sacramento may have 541 rapid rehousing units for families and 180 for single adults each year, for a total of 721 rapid rehousing units.

[40] National Alliance to End Homelessness *Rapid Re-Housing Successes*, 2012

Crisis Response

OUTCOME: Homeless crisis response system is oriented around prevention, not shelter

INDICATORS OF SUCCESS: By 2025, beginning with 2018 data, percentage of people accessing diversion, prevention or rapid rehousing instead of shelter or no services increases year over year.

CURRENT RESOURCES INCLUDE

- 617 emergency shelter beds; average stay ~50 days
  - 311 for individuals
  - 300 (74 units) for families
  - 6 for unaccompanied children
  - 9 bed TAY shelter
- 1,125 transitional housing beds at 100% capacity; average stay ~8.72 months
  - 525 for individuals
  - 411 (148 units) for families
  - 189 for transition aged youth (limited to former foster youth)
- 400 rapid rehousing beds for CalWORKS families operated by DHA
- 180 ESG rapid rehousing units preferencing families with children operated by VOA
- TAY drop-in center in Midtown
- Renters helpline operated by Sacramento Self-Help Housing

GAP

- Prevention resources
- Mainstream coordination

STRATEGY

1. Determine whether current mix of existing emergency shelter, transitional housing and rapid rehousing meet community needs.

ACTIONS

1A. Collect data from coordinated intake system regarding appropriate housing interventions for people accessing the homeless system of care **IN 2015.**

Responsible Party: SSF

1B. Collect data regarding the number of available emergency shelter, transitional housing, and rapid rehousing units, including eligibility requirements and geographic location, **ANNUALLY.**

Responsible Party: SSF

1C. Assess efficacy of current transitional housing projects. Review populations served, housing and income outcomes, possible barriers to conversion (including property use covenants) IN 2016.

Responsible Party: SSF

1D. Assess, based on Point-in-Time, coordinated intake, outreach worker and provider data the needs of people experiencing homelessness in Sacramento and the appropriate interventions ANNUALLY.

Responsible Party: SSF, Strategic Planning Steering Committee

1E. Align underutilized beds and services as appropriate per evaluation ANNUALLY.

Responsible Party: SSF, CoC Advisory Board

STRATEGY

2. Develop rapid rehousing beds for single adults

ACTIONS

2A. Determine the number of rapid rehousing units needed to serve single adults IN 2016.

Responsible Party: SSF, Housing Committee

2B. Explore converting existing Emergency Solutions Grants-funded rapid rehousing to serve single adults IN 2016.

Responsible Party: SSF, Volunteers of America (current recipient of ESG rapid rehousing)
Responsible Government Entity: SHRA

2C. Review existing Continuum of Care transitional housing stock to determine number appropriate for reallocation to rapid rehousing based on population served, outcomes, and other criteria determined by CoC ANNUALLY.

Responsible Party: SSF, Performance Review Committee

2D. Provide support and technical assistance to providers converting existing rapid rehousing for families and transitional housing units to ensure that new rapid rehousing projects are implemented in accordance with best practices for the target population IN 2015.

Responsible Party: SSF

2E. Identify additional potential sources of funding for rapid rehousing for single adults IN PHASE 2.

Responsible Party: SSF, Housing Committee

STRATEGY

3. Develop temporary housing assistance with wraparound services (including rapid rehousing and/or transitional housing) for transition-aged youth

ACTIONS

3A. Determine the number transition-aged youth in need of housing supports other than PSH IN 2016.

Responsible Party: SSF, Housing Committee

3B. Determine if existing Continuum of Care-funded transitional housing is appropriate for conversion to rapid rehousing for transition-aged youth ANNUALLY.

Responsible Party: SSF, CoC Review Panel

3D. Provide support and technical assistance to providers converting existing transitional housing units to ensure that new rapid rehousing projects are implemented in accordance with best practices for serving youth IN 2015.

Responsible Party: SSF

3E. Identify additional potential sources of funding for temporary housing assistance with wraparound services for transition-aged youth IN PHASE 2.

Responsible Party: SSF, Housing Committee

STRATEGY

4. Access homeless prevention resources

ACTIONS

4A. Convene community conversation to determine best use of ESG resources IN 2015.

Responsible Party: SSF, CoC Advisory Board, VOA, Emergency Shelter and Rapid Rehousing Committee
Responsible Government Entity: SHRA

4B. Identify and commit possible local resources for homeless prevention IN 2016.

Responsible Party: SSF, Strategic Planning Steering Committee

STRATEGY

5. Target prevention resources to priority groups

ACTIONS

5A. Establish working group of CoC members (Homeless Prevention Working Group) to determine need and eligibility criteria for prevention resources IN PHASE 2.

