SACRAMENTO
STEPS FORWARD

Ending Homelessness. Starting Fresh.

REQUEST FOR PROPOSALS

Coordinated Access Navigation (CAN) Team for the Coordinated Access System

RFP Released on: Thursday, June 16, 2022
Proposers Conference: Thursday, June 23, 2022
Mandatory letter of intent to apply: Friday, July 1, 2022 at 5p.m.
RFP Closes on: Friday, July 22, 2022 at 5p.m.

Sacramento Steps Forward (SSF) is a private non-profit organization committed to ending homelessness in the region through collaboration, innovation and connecting people to services.

GENERAL INFORMATION

Background

Sacramento County's current homeless crisis response system, overseen by the Continuum of Care (CoC) and supported by Sacramento Steps Forward (SSF), encompasses the universe of homeless assistance programs intended to assist people experiencing literal homelessness and those who are imminently facing literal homelessness. Generally, this includes street outreach programs, drop-in centers, emergency shelters, transitional housing, rapid rehousing, permanent supportive housing, and targeted homelessness prevention programs. Despite many ongoing efforts to address the homeless crisis, the current system of care is not able to meet the need. In 2020, data indicated that 11,222 people engaged with the system, with nearly half engaging for the first time. One quarter were either connected to housing or self-resolved and did not need further support. 8,417 people were left waiting in a housing crisis.

Sacramento County lacks a fully developed, community-wide coordinated access system. The pathway an individual or family follows to initially connect with crisis services to address a housing need varies widely and is often siloed, inhibiting access to the broader complement of community homeless crisis response services and rehousing assistance. Currently, there are 33 emergency shelters and transitional housing programs that provide 1,684 beds for 1,099 singles, and 195 families with minor children.[1] Homeless assistance agencies utilize various data systems with limited information sharing, creating challenges for households facing homelessness who need, effective, coordinated rehousing assistance.

The Coordinated Access System (CAS)

Under contract with SSF, 2-1-1 Sacramento, operated by Community Link Capital Region, will act as a universally available, virtual front door for people experiencing homelessness or at-risk of experiencing homelessness in Sacramento County. Call center staff employed by Community Link will be available 24 hours a day, 7 days a week to conduct a preliminary standardized screening and provide remote (via phone) housing problem-solving conversations that explore safe, alternative housing options and connection to diversion resources.

Households in need of housing support and resources will be routed to a CAS care coordinator. Based on triage questions and initial problem-solving, 2-1-1 will facilitate a connection or referral to homelessness prevention assistance and services if emergency shelter is not needed that night. Eligible clients in need of emergency shelter, will be referred by 2-1-1 to shelter using the Homeless Management Information System (HMIS) based on client needs, eligibility, and availability. Selected street outreach and problem-solving access points will also be able to triage households to emergency shelter based on immediate needs, through a referral to 2-1-1. This will help increase access for clients who lack a phone or prefer to seek assistance via outreach or a site-based access point. In the event that emergency shelter is not available, and they cannot be further supported by a care coordinator, the household will be placed on a waitlist household and connected to either a CAS outreach provider, PSAP or Coordinated Access Navigation (CAN) Team for immediate engagement, additional problem-solving, and navigation to available shelter and/or rehousing resources.

Please see Appendix A for key terms and definitions.

[1] Based on the 2021 HIC inventory, not including temporary warming shelters.

Summary

SSF seeks to fund one or more eligible entities to provide CAN Team services as part of the Coordinated Access System (CAS). The successful applicant(s) will employ up to eighteen (18) full-time, dedicated navigator staff to provide housing problem-solving, system navigation, and access to problem-solving funds (one-time financial assistance to resolve housing crises) administered by SSF. The selected CAN Team provider(s) will utilize SSF's HMIS and relevant CAS protocols to track and coordinate services with system partners, as further described below and the Proposal Information section of this RFP.

SSF will award an initial one-year contract from October 01, 2022 to September 30, 2023, with opportunity for further renewal. SSF will review provider performance, compliance, and the ability to continue successful operation of the CAN Team before determining renewal funding for the following year starting October 1, 2023. SSF reserves the right to renew, discontinue, or competitively rebid funding for CAN Team services.