Responsible Party: SSF

5B. Review available data sources to identify need for prevention resources, including VI-SPDAT data and families identified by school districts as unstably housed, IN PHASE 2.

Responsible Party: Homeless Prevention Working Group, SSF

5C. Determine best method to deliver prevention resources to identified populations IN PHASE 2.

Responsible Party: Homeless Prevention Working Group, SSF

STRATEGY

6. Expand existing renters' helpline; coordinate with mental health services.

ACTIONS

6A. Evaluate effectiveness of existing renters' helpline to determine best elements for expansion **IN 2016.**

Responsible Party: SSF

STRATEGY

7. Develop partnerships with mainstream partners, including Legal Services of Northern California, the Sacramento Rental Housing Association, and McGeorge School of Law to provide diversion services and eviction defense

ACTIONS

7A. Identify existing CoC relationships with Legal Services of Northern California, Sacramento Rental Housing Association, and McGeorge School of Law **IN PHASE 3.**

Responsible Party: SSF, CoC Advisory Board

7B. Establish working group to leverage existing relationships, coordinate and target services **IN PHASE 3.**

Responsible Party: SSF

Regional Collaboration

HEARTH and the CoC Interim Rule place strong emphasis on collaboration with all relevant entities within a Continuum of Care; in a CoC the size of Sacramento, with extensive geographic, economic and political diversity, special effort must be made to engage these agencies from all areas of the Continuum. Though HEARTH does not require CoCs to engage with entities beyond Continuum borders, because homelessness is a borderless issue and populations are fluid between communities, coordination across jurisdictional borders is the next appropriate step.

Coordination Among Jurisdictions Within Sacramento County

Collaboration among jurisdictions within a CoC's geographic area may be informal, through regular relationship-building and communication, or folded into CoC operations, perhaps with representation from each local government body on the CoC board. Some CoCs may have formal partnerships, such as a Joint Powers Authority (JPA), which may act on behalf of each member jurisdiction in specified matters.

- In Solano County, six of the Continuum's incorporated cities as well as the county formed the Community Action Partnership (CAP) Solano JPA to address the issues of homelessness and poverty. The CAP Solano JPA is the CoC collaborative applicant, the HMIS lead, and the state-designated Community Action Agency for receipt of Community Services Block Grant funds.

Current System

Sacramento's Continuum of Care encompasses the cities of Citrus Heights, Elk Grove, Folsom, Galt, Isleton, Rancho Cordova, and Sacramento, many populous unincorporated areas, and rural regions within the geographic boundaries of Sacramento County.

Currently, the City of Citrus Heights occupies a seat on the Continuum of Care Advisory Board; the representative reports on CoC issues to the Citrus Heights City Council. A Sacramento City Council Member, Sacramento County Supervisor, and the Sacramento County DHA Director also serve on the Advisory Board. Additionally, the Sacramento County Board of Supervisors, the Sacramento City Council, and individual elected representatives of other cities in the CoC have expressed interest in increased involvement in the Continuum of Care. Also, both the City of Sacramento and Sacramento County have dedicated funds for Continuum of Care outreach workers and emergency shelter or motel voucher beds, and the City of Sacramento is funding the CoC's coordinated entry pilot Common Cents. However, there is no existing forum for formal engagement with the Continuum's local governmental bodies.

The American River Conservancy, an advocacy organization dedicated to preserving the American River corridor for natural and recreational purposes, is concerned about the impact of homeless encampments along the river. Because the river stretches through a number of the incorporated cities in Sacramento County as well as unincorporated areas, this forum could provide an opportunity for increased intra-County communication and coordination. Sacramento Steps Forward's Executive Director has recently accepted a seat on the Board of Directors.

Coordination with the unincorporated areas of the County is informal, but promising. Members of the County Board of Supervisors regularly reach out to Sacramento Steps Forward to resolve

homeless-related issues in their districts; Sacramento Steps Forward is able to dispatch outreach workers to assist people experiencing homelessness in these areas. The Sacramento County Sherriff's Department has expressed strong interest in partnering with the Sacramento Steps Forward outreach workers on a more formal basis.

Because the Cities of Citrus Heights, Elk Grove, and Rancho Cordova receive Community Development Block Grant funds and are eligible to apply for Emergency Solutions Grants funds through the State of California (access to which funds is contingent upon coordination with the Continuum of Care) enhanced collaboration with these entities in particular must be a top priority in Sacramento.

Coordination with Surrounding Continuums of Care

Formal collaboration between Continuums of Care is as yet limited, though many regions have found a multi-county CoC the most efficient way to address homelessness. Additionally, there are many cross-county partnerships on other issues, particularly related to transportation and development.

- The Greater Richmond Continuum of Care coordinates efforts to end homelessness in the City of Richmond, VA, and seven neighboring counties. Homeward, the Continuum of Care's Collaborative Applicant, manages the HMIS for the region, identifies services gaps, implements the regional 10-year Strategic Plan, and provides technical assistance and community outreach. The Continuum of Care Board includes representatives from each of the member jurisdictions, as well as homeless service providers, health care providers, and the philanthropic sector.
- The Association of Bay Area Governments (ABAG) is a collaborative effort of all nine San Francisco Bay Area counties (Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, and Sonoma) and all Highway 101 area cities. ABAG is governed by a 38-member Executive Board composed of local elected officials; Board membership is based on population. ABAG administers the region-wide San Francisco Estuary Partnership, the Hazardous Waste/Green Business Program, the Bay Trail Project, and the Earthquake and Hazards Program, and also engages in regional planning work.

Current System

Sacramento County is bordered by the Yolo, Sutter/Yuba, Nevada/Placer, El Dorado, Central Sierra, San Joaquin, and Solano Continuums of Care. Sacramento Steps Forward representatives regularly attend regional gatherings of homeless system of care stakeholders from across Northern California, including neighboring communities. More formally, in 2013 the Yolo County Continuum of Care merged HMIS implementations with Sacramento; while this merger has not yet resulted in inter-CoC coordination, there are opportunities here for cross-system performance measurement and homeless enumeration. The City of West Sacramento (located in Yolo County) is separated from Sacramento by only the American River; therefore there is much movement between the two Continuums and therefore enhanced need for coordination.

In 2013, Sacramento engaged in conversations with El Dorado County regarding a possible merger. While the proposed merger did not take place at that time, the Sacramento Continuum of Care may wish to reconsider a regional CoC approach in the future.

In addition, the Sacramento Area Council of Governments (SACOG) is an association of local governments in the six-county Sacramento Region, including the counties of El Dorado, Placer, Sacramento, Sutter, Yolo and Yuba.

With a focus on transportation, SACOG also serves as a forum for the study and resolution of regional issues, including distribution of affordable housing in the region.

Regional Collaboration

OUTCOME: All jurisdictions within the Sacramento CoC are engaged with CoC activities. Response to homelessness is coordinated with efforts from neighboring counties.

INDICATOR OF SUCCESS: By 2025, reduce homelessness across the 8-CoC region by at least 25%.

CURRENT RESOURCES INCLUDE

- Representation from the City of Citrus Heights, City of Sacramento, and County of Sacramento on CoC Advisory Board
- City of Sacramento and County of Sacramento dedicated funds to CoC for homeless outreach
- Collaboration with Sacramento County Sherriff regarding homelessness in rural areas
- Joint HMIS implementation with Yolo CoC

GAP

- Formal collaboration with remaining cities
- Forum for regular intra-CoC jurisdictional engagement on homelessness
- Inter-CoC regional communication and collaboration

STRATEGY

1. Create forum for coordination between jurisdictions within the Sacramento CoC

ACTIONS

1A. Identify entities responsible for homeless-related issues at the County of Sacramento and each of the incorporated cities IN 2015.

Responsible Party: SSF

1B. Conduct outreach to identified individuals to establish a Regional Collaboration Committee IN 2015.

Responsible Party: SSF

1C. Develop plan for regular communication with elected officials from each jurisdiction IN 2016.

Responsible Party: Regional Collaboration Committee

1D. Explore interest among County jurisdictions in creating a Joint Powers Authority to address housing and homelessness issues in IN PHASE 3.

Responsible Party: SSF, Regional Collaboration Committee
Responsible Government Entities: County of Sacramento, Cities within County geography

Possible strategies include quarterly written reports and recurring updates at Board of Supervisors and City Council meetings.

STRATEGY

2. Create forum for inter-CoC collaboration

ACTIONS

2A. Reach out to Continuum of Care leadership for the seven neighboring CoCs, with particular emphasis on the Yolo, Nevada/Placer, and El Dorado CoCs as those with most population exchange with Sacramento IN 2016.

Responsible Party: SSF

Regular communication may begin through existing forums attended by these CoCs, including the quarterly Northern California/Central Valley Homeless Roundtable.

2B. Explore interest in creating a Regional Housing Task Force to share information and align regional priorities, comprised of representatives from all CoCs in the Sacramento region, and encompassing CoC stakeholders as well as CDBG representatives and affordable housing developers IN 2016.

Responsible Party: SSF

2C. Leverage joint HMIS implementation with Yolo county to discuss HMIS needs, data quality, and inter-CoC performance IN PHASE 3.

Responsible Party: SSF

2D. Approach Sierra Health Foundation and Sacramento Regional Community Foundation for possible sponsorship of inter-CoC collaboration IN PHASE 3.