Important Dates

- RFP Release: Thursday, 6/16/22
- Proposers Conference: Thursday, 6/23/22 from 9am-10am
- Mandatory Letter of Intent to Apply: Friday, 7/1/22
- Questions Due to SSF: Thursday, 7/7/22
- SSF Response to Questions: Monday, 7/11/22
- **Submission Due: Friday, 7/22/22**
- Interviews with RFP respondents (if necessary): by Monday, 8/15/22
- (SSF/CoC) Proposal Evaluation and Selection Process: Monday, 7/25/22 – Friday, 8/26/22
- Contractor Selection Date: Friday, 9/2/22
- Contract Execution Date: Friday, 9/30/22

Submission Instructions

RFPs submissions are due by 5p.m. on Friday, July 22, 2022. Please submit proposals to RFP@sacstepsforward.org. The proposal should be no more than ten (10) pages. Following receipt of the proposals, SSF may ask additional questions of the respondents.

Questions?

Questions regarding this Request for Proposals should be directed to RFP@sacstepsforward.org by 5p.m. on Thursday, July 7, 2022.

Proposers Conference Information

Thursday, June 23, 2022 from 9 a.m.- 10 a.m.

Link: https://us02web.zoom.us/j/83080825010

Meeting ID: 830 8082 5010
One tap mobile
+16699009128,,83080825010# US (San Jose)
+12532158782,,83080825010# US (Tacoma)

Find your local number: https://us02web.zoom.us/u/keAQVseyIP

PROPOSAL INFORMATION

Coordinated Access services, including those provided by Coordinated Access Navigators, are intended to help:

1. Improve accessibility to emergency shelter, rehousing assistance, and other crisis services and supports.
2. Prevent or quickly end homelessness or housing instability whenever possible.
3. Increase the number of households who successfully resolve their housing crisis.
4. Increase system equity, including equitable access through individualized problem-solving, support, and resource navigation.

Key Performance Indicators

The following indicators will be monitored by SSF to determine CAN Team performance and areas for improvement. Indicators may be revised during initial piloting

- Number of unique households provided CAN Team assistance, including demographic data.
- Average length of time from 2-1-1 referral to CAN Team intake.
- Number and percent of households successfully diverted from emergency shelter to other safe temporary or permanent housing.
- Number and percent of households successfully connected and admitted to emergency shelter.
- Number and percent of households referred to prevention assistance and other services and resources.
- Average length of time from CAN Team intake to enrollment in one or more forms of homeless assistance (street outreach, shelter, etc.) or successful housing resolution.
- Average amount of financial assistance provided.

Guiding Service Delivery Principles

The following guiding principles should be used to guide development, delivery, and ongoing improvement of Coordinated Access Navigation Team services:

- Stable housing is a necessary and evidence-based foundation for personal and community well-being. Unstable housing and homelessness cause both personal and community harm. Everyone deserves the opportunity to have decent, safe, and stable housing.
- People should be treated with dignity and respect, regardless of their current conditions, and afforded as much self-determination as possible.
- Community responses to housing instability and homelessness should be person-centered, systematic, coordinated, easily accessed from any location in the county, effective, efficient, and equitable.
- Services must be provided by people who are trained and capable of providing trauma-informed, crisis-oriented, and culturally aware and appropriate services, with **priority for people with lived expertise**, to engage people facing homelessness effectively and efficiently. This requires active engagement, problem-solving, and intentional efforts to inform individuals of

available services and options that best meet their needs and preferences, and a centered focus on equity and self-determination.

CAN Team Services and Responsibilities

The following outlines key services and responsibilities to be provided by the CAN Team, in coordination with other Coordinated Access System providers and SSF.