Responsible Party: SSF

STRATEGY

3. Re-open discussions regarding possible mergers with neighboring CoCs

ACTIONS

3A. Examine Continuum of Care governance structure, funding history, political will and stakeholder engagement in neighboring CoCs IN PHASE 3.

Responsible Party: SSF

3B. Determine whether partnership with any neighboring CoCs may be beneficial to both parties IN PHASE 3.

Responsible Party: CoC Advisory Board

3C. Approach identified Continuums of Care to determine interest in merger IN PHASE 3.

Responsible Party: SSF

3D. If merger agreed upon, request HUD technical assistance to facilitate merger process IN PHASE 3.

Responsible Party: SSF

Appendix A: Data and Community Engagement

DATA REVIEWED

Local data sources used to inform this plan are:

- 2013 Unsheltered/Sheltered Point-in-Time Count
- 2014 Housing Inventory Count
- HMIS reports
- Zero: 2016 Analysis

COMMUNITY ENGAGEMENT

Between August 2014 and April 2015, HomeBase and Sacramento Steps Forward engaged with a diverse group of stakeholders including local government representatives, homeless housing and services providers, currently and formerly homeless persons, mental health professionals, law enforcement, the faith community, youth advocates, business leaders, interested community members and others in a variety of forums:

- Strategic Action Planning Summit in September 2014, attended by 60 stakeholders
- Weekly blog posts/email blasts to a diverse listserve of interested parties from August-November 2014
- Electronic surveys regarding needs and priorities from August-November 2014
- Interviews with currently homeless persons
- Interviews with key local stakeholders
- Local Subject Matter Expert groups on youth, crisis response, housing development, and behavioral health

A list of acknowledgements may be found on Page 2 of this plan.

Appendix B: Data-Related Strategies

Topic	Strategy	Action	Responsible Party	Completion Date
Permanent Supportive Housing	1. Determine number of additional permanent supportive housing units necessary, including number of units needed for subpopulations	1A. Evaluate information collected during the Point-in-Time and Housing Inventory Counts in conjunction with Zero: 2016 analysis to determine necessary housing stock.	SSF	2015
		1B. Collect annual data regarding the number and target population of existing PSH beds to identify underserved populations.	SSF	Annually
		1C. Assess annually, based on Point-in-Time, HMIS, coordinated intake, outreach worker, institutional (such as hospitals and school districts) and provider data the needs of people experiencing homelessness in Sacramento and the appropriate interventions.	SSF, Performance Review Committee	Annually
		1D. Recommend for realignment (e.g. voluntary transition to more appropriate project type, reallocation to a new project, etc.) beds and services not aligned with identified needs per evaluation.	Performance Review Committee	Annually
	2. Increase number of CoC-funded PSH beds prioritizing chronically homeless persons	2A. Review number and target population of existing Continuum of Care PSH beds prioritizing (see definition of "prioritizing" on page 25) chronically homeless persons through turnover.	SSF	2015
		2B. Identify beds that should be prioritized to chronically homeless persons and are not.	SSF	2015
		2C. Determine turnover rate of prioritized beds.	SSF	2015
	3. Create new permanent supportive housing units; some units should target specific populations	3A. Review existing Continuum of Care transitional housing stock to determine number appropriate for reallocation to PSH.	Performance Review Committee	Annually
Affordable Housing	1. Determine how much affordable housing accessible to homeless people and current residents of permanent supportive housing is necessary to meet community need	1C. Evaluate information collected during survey, Point-in-Time and coordinated entry data to determine necessary affordable housing stock to serve people who are currently homeless or able to transition from PSH.	SSF	2016
		1D. Conduct evaluation of existing affordable housing stock targeting Extremely Low Income (30% AMI or below) households, including unit	SSF	2015

		size, target population and income targets.		
		1E. Biennially issue recommendation for creation of new affordable housing units accessible for homeless people and PSH residents	SSF, Housing Committee	Biennially
	3. Support efforts to maintain and increase affordable housing for extremely low-income households in Sacramento.	3A. Inventory existing Single Room Occupancy (SRO) units, including location and management of units.	Housing Committee	2015
Behavioral Health Services	2. Evaluate behavioral health needs of people experiencing homelessness	2A. Review aggregate data from coordinated entry assessments, Point-in-Time count, HMIS, outreach worker data (including Impact Team evaluation) and other system entries to determine behavioral health needs (both mental health and substance abuse) of people experiencing homelessness. Include assessment of behavioral health needs for subpopulations (veterans, youth, chronically homeless persons, seniors)	SSF	2016
		2B. Review evaluation data in partnership with DBHS, Guest House and Health Committee to determine appropriate system size and qualities (e.g. number of intake workers, psychiatrist hours, interventions for populations without SPMI diagnoses, cultural competency needs, etc.) to meet needs of people experiencing homelessness	SSF, DBHS, Guest House and Health Committee	2016
	4. Increase Guest House intake workers to reduce system delays	4A. Determine reasonable turnaround time from intake to services to avoid losing connection with service seekers	Health Committee	2015
		4B. Determine how many additional intake workers are necessary to reduce current turnaround time	Guest House, and Health Committee	2016
	7. Seek additional funding for expanded substance abuse treatment.	7A. Evaluate size of current substance abuse treatment system	Health Committee	2015
		7B. Draft analysis of unmet substance abuse needs, including potential practices to fill identified gaps	Health Committee, SSF	2016

Diversion and Discharge Planning	1. Build efforts to connect people to resources before discharge from corrections and health care institutions	1D. Undertake cost study quantifying the impact of homelessness on the healthcare and criminal justice systems and measuring the results of local interventions.	SSF	2016
	4. Develop CoC-wide diversion system to identify housing alternatives for households seeking shelter.	4A. Evaluate Coordinated Entry data to determine characteristics of households potentially appropriate for diversion	SSF	Phase 2
System Navigation	3. Ensure outreach workers are placed to reach all geographic areas of Sacramento	3A. Conduct biennial evaluation of outreach worker territory as compared to locations of unsheltered persons counted during Point-in-Time count, by outreach workers, and through police department service calls.	SSF	Biennially
Employment and Education Services	1. Increase awareness of and access to existing employment programs	1A. Compile resource list of existing employment programs, including eligibility criteria and program capacity.	Homeless Employment and Income Committee	2015
	2. Explore establishment of Integrated Employment model employment programs, providing rapid access to jobs instead of extensive reemployment readiness services.	2A. Assess prevalence of programmatic barriers such as "job readiness" in existing employment services	Homeless Employment and Income Committee	2016
	4. Improve education and training opportunities for all populations, particularly youth	4A. Identify scope of existing education and training opportunities targeting people who are homeless	SSF, Homeless Employment and Income Committee	2015
	5. Reduce logistical supports to employment, such as childcare and transportation	5B. Using data collected through coordinated entry, HMIS and service providers, identify extent of childcare and transportation barriers to employment	SSF, Homeless Employment and Income Committee	Phase 2
	6. Establish coordinated employment location system	6A. Identify projects demonstrating success at employment location and gaps in employment location services	SSF, Homeless Employment and Income Committee	Phase 2
	7. Expand access to Wheels to Work	7B. Evaluate Wheels to Work program outcomes, including participants connected to employment or training resources as a result of Wheels to Work assistance.	SSF	2016

		7C. Identify projects, geographic locations, and populations underutilizing Wheels to Work.	Homeless Employment and Income Committee	2016
Minimize Barriers	1. Increase Housing First implementation in all CoC-funded permanent supportive housing	1A. Collect data on admissions criteria and policies on program termination for CoC-funded PSH	Housing Committee, SSF	2015
		1B. Identify how many PSH beds are authentically using Housing First model	Housing Committee, SSF	2015
		1C. Among projects not implementing Housing First, determine barriers, including restrictions of other funding sources, programmatic philosophy, and neighborhood concerns	Housing Committee, SSF	2016
		1F. Annually evaluate the extent of Housing First implementation among CoC-funded PSH	SSF	Annually
	3. Consider transitioning some existing sober emergency shelter beds to accommodate active alcohol users	4A. Identify existing substance use policies of existing emergency shelters	Emergency Shelter and Rapid Rehousing Committee	2015
		4B. Identify existing shelter beds whose funding sources do not prohibit use of alcohol/drugs	Emergency Shelter and Rapid Rehousing Committee	2015
	4. Improve pet-friendly housing options for homeless people with pets	5A. Identify existing homeless housing and shelter providers serving people with pets	Housing Committee	2015
		5B. Determine for how many homeless people pet ownership is a barrier to housing; consider including pet ownership in supplement to VI-SPDAT assessment	SSF, Integrated Outreach Team	2015
Community Engagement	1. Develop public engagement program sensitive to the needs of different neighborhoods	1A. Identify areas with particularly strong concerns about homelessness and identify key community leaders in those areas	SSF	2015
Performance Measurement	1. Establish year-round collaborative performance review for CoC-funded projects	1I. Collect feedback annually regarding the strengths and weaknesses of review process to improve future review	HUD Committee	Annually