- With client consent, utilize HMIS to record intakes, assessments, services, and outcome data. HMIS will be the primary database to track and monitor outcomes, progress, and length of time for referrals. HMIS recording requirements will be documented in the operations manual.
- Develop CAN Team staff coverage and caseload plan in consultation with SSF, 2-1-1 and CAS Operations Team. The plan will address geographic coverage and other unique caseload considerations (e.g., CAN staff with more specialized focus/expertise, such as for families, persons with severe and persistent mental illness and/or substance abuse issues, etc.). At least one Navigator must exclusively serve transition age youth (TAY) who are 18-24 years old and may be unaccompanied or have minor children. Proposals may include potential staffing and caseload configurations across CAN staff, including but not limited to geographic coverage areas, partnerships and on-site staffing at defined access points and community-based locations where people seeking access to shelter may be engaged, and/or specialized roles and sub-population expertise and scope.
- Accept referrals from 2-1-1 during the hours of 8 a.m. to 8 p.m. for clients eligible for and wanting emergency shelter, but for whom immediate placement in is not possible due to capacity, required admission steps (e.g., clearing a warrant), lack of transportation, or other reasons. This includes actively collaborating with 2-1-1 to accept and manage referrals via HMIS-based referral pending (wait) list. CAN staff will be expected to be mobile and meet people seeking access to shelter where they are currently located, when safe and appropriate, to facilitate and expedite access to shelter and other assistance. As needed, the CAN Team will coordinate with 2-1-1 and other CAS providers to prioritize referrals based on date/time added to referral pending list and other factors to be determined.
- The CAN Team will coordinate with SSF and other CAS partners and access points to offer on-site support and navigation assistance at select locations and at select community events (e.g., outreach events, health fairs, etc.) to assist people with in-person system navigation and shelter access. This may include providing on-site CAN staff during defined periods at select locations (e.g., libraries, drop-in centers, hot meal programs, health centers, etc.) across Sacramento County according to a publicly communicated schedule. Proposals may include recommended locations and partnerships for site-based CAN staffing and navigational support services. The agency(ies) selected to provide CAN Team services will be expected to work in concert with SSF, local municipalities, and county representatives to identify, advertise, and provide CAN services at various locations.
- CAN staff <u>will not</u> do general outreach and case-finding among people who have not expressed interest in shelter or other services.

- The CAN Team will be expected to have a flexible schedule and be available to support people seeking shelter during evenings and weekends, in addition to normal business hours.
- The CAN Team will ensure contact within 24 hours of referral from 2-1-1 to apprise clients of the expected wait time and offer any available alternatives; contact clients who remain on referral list at least every 7 days to confirm the client is still experiencing literal homeless and desires emergency shelter.
- In general, Coordinated Access Navigators will be expected to engage with clients seeking shelter for brief periods and only if needed to access shelter or other next step rehousing assistance.
- For active clients enrolled with the CAN Team and being actively supported:
    - Each Navigator will be expected to maintain an active caseload of no more than 25 and no less than 15 households (families and/or individuals).
    - Navigators will:
        - Coordinate with street outreach and Coordinated Access System providers to ensure streamlined client support and facilitated access to emergency shelter, rehousing, and other crisis services.
        - Continue to provide active housing problem-solving, mediation, family re-unification (when appropriate and safe), and other strengths-based assistance to quickly resolve literal homelessness, including assistance to identify any available safe alternative housing options that prevent the need for a shelter placement or other literal homeless experience, including actively connecting clients to other immediate and/or ongoing prevention and housing stabilization services.
        - Provide individualized support to connect with next step (back-door) coordinated access assistance for rehousing services, including for clients not eligible for any emergency shelter or who no longer desire emergency shelter.
        - Upon notification by 2-1-1 of available shelter option, re-assess immediate client situation, confirm need and desire for emergency shelter, and facilitate shelter placement.
        - Offer transportation assistance and guidance for managing, storing, and otherwise transporting client personal belongings.
        - Offer and support any client in providing meeting additional emergency shelter admission requirements (e.g., providing photo ID, clearing warrants, etc.).
        - Facilitate case transfer with emergency shelter staff and client and ensure successful placement.
- To support client needs and facilitate access to other services, the CAN Team will establish formal screening, triage, and referral protocols with other service partners, including but not limited to the following:
    - Mental, physical, and behavioral healthcare providers and resources, including providers offering free or low-cost services, mobile services, etc.

    - Workforce training and employment assistance, including WIOA funded jobs centers and related services.
    - Public assistance benefits, including cash and non-cash forms of assistance and health insurance.
    - Emergency food pantries, meal programs, and clothing providers.
    - Domestic and intimate partner violence providers, including providers and resources for survivors of human trafficking.
    - Child and adult protective services providers.
    - Other crisis and non-crisis services commonly needed and desired among people facing homelessness.

- At minimum, CAN direct service staff and supervisors must receive initial and ongoing training in the following:
    - Coordinated access and other system policies and procedures, including outreach and emergency shelter providers, criteria, and coordination/admission requirements.
    - Housing problem-solving.
    - Trauma-informed care and crisis intervention practices.
    - Housing First concepts and best practices.
    - Mental health first aid.
    - Substance abuse and supports, including administration of emergency interventions (e.g., administration of Narcan in event of a client overdose).
    - Positive youth development.
    - Child abuse and neglect
    - Mandatory reporting requirements related to child welfare, elder abuse, duty to warn, etc.