	3. Implement system-wide performance measurement for CoC policymaking	3D. Annually use system-wide performance reports to create CoC funding priorities and initiatives	CoC Advisory Board, SSF	Annually
Crisis Response	1. Determine whether current mix of existing emergency shelter, transitional housing and rapid rehousing meet community needs.	1A. Collect data from coordinated intake system regarding appropriate housing interventions for people accessing the homeless system of care.	SSF	2015
		1B. Collect annual data regarding the number of available emergency shelter, transitional housing, and rapid rehousing units, including eligibility requirements and geographic location.	SSF	Annually
		1C. Assess efficacy of current transitional housing projects. Review populations served, housing and income outcomes, possible barriers to conversion (including property use covenants).	SSF	2016
		1D. Assess annually, based on Point-in-Time, coordinated intake, outreach worker and provider data the needs of people experiencing homelessness in Sacramento and the appropriate interventions.	SSF, Strategic Planning Steering Committee	Annually
	2. Develop rapid rehousing beds for single adults	2A. Using annual assessment of crisis response system, determine the number of rapid rehousing units needed to serve single adults	SSF, Housing Committee	2016
	5. Expand existing renters helpline; coordinate with mental health services.	6A. Evaluate effectiveness of existing renters helpline to determine best elements for expansion in 2015.	SSF	2016

Appendix C: Population-Specific Plan Example and Implementation Questions

CHILDREN AND YOUTH

YEAR ONE EXAMPLE

NEEDS	RESOURCES	KNOWN GAPS
Information regarding needs of children and youth in Sacramento County is limited 2013-14 School Year, Sacramento County • 835 students sleeping in emergency shelters or transitional housing projects • 237 unsheltered students	Housing resources: • 1 PSH project for former foster youth, 26 beds • Coming online in 2015: 27 CH TAY units (15 adult beds for families with children and 12 single beds) • 189 transitional housing beds for transition aged youth Foster Care resources: • We Help Youth collaborative/referral network • Homeless Youth Task Force • Independent Living Skills program • VOA's Former Foster Youth Transitional Housing Program and LSS's Adolfo Permanent Housing projects Outreach resources • 4 youth-focused outreach workers through Wind • Coming online in 2015: 1 youth-focused outreach workers funded through the County of Sacramento	• Universal transition aged youth access to available services • Year-round enumeration of homeless families and youth • Inclusion of students identified as homeless by school districts in PIT • Coordination with mainstream providers, especially for prevention services

RELEVANT INDICATORS OF SUCCESS

- End family and youth homelessness by 2020
- Chronic homeless population (including youth) is zero by 2016; functional zero maintained each year.
- By 2015, less than 5% of people (including youth) who have been homeless and been housed become homeless again
- By 2020, homeless people (including youth) in need of serious behavioral health intervention consistently access services within 10 days.
- By 2025, reduce by 50% the number of people presenting to Common Cents who come directly from a system of care (e.g. foster care) or whose homelessness could have been avoided through diversion
- By 2025, 75% of non-disabled homeless youth access education services or are employed
- Using improved data and best practices for counting each population, end family and youth homelessness by 2020.
- 100% of eligible people who are homeless (including youth) are enrolled in MediCal and have a medical home
- First-time homelessness (including among youth) reduced by 10% year over year.
- Beginning with 2018 data, percentage of people (including youth) accessing diversion, prevention or rapid rehousing instead of shelter or no services increases year over year.

Organized by Phase of Implementation

Year 1: 2015		
Diversion and Discharge Planning: With partners in the foster care and educational systems, build on available resources to ensure all former and emancipated foster youth can access the resources available to them.		
ACTIONS	**RESPONSIBLE ENTITY**	**COMPLETION DATE**
Partner with former and emancipated foster youth to determine barriers accessing resources	Homeless Youth Task Force	2015

Develop plan to minimize those barriers and divert former and emancipated foster youth from homelessness	Homeless Youth Task Force	2015
System Navigation: Ensure all outreach workers are competent to work with youth		
ACTIONS	**RESPONSIBLE ENTITY**	**COMPLETION DATE**
Develop trainings for working with key populations, including youth, veterans and persons with mental illness.	SSF (through consultation with providers for each population)	2015
Provide minimum quarterly training to all workers.	SSF (through consultation with providers for each population)	2015
Employment and Education Services: Improve education and training opportunities for youth		
ACTIONS	**RESPONSIBLE ENTITY**	**COMPLETION DATE**
Identify scope of existing education and training opportunities targeting people who are homeless	SSF, Homeless Employment and Income Committee	2015
Identify existing relationships between the CoC and the Sacramento County Office of Education (SCOE), community colleges and vocational training schools.	SSF, Homeless Employment and Income Committee	2015

Improve Accuracy of Homeless Family and Youth Count: Amend PIT count methodology to include best practices for counting youth		
ACTIONS	**RESPONSIBLE ENTITY**	**COMPLETION DATE**
Based on best practices, develop protocol for inclusion of homeless or formerly homeless youth in PIT count planning	Homeless Youth Task Force	2015
Mainstream Collaboration: Increase capacity within mainstream service providers to provide prevention services before households become homeless.		
ACTIONS	**RESPONSIBLE ENTITY**	**COMPLETION DATE**
Identify existing relationships between homeless service providers and CPS	SSF	2015
Crisis Response: Develop temporary housing assistance with wraparound services (including rapid rehousing and/or transitional housing) for transition-aged youth		
ACTIONS	**RESPONSIBLE ENTITY**	**COMPLETION DATE**
Provide support and technical assistance to providers converting existing transitional housing units to ensure that new rapid rehousing projects are implemented in accordance with best practices for serving youth.	SSF	2015

DISCUSSION QUESTIONS FOR IMPLEMENTATION:

- Are there other Year One Activities?
- Who could lead this work?
- What outcomes do we expect from these activities?
- What obstacles, if any, are being encountered in achieving this outcome?
- What resources or support are needed to achieve this outcome?

Appendix D: Past Planning Efforts

2006: Ten Year Plan to End Chronic Homelessness

Mission

Prevent, and eventually eliminate, chronic homelessness by providing permanent housing and coordinated services to help individuals achieve maximum self-sufficiency.

Five Strategies:

Housing First
House chronically homeless individuals as quickly as possible in permanent housing and stabilize through flexible services.

Outreach and Central Intake
Create an effective, culturally competent, and user-friendly process to move chronically homeless people into Permanent Supportive Housing (PSH).

Prevention
Prevent individuals and families from becoming homeless.

Leadership
A coordinated countywide effort led by a broad-based leadership team of public, private and civic sector interests.

Evaluation and Reporting to the Community
Develop and implement a comprehensive evaluation plan.

2009: Sacramento Steps Forward Launched

Mission

Create a national model that ends homelessness, bringing together the ideas, insights, talents and efforts of a broad range of organizations, businesses and individuals from across the Sacramento community.
In 2010, Sacramento Steps Forward published a First Anniversary Community Report, broadening the scope of Sacramento's strategic planning work:

Five Goals:

Permanent Housing | Empowering Services | Sustainable Funding | Regional Advocacy| Real Accountability

2011: Homeless Planning Activities Centralized

In part due to County budget challenges, a planning effort in the Sacramento CoC centralized homeless planning and administration in Sacramento Steps Forward. Sacramento Steps Forward now administers federal homeless assistance grants, evaluates the impact of Sacramento's efforts to end homelessness, advocates for community support for homeless services, and facilitates the CoC Advisory Board.

Appendix E: Definitions

At Risk of Homelessness (HUD Definition):
(A) An individual or family who:

(i) Has an annual income below 30 percent of median family income for the area, as determined by HUD;
(ii) Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from becoming homeless; and
(iii) Meets one of the following conditions:
1) Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
2) Is living in the home of another because of economic hardship;
3) Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days of the date of application for assistance;
4) Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
5) Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons, or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
6) Is exiting a publicly funded institution, or system of care (such as a healthcare facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
7) Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

(B) A child or youth who does not qualify as "homeless" under HUD's definition, but qualifies as "homeless" under another federal statute; or
(C) A child or youth who does not qualify as "homeless" under HUD's definition, but qualifies as "homeless" by the Department of Education's definition, and the parent(s) or guardian(s) of that child or youth if living with her or him.

Behavioral Health: Mental/emotional well-being and/or choices and actions that affect wellness. Behavioral health problems include (but are not limited to) substance abuse and misuse serious psychological distress, suicide, and mental illness.

Chronic Homelessness:
(1) An individual who:

(i) Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

(ii) Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last 3 years; and
(iii) Can be diagnosed with substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from brain injury, and/or chronic physical illness or disability;

(2) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
(3) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Continuum of Care: A regional group organized to carry out the responsibilities required by HUD that is composed of representatives of organizations, including nonprofit homeless providers, victim service providers, faith-based organizations, governments, businesses, advocates, public housing agencies, school districts, social service providers, mental health agencies, hospitals, universities, affordable housing developers, law enforcement, organizations that serve homeless and formerly homeless veterans, and homeless and formerly homeless persons to the extent these groups are represented within the geographic area and are available to participate.

Collaborative Applicant: The party that has been designated by the Continuum of Care to apply for a grant for Continuum of Care planning funds on behalf of the Continuum.

Coordinated Entry: A centralized or coordinated process designed to coordinate program participant intake assessment and provision of referrals. A coordinated entry system covers the geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool.

Emergency Shelter: Any facility, the primary purpose of which is to provide a temporary shelter for the homeless in general or for specific populations of the homeless and which does not require occupants to sign leases or occupancy agreements.

HEARTH Act: The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 required formalization of Continuum of Care structure, emphasized the importance of prevention, rapid rehousing, and ending chronic homelessness, and shined a renewed spotlight on outcomes.