- Applicants are strongly encouraged to hire people with lived expertise and include related costs for staff recruitment, training, and retention. The application must describe specific efforts to recruit and retain people with lived experience at every level of service and management of the CAN Team. Applicants must include a compensation package that accounts for local cost of living needs, including establishment of starting wages/salaries at or above local housing wage minimums necessary to afford a one-bedroom apartment ($22.85/hour).[2]

- Applicants are encouraged to consider CAN Team partnerships that result in more robust and specialized services, expertise, and access for people facing homelessness. This may include proposed subcontractors that would function in an integrated and seamless manner with other CAN Team members. Proposed subcontractors must be identified and a description of their organizational experience and capacity must be included.

[2] https://reports.nlihc.org/oor/california

Minimum Applicant Experience and Qualifications

- Experience providing services, developing service plans and resource referrals with vulnerable populations.
- Knowledgeable about and/or has leveraged resources available within the community via formal and informal partnerships.
- Familiar with the Homelessness Management Information System (HMIS) or a willingness to be trained and use HMIS for client data collection, service coordination, and reporting purposes.
- Providers currently funded by the City of Sacramento and/or the Sacramento County must be compliant with current partnership agreements and funding contracts.

Evaluation Criteria

SSF and CoC partners will validate and evaluate all proposals received. All requirements identified in this RFP must be satisfied to ensure that a proposal will qualify for consideration. Proposal Evaluation Criteria are outlined below.

Demonstrated Experience and Capacity – 10 pts

Demonstrates experience, client satisfaction especially with the unhoused population, successful outcomes providing services including problem-solving, individualized and trauma-informed navigational support, facilitated access to prevention, shelter, rehousing, and other resources, community partnerships, and ability to perform data collection.

Service plan - 15 pts

Clearly defined approaches to ensure standardized use of tools, equitable and accessible resource coverage, broad and collaborative partnerships.

Staffing – 15 pts

Staffing roles and expectations, caseload size, project timeframe, and budget aligned to meet the needs of the project. Emphasizes equitable and affirmative hiring practices that support employment opportunities for people with lived expertise, including recruitment and retention.

Quality Assurance and Continuous Improvement – 10 pts

PROPOSAL CONTENTS

1. **Organization**
    a. Applicant Organization Information
        i. Organization name, address, website
        ii. Point of contact for this proposal and contact info
        iii. Executive director/CEO name, contact info
        iv. ED/CEO signature, including certification statement (true/complete, will/can adhere to SSF and funding requirements)
        v. Require Table of Organization as attachment and non-profit status/IRS exemption
    b. Subcontractor Organization Information (include space for 2-3)
        i. Organization name, address, website
        ii. Point of contact for this proposal and contact info
        iii. Executive director/CEO name, contact info

2. **Experience and Capacity**

    Describe the following (for applicant and all proposed subcontractors):

    a. Experience providing mobile, on-demand, and individualized navigation and case management assistance for vulnerable populations. Address any specific experience, services provided, and success related to assisting people experiencing a housing crisis, including homelessness, people who are severely and persistently disabled, and/or people who face personal and systemic barriers to services and/or housing assistance.
    b. Experience partnering with organizations and entities that serve or otherwise encounter people experiencing or who are at risk of homelessness. Address partnerships with health care, workforce, housing, homeless assistance, basic needs services, and other key service partners.
    c. Experience hiring, supporting, and empowering people with lived expertise. Include any efforts to address racial inequities.
    d. Capacity and experience related to collecting, entering, and obtaining reports from HMIS or similar enterprise level client information system, and using data for service and performance monitoring and evaluation.
    e. Capacity and experience related to insurance requirements, authorization, record-keeping, and billing, specifically for CalAIM.
    f. Any current or outstanding audit or monitoring findings from public sources
    g. Identify if CARF, COA, and/or JCHO accredited and, if so, for any services included in the proposal. Address years accredited, next accreditation.
    h. Capacity/experience obtaining other Federal, state, local public and private funding.

3. **Service Plan**

    a. Approach to developing or furthering broad and collaborative partnerships, including but not limited to community providers, business partners, health care agencies, and

outreach/drop-in centers. Include roles and responsibilities of current key partners, including any identified in first section and others.

b. Approach to adopting and implementing standardized screening, engagement and housing problem-solving, individualized navigational assistance, and service coordination.
c. Approach to addressing inaccessibility to resources, especially among BIPOC populations and underserved areas.
d. Approach to issuing flexible financial assistance, if currently or previously administered. Address basic accounting controls and flexibilities that support expedited access (as it will be required to work with SSF in establishing a workflow for financial assistance requests).
e. Description of how people with lived expertise will be involved in the design, delivery and ongoing improvement of CAN Team services.
f. Include a summary of the characteristics and service needs of people seeking emergency shelter who may also need navigational supports.

4. Staffing

a. Proposed staffing chart to show proposed FTE by position title and consistent with RFP: an active caseload of no more than 25 and no less than 15 households (families and/or individuals). Provide a summary of each position, including roles and responsibilities, education, experience, and skill requirements.
b. Proposed staff to client ratio (for all direct service staff). Address potential staffing and caseload configurations, including but not limited to geographic coverage areas, partnerships and on-site staffing at defined access points, other community-based locations where people seeking access to shelter may be engaged. Describe any specialized roles and sub-population expertise and scope.
c. Approach to recruitment and retention of employees with lived expertise of homelessness, including equitable and affirmative hiring practices.
d. Example daily staffing schedule showing capacity for 211 referrals from 8 a.m. to 8 p.m. and flexible evening/weekend hours to ensure availability when needed. Describe approach for ensuring access to live staff support and backup coverage plan.
e. Inservice and staff training requirements, timeframes, and tracking approach. Describe how your agency will provide and ensure updated training for all CAN Team members related to the following:
    i. Coordinated access and other system policies and procedures, including outreach and emergency shelter providers, criteria, and coordination/admission requirements.
    ii. Housing problem-solving.
    iii. Trauma-informed care and crisis intervention practices.
    iv. Focus subpopulations - BIPOC, cultural sensitivity, LGBTQ, survivors, and youth.
    v. Housing First concepts and best practices.
    vi. Mental health first aid.
    vii. Substance abuse and supports, including administration of emergency interventions (e.g., administration of Narcan in event of a client overdose).

viii. Child abuse and neglect
ix. Mandatory reporting requirements related to child welfare, elder abuse, duty to warn, etc.

f. Describe any additional training CAN Team members will receive.

5. Quality Assurance and Continuous Improvement

a. Plan for ongoing program monitoring accounting for KPIs included in RFP and other key quantitative and qualitative indicators. Describe additional KPIs and CQI processes.
b. Plan for ensuring that clients are involved in planning and improvement process. Address strategy for gathering on-going client feedback, particularly as it relates to program improvements.

Appendix A

Key Terms and Definitions

Access Point: as defined by HUD, "access points are the places–either virtual or physical–where an individual or family in need of assistance accesses the coordinated entry process. These can include the following examples:

a. a central location or locations within a geographic area where individuals and families present to receive homeless housing and services;
b. a 211 or other hotline system that screens and directly connects callers to appropriate homeless housing and service providers in the area;
c. a "no wrong door" approach in which a homeless family or individual can present at any homeless housing and service provider in the geographic area but is assessed using the same tool and methodology so that referrals are consistently completed across the CoC;
d. a specialized team of case workers that provides assessment services at provider locations within the CoC; or
e. a regional approach in which "hubs" are created within smaller geographic areas."[3]

Centralized or Coordinated Assessment System ("Coordinated Access"): The CoC Program interim rule at 24 CFR 578.3 defines centralized or coordinated assessment as the following: "…a centralized or coordinated process designed to coordinate program participant intake assessment and provision of referrals. A centralized or coordinated assessment 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…." HUD considers the terms "Centralized or Coordinated Assessment System" and "Coordinated Entry Process" to be interchangeable.

Sacramento Steps Forward uses the term "Coordinated Access" to represent these same concepts and functionalities, further distinguishing Coordinated Access as involving two inter-related, but distinct features:

1. **Coordinated access to initial crisis response, prevention, and homeless assistance ("front-door" access),** with a focus on immediate housing problem-solving and diversion to avoid homelessness or otherwise facilitate coordinated access to available shelter and other homeless assistance.

2. **Coordinated access to rehousing assistance ("back door" access),** with a focus coordinated and standardized rehousing assessment and access to rehousing assistance, including one-time housing search/move-in assistance, Rapid Rehousing, and Permanent Supportive Housing.

Housing Problem Solving (HPS): Strategies and services that assist households to use their strengths, support networks, and community resources to find safe, decent, and appropriate housing as soon as possible outside of the homeless crisis response system, even if temporarily.

[3] Notice: CPD-17-01. Notice Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System. U.S. Department of Housing & Urban Development. https://www.hud.gov/sites/documents/17-01CPDN.PDF