High Performing Community: HUD will annually, subject to the availability of appropriate data, select those Continuums of Care that best meet application requirements to be designated a high-performing community (HPC). An HPC may use grant funds to provide housing relocation and stabilization services, and short- and/or medium-term rental assistance to individuals and families at risk of homelessness. This is the only time that Continuum of Care funds may be used to serve individuals and families at risk of homelessness.

Homelessness: Homelessness is defined differently by different federal agencies:

Department of Housing and Urban Development (HUD):
The definition of a homeless person includes:
(A) An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:
- (i) An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;
- (ii) An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, State, or local government programs for low-income individuals); or
- (iii) An individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution;

(B) An individual or family who will imminently lose their primary nighttime residence, provided that:
- (i) The primary nighttime residence will be lost within 14 days of the date of application for homeless assistance;
- (ii) No subsequent residence has been identified; and
- (iii) The individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, needed to obtain other permanent housing;

(C) Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:
- (i) Are defined as homeless under section 387 of the Runaway and Homeless Youth Act (42 U.S.C. 5732a), section 637 of the Head Start Act (42 U.S.C. 9832), section 41403 of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2), section 330(h) of the Public Health Service Act (42 U.S.C. 254b(h)), section 3 of the Food and Nutrition Act of 2008 (7 U.S.C. 2012), section 17(b) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)), or section 725 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a);
- (ii) Have not had a lease, ownership interest, or occupancy agreement in permanent housing at any time during the 60 days immediately preceding the date of application for homeless assistance;
- (iii) Have experienced persistent instability as measured by two moves or more during the 60-day period immediately preceding the date of applying for homeless assistance; and
- (iv) Can be expected to continue in such status for an extended period of time because of chronic disabilities; chronic physical health or mental health conditions; substance addiction; histories of domestic violence or childhood abuse (including neglect); the presence of a child or youth with a disability; or two or more barriers to employment, which include the lack of a high school degree or General Education Development (GED), illiteracy, low English proficiency, a history of incarceration or detention for criminal activity, and a history of unstable employment; or

(D) Any individual or family who:
- (i) Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the

individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence;
(ii) Has no other residence; and
(iii) Lacks the resources or support networks, e.g., family, friends, and faith-based or other social networks, to obtain other permanent housing.

Department of Education:
The term homeless children and youths —
(A) means individuals who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 103(a)(1)); and
(B) includes —
(i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;
(ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 103(a)(2)(C));
(iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and
(iv) migratory children (as such term is defined in section 1309 of the Elementary and Secondary Education Act of 1965) who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii).

Runaway and Homeless Youth Act:
A homeless youth is a person
(A) who is —
(i) less than 21 years of age, or, in the case of a youth seeking shelter in a youth center, less than 18 years of age or is less than a higher maximum age if the State where the center is located has an applicable State or local law (including a regulation) that permits such higher maximum age in compliance with licensure requirements for child- and youth-serving facilities; and
(ii) for the purposes of transitional living centers, not less than 16 years of age and either
1) less than 22 years of age; or
2) not less than 22 years of age but within the maximum stay length and completing a stay started before reaching 22 years of age;
(B) for whom it is not possible to live in a safe environment with a relative; and
(C) who has no other safe alternative living arrangement.

Housing Inventory Count: A count of housing available to homeless persons, carried out on one night in the last 10 calendar days of January as required by HUD.

Homeless Management Information System (HMIS): An information system, designated by the Continuum of Care and required by HUD, used to track participation in federally-funded homelessness projects.

Permanent Housing: Community-based housing without a designated length of stay, including both permanent supportive housing and rapid rehousing.
Permanent Supportive Housing: Permanent housing in which supportive services are provided to assist homeless persons with a disability to live independently.

Point-in-Time Count: A count of sheltered and unsheltered homeless persons carried out on one night in the last 10 calendar days of January as required by HUD.

Rapid Rehousing: Supportive services and/or short-term (up to 3 months) and/or medium-term (3 to 24 months) tenant-based rental assistance and accompanying appropriate services as necessary to help a homeless individual or family, with or without disabilities, move as quickly as possible into permanent housing and achieve stability in that housing.

Serious and Persistent Mental Illness: A mental disorder, other than other than alcohol or drug disorders, organic brain syndromes, developmental disabilities or social conditions, that causes extended impairment in functioning, including such a disorder that is currently controlled by medical or psychiatric treatment.

Transitional Housing: Housing for which all program participants have signed a lease or occupancy agreement, with the purpose of facilitating the movement of homeless individuals and families into permanent housing within 24 months or such longer period as HUD determines necessary. The program participant must have a lease or occupancy agreement for a term of at least one month that ends in 24 months and cannot be extended.

VI-SPDAT: Vulnerability Index & Service Prioritization Decision Assistance Tool, the standardized assessment tool chosen by the Sacramento Continuum of Care and Common Cents to place chronically homeless people in appropriate housing and services.